STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/19/2025

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 Investigations of Intakes 466367, 466443, and 465888. This visit was in conjunction with a Post Survey Revisit (PSR) to Investigation of Intakes 465531, 00465540, and 465661 completed on 10/24/25. Intake 466367 - State deficiencies related to the allegations are cited at R091 and R053. Intake 465805 - No deficiencies related to the allegations are cited. Intake 466443 - State deficiencies related to the allegations are cited at R306. Intake 465531 - Corrected Intake 465540 - Corrected Intake 465661 - Corrected Unrelated deficiency cited.	R 0000		

	Survey dates: December 18 and 19, 2025 Facility number: 016063 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 30, 2025.			
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on observation, interview, and record review, the facility failed to ensure a resident was free from verbal abuse and intimidated with two staff members presence in her room resulting in fear and intimidation for 1 of 3 residents reviewed for verbal abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 12/18/25 at 11:00 a.m. The resident's diagnosis included, but was not limited to, Chronic Pulmonary Disease (COPD), heart failure and stroke. A Quarterly Assessment, dated	R 0053		01/05/2026

	7/7/25, indicated Resident B did not have visual or hearing impairment. The resident did not have a diagnosis of dementia or Alzheimer's Disease. Resident B was able to verbalize her care needs and utilizes a wheelchair. A reportable incident to the Indiana Department of Health, dated 12/1/25, was provided by the Regional Director of Operations (RDO) on 12/18/25 at 11:30 a.m. It indicated on 11/25/25 at 3:30 a.m., 2 Certified Nursing Assistants (CNA 1 and CNA 2) were in Resident's B apartment uninvited. The resident overheard CNAs conversation that included discussions about other residents' conditions and finances. During the time, the CNAS denied the resident's request of positional change. The immediate action taken was the termination of CNA 1 and CNA 2. The reportable incident's investigation was provided by the Regional Director of Clinical Support (RNCS) on 12/18/25 at 1:30 p.m. It included the following documents: A grievance form written by Resident B's Representative, dated 11/28/25, indicated "On Wed. [Wednesday] Nov. [November] 26, Resident B reported a couple of aids [CNA 1 and CNA 2] entered her room			

	in the middle of the night the night before. They sat in her living room and told [Resident B] to stay in bed while talking to each other, discussing other residents and current events...I, [Resident B's Representative], had a voice recorder set up. It started at approx. [approximately] 1:15 p.m. on Tuesday 11/25/25 and recorded for 18 hours. During the recording you can clearly hear two aids (CNAs) enter the apartment. They did not address [Resident B] or offer any assistance, they proceeded to sit and chat. Talking and complaining about other residents and their jobs and other events in their lives. They used foul language and kept insisting [Resident B] stay in bed. This was very intimidating to [Resident B]. She said, 'They didn't leave, even when they knew that I knew they were there, so when they told me to lay down, I did, Because I was scared.'..." A written statement signed by Resident B, dated 12/4/25, indicated on 11/25/25, "...2 CNAs [CNA 1 and CNA 2] were in room talking, one in recliner and one on sofa. When I sat up, they told me to lay back down. They did not ask if I needed anything. Did not say anything to me except to 'lay back down.' I felt scared. I did not want them in my room. I did not push my			

call light, and I did not invite them in. I felt unsafe. They did not give any explanation as why they were in my room. I was afraid to ask questions."

A documented record of the audio recording in Resident B's room, dated 11/25/25, indicated approximately forty minutes of a recorded conversation between CNA 1 and CNA 2 in the resident's room while Resident B was lying in bed on 11/25/25. The audio was recorded from the time the CNAs had entered the resident's room and through out their stay. The conversation consisted of foul language with the frequency of the usage of f***. Residents and their families that reside in the facility were discussed by name that included the residents' finances, their aggravation with the residents and laughing while making fun of residents inabilities and face appearances while eating. The recorded conversation document between the CNAs included but was not limited to the following statements: there should be an "old people's jail," a resident identified by name was "crazy," another resident was identified by name was "irritating as f***,"I hope they take his a**," and stated a significant other of one of the CNAs in the room was on "house arrest." During the conversation, the CNAs had stated they were going to close

