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 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 a State Residential Licensure Survey. Survey dates: October 7, 8, and 9, 2025 Facility number: 016063 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 14, 2025.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	Resident potentially affected: All RDO/Designee to perform Inservice with Maintenance Director regarding monthly fire drill expectations and documenting.	11/08/2025

alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.

(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.

Based on interview and record review, the facility failed to hold monthly fire drills for 1 of 11 months reviewed for monthly fire drills. (Facility)

Findings include:

The fire drills logbook was provided by the Director of Nursing (DON) on 10/9/25 at 1:15 p.m. It indicated fire drills were conducted monthly, from November 2024 to September 2025, with one month, in August 2025, that the fire drills were not conducted.

During an interview with the

	Regional Director of Clinical Services (RDCS) on 10/9/25 at 2:15 p.m., they indicated there were no fire drills for August 2025 present in their fire drills logbook. The RDCS indicated it was the maintenance director who was responsible for making sure monthly fire drills were conducted at the facility. Based on interview and record review, the facility failed to hold monthly fire drills for 1 of 11 months reviewed for monthly fire drills. (Facility) Findings include: The fire drills logbook was provided by the Director of Nursing (DON) on 10/9/25 at 1:15 p.m. It indicated fire drills were conducted monthly, from November 2024 to September 2025, with one month, in August 2025, that the fire drills were not conducted. During an interview with the Regional Director of Clinical Services (RDCS) on 10/9/25 at 2:15 p.m., they indicated there were no fire drills for August 2025 present in their fire drills logbook. The RDCS indicated it was the maintenance director who was responsible for making sure monthly fire drills were conducted at the facility.			
R 0217	Evaluation - Deficiency	R 0217	Residents potentially affected: All	11/08/2025

	410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is		residents RDC/Designee to provide inservice on Service Plan signatures to DON. RDC/Designee to audit service plan signatures x4 weeks weekly and each month thereafter.	

	needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to have service plans signed and dated by the resident or residents' representative for 3 of 6 residents reviewed for service plans. (Residents 3, 4, and 5) Findings include: 1.) The clinical record for Resident 3 was reviewed on 10/8/25 at 1:40 p.m. The diagnoses included, but were not limited to, blindness and hypertension. During an interview with Resident 3 on 10/8/25 at 10:25 a.m., they indicated they could not remember having a service plan meeting since they were admitted to the facility on 5/21/25. An individual service plan for Resident 3, dated 10/7/25, was provided by the Director of Nursing (DON) on 10/9/25 at 9:15 a.m. It indicated Resident 3, nor a resident representative had signed or dated their service plan. 2.) The clinical record for Resident 4 was reviewed on 10/9/25 at 10:30 a.m. The diagnoses included, but were			

not limited to, low back pain and congestive heart failure.

An individual service plan for Resident 4, dated 7/11/25, was provided by the DON on 10/9/25 at 1:10 p.m. It indicated Resident 4, nor a resident representative had signed or dated their service plan.

3.) Review of the clinical record of Resident 5, on 10/7/25 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, coronary artery disease, anemia and restless leg syndrome.

Review of Resident 5's service plan, dated 8/18/25, did not have the resident's or resident's representative signature.

During an interview with the Regional Director of Clinical Services on 10/9/25 at 11:05 a.m., they indicated it was the responsibility of the clinical staff to ensure residents' service plans were signed and dated.

During an interview with the Regional Director of Clinical Services on 10/9/25 at 1:05 p.m., they indicated the facility did not have a policy related to service plans. The facility's expectation was that service plans would be signed and dated by the resident or the resident representative.

Based on interview and record review, the facility failed to have service plans signed and dated by the resident or residents' representative for 3 of 6 residents reviewed for service plans. (Residents 3, 4, and 5)

Findings include:

1.) The clinical record for Resident 3 was reviewed on 10/8/25 at 1:40 p.m. The diagnoses included, but were not limited to, blindness and hypertension.

During an interview with Resident 3 on 10/8/25 at 10:25 a.m., they indicated they could not remember having a service plan meeting since they were admitted to the facility on 5/21/25.

