STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/03/2025

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 Complaint IN00462203, IN00461757, and IN00461782. Complaint IN00462203 - No deficiencies related to the allegations are cited. Complaint IN00461757 - No deficiencies related to the allegations are cited. Complaint IN00461782 - State deficiencies related to the allegations are cited at R0214. Unrelated finding are cited at R0270. Survey dates: July 2 and 3, 2025 Facility number: 015081 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed July 14, 2025.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, record review, and interview, the facility failed to proved the resident with an assessment for the needs of nursing services and implement treatment orders as indicated in the clinical record until home services were initiated for 1 of 5 residents reviewed for infections. (Resident B) Findings include: Resident B's clinical record was reviewed on 7/3/25 at 10:53 a.m. Diagnoses included type 2 diabetes mellitus, hypertension, and chronic embolism and thrombosis of deep veins of lower extremity. Current orders included rivaroxaban (blood thinner) 20 milligrams (mg) one tablet daily for chronic embolism,	R 0214	1 Resident B wound care service started with Faithful Friends Home Health Care on 6/27/25. 2 Residents that require Home Health Care are at risk for alleged deficient practice. Resident orders reviewed by Director of Nursing, all residents with Home Health Care orders are currently receiving services by Home Health Care. 3 Director of Nursing will Inservice nurses on orders for Home Health Care, assessment of services needed to provide care ordered by provider and documentation required. Providers’ orders will be reviewed daily by nurses and will be initiated on finding Home Health Care provider to fulfill provider orders for Home Health Care, assessment of services will be documented. 4 Director of Nursing will audit evaluation of resident Home Health Care services weekly x 8 weeks, monthly x 4 months. QA	08/03/2025

	triamcinolone cream 0.1% to be applied topically to legs three times weekly on Monday, Wednesday, and Friday (unsupervised self-administration for rash), and home health skilled nursing to cleanse left lower extremity with normal saline, pat dry, cover with nonadherent dressing and wrap with sterile gauze bandage for ten days (6/10/25). A progress note, dated 6/11/25 at 7:03 a.m., indicated the Nurse Practitioner (NP) saw the resident on 6/10/25 and gave a new order for home health skilled nursing to provide dressing changes, daily, for ten days. A progress note, dated 6/11/25 at 4:30 p.m., indicated the resident's right lower leg was cleaned and wrapped per the NP's request. The NP submitted an order for home health care to do wound dressing on Resident B. There was no answer from the home health agency at that time. A progress note, dated 6/13/25 at 11:36 a.m., indicated Resident B was concerned that home health staff had not come to wrap his legs at that time. Two messages were left with the home health agency. The charge nurse was to clean and wrap the resident's leg.		committee will review audits monthly x 6 months and make recommendations as necessary. 5 Compliance date: August 3, 2025.	

	The clinical record lacked documentation of a dressing change by the charge nurse. A progress note, dated 6/13/25 at 3:47 p.m., indicated the home health agency was contacted again, but was unavailable at that time. A different home health agency was contacted but their voice mail was full, so no message was left. A progress note, dated 6/16/25 at 1:08 p.m., indicated the home health agency requested a new order for Resident B's dressing change. The dressing change was to be done by a home health nurse. Resident B's service plan, updated on 1/22/25, lacked information about the left lower leg infection (cellulitis) or treatment ordered for the cellulitis. During an interview with Resident B on 7/3/24 at 11:40 a.m., the resident indicated he had swelling in the left lower extremity. The leg was swollen with red and had purple discoloration. There were no visible blisters or drainage. He indicated he called the home health agency on 6/20/25 and his call was answered immediately. After his conversation with the agency, they started coming three times a week to do the dressing			

	changes. It took ten days after the order was given for the dressing changes to start. During an interview with the Director of the home health agency, on 7/3/25 at 11:56 a.m., she indicated the orders received from the facility were for daily dressing changes for ten days. The Veteran's Administration (VA) would not approve the treatments. One day at the facility (she was unsure of the date), she saw Resident B and he told her the facility had been trying to get in touch with her agency. She told him nobody from the facility had left any messages, faxes or emails. When the Director talked to the DON about her conversation with Resident B, the DON gave her the name of someone at the VA to ask about the orders. Before she saw Resident B at the facility, the Director knew nothing about the order(s) for dressing changes. The DON indicated she had called the home health agency but got cut off from the phone call. The Director asked her if she called back after being disconnected and the DON responded "no." The DIR was concerned about Resident B because he was unable to wrap his own leg(s) and the discoloration to his leg was significant. During an interview with the			

