STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/25/2026

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 Intakes 468829, 468703, and 468480. Intake 468829- No deficiencies related to the allegations are cited. Intake 468480 - State deficiencies related to the allegations are cited at R053. Intake 468703 - No deficiencies related to the allegations are cited. Survey dates: March 24 and 25, 2026 Facility number: 015081 Residential Census: 83 These State Residential Finding are cited in accordance with 410 IAC 16.2-5. Quality review completed April 2, 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 record review and interview, the facility failed to protect a resident's right to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse. (Resident D and QMA 1) Findings include: During an interview, on 3/24/26 at 10:35 a.m., QMA 2 indicated she did not believe Resident D was cognitively capable of comprehending if he had been mistreated. The resident was not combative or threatening. The resident had wandered a lot, going into other residents' rooms, sleeping in their beds, using their bathroom, and had been hard to re-direct. The resident had just lost his mother approximately six months prior and he often thought other female residents were his mother. Staff had a difficult time getting Resident D to stop bothering them when they wanted him to go away. The resident ate two trays every meal and snacked often. During an interview, on 3/24/26	R 0053	R 053 Resident rights-Deficiency 1. Resident D showed no long-term distress during the following days of alleged verbal abuse.Resident D has since been discharged from community and moved to other Memory Care.QMA 1 is no longer employed at Vita at Marion. 2. No other residents found to be affected by alleged deficiency practice. 3. Executive Director will inservice staff on Abuse and Neglect policy by April 27, 2026. Executive Director or designee will make rounds in Memory Care daily x 7 days, weekly x 4 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.	04/27/2026

	at 10:49 a.m., CNA 3 indicated Resident D was known to wander. The resident would go into the rooms of other residents and thought other female residents were his mother. The resident was not violent. QMA 1 was very "stern" with the resident. QMA 1 would tell the resident "Just stay away from her. That is not your mom". QMA 1 would repeat it over and over again and becoming more frustrated instead of re-directing the resident. During an interview, on 3/24/26 at 10:50 a.m., QMA 5 indicated Resident D was non-violent, friendly, but hard to re-direct. The resident was fixated on older women, believing them to be his mother. The resident would "hover" over them but was not physical. The resident could be re-directed for extended periods of time if given a deck of cards and staff sat with him. QMA 5 indicated, within the last couple of weeks, a CNA 6 came to her and verbalized a concern about how QMA 1 was treating Resident D. She indicated QMA 1 was being "mean and verbally aggressive" towards Resident D. Also, QMA 1 had been discussing Resident D with the family member of another resident and told Resident D "He is going to beat your f***ing a**."		Compliance date April 27, 2026	

During an interview, on 3/24/26 at 12:55 p.m., CNA 7 indicated QMA 1 would often become frustrated with the dementia residents. QMA 1 had told CNA 7 to get Resident D away from her. CNA 7 had witnessed CNA 8 scream and holler at the resident saying, "I said stay out of there!"

During an interview, on 3/25/26 at 1:29 p.m., CNA 4 indicated a family member of another resident was upset because Resident D had been in his mother's room. QMA 1 had told Resident D to stop, or a family member was going to beat his a**. CNA 4 indicated staff were supposed to re-direct the resident, but QMA 1 would argue with the resident and say things like "Yes you did it. You can't lie to me." CNA 4 did not report this concern because she believed another staff member was going to report it.

Resident D's clinical record was reviewed on 3/24/26 at 12:03 p.m. Diagnoses included frontotemporal dementia, overweight, and atrial fibrillation. The resident was admitted to the secured memory care unit on 1/15/26.

Review of an updated service plan, dated 1/30/26, indicated Resident D had a history of wandering and exit seeking behaviors. The service plan

lacked identification of a problem, including individualized interventions, for the resident wandering into other residents' rooms or behaviors related to the resident thinking other residents were his mother.

Review of a written statement, dated 3/6/26 and provided by the facility, indicated the following:

[Name of CNA 9] would like to report an incident that occurred involving staff member [QMA 1] and a resident. During lunch, the resident had already eaten his entire meal and began trying to eat food from other residents' trays. QMA 1 began yelling at the resident in front of a family member. The resident then walked over to the extra food trays and attempted to get one. At that time, QMA 1 continued yelling at him and said, 'Do I have to smack your fingers or hand?' and told him to go sit down. The resident went and sat down, but continued trying to eat food from other residents at the table he was sitting at. QMA 1 then approached him approximately two different times and scooted his chair back in a rough and rude manner while he was sitting in it. Because it appeared the resident was still hungry, [CNA 9]went to give him an extra tray. At that time, QMA 1 told one of

the resident's family members, "This is why he doesn't listen and does whatever he wants." The family member appeared upset and said something along the lines of, 'They told me he would be gone anyway, this is just crazy how he acts. I'm just going to stand here and watch while talking to [name of QMA 1] about him. [CNA 9] then walked away. After the incident, [CNA 9] went upstairs to write a report and informed the scheduler about what had happened. [CNA 9] was told to write a statement and turn it in to the Executive Director (ED)."

Review of a current facility policy, dated 3/2022 and titled "Abuse, Neglect, and Financial Exploitation Prevention" was provided by the Administration on 3/24/26 at 11:26 a.m. The policy 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 468480.

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) DATE04/14/2026