An individual service plan for Resident 3, dated 10/7/25, was provided by the Director of Nursing (DON) on 10/9/25 at 9:15 a.m. It indicated Resident 3, nor a resident representative had signed or dated their service plan.

2.) The clinical record for Resident 4 was reviewed on 10/9/25 at 10:30 a.m. The diagnoses included, but were not limited to, low back pain and congestive heart failure.

An individual service plan for Resident 4, dated 7/11/25, was provided by the DON on 10/9/25

at 1:10 p.m. It indicated Resident 4, nor a resident representative had signed or dated their service plan.

3.) Review of the clinical record of Resident 5, on 10/7/25 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, coronary artery disease, anemia and restless leg syndrome.

Review of Resident 5's service plan, dated 8/18/25, did not have the resident's or resident's representative signature.

During an interview with the Regional Director of Clinical Services on 10/9/25 at 11:05 a.m., they indicated it was the responsibility of the clinical staff to ensure residents' service plans were signed and dated.

During an interview with the Regional Director of Clinical Services on 10/9/25 at 1:05 p.m., they indicated the facility did not have a policy related to service plans. The facility's expectation was that service plans would be signed and dated by the resident or the resident representative.

Based on interview and record review, the facility failed to have service plans signed and dated by the resident or residents' representative for 3 of 6 residents reviewed for service

plans. (Residents 3, 4, and 5)

Findings include:

1.) The clinical record for Resident 3 was reviewed on 10/8/25 at 1:40 p.m. The diagnoses included, but were not limited to, blindness and hypertension.

During an interview with Resident 3 on 10/8/25 at 10:25 a.m., they indicated they could not remember having a service plan meeting since they were admitted to the facility on 5/21/25.

An individual service plan for Resident 3, dated 10/7/25, was provided by the Director of Nursing (DON) on 10/9/25 at 9:15 a.m. It indicated Resident 3, nor a resident representative had signed or dated their service plan.

2.) The clinical record for Resident 4 was reviewed on 10/9/25 at 10:30 a.m. The diagnoses included, but were not limited to, low back pain and congestive heart failure.

An individual service plan for Resident 4, dated 7/11/25, was provided by the DON on 10/9/25 at 1:10 p.m. It indicated Resident 4, nor a resident representative had signed or dated their service plan.

3.) Review of the clinical record

of Resident 5, on 10/7/25 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, coronary artery disease, anemia and restless leg syndrome.

Review of Resident 5's service plan, dated 8/18/25, did not have the resident's or resident's representative signature.

During an interview with the Regional Director of Clinical Services on 10/9/25 at 11:05 a.m., they indicated it was the responsibility of the clinical staff to ensure residents' service plans were signed and dated.

During an interview with the Regional Director of Clinical Services on 10/9/25 at 1:05 p.m., they indicated the facility did not have a policy related to service plans. The facility's expectation was that service plans would be signed and dated by the resident or the resident representative.

Based on interview and record review, the facility failed to have service plans signed and dated by the resident or residents' representative for 3 of 6 residents reviewed for service plans. (Residents 3, 4, and 5)

Findings include:

1.) The clinical record for Resident 3 was reviewed on

	10/8/25 at 1:40 p.m. The diagnoses included, but were not limited to, blindness and hypertension. During an interview with Resident 3 on 10/8/25 at 10:25 a.m., they indicated they could not remember having a service plan meeting since they were admitted to the facility on 5/21/25. An individual service plan for Resident 3, dated 10/7/25, was provided by the Director of Nursing (DON) on 10/9/25 at 9:15 a.m. It indicated Resident 3, nor a resident representative had signed or dated their service plan. 2.) The clinical record for Resident 4 was reviewed on 10/9/25 at 10:30 a.m. The diagnoses included, but were not limited to, low back pain and congestive heart failure. An individual service plan for Resident 4, dated 7/11/25, was provided by the DON on 10/9/25 at 1:10 p.m. It indicated Resident 4, nor a resident representative had signed or dated their service plan. 3.) Review of the clinical record of Resident 5, on 10/7/25 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, coronary artery disease, anemia and restless			