	the exterior door to the resident's room. Through out the conversation between CNA 1 and CNA 2, Resident B had repeatly attempted to sit up and/or get out of bed, but was told to lay back down by the CNAS. One attempt, the resident had voiced she wanted to get up and sit in the chair for awhile. One of the CNAs responded to Resident B, "I want you to stay in bed, cuz it's almost 3:00 in the morning and you be falling. Let's lay back down, it's so early and then in one hour we gonna get you changed and cleaned up closer when day shift, [CNA 3] gets here, okay." Resident B responded "okay." Another attempt by the resident to get up she was told by one of the CNAs "what are you doing? what are you doing?" Resident B responded, "sitting up." CNA stated, " No ma' ma you are unsteady on your feet, we are not doing that. You don't want to fall and then you will have to go to the hospital. Do you want to be at the hospital on Thanksgiving? Resident B responded, "oh no!" CNA responded, then relax your legs..." The CNAs conversation was continued until they had exited the resident's room. An interview was conducted with RDO and RNCS on 12/18/25 at 11:45 a.m. The RDO had indicated Resident B's			

	Representative had reported an incident that had occurred in Resident B's room. CNA 1 and CNA 2 had gone into the resident's room uninvited and had inappropriate discussions that had been audio recorded. Through out their time in the room, Resident B was not allowed to get up out of bed. The CNAS had closed the exterior door to the resident's room during that time. Resident B's Representative had forwarded the audio recording and was very unhappy about what was captured on the audio recording. Resident B had reported to her representative; she was scared that night. During an interview with CNA 1 about the incident, she had become irate and physical. The police was notified, and they had to address the situation. The RDO was unaware Resident B's Representative had placed an audio recording in the resident's apartment that day. Resident B's Representative had stated she placed in the resident's apartment for personal reasons, and the recording had continued recording for several hours that captured the incident by error. The RDO had reviewed the video monitoring of the hallway that morning and was able to identify CNA 1 and CNA 2 had entered the resident's room together. The CNAs had been in the resident's room for			

	approximately 30 minutes, and then exited the resident's room. An observation was made of Resident B's apartment with Resident B on 12/18/25 at 1:49 p.m. The resident had pointed with her finger to a chair and a sofa the locations the two CNAs had been sitting in her living room while she was in bed that night. The resident's bedroom door was opened and living area was in her view. She indicated she had heard the two CNAs talking to each other in the living room while she was in bed. Resident B indicated she was having a hard time remembering the incident. An interview was conducted with Resident B's Representative on 12/18/25 at 2:28 p.m. She indicated Resident B was very guarded and won't talk about the incident. On 11/24/25, she had placed an audio recorder in the Resident B's apartment due to personal reasons, and it had audio recorded the resident's apartment for eighteen hours. On 11/25/25, CNA 3 had informed her Resident B had reported two CNAs had been sitting and talking in her room last night. After, speaking with Resident B, she had reported the same thing to her. Resident B had told her she was scared that night. She then went home and listened to the audio			

	recording to see if it had picked up anything and it had. She had first thought Resident B was confused, but it was the truth. The conversation between CNA 1 and CNA 2 that transpired in the resident's room that night was "awful" to hear what they were saying about the residents. Through out the CNAs conversation that night, they were identifying the residents' by name while using foul language through out the conversation. During that time, Resident B had attempted to get up several times, and the CNAs refused to let her get out of bed. After, the review of the audio recording she had gone to the RDO and reported it. An interview was conducted with RDO on 12/18/25 at 3:27 p.m. She indicated after listening to the audio recording between CNA 1 and CNA 2; "I was mortified. It was the worst verbal abuse I had ever heard." An audio recorded conversation was provided by the RDO via email on 12/18/25 at 4:11 p.m. The recorded conversation between CNA 1 and CNA 2 was reviewed. The conversation was approximately forty minutes in length. The two CNAs that were in Resident B's apartment had discussions that identified residents by their names. Foul language was utilized through out the conversation. The			

