STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/16/2025

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 Intake IN00464584 and Intake IN00463990. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Intake IN00463024 completed on July 24, 2025. This visit was in conjunction with the PSR to the Investigation of Intake IN00462199 completed on July 2, 2025. Intake IN00464584- No deficiencies related to the allegations are cited. Intake IN00463990- State deficiencies related to the allegations are cited at R0029. Unrelated deficiencies are cited. Survey date: September 15 and 16, 2025 Facility number: 016063	R 0000	he preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State laws. Please feel free to contact Vita New Greenfield . We respectfully request a desk review for compliance review.	

	Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 17, 2025.			
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure residents residing in the memory care unit were treated with dignity and respect by their peers for 3 of 6 residents reviewed for dignity. (Resident F, Resident G and Resident J) Findings include: 1. The clinical record for Resident F was reviewed on 9/15/25 at 11:00 a.m. The diagnoses included, but were not limited to, diabetes and dementia. He was admitted to the facility on 9/2/25. An Initial Assessment indicated he had severely impaired cognition. 2. The clinical record for Resident G was reviewed on	R 0029	Residents potentially affected: All MC Residents DON/ Designee will perform in-service for staff including resident rights and maintenance of resident dignity	10/26/2025

9/15/25 at 11:10 a.m. The diagnoses included, but were not limited to, anxiety disorder and diabetes.

A Quarterly Evaluation, dated 7/2/25, indicated she had severely impaired cognition.

3. The clinical record for Resident J was reviewed on 9/15/25 at 1:30 p.m. The diagnoses included, but were not limited to, dementia.

A cognitive assessment, dated 5/23/25, indicated she had severely impaired cognition.

An observation note in Resident F's clinical record, dated 9/5/25 at 11:00 p.m., indicated Resident F had been sexually inappropriate with staff during dinner, but was easily redirected.

An observation note in Resident F's clinical record, dated 9/6/25 at 2:16 p.m., indicated Resident F had been exit seeking and looking for his family. Resident F had gotten involved with another resident saying inappropriate things to her and had made her upset. Staff intervened and separated Resident F and the other resident. Staff reported that Resident F was grabbing them in inappropriate places.

An observation note in Resident F's clinical record, dated 9/7/25

	at 2:21 p.m., indicated Resident F was interacting with another female resident and staff was present watching the interaction. Resident F offered to put a cover on the female resident. Resident F "went up her arm and attempted to touch her breast". Staff quickly intervened and told Resident F that was wrong and would not be tolerated. An observation note in Resident F's clinical record, dated 9/8/25 at 10:46 a.m., indicated Resident F had been witnessed by staff attempting to enter female resident's rooms. Resident F waited until staff walked away, and reattempted to enter female resident's room. Resident F was also inappropriately attempting to grab staff's breasts and caress hands and arms of staff. Resident F was reminded that the conduct was inappropriate. Resident G's clinical record contained an Incident Report, dated 9/8/25 at 3:25 p.m., that indicated Alleged Client Abuse. The other resident involved was listed as Resident F and the location of the incident was listed as the dining room. Resident G reported to staff that a fellow resident was touching her breasts inappropriately. Resident G did not remember the date or time of the incident. A head-to-toe assessment was			

performed, and the physician was notified.

Resident F's clinical record contained an observation note, dated 9/8/25 at 9:51 p.m., that indicated Resident F was on 15-minute checks due to wandering into female resident rooms, making sexual inappropriate statements, and attempting touching. Management was aware of the situation and addressing the situation.

Resident F's clinical record contained an observation note, dated 9/9/25 at 1:24 p.m., that indicated Resident F continued on 15-minute checks. Staff reported that Resident F reached out for a female resident's breasts but was unsuccessful in making contact.

An observation note in Resident F's clinical record, dated 9/11/25 at 2:36 p.m., indicated Resident F had been watched throughout the shift and had tried grabbing a few residents and staff inappropriately, which was communicated to the memory care director.

An observation note in Resident F's clinical record, dated 9/12/25 at 6:10 p.m., indicated Resident F had been transferred to another facility.

