STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITA OF GREENFIELD	1683 COMMUNITY WAY, GREENFIELD, , 46140

(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 IN00463024. Complaint IN00463024 - State deficiencies related to the allegations are cited at R0117 and R0296. Unrelated deficiency is cited. Survey dates: July 22, 23 and 24, 2025 Facility number: 016063 Residential Census: 62 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 26, 2025.	R 0000		
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6)	R 0090	All Residents potentially affected. State reportable incidents will be audited by Don, ED or designee weekly x 4 weeks, then monthly thereafter to ensure timely follow	08/22/2025

	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate		up. RDO will provide ISDH reporting and follow up education to DON.	

	record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to file an updated post-incident report with the Indiana Department of Health's Long-Term Care Division within five (5) days of the initial incident report, regarding an allegation of staff to resident abuse for 1 of 1 resident reviewed for abuse. Findings include: The facility filed a reportable incident on 7-9-25, related to Resident B alleging Licensed Practical Nurse (LPN) 3 scratched her wrist during medication administration. The			

	reportable indicated that the facility initiated an investigation on 7-9-25, which included but was not limited to, an assessment of the resident, notification of the resident's physician and power-of-attorney, notification to the local police department and the suspension of LPN 3, pending investigation findings. In an interview on 7-22-25 at 1:00 p.m., the Corporate Nurse indicated the facility did not file a follow-up report with the Indiana Department of Health's Long-Term Care Division. On 7-23-25 at 4:00 p.m., the Director of Nursing provided a copy of a follow-up to this incident, dated 7-23-25, regarding the findings of the investigation. On 7-24-25 at 1:13 p.m., the Director of Nursing provided a copy of an undated policy, entitled, "Incident Reporting." This policy indicated, "Any incident or unusual occurrence involving a resident ...is reported in full ...Examples of incidents or occurrences which should be reported ...An injury, or any occurrence which might have potential adverse effect on any resident ...suspected abuse ...If the incident involves a resident, within state regulatory guidelines for reporting, the Executive Director, Director of Nursing or designee, will			

	complete required reporting of resident incidents to any state regulatory authorities, as required by state law ..." 2.5-1.3(g)(1)(D) Based on interview and record review, the facility failed to file an updated post-incident report with the Indiana Department of Health's Long-Term Care Division within five (5) days of the initial incident report, regarding an allegation of staff to resident abuse for 1 of 1 resident reviewed for abuse. Findings include: The facility filed a reportable incident on 7-9-25, related to Resident B alleging Licensed Practical Nurse (LPN) 3 scratched her wrist during medication administration. The reportable indicated that the facility initiated an investigation on 7-9-25, which included but was not limited to, an assessment of the resident, notification of the resident's physician and power-of-attorney, notification to the local police department and the suspension of LPN 3, pending investigation findings. In an interview on 7-22-25 at 1:00 p.m., the Corporate Nurse indicated the facility did not file a follow-up report with the Indiana Department of Health's Long-Term Care Division. On			

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R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided.	R 0117	All residents potentially affected. Don, ED or designee will provide staffing education to scheduler. ED, DON or designee will conduct audits of schedule daily x 30 days then weekly thereafter to ensure appropriate staffing according to state regulations for all shifts.	08/12/2025

	The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure 57 residents, including 25 residents on the secured memory care unit, had adequate staffing to meet their care needs, on two consecutive nights in July of 2025. This had the potential to adversely affect all 57 residents of the facility. Findings include: In a telephone interview with Registered Nurse (RN) 5 on 7-22-25 at 5:47 p.m., she indicated for the night shift of 7-5-25 at approximately 9:30			

	p.m. and through 6:00 a.m. on 7-6-25, "I was the only Vita employee in the building. There were two falls that night, one on [the secured] memory care unit and one on AL [assisted living portion of the building]. Neither one caused any injuries. Had to call EMS [emergency medical services] to give me help to get them up ...did the best I could." She recalled the census at that time was 54. She indicated the Director of Nursing (DON), the staffing coordinator and the management team were aware of the staffing situation. "I was not aware I would be there by myself after 9:30 p.m., until I came to work at 6:00 p.m." RN 5 did not provide the names of the residents who fell during the time she was alone in the facility. She did emphasize she did spend the majority of her time alone working on the secured memory care unit but did have to leave it unsupervised several times to go to the assisted living portion of the facility. In an interview with the DON on 7-23-25 at 10:50 a.m., she recalled she had worked the night shift on 7-4-25 from 6:00 p.m. to 6:00 a.m. on 7-5-25., and was the only nurse and only employee from around 1:00 a.m. until 6:00 a.m. on 7-5-25 due to a staff member having called off work. "We didn't have anybody else. I did the best that			

