

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER VITA OF MARION		STREET ADDRESS, CITY, STATE, ZIP CODE 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 469625, 470353, 470610, and 470872. Intake 469625 - No deficiencies related to the allegations are cited. Intake 470353 - No deficiencies related to the allegations are cited. Intake 470610 - State deficiencies related to the allegations are cited at R179. Intake 470872 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey date: July 16 and 17, 2026 Facility number: 015081 Residential Census: 84 These State Residential	R 0000			

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	Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 27, 2026.			
R 0179	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(c) (c) Each facility shall have an adequate air conditioning system, as governed by applicable rules of the fire prevention and building safety commission (675 IAC). The air conditioning system shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all resident and public areas. Based on observation, interview, and record review, the facility failed to ensure there was adequate air conditioning on the second, third, and fourth floors of the facility. This deficient practice had the potential to affect 62 of 62 residents residing in the assisted living area of the facility. Findings include: Review of an anonymous intake filed with the Indiana Department of Health (IDOH), indicated there were certain areas of the facility that were not	R 0179	R-179 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents showed any negative outcome from alleged deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? We had no adverse effects with the roof top units being out. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The roof top unit was fixed on 7/28/2026. The community will have the roof top units inspected in Spring, Summer and Fall.	08/04/2026

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air conditioned and the air conditioner had been broken for a month.

During an initial tour of the facility, on 7/16/26 at 9:43 a.m., signage located on Elevator 2 indicated that the elevator was out of order. A floor fan was circulating air in the hall on the second floor.

During an interview on 7/16/26 at 10:30 a.m., the Administrator indicated that the air conditioners in the hallways of the second, third, and fourth floors of the facility had not been working for approximately a month and a half. The parts had been ordered.

On 7/16/26 at 1:58 a.m., Resident G indicated that it was hot in the upstairs hallways, the air conditioner was broken, and it had been broken for weeks.

During a resident council meeting observation, on 7/16/26 at 2:16 p.m., the Administrator indicated that the air conditioning would be fixed in September or October.

On 7/17/26 at 8:45 a.m., the Administrator provided two Proposed Project Agreements from the air conditioning repair company. One agreement was dated 6/25/26 and the other dated 7/1/26.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Audits will be reviewed monthly in QA meetings for 6 months, committee to make recommendations for need of ongoing audits.

5. By what date the systemic changes will be completed.
8/4/2026

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	During an interview, on 7/17/26 at 8:54 a.m., the Maintenance Director indicated the rooftop air conditioner for the hallways quit working on 5/18/26. Three different technicians came to the facility over a three-week period, then a week later, the proposal was sent, and was reviewed by the owners of the facility. After the approval, approximately a week later, the technicians returned to the facility and found other things that needed fixed and the process started over. The new proposal was dated 7/1/26. Elevator 2 was out and the residents had to walk down to the other elevator. There were needed repairs on both elevators. On 7/17/26 at 9:50 a.m., Resident H indicated she lived on the fourth floor, and the air conditioning had been out a long time. She did not have far to walk to the elevator to attend meals downstairs, but she visited her friend, who also lived on the fourth floor, on the other side of the facility. During an interview, on 7/17/26 at 10:02 a.m., Resident K indicated that he walked slowly with a walker. His room was located on the fourth floor, and he walked from his room to the working elevator, in the heat, which was not near his room.			
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During an interview, on 7/17/26 at 1:29 p.m., Resident M indicated that he pushed his wife in a wheelchair to meals and she wore oxygen at all times. The air conditioner did not work in the hallways. Their room was located on the southwest corner of the facility, and the working elevator was on the east side of the facility, the elevator near their room was out of order. Not having air conditioning in the hallway was "miserable and it sucked".

During a tour with the Maintenance Director, on 7/17/26 at 12:07 p.m., he used a thermometer to take the temperatures of the hallways on each floor. The second-floor temperature was 79.7 degrees Fahrenheit, the third floor was 81.1 degrees Fahrenheit, and the fourth floor was 84.7 degrees Fahrenheit. There was one fan on each floor.