During an interview on 9/15/25 at 1:13 p.m., the Memory Care

	Director (MCD) indicated she was unsure which female resident's rooms that Resident F had wandered into. The staff had been conducting 15-minute checks on Resident F to watch for any behaviors. She was aware that Resident F had displayed behaviors but was not sure of the details of the behaviors. During an interview on 9/15/25 at 1:49 p.m., Certified Nurse Aide (CNA) 3 indicated that Resident F could be "real handsy". The staff attempted to keep him separated from the other residents. CNA 3 had not witnessed Resident F touch any of the other residents inappropriately but was concerned it could happen. When she was assigned to Resident F's care she would stay in the hallway "all day" to guard against him being inappropriate or trying to enter female resident's rooms. Resident F could propel himself in his wheelchair independently. During an interview on 9/15/25 at 2:11 p.m., Licensed Practical Nurse (LPN) 2 indicated that Resident F would come out of his room and wait for female residents to pass and then try to reach out and touch them. The female residents would try to avoid him. She was unsure about the names of the female residents he had attempted to			

	touch. There had been male residents on the memory care unit who would touch others and talk with them, rubbing their shoulders. LPN 2 had reported the incidents to the management staff and has been told "guys will be guys". LPN 2 felt that the residents on the memory care unit could not give consent to the contact, and it was not okay. A family member of Resident G had brought up concerns that Resident F had inappropriately touched Resident G, but there were no witnesses, and Resident G could not remember the details. During an interview on 9/15/25 at 3:04 p.m., the Corporate Nurse Consultant (CNC) and the Interim Executive Director (IED) indicated Resident F did attempt to touch female resident's but did not make direct contact with the female resident's breasts. Resident F's behavior started shortly after his admission. Family had not disclosed any inappropriate behaviors during the pre-admission assessment. Resident F was started on 15-minute checks when the behaviors were noted. The facility did not provide one-on-one care due to it being an assisted living environment. The IED was unaware of the incidents of attempted inappropriate touching and attempting to enter female			

	resident's rooms. The IED and CNC did not know the name of the female resident that had been upset by Resident F in the 9/6/25 observation note. During an interview on 9/16/25 at 12:33 p.m., Qualified Medication Aide (QMA) 1 indicated he had witnessed the 9/7/25 incident and written the observation note dated 9/7/25 at 2:21 p.m. Resident J had a cover (blanket) sitting on her lap. Resident F approached her and offered to put the cover on her, he then started rubbing up her arm and attempted to touch her breast. QMA 1 immediately stepped in and stopped Resident F from touching Resident J's breasts. QMA 1 told Resident F that his behavior was wrong and would not be tolerated. Resident J was mostly non-verbal and did not say anything during the encounter, however she had visibly pulled away from Resident F while he was touching her. Resident J became visibly tense during the encounter and seemed to relax when QMA 1 removed her from the reach of Resident F. QMA 1 had reported the incident to the Dementia Care Director. Resident G had warned QMA 1 to "watch out for that one", speaking of Resident F. Resident G was more cognitively intact than some of the other residents on the dementia care unit, however still			

displayed memory issues.

During an interview on 9/16/25 at 1:05 p.m., the CNC indicated the facility did not have a Dignity Policy and followed the Resident's Rights Regulations.

On 9/16/25 at 1:28 p.m., the CNC provided the signed Statement of Resident Rights for Resident G and Resident J which indicated "...Residents shall be informed of all rights in conjunction with any contracted housing and services. Each Resident shall have the right to: 1. A dignified existence, self-determination, and communication with and access to persons and services inside and outside the Community...6. Be treated at all times with consideration, respect, and recognition of their dignity and individuality..."

This Residential tag relates to Intake IN00463990.

Based on interview and record review, the facility failed to ensure residents residing in the memory care unit were treated with dignity and respect by their peers for 3 of 6 residents reviewed for dignity. (Resident F, Resident G and Resident J)

Findings include:

1. The clinical record for Resident F was reviewed on 9/15/25 at 11:00 a.m. The

	diagnoses included, but were not limited to, diabetes and dementia. He was admitted to the facility on 9/2/25. An Initial Assessment indicated he had severely impaired cognition. 2. The clinical record for Resident G was reviewed on 9/15/25 at 11:10 a.m. The diagnoses included, but were not limited to, anxiety disorder and diabetes. A Quarterly Evaluation, dated 7/2/25, indicated she had severely impaired cognition. 3. The clinical record for Resident J was reviewed on 9/15/25 at 1:30 p.m. The diagnoses included, but were not limited to, dementia. A cognitive assessment, dated 5/23/25, indicated she had severely impaired cognition. An observation note in Resident F's clinical record, dated 9/5/25 at 11:00 p.m., indicated Resident F had been sexually inappropriate with staff during dinner, but was easily redirected. An observation note in Resident F's clinical record, dated 9/6/25 at 2:16 p.m., indicated Resident F had been exit seeking and looking for his family. Resident F had gotten involved with			