	I could. I will admit that I did have to leave the memory care unattended for a time or two during the time I was here by myself, but I did have my cell phone with me that has all the hall cameras up and that way I could see if anyone was up and about. Then on Saturday night, from 6:00 p.m. [on 7-5-25] to 6:00 a.m. on 7-6-25, [name of RN 5] was here by herself for the same reason. It looks like [name of CNA 6] was here then until 9:30 p.m.," on 7-5-25. In an interview with the Corporate Nurse at the same time, she indicated the facility's census on both days was 57. Further census clarification on 7-24-25 at 1:57 p.m., indicated the secured memory care unit had a census of 25 during that time frame. On 7-23-25 at 3:15 p.m., the DON provided a fall log which indicated the following falls occurred during the times of 1:00 a.m. until 6:00 a.m. on 7-5-25, and 9:30 p.m. on 7-5-25 to 6:00 a.m. on 7-6-25: -7-5-25 at 1:36 a.m., one resident on the secured memory care unit fell and sustained no injury. -7-5-25 at 4:50 a.m., one resident on the secured memory care unit fell, resulting in a loss of consciousness and was sent			

	to the local emergency room for further evaluation and treatment. -7-6-25 at 5:15 a.m., one resident on the secured memory care unit fell and sustained no injury. In an interview with the Corporate Nurse on 7-23-25 at 10:50 a.m., she indicated the facility does not have a specific policy on staffing but follows the state regulations regarding staffing. This Residential tag relates to Complaint IN00463024. 2.5-1.4(b) 2.5-1.3(l)(1) 2.5-1.3(m)(1) 2.5-1.3(m)(2)(B)(ii) 2.5-1.3(m)(1)(B)(iii) Based on interview and record review, the facility failed to ensure 57 residents, including 25 residents on the secured memory care unit, had adequate staffing to meet their care needs, on two consecutive nights in July of 2025. This had the potential to adversely affect all 57 residents of the facility. Findings include: In a telephone interview with			

	Registered Nurse (RN) 5 on 7-22-25 at 5:47 p.m., she indicated for the night shift of 7-5-25 at approximately 9:30 p.m. and through 6:00 a.m. on 7-6-25, "I was the only Vita employee in the building. There were two falls that night, one on [the secured] memory care unit and one on AL [assisted living portion of the building]. Neither one caused any injuries. Had to call EMS [emergency medical services] to give me help to get them up ...did the best I could." She recalled the census at that time was 54. She indicated the Director of Nursing (DON), the staffing coordinator and the management team were aware of the staffing situation. "I was not aware I would be there by myself after 9:30 p.m., until I came to work at 6:00 p.m." RN 5 did not provide the names of the residents who fell during the time she was alone in the facility. She did emphasize she did spend the majority of her time alone working on the secured memory care unit but did have to leave it unsupervised several times to go to the assisted living portion of the facility. In an interview with the DON on 7-23-25 at 10:50 a.m., she recalled she had worked the night shift on 7-4-25 from 6:00 p.m. to 6:00 a.m. on 7-5-25., and was the only nurse and only employee from around 1:00			

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R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication	R 0296	All residents pontentially affected. DON, ED or designee will provide an Inservice on infection control and medication administration will be conducted for clinical staff.	08/22/2025

staff.

Based on observation, interview, and record review, the facility failed to ensure a medication dropped during a medication pass observation was not picked up with bare hands and then administered to a resident during 1 of 3 medication pass observations with 1 of 2 staff members. (Resident D, QMA 4)

Findings include:

During a medication pass on 7-23-25 at 8:48 a.m., with Qualified Medication Aide (QMA) 4, she was observed to prepare 12 medications for Resident D.

During the process of preparing the medications, QMA 4 was observed to drop one white pill from the medication packet onto the top of the medication cart, quickly picked it up with her bare fingers and placed it into a pill cup prior to administering the medications. In an interview with QMA 4, on 7-23-35 at 12:50 p.m., she indicated she was trying to keep the pill from falling on the floor and acknowledged she should not have touched the pill with bare hands and then give the medication after touching the pill.

On 7-24-25 at 1:50 p.m., the Director of Nursing (DON)

provided a copy of a policy, dated 5-30-25, and entitled, "Medication Administration Policy." This policy indicated, "Only licensed nurses or certified QMA's may administer medications. Staff must complete required training and maintain current certification." In an interview with the DON at this time, she indicated if a medication is dropped, it should be disposed of, and the pharmacy should be contacted in order to obtain a new dosage of the dropped medication. She indicated medications should not be touched by bare hands.

This Residential tag relates to Complaint IN00463024.

2.5-6(b)

Based on observation, interview, and record review, the facility failed to ensure a medication dropped during a medication pass observation was not picked up with bare hands and then administered to a resident during 1 of 3 medication pass observations with 1 of 2 staff members. (Resident D, QMA 4)

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	indicated medications should not be touched by bare hands. This Residential tag relates to Complaint IN00463024. 2.5-6(b)			

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 SIGNATUREAllison Catron	TITLERDCS	(X6) DATE09/26/2025