STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITA OF NEW WHITELAND	532 COUNTRY GATE DRIVE , NEW WHITELAND, , 46184

(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 Complaint IN00463705. Complaint IN00463705 - State deficiencies related to the allegations are cited at R0052. Survey date: August 5, 2025 Facility number: 016046 Residential Census: 73 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed August 6, 2025.	R 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Vita of New Whiteland respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B care plan reviewed	08/15/2025

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed for supervision. A resident who resided on the secured memory care unit exited the facility through an unlocked door without staff knowledge. (Resident B)

Findings include:

During an interview on 8/5/25 at 9:13 a.m., Qualified Medication Aide (QMA) 1 indicated, on 7/12/25 at approximately 7:00 a.m., Resident B walked out of the facility through the northeast emergency exit and was located approximately four minutes later by a staff member that was pulling into the back parking lot. The night shift staff were not aware that Resident B had been outside the facility.

During an interview on 8/5/25 at 9:28 a.m. CNA 1 indicated when she pulled into the employee parking lot, on 7/12/25 at approximately 7:00 a.m., Resident B was outside

and updated. Involved staff educated.

How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:

All residents who self-ambulate in the Memory Care area without assistance have the potential to be affected by the alleged deficient practice.

Remote door unlocking features have been removed to avoid any potential malfunction to prevent the potential for elopement of residents who might lack cognition to make appropriate decisions.

Care staff to conduct rounds every two hours.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

	standing on the sidewalk in front of the east entrance. As CNA 1 walked up to Resident B, three staff members came outside to get her and indicated they did not know Resident B had been outside the facility. Resident B exited through the northeast emergency exit door which had been left unlocked for approximately twelve hours. On 8/5/25 at 9:30 a.m., observed the path Resident B walked from the northeast emergency exit door to the east entrance. Outside the northeast exit door was a well kept sidewalk approximately fifteen feet. Then Resident B turned right, on the sidewalk, and walked approximately 50 feet to the east entrance. The clinical record for Resident B was reviewed on 8/5/25 at 9:43 a.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, and insomnia. An assessment, dated 9/22/24, indicated Resident B was independent with ambulation and was at risk for an elopement because she wandered, required directions or reminding, continuous daily cuing, and required 24 hour monitoring. A progress note, dated 7/12/25 at 7:05 a.m., indicated Resident		ED/Designee will complete an inservice with staff to ensure staff education on resident right to be free of abuse/neglect completed by 7/16/25. DON/Designee educated regarding remote door access in/out Memory Care Unit on 8/7/25. Remote door unlocking features have been removed to avoid any potential malfunction to prevent the potential for elopement of residents who might lack cognition to make appropriate decisions. **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:** DON/Designee will be responsible for reviewing and providing interventions to all memory care residents that show increases in wandering behavior 5 times a	

	B exited the facility through the northeast emergency exit door on the secured memory care unit and walked around to the back door where Resident B was immediately seen by CNA 1 and escorted back into the building. During an interview on 8/5/25 at 11:25 a.m., the Information Technology Specialist (IT) indicated he was able to review the security system user activity log to find out when the northeast emergency exit door was unlocked and by whom. The northeast emergency exit door was unlocked, on 7/11/25 at approximately 7:00 a.m., and was relocked, on 7/12/25 at approximately 7:00 a.m. The electronic device that unlocked that door was used by the Director of Nursing (DON). On 8/5/25 at 9:50 a.m., the Administrator provided a copy of a facility policy, titled Elopement Risk and Missing Resident Policy, dated 11/2023, and indicated this was the current policy used by the facility. A review of the policy indicated the facility's goal was to provide a safe environment for all residents. This citation relates to Complaint IN00463705. Based on interview and record review, the facility failed to		week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed:** 8/15/25	

	protect the resident's right to be free from neglect for 1 of 3 residents reviewed for supervision. A resident who resided on the secured memory care unit exited the facility through an unlocked door without staff knowledge. (Resident B) Findings include: During an interview on 8/5/25 at 9:13 a.m., Qualified Medication Aide (QMA) 1 indicated, on 7/12/25 at approximately 7:00 a.m., Resident B walked out of the facility through the northeast emergency exit and was located approximately four minutes later by a staff member that was pulling into the back parking lot. The night shift staff were not aware that Resident B had been outside the facility.			

During an interview on 8/5/25 at 9:28 a.m. CNA 1 indicated when she pulled into the employee parking lot, on 7/12/25 at approximately 7:00 a.m., Resident B was outside standing on the sidewalk in front of the east entrance. As CNA 1 walked up to Resident B, three staff members came outside to get her and indicated they did not know Resident B had been outside the facility. Resident B exited through the northeast emergency exit door which had been left unlocked for approximately twelve hours.

On 8/5/25 at 9:30 a.m., observed the path Resident B walked from the northeast emergency exit door to the east entrance. Outside the northeast exit door was a well kept sidewalk approximately fifteen feet. Then Resident B turned right, on the sidewalk, and walked approximately 50 feet to the east entrance.

The clinical record for Resident B was reviewed on 8/5/25 at 9:43 a.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, and insomnia.

An assessment, dated 9/22/24, indicated Resident B was independent with ambulation and was at risk for an elopement because she wandered, required directions or

	reminding, continuous daily cuing, and required 24 hour monitoring. A progress note, dated 7/12/25 at 7:05 a.m., indicated Resident B exited the facility through the northeast emergency exit door on the secured memory care unit and walked around to the back door where Resident B was immediately seen by CNA 1 and escorted back into the building. During an interview on 8/5/25 at 11:25 a.m., the Information Technology Specialist (IT) indicated he was able to review the security system user activity log to find out when the northeast emergency exit door was unlocked and by whom. The northeast emergency exit door was unlocked, on 7/11/25 at approximately 7:00 a.m., and was relocked, on 7/12/25 at approximately 7:00 a.m. The electronic device that unlocked that door was used by the Director of Nursing (DON).			

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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 SIGNATURE	TITLE	(X6) DATE