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	not attempt to get up on her own without assistance and fall. The resident had dementia and did require staff assistance to get out bed. The resident was never told by either CNA to not get up from her bed. While in the living room area, they were talking about other residents that reside in the facility, but they had not identify the residents by name. She had not used foul language while in the resident's room, but she was unable to recall if CNA 2 had. The resident's exterior door to her apartment was left cracked open. It was never closed and locked. The resident's apartment was not in complete darkness, but not well lit. The resident had a night light in the bathroom and kitchen over light on at night. She was unable to recall if the kitchen light was on while they were sitting in the living room that morning, but the bathroom night light was. CNA 1 indicated she and CNA 2 were in Resident B's room approximately 30 minutes that night. CNA 2 was unavailable for interview. An interview was conducted with CNA 3 on 12/19/25 at 12:15 p.m. He indicated on the morning of 11/25/25, Resident B had reported first thing that morning there had been two CNAs in her room sitting and			

	talking in her living room on night shift. The resident was "offended" and "angry" about what happened that night. The resident had stated one CNA was sitting in the chair and the other CNA was sitting on the sofa. Resident B had tried to get out of bed to see who was in her living room due to darkness in the apartment, but was told by the CNAs to lay back down. The CNAs never went into her bedroom. They stayed in the living room area. The resident was unable to get out of bed on her own. She required limited assistance by the staff to get out of bed. The resident at times did get confused, but he believed her what she was saying had happened. She was very adamant that it happened. Resident B was not the first resident that had made statements about night staff "hanging out" in their apartments at night. He had reported to the Qualified Medication Aide (QMA) that morning and Resident B's Representative. An abuse policy was provided by the RDO on 12/18/25 at 2:22 p.m. It indicated, "...It is the policy of this facility to ensure that all residents are free from abuse, neglect, involuntary seclusion, and misappropriation of property in accordance with Indiana State regulations... and ISDH [Indiana State Department			

	of Health] guidelines...Definitions:...Verbal abuse is the use of oral, written, or gestured language containing disparaging, derogatory, or disrespectful remarks directed toward a resident or their family, regardless of the individual's age, cognitive ability, or disability. This includes threats, inappropriate jokes, or demands...Procedures...The facility actively works to prevent abuse, neglect, and misappropriation by identifying and mitigating environmental and operational risks that may contribute to incidents..." This citation is relates to Intake 466367. Based on observation, interview, and record review, the facility failed to ensure a resident was free from verbal abuse and intimidated with two staff members presence in her room resulting in fear and intimidation for 1 of 3 residents reviewed for verbal abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 12/18/25 at 11:00 a.m. The resident's diagnosis included, but was not limited to, Chronic Pulmonary Disease (COPD), heart failure and stroke. A Quarterly Assessment, dated			

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	of Health] guidelines...Definitions:...Verbal abuse is the use of oral, written, or gestured language containing disparaging, derogatory, or disrespectful remarks directed toward a resident or their family, regardless of the individual's age, cognitive ability, or disability. This includes threats, inappropriate jokes, or demands...Procedures...The facility actively works to prevent abuse, neglect, and misappropriation by identifying and mitigating environmental and operational risks that may contribute to incidents..." This citation is relates to Intake 466367.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon	R 0091		01/05/2026

request.

Based on interview and record review, the facility failed to ensure a complete and thorough investigation was conducted for 1 of 3 reportable incidents reviewed. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 12/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, Chronic Pulmonary Disease (COPD), heart failure and stroke.

A Quarterly Assessment, dated 7/7/25, indicated Resident B did not have visual or hearing impairment. The resident did not have a diagnosis of dementia or Alzheimer's Disease. Resident B was able to verbalize her care needs and utilizes a wheelchair.

A reportable incident to the Indiana Department of Health, dated 12/1/25, was provided by the Regional Director of Operations (RDO) on 12/18/25 at 11:30 a.m. It indicated on 11/25/25 at 3:30 a.m., 2 Certified Nursing Assistants (CNA 1 and CNA 2) were in Resident's B apartment uninvited. The resident overheard CNAs conversation that included discussions about other residents' conditions and finances. During the time, the

