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	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

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R 0000 Bldg. 00	This visit was for an Initial State Residential Licensure Survey. Survey dates: February 27 and 28, 2023 Facility number: 015081 Residential Census: 20 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 6, 2023.	R 0000	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request consideration for desk review and paper compliance.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terrence Jent	RDO	03/24/2023

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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	shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure fire drills were conducted. This deficient practice had the potential to affect 20 of 20 residents residing in the facility. Findings include: During an interview, on 2/27/23 at 2:52 p.m., the Maintenance Manager indicated he had educated the staff on fire safety, including education on the maintenance fire panels that showed where the fire was located. He indicated a fire drill had not been completed since the building had been opened. Review of the State Licensed Only (SLO) Initial Health Survey Inspection Request, on 2/27/23 at 3:26 p.m., indicated the provisional license start date was 1/11/23. An undated current facility policy, provided by the Administrator on 2/28/23 at 2:41 p.m., and titled "Fire," indicated " ...Fire drills will occur on a monthly basis ...."	R 0092	It is the intent of Vita of Marion to conduct fire drills as required by 410 IAC 16.2-5-1.3. This deficiency had the potential to affect all residents. The deficiency was corrected upon identification. The community utilizes TELS for documentation of fire drills. As a preventive measure, maintenance staff will be re-educated on Fire Drill Policy & Procedure by 4/14/23. To prevent reoccurrence, the Maintenance Director, or his designee, will audit fire drills as they occur to ensure compliance. Any findings will be reported to the Quality Assurance Committee.	04/14/2023
R 0093 Bldg. 00	410 IAC 16.2-5-1.3(j)(1-4) Administration and Management - Noncompliance (j) If professional or diagnostic services are to be provided to the facility by an outside resource, either individual or institutional, an arrangement shall be developed between the licensee and the outside resource for the provision of the services. If a written agreement is used, it shall specify the			

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	following: (1) the responsibilities of both the facility and the outside resource; (2) the qualifications of the outside resource staff; (3) a description of the type of services to be provided, including action taken and reports of findings; and (4) the duration of the agreement. Based on interview and record review, the facility failed to ensure a contract or service agreement was in place for the provision of dialysis services for 1 of 1 resident reviewed for dialysis (Resident 2). Findings include: During an interview, on 2/27/23 at 9:00 AM, the Director of Nursing (DON) indicated the facility currently had one resident who received dialysis services. She did not believe the facility had a contract with a dialysis services provider, as the resident had received dialysis prior to admittance to the facility and continued her dialysis routine after admittance. Review of a document titled "Contract and Service Agreement Checklist," provided by the Administrator on 2/27/23 at 2:49 p.m., indicated there was no contract or service agreement with a dialysis services provider. During an interview, at the time of the receipt of the document, the Administrator indicated he did not believe the facility had a contract with a dialysis service provider. Review of Resident 2's clinical record, on 2/28/23 at 11:21 a.m., indicated the physician's orders included an order, dated 2/6/23, for dialysis on Monday, Wednesday, and Friday.	R 0093	It is the intent of Vita of Marion to have service contracts in place for any resident receiving dialysis. This deficiency had the potential to affect 1 resident. The community is establishing a service contract with the preferred provider. The contract will be in place by 4/14/23. As a preventive measure, future residents requiring dialysis services will be audited by the DON, or designee, to ensure a contract is in place. Any findings will be reported to the Quality Assurance Committee.	04/14/2023

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	During an interview, on 2/28/23 at 11:55 a.m., the Administrator indicated since the resident was independent, he was uncertain a contract with a dialysis provider was needed. He indicated the previous administrator may have completed a contract with the dialysis provider. During an interview, on 2/28/23 at 4:19 p.m., the Administrator indicated he did not have a policy on contracts/service agreements.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility	R 0117	It is the intent of Vita of Marion to	04/14/2023

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	failed to ensure a first aid - trained staff member was scheduled onsite for 9 of 21 shifts reviewed, and a staff member trained in cardiopulmonary resuscitation (CPR) was scheduled onsite for 5 of 21 shifts reviewed. This deficiency had the potential to affect 20 of 20 residents residing in the facility. Findings include: A review of the employee CPR and first aid certifications provided by the Administrator on 2/28/23 at 12:43 p.m., and the facility employee schedule, provided by the Administrator, on 2/27/23 at 2:49 p.m., was completed on on 2/28/23 at 2:32 p.m., and indicated the following: a. No staff member trained in first aid was scheduled on day shift from 6:00 a.m. to 10:00 a.m. on 2/26/23, on second shift 2/26/23, 2/28/23, 3/1/23, 3/2/23, 3/3/23, and 3/4/23, nor on third shift 3/3/23 and 3/4/23. b. No staff member trained in CPR was scheduled on day shift from 6:00 a.m. to 10:00 a.m. 2/26/23, nor on second shift 2/26/23, 3/2/23, 3/3/23, and 3/4/23. During an interview, on 2/28/23 at 3:34 p.m., the DON indicated the employees were given first aid and CPR training upon the opening of the building in January. The newer employees, who were not CPR and first aid certified, were scheduled to take a CPR and first aid certification class in March. She was unable to locate any additional documentation of employee first aid or CPR certifications. An undated current facility policy, provided by the Administrator on 2/28/23 at 4:19 p.m., and		ensure a first aid trained staff member is onsite for every shift. The deficient practice had the potential to affect all residents. A staff member with requisite certifications will be scheduled on each shift. An audit of all clinical staff members will be performed to ensure certifications are current. Training will be provided to those in need by 4/14/23. To prevent reoccurrence, the DON, or designee, will audit certifications monthly. Any findings will be reported to the Quality Assurance Committee.	

