STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/09/2025

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 Intake IN00465215. Intake IN00465215 - State deficiencies related to the allegations are cited at R0297. Survey date: October 8 and 9, 2025 Facility number: 015081 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 21, 2025.	R 0000		
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the	R 0297	1 Resident B had no adverse effects related to alleged deficiency. 2	11/08/2025

following for that resident:

(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.

A. Based on interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed for medication administration (Resident B).

B. Based on interview and record review, the facility failed to monitor vital signs prior to administering medications per physician orders for 1 of 3 residents reviewed (Resident B).

C. Based on interview and record review, the facility failed to monitor blood sugars per physician orders for 1 of 3 residents reviewed (Resident B).

Findings include:

A. Resident B's clinical record was reviewed on 10/8/25 at 11:30 a.m. Diagnoses included hypertension, anxiety, depression, breast cancer and abdominal aortic aneurysm.

Current orders included Eliquis (anticoagulant) 5 milligram (mg) twice daily. Hold Eliquis 3 days before surgery and restart 24

Any residents that have medications with vital signs parameters could be affected. Audit will be conducted to identify any other residents by alleged deficiency; corrections will be completed at time of audit if necessary.

3
Staff were in-service on Medication Administration and adding vital signs into the order by the Director of Nursing on 10/1/25. Director of Nursing or designee will audit medications with required vital signs weekly for 4 weeks and then monthly for 5 months

4
Audits will review by the QA committee for 6 months and make recommendations as necessary.

hours after surgery (7/25/25). Hold Eliquis 9/19/25-9/20/25 for injections (8/25/25) and enoxaparin (anticoagulant) 40 mg injection daily starting on 9/20/25 and ending on 9/23/25 then resume on 9/25/25 and take through 9/27/25 (9/19/25).

A Preoperative surgery Review Report dated 9/17/25, received on 10/9/25, from the DON, indicated to hold Eliquis five days prior to surgery per primary care physician recommendations.

Resident B had surgery on 9/24/25.

Resident B's Eliquis was held on 9/17/25 through 9/24/25, seven days prior to her surgery.

Resident B's enoxaparin injection was restarted on 9/26/25 through 9/28/25.

An office clinic note dated 9/29/25, received on 10/9/25 at 11:44 a.m., from the DON, indicated LPN 3 notified the surgeon regarding a missed enoxaparin injection on 9/25/25, the day after Resident B's surgery but did receive her Eliquis dose. Both Resident B's primary care physician and surgeon agreed the last dose of enoxaparin could be held since Eliquis was resumed the day after surgery.

During an interview, on 10/8/25

at 3:59 p.m., LPN 3 indicated Resident B's representative called the facility and stated her Eliquis needed to be stopped on 9/17/25.

During an interview, on 10/9/25 at 11:29 a.m., the DON indicated Resident B's Eliquis should have been held five days prior to surgery. They faxed the order to the pharmacy, who transcribed the order in the facilities computer system to hold the Eliquis seven days prior to surgery.

B. Resident B's clinical record was reviewed on 10/8/25 at 11:30 a.m. Diagnoses included hypertension.

Current orders included amlodipine 5 mg once daily. Hold for systolic blood pressure below 110 millimeters of mercury (mmHg) (9/13/25).

A Medication Administration Report (MAR), for September 2025, indicated Resident B received amlodipine without obtaining a blood pressure reading as follows:

9/14, 9/15, 9/16, 9/17, 9/18, 9/20, 9/21, 9/23, 9/24, 9/25, 9/26, 9/27, 9/28, 9/29

A MAR, for October 2025, indicated Resident B received amlodipine without obtaining vital signs as follows:

10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9

An anonymous interview, during the survey period, indicated Resident B did not have her blood pressure checked before administering the amlodipine. The computer system did not flag that Resident B's blood pressure needed to be checked before administering the medication.

During an interview, on 10/9/25 at 10:33 a.m., LPN 3 indicated she does not check Resident B's blood pressure before administering the amlodipine medication.

On 10/9/25 at 11:29 a.m., the DON indicated Resident B's blood pressure was only checked twice between 9/14/25 and 10/9/25.

C. Resident B's clinical record was reviewed on 10/8/25 at 11:30 a.m. Diagnoses included hypertension, anxiety, depression, breast cancer and abdominal aortic aneurysm.

Current orders included accu-chek guide me monitor (7/29/25), accu- chek guide test strips use twice daily (7/29/25), and accu-chek twice daily (9/25/25).

A vital sign report indicated Resident B did not receive accu-cheks twice daily on

9/25/25, 10/6/25, and 10/7/25.

An anonymous interview, during the survey period, indicated Resident B's blood sugars would be documented under the vitals tab.

During an interview, on 10/9/25 at 11:29 a.m., the DON indicated blood sugar checks were not performed per physician order.

Review of a current facility policy, titled "Medication Management, Administration, and Storage," provided by the DON, on 10/9/25 at 1:16 p.m., indicated the following: " ...B. Medication administration will be administered as ordered by the residents provider ...."

Review of a current facility policy, titled "Medication Administration," provided by the DON on 10/21/24 at 9:28 a.m., indicated the following: " ...Medications are administered in accordance with written orders of the physician/prescriber ...."

This citation relates to Intake IN00465215.

A. Based on interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed for medication administration (Resident B).

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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) DATE11/03/2025