According to the accuweather.com website, the high temperature for 7/17/26 was 89 degrees Fahrenheit.

A review of past high temperatures on accuweather.com from 7/1/26 through 7/17/26 indicated the temperature reached a high at or above 80 degrees for 16 of the 17 days reviewed.

During an interview with the

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	Maintenance Director present, on 7/17/26 at 1:44 p.m., the Administrator indicated that there was one company that they used for repairs to the air conditioning unit. The Maintenance Director indicated if they went through another company for the repairs there would be an issue with obtaining parts. He thought about getting portable air conditioning units or fans with spritzers, but they could be a trip hazard, and some residents used motorized scooters. The portable air conditioners only covered approximately 300 square feet. The company had one of the parts in and were waiting for two other parts. They were hoping to have the other parts in by next week. It was the same problems they ran into with the elevator. The Administrator indicated that the facility did not have a policy related to the air conditioners or equipment repairs. This citation relates to Intake 470610.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual 's medication and treatment records that indicate the:	R 0243	<u>R-0243 Pharmaceutical services- Noncompliance</u> 1. <u>What corrective action(s) will be accomplished for those residents found to have been affected by the</u>	08/04/2026

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FORM APPROVED

OMB NO. 0938-0391

(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 medication was administered according to physician's orders and documented according to facility policy for 1 of 3 residents reviewed for medication administration documentation. (Resident D)

Findings include:

Resident D's clinical record was reviewed on 7/16/26 at 11:34 a.m. Diagnoses included unspecified dementia with behavioral disturbance, generalized anxiety disorder, mild cognitive impairment, unspecified osteoarthritis, other fracture of T7-T8 thoracic vertebra, subsequent encounter, wedge compression fracture of T9-T10 vertebra, subsequent encounter, and multiple fractures of ribs, left side, subsequent encounter.

A 3/26/26 St. Louis University Mental Status (SLUMS) assessment indicated she had

deficient practice. Resident D showed no negative outcome from alleged deficient practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**All residents that receive medication administration have the potential to be affected by the deficient practice. No other residents noted negative outcomes from alleged deficient practice.
3. Nursing staff educated on Medication Management 7/6/2026 by Director of Nursing. Medication administration records are to be audited 3 times a week for 4 weeks, weekly for 2 months, then monthly for 2 months by the Director of Nursing and/or designee.
4. Audits will be reviewed monthly in QA meetings for 6 months, committee to make recommendations for need of ongoing audits.
5. Compliance date 8/4/2026

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dementia.

Her medications included hydrocodone-acetaminophen 5-325 milligram (mg) every four hours.

Her June Medication Administration Record (MAR) and her narcotic inventory sheet indicated she had missed doses on 6/10/26 at 4:00 p.m., 6/21/26 at 4:00 a.m., 6/25/26 at 8:00 a.m., 6/26/26 at 4:00 p.m., 6/27/26 at 8:00 p.m., and 6/29/26 at 4:00 a.m.

Her July MAR and her narcotic inventory sheet indicated she had missed doses on 7/2/26 at 4:00 p.m. and 7/3/26 at 4:00 p.m.

A 6/17/26 initial service plan indicated she needed pain medication to control pain.

During an interview, on 7/17/26 at 10:40 a.m., QMA 15 indicated Resident D refused her medication.

During an interview, on 7/17/26 at 1:55 p.m., the DON indicated she was unsure why the medications were not signed out, but it would be a topic of discussion with staff. If the resident refused and it was not documented in the MAR, they would put a note in the clinical record.

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A 5/2026 revised current facility policy, titled "Medication Management, Administration, & Storage," provided by the Administrator on 7/17/26 at 2:50 p.m., indicated the following: "...Policy...B. Medication Administration: Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA. 1. Rights of Medication Administration...The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation...."

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) DATE08/04/2026