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	titled "Emergency Care," indicated " ...Staff will be trained in first aid and CPR for early management of problems ...."			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review, the facility failed to ensure a medication was administered in the appropriate dosage, and correct location, for 1 of 5 residents reviewed for medication administration (Resident 12). Findings include: During an observation, on 2/27/23 at 1:36 p.m., Qualified Medication Aide (QMA) 4 squeezed out an unmeasured amount of diclofenac 1% gel into her gloved hand, and applied it to Resident 12's right shoulder. She again squeezed out an unmeasured amount of the same medicated gel into her hand and applied to Resident 12's left shoulder. During an interview, on 2/27/23 at 1:40 p.m., QMA 4 indicated she did not have a specific amount of the gel she was to apply to the resident. She checked the order, and the resident was to receive it to the right shoulder, but she had applied it to both shoulders for some time. She had told the nurse about the resident's request for gel to both shoulders.	R 0243	It is the intent of Vita of Marion to ensure that medications are administered in the appropriate dosage and correct location. The deficient practice had the potential to affect all residents. There have been no adverse effects noted to any residents. Nurses and QMA's will be re-educated on medication administration policy and procedure by 4/14/23. As a preventive measure, the DON, or designee, will observe medication pass 1x weekly until 100% compliance is maintained for 3 consecutive months. Any findings will be reported to the Quality Assurance Committee.	04/14/2023

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	Resident 12's clinical record was reviewed on 2/28/23 at 10:44 a.m. Her physician's orders included a 1/23/23 order for diclofenac sodium external gel 1 % - apply to right shoulder topically three times a day for pain. The resident's medication administration record for 1/2023 and 2/2023 indicated the resident received diclofenac gel to both shoulders for 24 of 108 administrations. The administration of the gel to both shoulders was documented by eight different staff members. According to the Mayo Clinic website, retrieved on 2/28/23 at 11:24 a.m., from www.mayoclinic.org, the page "Diclofenac Topical Application Route" indicated " ...the total dose should not exceed 32 grams per day over all affected joints. Use the enclosed dosing card to measure the appropriate dose ...." During an interview, on 2/28/23 at 3:34 p.m., the DON indicated the QMA should not have made a judgement call to administer the medication to both shoulders. The medication was received with the resident on admission and did not contain a dosage card. A current facility policy, dated 2/2019 and provided by the Administrator, on 2/28/23 at 3:18 p.m., titled "Resident Medication Administration," indicated the following: " ...Medication is to be administered as ordered by the Provider ...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and			

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	local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to utilize pasteurized eggs for the preparation of soft-cooked eggs for the residents. Findings include: During a tour of the kitchen, on 2/27/23 at 9:32 a.m., raw, whole, unpasteurized eggs were observed in the refrigerator. The Dietary Manager indicated the whole eggs were used for the preparation of scrambled and fried eggs. The fried eggs included eggs fried over easy, over medium, and over hard. The raw eggs were not pasteurized. A menu, provided on 2/27/23 at 2:49 p.m. by the Administrator, indicated scrambled eggs were on the breakfast menu on 2/27/23, scrambled eggs with cheese were on the breakfast menu for 2/28/23, fried egg and cheese sandwich was on the breakfast menu for 3/1/23, scrambled eggs were on the breakfast menu for 3/3/23, and choice of egg was on the breakfast menu for 3/4/23. An undated, current facility policy, provided by the Administrator on 2/28/23 at 3:13 p.m. and titled "Storage of Refrigerated and Dry Foods," indicated " ...All eggs shall be sourced through an approved vendor and be a pasteurized product ...."	R 0273	It is the intent of Vita of Marion to utilize pasteurized eggs for residents. The deficient practice had the potential to affect all residents. The concern was corrected upon identification. The community will only order and maintain pasteurized eggs. As a preventive measure, the Dining Director will be re-educated by 4/14/2023. To prevent reoccurrence, the Dining Director, or his designee, will audit deliveries upon arrival to ensure correct products are received. Any findings will be reported to the Quality Assurance Committee.	04/14/2023
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of			

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	induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure residents received a two-step tuberculosis test (TB) upon admission for TB screening for 3 of 6 recently admitted residents reviewed for TB tests. Findings include: Resident 3's clinical record, reviewed on 2/28/23 at 9:10 a.m., lacked documentation of a second step TB test being administered and interpreted with results. Resident 15's clinical record, reviewed on 2/28/23 at 10:44 a.m., indicated a second step TB test had been administered on 1/30/2023. The record lacked documentation of the test being interpreted with results. Resident 2's clinical record, reviewed on 2/28/23 at 11:21 a.m., lacked documentation of a second step TB test being administered and interpreted with results.	R 0410	It is the intent of Vita of Marion to ensure residents receive a two-step tuberculosis test (TB) upon admission for TB screening. The deficient practice had the potential to affect all residents. An audit will completed for all residents to ensure that requisite TB testing is taking place. As a preventive measure, all licensed staff will be re-educated regarding TB policy and procedure by 4/14/23. To prevent reoccurrence, the DON, or her designee, will audit TB tests monthly to ensure completion. Any findings will be reported to the Quality Assurance Committee.	04/14/2023

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	During an interview, on 2/28/23 at 4:34 p.m., the DON indicated the TB tests should have been completed. She was unable to locate documentation of the TB tests or their results for Residents 2 and 3. She was unable to locate documentation of the interpretation of the results for Resident 15. An undated current policy, provided by the Administrator, on 2/28/23 at 4:09 p.m., and titled "Mantoux Testing Policy," indicated " ...All assisted living residents will have a two-step Mantoux test within 3 days of admission ...."			