	leg syndrome. Review of Resident 5's service plan, dated 8/18/25, did not have the resident's or resident's representative signature. During an interview with the Regional Director of Clinical Services on 10/9/25 at 11:05 a.m., they indicated it was the responsibility of the clinical staff to ensure residents' service plans were signed and dated. During an interview with the Regional Director of Clinical Services on 10/9/25 at 1:05 p.m., they indicated the facility did not have a policy related to service plans. The facility's expectation was that service plans would be signed and dated by the resident or the resident representative.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.	R 0246	Residents potentially affected: All residents DON/designee to perform in-service for QMA's to include PRN medication administration and authorization to give PRN medication.	11/08/2025

Based on interview and record review, the facility failed to have documentation that a Qualified Medication Aide (QMA) received authorization to provide a resident with a PRN (as needed) Xanax (antianxiety medication) for 1 of 5 residents reviewed for PRN medications (Resident 2).

Findings include:

Review of the clinical record of Resident 2, on 10/8/25 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, major depression and anxiety.

The Medication Administration Record (MAR) for Resident 2, dated October 3, 2025, indicated QMA 1 administered Xanax 0.25 milligrams (mg) PRN at 9:30 a.m. for anxiety. The record did not have documentation that QMA 1 had received authorization from a nurse to provide the resident with the PRN Xanax.

During an interview with QMA 1 on 10/8/25 at 11:30 a.m., she indicated she did administer Resident 2 Xanax 0.25 mg PRN on 10/3/25 at 9:30 a.m.

During an interview with the Director of Nursing (DON) on 10/9/25 at 11:10 a.m., they indicated QMA 1, and the Nurse

should have documented on Resident 2's MAR or in the progress notes that a nurse had authorized QMA 1 to administer Resident 2 Xanax 0.25 mg PRN on 10/3/25.

The Medication Administration policy was provided by the Regional Director of Operations on 10/9/25 at 1:40 p.m. The policy indicated a PRN (as needed) medication must be approved by a licensed nurse and require documentation of the resident's symptoms and the nurse's authorization. The nurse must cosign the administration record.

Based on interview and record review, the facility failed to have documentation that a Qualified Medication Aide (QMA) received authorization to provide a resident with a PRN (as needed) Xanax (antianxiety medication) for 1 of 5 residents reviewed for PRN medications (Resident 2).

Findings include:

Review of the clinical record of Resident 2, on 10/8/25 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, major depression and anxiety.

The Medication Administration Record (MAR) for Resident 2, dated October 3, 2025, indicated QMA 1 administered

	Xanax 0.25 milligrams (mg) PRN at 9:30 a.m. for anxiety. The record did not have documentation that QMA 1 had received authorization from a nurse to provide the resident with the PRN Xanax. During an interview with QMA 1 on 10/8/25 at 11:30 a.m., she indicated she did administer Resident 2 Xanax 0.25 mg PRN on 10/3/25 at 9:30 a.m. During an interview with the Director of Nursing (DON) on 10/9/25 at 11:10 a.m., they indicated QMA 1, and the Nurse should have documented on Resident 2's MAR or in the progress notes that a nurse had authorized QMA 1 to administer Resident 2 Xanax 0.25 mg PRN on 10/3/25. The Medication Administration policy was provided by the Regional Director of Operations on 10/9/25 at 1:40 p.m. The policy indicated a PRN (as needed) medication must be approved by a licensed nurse and require documentation of the resident's symptoms and the nurse's authorization. The nurse must cosign the administration record.			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5)	R 0301	Residents potentially affected: All residents	11/08/2025

	(5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to label insulin with an open date to ensure it was not administered after it was expired for 1 of 1 resident reviewed for insulin administration (Resident 8). Findings include: During a medication administration observation on 10/8/25 at 11:48 a.m., Qualified Medication Aide (QMA) 2 administered four units of Humalog (fast-acting insulin) subcutaneous (SUB-Q) to Resident 8's left arm. Resident 8's blood sugar was 240. The		DON/designee to provide in-service including medication labeling to clinical staff (QMA, LPN's, and RN's)	

