STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/15/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 468909. Intake 468909 - State deficiency related to the allegation is cited at R0053. Survey date: April 14, 2026 Facility number: 015081 Residential Census: 85 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 20, 2026.	R 0000		
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to	R 0053	R 053 Resident rights-Deficiency 1. Resident B showed no long-term distress during the following days of alleged verbal abuse.	05/03/2026

protect residents rights to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse. (Residents B)

Findings include:

Resident B's clinical record was reviewed on 4/14/26 at 10:40 a.m. Diagnoses included vascular dementia without behavioral disturbance, anxiety disorder, and mild cognitive impairment.

A current, 1/22/26, service plan indicated the resident was moderately cognitively impaired and resided in the memory care unit. He was independent for activities of daily living, required some set-up and supervision for dressing, and ambulated independently.

A progress note, dated 3/26/26 at 12:30 p.m., indicated a staff member was raising her voice to Resident B, which caused him to become angry. Resident B was immediately removed from the situation, and the staff member was sent home pending investigation.

An undated written statement by a corporate nurse indicated the following: On 3/26/26 at approximately 2:30 p.m., the corporate nurse went back to the memory care unit to retrieve a file. While there, she came

Resident B has since been to Assurance for a Psyche stay and discharged back to community and has been well.

2. No other residents found to be affected by alleged deficiency practice.
3. Executive Director will in-service staff on Abuse and Neglect policy by May 3, 2026. Executive Director or designee will make rounds in Memory Care daily x 7 days, weekly x 3 weeks, then monthly x 5 months. Rounds will include an interview with minimum of 1 staff member to ensure no concerns of verbal abuse noted.
4. Audits of interview/rounds will be reviewed monthly at QAPI meeting. QAPI committee will make recommendations as necessary.

Compliance date May 3, 2026

upon the incident between Resident B and the Activities Assistant (AA). The AA was arguing with Resident B about how he should not be talking to staff the way he was, and how she did not care what he had to say. He was not allowed to leave the unit. She had a very angry look on her face while speaking to the resident. The incident happened in front of a dining room full of memory care residents. They all seemed extremely frightened. The corporate nurse intervened and told the AA to walk away from the resident. The resident then returned to his room.

An undated written statement by the AA indicated the following: On 3/26/26, the AA was walking to the dining room when she heard Resident B yelling at a CNA. The AA asked the CNA what was going on and the CNA indicated Resident B was mad because he wanted her to let him out of the unit and she told him she could not. He started yelling at the CNA. The AA called the resident by name and told him he should not be talking to the CNAs that way. Resident B told the AA he did not give a da** if the CNA was her granddaughter. He walked toward the CNA. The AA told him there was no reason for him to talk that way to her and he responded that he could talk to

her any way he wanted. The AA stated, "She cannot let you out - you can go to the courtyard if you want, but she can't let you off the hall without your POA [power of attorney]." Resident B said he would get out and nobody could stop him. Then the corporate nurse came in and told the AA to walk away. As she walked away, Resident B told her to never talk to him again.

During a phone interview with the AA on 4/14/26 at 2:26 p.m., she indicated she was walking down the hall from the activities office to the dining room and heard Resident B yelling at a CNA. The CNA explained to her what was happening. Resident B said he did not care; he wanted to go outside and none of them could stop him. The AA told him to calm down and offered to let him into the courtyard, but not off the unit. He was walking toward her with his finger in her face when somebody walked up and told her to walk away. She never raised her voice. Her employment was terminated. She was told she spoke too harshly to the resident and had a mean look on her face.

During an interview with the Administrator, on 4/14/26 at 12:35 p.m., she indicated the report she received from the

corporate nurse regarding the incident between the AA and Resident B left her with no doubt that the incident did happen. She terminated the AA's employment. She previously saw signs of burnout in the AA and suggested she take a break. Having a long history working in memory care herself, the Administrator knew the signs of burn out and felt the AA was exhibiting signs of burn out prior to the incident with Resident B.

The corporate nurse was unavailable for interview during the survey dates.

A current facility policy, titled "Abuse, Neglect, and Financial Exploitation Prevention", provided by the Administrator on 4/14/26 at 10:00 a.m., indicated the following: " ...Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...."

This citation relates to Intake 468909.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREKeisha Dube	TITLEExecutive Director	(X6) DATE04/30/2026