DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF NEW WHITELAND	532 COUNTRY GATE DRIVE NEW WHITELAND, IN 46184

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00459080 and IN00459388. Complaint IN00459080 - No deficiencies related to the allegations are cited. Complaint IN00459388 - State deficiencies related to the allegations are cited at R52. Survey dates: May 16 and 19, 2025 Facility number: 016046 Residential Census: 66 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed May 20, 2025.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense A. Based on observation, interview, and record review, the facility failed to protect the residents right to be free from neglect for 1 of 3 residents reviewed. A resident exited the secured unit unsupervised. (Resident B) B. Based on interview and record, the facility failed to protect the residents right to be free from physical abuse by another resident for 2 of 3 residents reviewed for abuse. (Resident C, Resident D, Resident E) Findings include:	R 0052	**R052** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** This deficiency was identified for 1 resident who exited the secured unit unsupervised (Resident B) and 2 residents who experienced physical abuse by another resident (Resident C, Resident D, Resident E). **How the facility will identify**	06/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maurice Woolfolk	Executive Director	05/30/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	A. During an interview on 5/16/25 at 9:58 a.m., Qualified Medication Aide (QMA) 1 indicated on three separate occasions Resident B had walked out of the secured memory care unit unassisted by staff. Resident B walked through a door that led to an unsecured mail room when a dietary aide opened that door to enter the unit. Resident B had also exited the secured unit through the east exit door and walked out in the parking lot. On 5/16/25 at 10:17 a.m., observed the east secured entrance/exit door. Near the center of a long corridor was a hallway that opened to a reception area. In the reception area observed a large, secured glass door with a scanner to one side. The secured glass door led into a vestibule approximately 10 feet long to an unsecured glass door. The unsecured glass door led out to a sidewalk and the parking lot. At that time, CNA 2 indicated Resident B had walked off the secured memory care unit through the mail room door as well. During an interview on 5/16/25 at 10:57 a.m., the Housekeeper indicated approximately three weeks ago, she was entering the secured unit through the mail room door and Resident B had become aggressive and tried to exit through the door. The Housekeeper reported to the QMA. On 5/9/25 at approximately 3:00 p.m., she exited through the east exit door to leave work for the day. When the Housekeeper got to her car, she turned around and Resident B was standing in the parking lot approximately 20 feet from the building. On 5/16/25 at 12:05 p.m., reviewed the security footage of Resident B exiting the facility through the east exit door. The security footage, dated 5/9/25, indicated:		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Resident B was immediately escorted back to the secured unit upon discovery by staff. Reviewed and updated the resident's care plan to include additional safety measures. Resident was put on15-minute checks. Facility limited exit points from memory care back east entrance, all families visiting loved ones on memory care were informed, starting on 5-19-25 to enter and exit through the main front west entrance. Also, the families were informed that the back east entrance would only be used for employees. Staff were educated on 5-14-25 about the prevention of residents exiting the secure area unsupervised. Contractor was contacted regarding the mailroom door to secure the door with a maglock from the opposite side to prevent other residents or families from letting memory care residents out on the assisted living unsecured side. Residents C, D, and E were separated during each incident. Residents were assessed for injuries after each incident. We also informed the residents' families and legal representatives, and corrective actions were taken. Resident C had a	

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	- At 2:53:12 p.m., a visitor was standing at the secured door as the Housekeeper approached. - At 2:53:13 p.m., Resident B walked into camera view and toward the secured exit door. - At 2:53:16 p.m., the Housekeeper walked out of the secured exit door. - At 2:53:24 p.m., Resident B approached the secured exit door and as the visitor walked in, Resident B exited through the secured door. - At 2:53:32 p.m., Resident B walked out the second unsecured exit door onto the sidewalk and then to the parking lot away from the facility. - At 2:53:45 p.m., the housekeeper saw Resident B when she got to her car and turned around. - At 2:54:00 p.m., the housekeeper walked Resident B back into the facility. On 5/16/25 at 12:30 p.m., observed the residents' mail room. The mail room was a narrow room lined with mailboxes. At the other side of the room was a large door and a scanner on the wall to the side. Observed the mailbox room door that led to the secured memory care unit to be unsecured. A badge was not required to open the door from the mail room into the secured unit. During an interview on 5/19/25 at 8:12 a.m., the Director of Nursing (DON) indicated there were two times Resident B walked off the secured unit through the mail room door. A resident from the assisted living area of the facility opened the mail room door and let him out and another time when a new dietary aide entered the secured unit and Resident B exited.		reportable event on 5/8/25 towards Resident C. Staff kept residents separated for the rest of the day and staff monitored for any signs of aggression. On 5/15/25 Resident C was the aggressor towards Resident E. Staff was educated to monitor Resident C and redirected when resident approached any other residents' belongings. On 5/16/25 Resident C was the aggressor towards Resident E. DON and Administrator notified family that resident needed to be sent out due to behaviors and to allow the newly prescribed medication to take effect for behaviors. Facility sent referrals to two psych stay providers for Resident C's aggressive behaviors. The resident's daughter ended up planning for Resident C to stay with family during medication changes for approximately a week. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility to protect the residents' right to be free from neglect and physical abuse. Staff will be educated regarding abuse and the prevention of abuse. The Director of Nursing/designee will be responsible for reviewing and providing interventions to all	