	Humalog flex pen did not have an open date on the label. QMA 2 verified it did not have an open date or a date when the pharmacy had delivered the Humalog insulin flex pen. During an interview with the Director of Nursing (DON) on 10/9/25 at 11:07 a.m., they indicated it was the responsibility of whoever opened Resident 8's Humalog pen to put the date on it. The DON indicated Humalog could be used for 28 days after it was opened. Review of the clinical record of Resident 8, on 10/9/25 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes. A physician's order for Resident 8, dated 9/4/25, indicated the resident was ordered Humalog four units twice a day SUB-Q. The facility policy for stability of common insulin in pens was provided by the DON on 10/9/25 at 1:40 p.m. The policy indicated Humalog expired 28 days after it was opened.			

Based on observation, interview, and record review, the facility failed to label insulin with an open date to ensure it was not administered after it was expired for 1 of 1 resident reviewed for insulin administration (Resident 8).

Findings include:

During a medication administration observation on 10/8/25 at 11:48 a.m., Qualified Medication Aide (QMA) 2 administered four units of Humalog (fast-acting insulin) subcutaneous (SUB-Q) to Resident 8's left arm. Resident 8's blood sugar was 240. The Humalog flex pen did not have an open date on the label. QMA 2 verified it did not have an open date or a date when the pharmacy had delivered the Humalog insulin flex pen.

During an interview with the Director of Nursing (DON) on 10/9/25 at 11:07 a.m., they indicated it was the responsibility of whoever opened Resident 8's Humalog pen to put the date on it. The DON indicated Humalog could be used for 28 days after it was opened.

Review of the clinical record of Resident 8, on 10/9/25 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes.

	A physician's order for Resident 8, dated 9/4/25, indicated the resident was ordered Humalog four units twice a day SUB-Q. The facility policy for stability of common insulin in pens was provided by the DON on 10/9/25 at 1:40 p.m. The policy indicated Humalog expired 28 days after it was opened.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to accurately track and trend infections for 6 of 10 months reviewed for infection control tracking and trending. (Facility)	R 0407	Residents potentially affected: All residents RDC/designee to provide in-service including infection prevention tracking and trending to DON.	11/08/2025

Findings include:

The tracking and trending binder for infections was provided by the Director of Nursing (DON) on 10/9/25 at 1:00 p.m. It indicated tracking and trending for infections was not conducted for the following months: November and December 2024, January, February, March, and April 2025.

During an interview with the DON on 10/9/25 at 1:05 p.m., they indicated there was no tracking or trending for infections conducted for November and December 2024, and for January, February, March, and April 2025. The DON indicated it was the DON/infection prevention nurse who was responsible to ensure this tracking and trending for infections was completed monthly and accurately.

The Infection Control policy was provided by the Regional Director of Operations on 10/9/25 at 1:40 p.m. It indicated "...Director of Nursing/Infection Control Coordinator: Oversees procedures, tracks infections...9. Surveillance and Reporting: Track infections...Recordkeeping: Maintain infection logs..."

Based on interview and record review, the facility failed to accurately track and trend

infections for 6 of 10 months reviewed for infection control tracking and trending. (Facility)

Findings include:

The tracking and trending binder for infections was provided by the Director of Nursing (DON) on 10/9/25 at 1:00 p.m. It indicated tracking and trending for infections was not conducted for the following months: November and December 2024, January, February, March, and April 2025.

During an interview with the DON on 10/9/25 at 1:05 p.m., they indicated there was no tracking or trending for infections conducted for November and December 2024, and for January, February, March, and April 2025. The DON indicated it was the DON/infection prevention nurse who was responsible to ensure this tracking and trending for infections was completed monthly and accurately.

The Infection Control policy was provided by the Regional Director of Operations on 10/9/25 at 1:40 p.m. It indicated "...Director of Nursing/Infection Control Coordinator: Oversees procedures, tracks infections...9. Surveillance and Reporting: Track infections...Recordkeeping: Maintain infection logs..."

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 SIGNATURESavannah Corner	TITLERegional Director Operations	(X6) DATE10/29/2025