

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

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                   |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>07/26/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>VITA OF MARION                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>4211 S ADAMS STREET, MARION, ,<br>46953 |                                  |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                                                                                                                                                                                                             | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION... | (X5)<br>COMPLETION<br>DATE                                      |                                                 |
| R 0000                                                                                                                                                                                                                                            | <p>INITIAL COMMENTS</p> <p>This visit was for the<br/>Investigation of Complaint<br/>IN00413722.</p> <p>Complaint IN00413722 - No<br/>deficiencies related to the<br/>allegations are cited.</p> <p>Survey date: July 26, 2023</p> <p>Facility number: 015081</p> <p>Residential Census: 59</p> <p>Vita Of Marion was found to be<br/>in compliance with 410 IAC<br/>16.2-5 in regard to the<br/>Investigation of Complaint<br/>IN00413722.</p> <p>Quality review completed July<br/>26, 2023.</p> | R 0000                                                                                  |                                  |                                                                 |                                                 |
| 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<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         | TITLE                            | (X6) DATE                                                       |                                                 |