	facility DON on 7/3/24 at 1:32 p.m., she indicated there was an original order from the VA for the dressing change, but she did not recall the specifics of the order or when it was given. The 6/10/25 order was written by the facility's NP. Whenever home health staff went into the facility, they were to let nursing know they were in the building, who they were seeing, and their plan of care. If the home health staff did not check in, the facility's nursing staff would go to the resident to find out what services were provided. She was unsure of the time between when the order was given to treat Resident B's leg and when the treatment started. The facility's charge nurse was unavailable for interview during the survey. A VA document, titled "Urgent Care Practitioner Note", dated 6/9/25 at 11:55 a.m., provided by the DON on 7/3/25 at 2:48 p.m., indicated the following: " ...(Resident B) presents to urgent care today for ...wound in his lower left leg that started small and has been getting bigger. Uses compression stockings ...three small 0.5 to 1 centimeter (cm) diameter, shallow ulcers in the left lower leg. There is venous stasis and edema with pitting. Mild redness around the wounds ...Assessment/Plan - 1. Chronic			

	lymphedema/leg edema. 2. Cellulitis with shallow ulcers - Keflex (antibiotic). Daily dressing. Follow up with PACT (patient aligned care team) and podiatry or wound clinic ...." A document, titled "Timeline for (Resident B's) Wound Care", undated, provided by the DON on 7/3/25 at 2:48 p.m., indicated the following: " ...6/9/25 - Order received from VA. 6/11/25 - New order for home health skilled nursing with (name of home health agency) for dressing changes daily x's 10 days. 6/13/25 - Left 2 messages with (home health agency). No response. 6/16/25 - (Home health agency) requested new order. Facility staff drove (the) order to (the agency). Received by receptionist. 6/20/25 - Contacted (DIR) with (agency). Faxed and emailed face sheet to her. 6/24/25 - Spoke with (agency). Wound care to begin 6/27/25 ...." A fax cover sheet, dated 6/20/25, provided by the DON on 7/3/25 at 2:48 p.m., indicated the DON sent the information requested by the home health agency. Included in the fax was the emergency printout information for Resident B which included diagnoses, allergies, insurance information, primary care provider, nurse practitioners, phone numbers for those providers, current			

medications and treatments, and emergency contact(s).

This citation relates to Complaint IN00461782.

Based on observation, record review, and interview, the facility failed to proved the resident with an assessment for the needs of nursing services and implement treatment orders as indicated in the clinical record until home services were initiated for 1 of 5 residents reviewed for infections. (Resident B)

Findings include:

Resident B's clinical record was reviewed on 7/3/25 at 10:53 a.m. Diagnoses included type 2 diabetes mellitus, hypertension, and chronic embolism and thrombosis of deep veins of lower extremity.

Current orders included rivaroxaban (blood thinner) 20 milligrams (mg) one tablet daily for chronic embolism, triamcinolone cream 0.1% to be applied topically to legs three times weekly on Monday, Wednesday, and Friday (unsupervised self-administration for rash), and home health skilled nursing to cleanse left lower extremity with normal saline, pat dry, cover with nonadherent dressing and wrap with sterile gauze bandage for ten days (6/10/25).

A progress note, dated 6/11/25 at 7:03 a.m., indicated the Nurse Practitioner (NP) saw the resident on 6/10/25 and gave a new order for home health skilled nursing to provide dressing changes, daily, for ten days.

A progress note, dated 6/11/25 at 4:30 p.m., indicated the resident's right lower leg was cleaned and wrapped per the NP's request. The NP submitted an order for home health care to do wound dressing on Resident B. There was no answer from the home health agency at that time.

A progress note, dated 6/13/25 at 11:36 a.m., indicated Resident B was concerned that home health staff had not come to wrap his legs at that time. Two messages were left with the home health agency. The charge nurse was to clean and wrap the resident's leg.

The clinical record lacked documentation of a dressing change by the charge nurse.

A progress note, dated 6/13/25 at 3:47 p.m., indicated the home health agency was contacted again, but was unavailable at that time. A different home health agency was contacted but their voice mail was full, so no message was left.

