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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00447355 and IN00446460. Complaint IN00477355 - State deficiencies related to the allegations are cited at R214. Complaint IN00446460 - No deficiencies related to the allegations are cited. Survey date: November 21 and 22, 2024 Facility number: 016046 Residential Census: 67 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed November 27, 2024.	R 0000		
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure post fall evaluations and fall risk assessments were completed for a resident with multiple falls as indicated by the facility's policy for 1 of 3 residents reviewed for falls. (Resident B) Findings include: During an interview on 11/21/24 at 9:36 a.m., Qualified Medication Aide (QMA) 1 indicated, Resident B was a fall risk and had several falls recently. Resident B was on 15 minute checks.	R 0214	All residents that have had a fall from 11/1/2024 to 12/31/2024 will be reviewed for post fall assessment and investigation to ensure that no other residents had missing post fall assessments by Director of Nursing or nurse designee. Resident service plans will be updated accordingly by Director of Nursing or nurse designee. This resident chart review will be completed by January 15th 2025.	01/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linsey Fitterling	Executive Director	12/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	The clinical record for Resident B was reviewed on 11/21/24 at 10:13 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and sciatica. The Progress Notes included, but were not limited to: On 11/2/24 at 1:18 a.m., indicated on 11/1/24 at approximately 11:30 p.m., Resident B was on the floor in her room. Resident B was sent to the hospital because she could not bear weight. On 11/12/24 at 8:48 a.m., indicated Resident B slid off of a chair onto the floor. Resident B did not have any injuries. On 11/12/24 at 10:14 a.m., indicated Resident B was sitting on the floor in the hallway and was assisted up by staff. No injuries were noted. On 11/12/24 at 12:40 p.m., indicated Resident B was on the floor and was lifted into the wheelchair with the assistance of two staff. On 11/12/24 at 3:48 p.m., indicated Resident B lost her balance while being assisted to the restroom and fell. No apparent injuries. On 11/16/24 at 5:48 a.m., indicated Resident B was found sitting beside her bed at 5:38 a.m. Resident B denied pain and did not have any bruising. During an interview on 11/22/24 at 9:00 a.m., the Director of Nursing (DON) indicated a post fall investigation and a fall risk assessment should have been completed after each of Resident B's falls but none of them were completed. The service plan should have been updated after the investigation was completed.		Training and education will be provided for licensed staff that have responsibility to complete the post fall assessments and investigations, training and education will be completed by January 15th, 2025. All new hires of licensed staff that will have the responsibility to complete the post fall assessments and investigations will have training and education provided on orientation and annually. All falls starting 1/1/2025 will be reported on a quality assurance report that will be reviewed by Director of Nurses or nurse designee and Vice President of Clinical Operations monthly for six months to ensure that no assessments are missed and that resident service plans are being updated appropriately. The six-month review will begin January 2025 and will end on June 2025. Audits after June 2025 will be conducted on a quarterly basis. Audit will be completed by Director of Nurses or nurse designee and reviewed with Vice President of Clinical Operations in an on-going manner.	

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	On 11/21/24 at 9:51 a.m., the DON provided a copy of a facility policy, titled Fall Prevention and Response, dated 6/18/29, and indicated this was the current policy used by the facility. A review of the policy indicated a post fall investigation and fall risk assessment are to be completed on all falls. This State tag relates to Complaint IN00447355			