	CNAS denied the resident's request of positional change. The immediate action taken was the termination of CNA 1 and CNA 2. The reportable incident's investigation was provided by the Regional Director of Clinical Support (RNCS) on 12/18/25 at 1:30 p.m. It included the following documents: A grievance form written by Resident B's Representative, dated 11/28/25, indicated "On Wed. [Wednesday] Nov. [November] 26, Resident B reported a couple of aids [CNA 1 and CNA 2] entered her room in the middle of the night the night before. They sat in her living room and told [Resident B] to stay in bed while talking to each other, discussing other residents and current events...I, [Resident B's Representative], had a voice recorder set up. It started at approx. [approximately] 1:15 p.m. on Tuesday 11/25/25 and recorded for 18 hours. During the recording you can clearly hear two aids (CNAs) enter the apartment. They did not address [Resident B] or offer any assistance, they proceeded to sit and chat. Talking and complaining about other residents and their jobs and other events in their lives. They used foul language and kept insisting [Resident B] stay in			

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A written statement signed by Resident B, dated 12/4/25, indicated on 11/25/25, "...2 CNAs [CNA 1 and CNA 2] were in room talking, one in recliner and one on sofa. When I sat up, they told me to lay back down. They did not ask if I needed anything. Did not say anything to me except to 'lay back down.' I felt scared. I did not want them in my room. I did not push my call light, and I did not invite them in. I felt unsafe. They did not give any explanation as why they were in my room. I was afraid to ask questions."

A documented record of the audio recording in Resident B's room, dated 11/25/25, indicated approximately forty minutes of a recorded conversation between CNA 1 and CNA 2 in the resident's room while Resident B was lying in bed on 11/25/25. The audio was recorded from the time the CNAs had entered the resident's room and through out their stay. The conversation consisted of foul language with the frequency of the usage of f***. Residents and their families that reside in the facility were discussed by name that

	included the residents' finances, their aggravation with the residents and laughing while making fun of residents inabilities and face appearances while eating. The recorded conversation document between the CNAs included but was not limited to the following statements: there should be an "old people's jail," a resident identified by name was "crazy," another resident was identified by name was "irritating as f***,"I hope they take his a**," and stated a significant other of one of the CNAs in the room was on "house arrest." During the conversation, the CNAs had stated they were going to close the exterior door to the resident's room. Through out the conversation between CNA 1 and CNA 2, Resident B had repeatly attempted to sit up and/or get out of bed, but was told to lay back down by the CNAS. One attempt, the resident had voiced she wanted to get up and sit in the chair for awhile. One of the CNAs responded to Resident B, "I want you to stay in bed, cuz it's almost 3:00 in the morning and you be fallin. Let's lay back down, it's so early and then in one hour we gonna get you changed and cleaned up closer when day shift, [CNA 3] gets here, okay." Resident B responded "okay." Another attempt by the resident to get up she was told by one of the			

	CNAs "what are you doing? what are you doing?" Resident B responded, "sitting up." CNA stated, " No ma' ma you are unsteady on your feet, we are not doing that. You don't want to fall and then you will have to go to the hospital. Do you want to be at the hospital on Thanksgiving? Resident B responded, "oh no!" CNA responded, then relax your legs..." The CNAs conversation was continued until they had exited the resident's room. The investigation did not include interviews conducted with the alleged staff members accused of the incident, interviews with witnessed staff members, and/or any interviews with other residents related to the incident. An interview was conducted with CNA 1 on 12/19/25 at 10:23 a.m. She indicated the management staff had not discussed with her the reason why she had been investigated. She was not asked to provide a statement of what occurred in Resident B's room on 11/25/25. She had not signed any documentation while she was in the office with the RDO. An interview was conducted with CNA 3 on 12/19/25 at 12:15 p.m. He indicated on the morning of 11/25/25, Resident B had reported first thing that morning there had been two			