A progress note, dated 6/16/25

	at 1:08 p.m., indicated the home health agency requested a new order for Resident B's dressing change. The dressing change was to be done by a home health nurse. Resident B's service plan, updated on 1/22/25, lacked information about the left lower leg infection (cellulitis) or treatment ordered for the cellulitis. During an interview with Resident B on 7/3/24 at 11:40 a.m., the resident indicated he had swelling in the left lower extremity. The leg was swollen with red and had purple discoloration. There were no visible blisters or drainage. He indicated he called the home health agency on 6/20/25 and his call was answered immediately. After his conversation with the agency, they started coming three times a week to do the dressing changes. It took ten days after the order was given for the dressing changes to start. During an interview with the Director of the home health agency, on 7/3/25 at 11:56 a.m., she indicated the orders received from the facility were for daily dressing changes for ten days. The Veteran's Administration (VA) would not approve the treatments. One day at the facility (she was			

	unsure of the date), she saw Resident B and he told her the facility had been trying to get in touch with her agency. She told him nobody from the facility had left any messages, faxes or emails. When the Director talked to the DON about her conversation with Resident B, the DON gave her the name of someone at the VA to ask about the orders. Before she saw Resident B at the facility, the Director knew nothing about the order(s) for dressing changes. The DON indicated she had called the home health agency but got cut off from the phone call. The Director asked her if she called back after being disconnected and the DON responded "no." The DIR was concerned about Resident B because he was unable to wrap his own leg(s) and the discoloration to his leg was significant. During an interview with the facility DON on 7/3/24 at 1:32 p.m., she indicated there was an original order from the VA for the dressing change, but she did not recall the specifics of the order or when it was given. The 6/10/25 order was written by the facility's NP. Whenever home health staff went into the facility, they were to let nursing know they were in the building, who they were seeing, and their plan of care. If the home health staff did not check in, the facility's			

nursing staff would go to the resident to find out what services were provided. She was unsure of the time between when the order was given to treat Resident B's leg and when the treatment started.

The facility's charge nurse was unavailable for interview during the survey.

A VA document, titled "Urgent Care Practitioner Note", dated 6/9/25 at 11:55 a.m., provided by the DON on 7/3/25 at 2:48 p.m., indicated the following: " ...(Resident B) presents to urgent care today for ...wound in his lower left leg that started small and has been getting bigger. Uses compression stockings ...three small 0.5 to 1 centimeter (cm) diameter, shallow ulcers in the left lower leg. There is venous stasis and edema with pitting. Mild redness around the wounds ...Assessment/Plan - 1. Chronic lymphedema/leg edema. 2. Cellulitis with shallow ulcers - Keflex (antibiotic). Daily dressing. Follow up with PACT (patient aligned care team) and podiatry or wound clinic ...."

A document, titled "Timeline for (Resident B's) Wound Care", undated, provided by the DON on 7/3/25 at 2:48 p.m., indicated the following: " ...6/9/25 - Order received from VA. 6/11/25 - New order for home health

	skilled nursing with (name of home health agency) for dressing changes daily x's 10 days. 6/13/25 - Left 2 messages with (home health agency). No response. 6/16/25 - (Home health agency) requested new order. Facility staff drove (the) order to (the agency). Received by receptionist. 6/20/25 - Contacted (DIR) with (agency). Faxed and emailed face sheet to her. 6/24/25 - Spoke with (agency). Wound care to begin 6/27/25 ...." A fax cover sheet, dated 6/20/25, provided by the DON on 7/3/25 at 2:48 p.m., indicated the DON sent the information requested by the home health agency. Included in the fax was the emergency printout information for Resident B which included diagnoses, allergies, insurance information, primary care provider, nurse practitioners, phone numbers for those providers, current medications and treatments, and emergency contact(s). This citation relates to Complaint IN00461782.			
R 0270	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(c)(1-3) (c) The facility must meet: (1) daily dietary requirements and	R 0270	1 C.N.A 2 was provided with an education on resident rights in dining services.	08/03/2025

	requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review, and interview, the facility failed to offer or provide food substitutions for meals during a random meal observation for 1 of 5 residents reviewed for dining. (Resident E) Findings include: Resident E's clinical record was reviewed on 7/2/25 at 9:00 a.m. Diagnoses included type 2 diabetes mellitus, dementia, major depressive disorder, anxiety disorder, insomnia, and rheumatoid arthritis. Current orders included buspirone hydrochloride (for anxiety) 10 milligrams (mg), donepezil (for dementia) 10 mg, fluoxetine (antidepressant) 20 mg, and lorazepam (for anxiety) 0.5 mg. A current service plan, dated 6/24/25, indicated Resident E understood information conveyed to her but might miss some or part of the message and/or it's intent, had limited ability to express herself to make concrete requests regarding her basic needs, was		2 The Culinary Director or designee will provide education to all staff on options available from the kitchen for residents by compliance date. 3 The culinary Director or designee will monitor a meal service 2x week for 4 weeks, then monthly x6 months and make any corrections needed at time of service. QA committee will monitor for 6 months. 4 Compliance Date: August 3, 2025	

disoriented to the point of not being able to function independently three or more days in a seven-day period, needed reassurance three or more days in a seven-day period, might refuse to make decisions, be negative or hostile, made poor decisions and required cueing and supervision, had significant memory loss which included wandering and required direction or reminders, and continuous daily cueing. Resident E had difficulty understanding her needs but would cooperate when given directions or explanations. She could feed herself but required cues to maintain adequate intake of liquids and solids. Staff were to accommodate the residents' desires and preferences when safe to do so.

During an observation on 7/2/25 at 12:17 p.m., Resident E was eating lunch at a table with two other residents. Resident E requested a napkin, but got no response from CNA 2 who was sitting at the same table assisting another resident with eating. Resident E complained about the food not tasting good. She asked for something to put on the fried chicken, to which CNA 2 responded it was fried chicken and everybody likes it differently. Resident E stated "Yeah, but I'm doing without and that is not right. I know what

good food is and this is NOT good. CNA 2 continued to assist the other resident with eating without further responding to Resident E. The resident picked up her dessert and ate it. No alternatives were offered to Resident E.

During an interview with CNA 2, on 7/2/25 at 2:02 p.m., she indicated Resident E was having a very bad day. She thought an alternative menu was available and did not know why she did not offer Resident E something else to eat. CNA 2 felt Resident E would have been unhappy with anything offered to her at that point, but should have offered something else to the resident.

During an interview with the DON and Administrator on 7/3/25 at 1:32 p.m., both indicated Resident E should have been offered an alternative meal on 7/2/25 during lunch. The Administrator indicated an alternative menu was posted in the unit where Resident E resided and staff knew they should offer alternatives when the residents did not like the food being served.

A current facility policy, titled "Meal Service Policy and Procedure", provided by the ADM on 7/3/25 at 2:48 p.m., indicated the following: " ...It is the policy of the facility to

provide our residents with 3 well-balanced and nutritious meals per day, as well as snacks. At lunch and dinner, residents will have a choice of at least 2 entrees at each meal ...."

Based on observation, record review, and interview, the facility failed to offer or provide food substitutions for meals during a random meal observation for 1 of 5 residents reviewed for dining. (Resident E)

Findings include:

Resident E's clinical record was reviewed on 7/2/25 at 9:00 a.m. Diagnoses included type 2 diabetes mellitus, dementia, major depressive disorder, anxiety disorder, insomnia, and rheumatoid arthritis.

Current orders included buspirone hydrochloride (for anxiety) 10 milligrams (mg), donepezil (for dementia) 10 mg, fluoxetine (antidepressant) 20 mg, and lorazepam (for anxiety) 0.5 mg.

A current service plan, dated 6/24/25, indicated Resident E understood information conveyed to her but might miss some or part of the message and/or it's intent, had limited ability to express herself to make concrete requests regarding her basic needs, was disoriented to the point of not being able to function

independently three or more days in a seven-day period, needed reassurance three or more days in a seven-day period, might refuse to make decisions, be negative or hostile, made poor decisions and required cueing and supervision, had significant memory loss which included wandering and required direction or reminders, and continuous daily cueing. Resident E had difficulty understanding her needs but would cooperate when given directions or explanations. She could feed herself but required cues to maintain adequate intake of liquids and solids. Staff were to accommodate the residents' desires and preferences when safe to do so.

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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 SIGNATURE	TITLE	(X6) DATE