	another resident saying inappropriate things to her and had made her upset. Staff intervened and separated Resident F and the other resident. Staff reported that Resident F was grabbing them in inappropriate places. An observation note in Resident F's clinical record, dated 9/7/25 at 2:21 p.m., indicated Resident F was interacting with another female resident and staff was present watching the interaction. Resident F offered to put a cover on the female resident. Resident F "went up her arm and attempted to touch her breast". Staff quickly intervened and told Resident F that was wrong and would not be tolerated. An observation note in Resident F's clinical record, dated 9/8/25 at 10:46 a.m., indicated Resident F had been witnessed by staff attempting to enter female resident's rooms. Resident F waited until staff walked away, and reattempted to enter female resident's room. Resident F was also inappropriately attempting to grab staff's breasts and caress hands and arms of staff. Resident F was reminded that the conduct was inappropriate. Resident G's clinical record contained an Incident Report, dated 9/8/25 at 3:25 p.m., that			

	indicated Alleged Client Abuse. The other resident involved was listed as Resident F and the location of the incident was listed as the dining room. Resident G reported to staff that a fellow resident was touching her breasts inappropriately. Resident G did not remember the date or time of the incident. A head-to-toe assessment was performed, and the physician was notified. Resident F's clinical record contained an observation note, dated 9/8/25 at 9:51 p.m., that indicated Resident F was on 15-minute checks due to wandering into female resident rooms, making sexual inappropriate statements, and attempting touching. Management was aware of the situation and addressing the situation. Resident F's clinical record contained an observation note, dated 9/9/25 at 1:24 p.m., that indicated Resident F continued on 15-minute checks. Staff reported that Resident F reached out for a female resident's breasts but was unsuccessful in making contact. An observation note in Resident F's clinical record, dated 9/11/25 at 2:36 p.m., indicated Resident F had been watched throughout the shift and had tried grabbing a few residents and staff			

	inappropriately, which was communicated to the memory care director. An observation note in Resident F's clinical record, dated 9/12/25 at 6:10 p.m., indicated Resident F had been transferred to another facility. During an interview on 9/15/25 at 1:13 p.m., the Memory Care Director (MCD) indicated she was unsure which female resident's rooms that Resident F had wandered into. The staff had been conducting 15-minute checks on Resident F to watch for any behaviors. She was aware that Resident F had displayed behaviors but was not sure of the details of the behaviors.			

	During an interview on 9/15/25 at 1:49 p.m., Certified Nurse Aide (CNA) 3 indicated that Resident F could be "real handsy". The staff attempted to keep him separated from the other residents. CNA 3 had not witnessed Resident F touch any of the other residents inappropriately but was concerned it could happen. When she was assigned to Resident F's care she would stay in the hallway "all day" to guard against him being inappropriate or trying to enter female resident's rooms. Resident F could propel himself in his wheelchair independently. During an interview on 9/15/25 at 2:11 p.m., Licensed Practical Nurse (LPN) 2 indicated that Resident F would come out of his room and wait for female residents to pass and then try to reach out and touch them. The female residents would try to avoid him. She was unsure about the names of the female residents he had attempted to touch. There had been male residents on the memory care unit who would touch others and talk with them, rubbing their shoulders. LPN 2 had reported the incidents to the management staff and has been told "guys will be guys". LPN 2 felt that the residents on the memory care unit could not give consent to the contact, and it was not okay. A family member			

	of Resident G had brought up concerns that Resident F had inappropriately touched Resident G, but there were no witnesses, and Resident G could not remember the details. During an interview on 9/15/25 at 3:04 p.m., the Corporate Nurse Consultant (CNC) and the Interim Executive Director (IED) indicated Resident F did attempt to touch female resident's but did not make direct contact with the female resident's breasts. Resident F's behavior started shortly after his admission. Family had not disclosed any inappropriate behaviors during the pre-admission assessment. Resident F was started on 15-minute checks when the behaviors were noted. The facility did not provide one-on-one care due to it being an assisted living environment. The IED was unaware of the incidents of attempted inappropriate touching and attempting to enter female resident's rooms. The IED and CNC did not know the name of the female resident that had been upset by Resident F in the 9/6/25 observation note. During an interview on 9/16/25 at 12:33 p.m., Qualified Medication Aide (QMA) 1 indicated he had witnessed the 9/7/25 incident and written the observation note dated 9/7/25 at			