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	The clinical record for Resident B was reviewed on 5/19/25 at 12:45 p.m. The diagnoses included, but were not limited to, mild cognitive impairment, diabetes, and depression. Resident B resided on the secured memory care unit. A progress note, 4/27/25 at 6:44 p.m., indicated Resident B exited the secured unit through the mail room door. Resident B was seen by dietary staff who immediately returned him to the secured memory care unit. A progress note, dated 5/9/25 at 3:00 p.m., indicated Resident B exited out the east entrance doors before they were fully closed. Resident B was seen by staff in the parking lot and brought back into the secured memory care unit. A progress note, dated 5/13/25 at 5:32 p.m., indicated Resident B was at the mail room door attempting to leave the secured memory care unit. When a dietary aide went through the mail room door, Resident B exited the unit. The CNA was able to redirect Resident B back to the secured memory care unit. On 5/16/25 at 8:15 a.m., the Administrator provided a copy of a facility policy, titled Wandering and Egress Prevention, dated 2/12/24, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility to safeguard against egress. B. On 5/16/25 at 9:30 a.m., the Administrator provided a copy of the facility reportable incidents, dated 5/8/25 at 1:30 p.m. A review of the reportable incident indicated Resident C walked over to Resident D, in the dining room, and		memory care residents that show increases in wandering behavior 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. The Director of Nursing/designee will be responsible for reviewing and providing interventions to all memory care residents with increases in aggressive behavior 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Administrator and/or designee. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. Re-education, frequency and/or duration of reviews will be increased if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Administrator and/or designee is responsible for ensuring compliance with this plan of correction. **Date of Compliance: 6/16/25**	

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reached for Resident D's drink. Resident D reached out and struck Resident C with an open hand in the face. Resident C then reached out and slapped Resident D with and open hand and grabbed Resident D's arm preventing her from slapping her again. At that time, the Administrator provided a second facility reportable incident, dated 5/15/25 at 10:45 a.m. A review of the incident indicated Resident C walked up to another resident's walker. Resident E stood up to stop Resident C from touching the walker. Resident C slapped Resident E on the arm and torso twice with an open hand and walked away.

During an interview on 5/16/25 at 10:17 a.m., CNA 2 indicated on 5/8/25 Resident C walked up to the dining table where Resident D was sitting and tried to pick up her cup. Resident D smacked Resident C's hand away. Then Resident C open hand slapped Resident D.

During an interview on 5/16/25 at 10:57 a.m., the Housekeeper indicated a couple weeks ago, she witnessed Resident C slap Resident D in the face when they were in the dining room.

The clinical record for Resident C was reviewed on 5/19/25 at 12:38 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, irritability, and anger. Resident C resided on the secured memory care unit.

A progress note, dated 5/8/25 at 1:37 p.m., indicated Resident D was sitting in the dining room following lunch when Resident C approached her table and reached out to grab Resident D's cup. Resident D reached out striking Resident C with an open hand. Resident C then struck Resident D with open hand.

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A progress note, dated 5/15/25 at 4:30 p.m., indicated at approximately 10:30 a.m., Resident C walked up to Resident E's walker and Resident E stood up to stop Resident C from touching her walker. Resident C slapped Resident E on the arm and torso with an open hand and walked away.

The clinical record for Resident D was reviewed on 5/19/25 at 1:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease and major depression. Resident D resided on the secured memory care unit.

A progress note, dated 5/8/25 at 1:32 p.m. Resident D was sitting in dining room following lunch when Resident C approached the table and reached out to grab Resident D's cup. Resident D reached out striking Resident C with an open hand. Resident C then struck Resident D with open hand.

The clinical record for Resident E was reviewed, on 5/19/25 at 1:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and prediabetes. Resident E resided on the secured memory care unit.

A progress note, dated 5/15/25 at 2:34 p.m., indicated at approximately 10:30 a.m., Resident C walked up to another resident's walker. Resident E stood up to stop Resident C from touching the walker. Resident C slapped Resident E on her arm and torso twice with an open hand and walked away.

On 5/16/25 at 8:15 a.m., the Administrator provided a copy of a facility policy, titled Vulnerable Adult Maltreatment - Prevention and Reporting, dated 2/20/24, and indicated this was the current policy used by the facility. A review of

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	the policy indicated the community prohibits abuse of residents. This citation relates to Complaint IN00459388.			