STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/19/2026

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 Intakes 467650 and 467883. This visit was in conjunction with a Post Survey Revisit (PSR) to Investigation of Intakes 466367 and 466443 completed on December 19, 2025, that resulted in unrelated deficiencies. Intake 467650 - No deficiencies related to the allegations are cited. Intake 467883 - No deficiencies related tot he allegations are cited. Intake 466367 - State deficiencies related to the allegations are cited at R53. Intake 466443 - Corrected. Unrelated deficiencies cited.	R 0000		

	Survey dates: February 18 and 19, 2026 Facility number: 016063 Residential Census: 92 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 24, 2026.			
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 the facility. Based on interview and record	R 0216		03/03/2026

review, the facility failed to ensure a medication self-administration assessment had been completed prior to residents administering their own medications for 1 of 3 residents reviewed for medication administration. (Resident E)

Findings include:

During an interview on 2/18/26 at 9:00 a.m., Resident E indicated she received all of her medications the way her doctor had ordered and sometimes she administered her own inhaler.

The clinical record for Resident E was reviewed on 2/18/26 at 9:05 a.m. The diagnoses included, but were not limited to, congestive heart failure and major depressive disorder with anxiety.

A physician's order, initiated 7/18/25, indicated fluticasone propionate (nasal spray to treat allergies) 50 micrograms (mcg), instill two sprays in each nostril daily.

A physician's order, initiated 6/1/25, indicated furosemide (prescription medication to remove fluid from the body) 20 milligrams (mg) take half tablet by mouth daily.

The Medication Administration Record, dated 1/1/26 at 12:00

	a.m. until 1/31/26 at 11:59 p.m., indicated Resident E self-administered fluticasone 50 mcg nasal spray on 1/23/26, 1/27/26, and 1/28/26. The Medication Administration Record, dated 1/1/26 at 12:00 a.m. until 1/31/26 at 11:59 p.m., indicated Resident E self-administered furosemide 20 mg on 1/19/26. During an interview on 2/19/26 at 9:20 a.m., the Director of Nursing indicated the medication self-administration assessment should have been completed before Resident E administered her own medications. During an interview on 2/19/26 at 10:18 a.m., the Regional Administrator indicated there was no medication self-administration assessment completed for Resident E. On 2/19/26 at 10:14 a.m., the Regional Administrator provided a copy of a facility policy, titled Medication Administration Policy, dated 11/2025, and indicated this was the current policy used by the facility. A review of the policy indicated residents may self-administer medications if deemed safe to do so per the self-administration evaluation performed by community nurse.			

R 0217	Evaluation - Deficiency 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.	R 0217		03/03/2026

(5) If administration of medications or the provision of residential nursing services, or both, is 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 ensure the resident's service plans were signed by the residents for 2 of 3 residents reviewed for evaluations. (Resident C, Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 2/18/26 at 10:40 a.m. The diagnoses included, but were not limited to, depression, diabetes, and cognitive impairment.

Resident C's service plan, dated 1/10/26, was signed by the Director of Nursing (DON) but was not signed by Resident C nor a family member.

2. The clinical record for Resident D was reviewed on 2/18/26 at 10:32 a.m. The diagnoses included, but were not limited to, dementia, depressive disorder, and anxiety.

Resident D's service plan, dated 1/10/26, was signed by the DON but was not signed by Resident

	D nor a family member. During an interview on 2/19/26 at 9:20 a.m., the DON indicated Resident C's and Resident D's service plans should have been signed by the residents or a family member if the resident was not able to sign them. During an interview on 2/19/26 at 10:18 a.m., the Regional Administrator indicated the facility did not have a policy regarding service plans.			

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