	2:21 p.m. Resident J had a cover (blanket) sitting on her lap. Resident F approached her and offered to put the cover on her, he then started rubbing up her arm and attempted to touch her breast. QMA 1 immediately stepped in and stopped Resident F from touching Resident J's breasts. QMA 1 told Resident F that his behavior was wrong and would not be tolerated. Resident J was mostly non-verbal and did not say anything during the encounter, however she had visibly pulled away from Resident F while he was touching her. Resident J became visibly tense during the encounter and seemed to relax when QMA 1 removed her from the reach of Resident F. QMA 1 had reported the incident to the Dementia Care Director. Resident G had warned QMA 1 to "watch out for that one", speaking of Resident F. Resident G was more cognitively intact than some of the other residents on the dementia care unit, however still displayed memory issues. During an interview on 9/16/25 at 1:05 p.m., the CNC indicated the facility did not have a Dignity Policy and followed the Resident's Rights Regulations. On 9/16/25 at 1:28 p.m., the CNC provided the signed Statement of Resident Rights for Resident G and Resident J			

	which indicated "...Residents shall be informed of all rights in conjunction with any contracted housing and services. Each Resident shall have the right to: 1. A dignified existence, self-determination, and communication with and access to persons and services inside and outside the Community...6. Be treated at all times with consideration, respect, and recognition of their dignity and individuality..." This Residential tag relates to Intake IN00463990.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in	R 0216	Residents potentially affected: All residents DON/Designee will ensure all residents have a self-administration evaluation completed on all residents. Evaluations will be audited weekly x 4 weeks, then monthly thereafter by DON/ Designee. DON/Designee will perform Self-administration evaluation on all potential residents prior to move in.	10/26/2025

	the facility. Based on observation, interview, and record review, the facility failed to ensure a resident's ability to self-administer medications by completing a self-administration evaluation for 1 of 1 resident observed with medications in their room. (Residents D) Findings include: The clinical record for Resident D was reviewed on 9/15/25 at 11:30 a.m. The diagnoses included, but were not limited to, alcohol induced dementia. The resident had been admitted on 9/5/25. An observation was conducted of Resident D in his room on 9/15/25 at 1:14 p.m. The resident's kitchen counter was observed with a medication cup with pill medications in it. The resident indicated he felt like it was "degrading" for staff to "watch over him" while he takes his medications. The pill medication was his afternoon medications, and he did plan on taking them. Resident D's clinical record did not include a self-medication assessment that had been conducted. An interview was conducted with the Director of Nursing on			

	9/15/25 at 1:45 p.m. She indicated, on admission, Resident D had voiced his preference for staff to administer his medications. She did not conduct a self-medication assessment on him at that time. The resident's medication should not be left in the room without staff presence to ensure he takes them. Based on observation, interview, and record review, the facility failed to ensure a resident's ability to self-administer medications by completing a self-administration evaluation for 1 of 1 resident observed with medications in their room. (Residents D) Findings include: The clinical record for Resident D was reviewed on 9/15/25 at 11:30 a.m. The diagnoses included, but were not limited to, alcohol induced dementia. The resident had been admitted on 9/5/25. An observation was conducted of Resident D in his room on 9/15/25 at 1:14 p.m. The resident's kitchen counter was observed with a medication cup with pill medications in it. The resident indicated he felt like it was "degrading" for staff to "watch over him" while he takes his medications. The pill medication was his afternoon			

	medications, and he did plan on taking them. Resident D's clinical record did not include a self-medication assessment that had been conducted. An interview was conducted with the Director of Nursing on 9/15/25 at 1:45 p.m. She indicated, on admission, Resident D had voiced his preference for staff to administer his medications. She did not conduct a self-medication assessment on him at that time. The resident's medication should not be left in the room without staff presence to ensure he takes them.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number	R 0356	Residents potentially affected: All residents DON/Designee will perform audits to resident profiles weekly x 4, then monthly thereafter ti ensure all residents have correct contact, demographic and medication information entered into EMAR. DON/ Designee will ensure that new residents have contact, demographic and medication information entered into EMAR at time of move in.	10/26/2025

of the resident ' s physician of record.

(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.

(6) Information on any known allergies.

(7) A photograph (for identification of the resident).

(8) Copy of advance directives, if available.

Based on interview and record review, the facility failed to ensure residents' emergency information was in the resident's record for 2 of 3 residents records reviewed. (Resident F and Resident D)

Findings include:

An interview was conducted with the Interim Executive Director on 9/16/25 at 10:53 a.m. She indicated the facility was currently changing the residents' medical records from paper charting to electronic medical charting. The staff should have pertinent information on newly admitted residents within 72 hours of admission.

