STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/24/2025

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 Intakes IN00464837, IN00464789, IN00464603, and IN00463949. Intake IN00464837 - No deficiencies related to the allegations are cited. Intake IN00464789 - No deficiencies related to the allegations are cited. Intake IN00464603 - State deficiencies related to the allegations are cited at R064. Intake IN00463949 - No deficiencies related to the allegations are cited. Survey dates: September 22, 23, and 24, 2025 Facility number: 015081 Residential Census: 83	R 0000	Vita of Marion submits this plan of correction with a compliance date of 10/24/25	

	This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed October 6, 2025.			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to protect the residents' property from loss and or theft. This deficient practice effected 1 of 3 residents reviewed for misappropriation of property. (Resident D) Findings include: Resident D's clinical record was reviewed on 9/22/2025 at 2:00 p.m. Diagnoses included vitamin B12 deficiency anemia, hypothyroidism, hyperlipidemia, Insomnia, hypertension, asthma, gastro-esophageal reflux disease without esophagitis, low back pain, and osteoporosis.	R 0064	11.Resident D was not affected by alleged deficiency as she no longer lives in the community. 2 Any residents with Narcotics have potential to be affected by alleged deficiency. All Narcotics are accounted for, no other residents are affected. 3 Clinical staff that were identified as failing to adhere to company policy were issued disciplinary action. Director of Nursing will in-service by October 24, 2025 to clinical staff that are licensed or certified in managing medication on Medication Management, administration, and storage, and destruction of medications. DON or designee will Audit the narcotic count documentation weekly x 4 weeks and monthly x 6 months. Any	10/24/2025

	The clinical record included an order, dated 2/21/2025, for Hydrocodone 5 mg twice daily. Review of a pharmacy packing slip, dated 6/9/2025, indicated 120 Hydrocodone/apap (narcotic pain medication) 5-325 mg tablets were delivered to the facility for Resident D. In a written facility statement, dated 9/4/2025, QMA 1 indicated she and QMA 2 counted the delievered narcotics and all were accounted for. In a written facility statement, dated 9/5/2025, LPN 3 indicated on 9/2/2025, she removed narcotic sheets from the narcotic book of medication cart 3 after learning the resident had expired. She left the narcotic sheets on the medication cart as a reminder to destroy the medications. On 9/4/2025, she looked for the narcotic sheets but they were not on the medication cart. The sheets were located and she asked the nurse on duty to open the narcotic box. The medications were not in the narcotic box. In a written facility statement, dated 9/9/2025, QMA 1 indicated, on 9/3/2025, she worked 2:00 p.m. to 6:00 p.m. QMA 2's replacement, LPN 4, was going to be late. QMA 1 and QMA 2 counted medication cart 3. During the narcotic		discrepancies will be completed, and re-education/corrective action as needed. QAPI committee will review audits monthly for 6 months and make recommendations as needed.	

count, Resident D's narcotics were not present. The narcotic sheets were on the prn (as needed) medication cart. LPN 4 arrived at 7:40 p.m. QMA 1 and LPN 4 counted he medication cart and she gave him the keys to the medication cart.

In an undated written facility statement, QMA 2 indicated, on 9/3/2025, Resident D had discontinued medication that was in the office when she counted the medication cart. After counting, the medications were moved to another floor. On 9/6/2025, when she arrived for her shift, she was informed the medications were missing.

In a written facility statement, dated 9/5/2025, LPN 4 indicated when he arrived at the facility on 8/28/2025 for his 6:00 p.m. shift, he noticed Resident D's narcotic count sheets were on top of the medication cart. He indicated this usually meant the medications were to be destroyed or that the resident had transferred to another facility. At 8:00 a.m., he asked QMA 2 what he was supposed to do with the narcotic sheets. QMA 2 indicated she was not sure but she would contact LPN 3 during her shift to find out what needed to be done. When he returned to work on 8/29/2025, the narcotic sheets were not on the medication cart. Resident D's narcotics were not

in the medication cart narcotic box. He did not become aware of the resident's passing until 9/4/2025.

Review of a facility self reported incident, dated 9/4/2025, indicated on 9/5/2025 the DON was notified 117 tablets of hydrocodone/apap (narcotic pain medication) 5-325 mg that had belonged to a recently discharged resident (Resident D) were missing.

Review of Resident D's narcotic administration sheets 6/10/2025 through 7/9/2025, indicated on 7/2/2025 at 8:00 a.m. one hydrocodone/apap 5-325 mg table was given and the count sheet indicated one tablet was left. On 7/2/2025 at 4:00 p.m., the new count sheet indicated there were 29 tablets.

During an interview, on 9/23/2025 at 9:43 a.m., QMA 5 indicated narcotic counts were done at the beginning and end of every shift. She indicated she heard Resident D had expired and her medications were missing.

During an interview on 9/23/2025 at 10:04 a.m., LPN 6 indicated she had been present when Resident D's medications were discovered as missing. The charge nurse, LPN 3, asked if the resident's narcotics were in the medication carts. The

medications were not in the cart and the narcotic sheets were not in the book and no destruction documentation could be located. QMA 1 found the empty narcotic cards in the trash. LPN 6 found the torn up tops of the medication cards with the prescription number in the shred box.

Review of a current facility policy, dated 4/2024, titled "Medication Disposal" and provided by the DON on 9/24.2025 at 4:51 p.m. The policy indicated the following:

".... Medication Disposal Guidelines: ....

C. Any controlled substance that is considered hazardous waste will be managed in accordance with federal, state and local hazardous waste regulations, as well as the Controlled Substance Act and DEA regulations. ....

E. For unused, non-hazardous controlled substances the "Medication Disposal Log Form" will contain the following information:

1. The resident's name;

2. Date medication disposed

3. A description of packet contents or the name and strength of the specific medication being disposed;

4. The quantity disposed;

5. Reason for disposition; and

6. Signature of witnesses

F. Completed medication disposition records shall be kept on file in the facility for at least three (3) years or as mandated by state law governing the retention and storage of such records.

G. When these medicines are placed in the trash, be sue to place them in an inaccessible location to minimized the chance of accidental poisoning of children and pets.

H. In the case of a resident transferring, "a count" of each specific medication shall be done of the medications being released to the resident/family. This count should be reflected in the resident's nursing notes."

This citation relates to Intake IN00464603.

Based on interview and record review, the facility failed to protect the residents' property from loss and or theft. This deficient practice effected 1 of 3 residents reviewed for misappropriation of property.

(Resident D)

Findings include:

Resident D's clinical record was reviewed on 9/22/2025 at 2:00 p.m. Diagnoses included vitamin B12 deficiency anemia, hypothyroidism, hyperlipidemia, Insomnia, hypertension, asthma, gastro-esophageal reflux disease without esophagitis, low back pain, and osteoporosis.

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medication cart. The sheets were located and she asked the nurse on duty to open the narcotic box. The medications were not in the narcotic box.

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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 SIGNATUREDustin Newsome	TITLEExecutive Director	(X6) DATE10/17/2025