1. The clinical record for Resident D was reviewed on 9/15/25 at 11:30 a.m. The diagnoses included, but were

not limited to, alcohol induced dementia. The resident was admitted to the facility on 9/5/25.

Resident D's electronic medical record did not contain the following information: photo identification, physician name or number, allergies to food or medications, hospital preferences, medical diagnoses, representatives and/or representatives to contact for emergencies and advance directives.

A folder for Resident D was provided by the Director of Nursing (DON) on 9/15/25 at 1:00 p.m. It included: evaluation/assessment, medications, and advance directives. It did not include hospital preferences, representatives and/or representatives to contact for emergencies.

2. The clinical record for Resident F was reviewed on 9/15/25 at 11:30 a.m. The diagnoses included, but were not limited to, alcohol induced diabetes mellitus. The resident had been admitted on 9/1/25.

Resident F's electronic medical record did not contain the following information: the resident's gender, physician name or number, advance directives, allergies to food or

medications, hospital preference and medical diagnoses.

A nursing note by Licensed Practical Nurse (LPN) 2, dated 9/8/25, indicated "This writer overheard resident [F] yelling for help. Upon entering room resident was observed on the floor to the right of the bed. Back resting on base of bed, sitting on buttocks, with legs outstretched in front of resident. Head to toe assessment completed...DON notified. No physician information available to allow for notification. Emergency contact not listed in computer yet, Unable to notify family at this time."

An interview was conducted with LPN 2 on 9/15/25 at 2:11 p.m. She indicated it was difficult to retrieve pertinent information about the residents in the medical charts. The medical charts were not completed. The medical charts were missing emergency contact information, medical provider name and numbers. She didn't even know if Resident F was a full code or DNR (do not resuscitate). He had fallen on 9/8/25. She was unable to notify the physician and the family/representative due to the information not being located in the resident's medical chart. She had voiced that to the marketing staff person the next day that she was unable to

notify Resident F's Representative about the fall. The Marketing Staff Person provided the resident's emergency contact number at that time, but it was not in the medical chart.

A paper chart was provided by the Corporate Nurse Consultant on 9/16/25 at 12:00 p.m. It did not include: resident's gender, medical diagnoses, hospital preference, physician contact name or number, and allergies of food or medications.

An interview was conducted with Qualified Medication Aide (QMA) 1 on 9/16/25 at 12:33 p.m. He indicated residents' information as in code status, diagnoses, allergies, medical provider, emergency contact information would all be under the emergency packet tab in the electronic medical record. If the information was not available in the electronic medical record. The staff would need to go into the DON's office and "dig" into the file cabinet for the folders to see if the information was in there. She kept the residents' medical information in folders in her office. The DON's office was locked after hours.

Based on interview and record review, the facility failed to ensure residents' emergency information was in the resident's record for 2 of 3 residents

records reviewed. (Resident F and Resident D)

Findings include:

An interview was conducted with the Interim Executive Director on 9/16/25 at 10:53 a.m. She indicated the facility was currently changing the residents' medical records from paper charting to electronic medical charting. The staff should have pertinent information on newly admitted residents within 72 hours of admission.

1. The clinical record for Resident D was reviewed on 9/15/25 at 11:30 a.m. The diagnoses included, but were not limited to, alcohol induced dementia. The resident was admitted to the facility on 9/5/25.

Resident D's electronic medical record did not contain the following information: photo identification, physician name or number, allergies to food or medications, hospital preferences, medical diagnoses, representatives and/or representatives to contact for emergencies and advance directives.

A folder for Resident D was provided by the Director of Nursing (DON) on 9/15/25 at 1:00 p.m. It included: evaluation/assessment,

medications, and advance directives. It did not include hospital preferences, representatives and/or representatives to contact for emergencies.

2. The clinical record for Resident F was reviewed on 9/15/25 at 11:30 a.m. The diagnoses included, but were not limited to, alcohol induced diabetes mellitus. The resident had been admitted on 9/1/25.

Resident F's electronic medical record did not contain the following information: the resident's gender, physician name or number, advance directives, allergies to food or medications, hospital preference and medical diagnoses.

A nursing note by Licensed Practical Nurse (LPN) 2, dated 9/8/25, indicated "This writer overheard resident [F] yelling for help. Upon entering room resident was observed on the floor to the right of the bed. Back resting on base of bed, sitting on buttocks, with legs outstretched in front of resident. Head to toe assessment completed...DON notified. No physician information available to allow for notification. Emergency contact not listed in computer yet, Unable to notify family at this time."

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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 SIGNATUREAllison Catron	TITLERDCS	(X6) DATE10/17/2025