	CNAs in her room sitting and talking in her living room on night shift. The resident was "offended" and "angry" about what happened that night. The resident had stated one CNA was sitting in the chair and the other CNA was sitting on the sofa. Resident B had tried to get out of bed to see who was in her living room due to darkness in the apartment, but was told by the CNAs to lay back down. The resident at times does get confused, but he believed her what she was saying what happened. She was very adamant that it happened. Resident B was not the first resident that had made statements about night staff "hanging out" in their apartments at night. He had reported to the Qualified Medication Aide (QMA) that morning and Resident B's Representative. An interview was conducted with the RDO on 12/18/25 at 3:27 p.m. She indicated she did not have written statements that had been conducted with CNA 1 nor CNA 2 during the investigations. During an interview with CNA 1 about the incident, she had become irate and physical. The police was notified, and they had to address the situation. CNA 1 and CNA 2 are not allowed back on the property. She believed CNA 3's statement was not			

	necessary to include in the investigation file. It was reported to her CNA 3 was told CNA 1 and CNA 2 had only been sleeping in Resident B's living room on night shift of 11/25/25. An abuse policy was provided by the RDO on 12/18/25 at 2:22 p.m. It indicated, "...It is the policy of this facility to ensure that all residents are free from abuse, neglect, involuntary seclusion, and misappropriation of property in accordance with Indiana State regulations... and ISDH [Indiana State Department of Health] guidelines...Definitions:...Verbal abuse is the use of oral, written, or gestured language containing disparaging, derogatory, or disrespectful remarks directed toward a resident or their family, regardless of the individual's age, cognitive ability, or disability. This includes threats, inappropriate jokes, or demands...Procedures...Investigations into allegations of abuse, neglect, or misappropriation are conducted thoroughly and promptly. The Abuse Coordinator or Executive Director collects information, interviews involved parties and reviews all relevant documentation or evidence. A written report of the investigation is completed and retained in corrective action, which may include termination of employment and reporting to			

applicable state registries..."

This citation is related to Intake 466367.

Based on interview and record review, the facility failed to ensure a complete and thorough investigation was conducted for 1 of 3 reportable incidents reviewed. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 12/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, Chronic Pulmonary Disease (COPD), heart failure and stroke.

A Quarterly Assessment, dated 7/7/25, indicated Resident B did not have visual or hearing impairment. The resident did not have a diagnosis of dementia or Alzheimer's Disease. Resident B was able to verbalize her care needs and utilizes a wheelchair.

A reportable incident to the Indiana Department of Health, dated 12/1/25, was provided by the Regional Director of Operations (RDO) on 12/18/25 at 11:30 a.m. It indicated on 11/25/25 at 3:30 a.m., 2 Certified Nursing Assistants (CNA 1 and CNA 2) were in Resident's B apartment uninvited. The resident overheard CNAs conversation that included discussions about

other residents' conditions and finances. During the time, the CNAS denied the resident's request of positional change. The immediate action taken was the termination of CNA 1 and CNA 2.

The reportable incident's investigation was provided by the Regional Director of Clinical Support (RNCS) on 12/18/25 at 1:30 p.m. It included the following documents:

A grievance form written by Resident B's Representative, dated 11/28/25, indicated "On Wed. [Wednesday] Nov. [November] 26, Resident B reported a couple of aids [CNA 1 and CNA 2] entered her room in the middle of the night the night before. They sat in her living room and told [Resident B] to stay in bed while talking to each other, discussing other residents and current events...I, [Resident B's Representative], had a voice recorder set up. It started at approx. [approximately] 1:15 p.m. on Tuesday 11/25/25 and recorded for 18 hours. During the recording you can clearly hear two aids (CNAs) enter the apartment. They did not address [Resident B] or offer any assistance, they proceeded to sit and chat. Talking and complaining about other residents and their jobs and other events in their lives. They

	used foul language and kept insisting [Resident B] stay in bed. This was very intimidating to [Resident B]. She said, 'They didn't leave, even when they knew that I knew they were there, so when they told me to lay down, I did, Because I was scared.' A written statement signed by Resident B, dated 12/4/25, indicated on 11/25/25, "...2 CNAs [CNA 1 and CNA 2] were in room talking, one in recliner and one on sofa. When I sat up, they told me to lay back down. They did not ask if I needed anything. Did not say anything to me except to 'lay back down.' I felt scared. I did not want them in my room. I did not push my call light, and I did not invite them in. I felt unsafe. They did not give any explanation as why they were in my room. I was afraid to ask questions." A documented record of the audio recording in Resident B's room, dated 11/25/25, indicated approximately forty minutes of a recorded conversation between CNA 1 and CNA 2 in the resident's room while Resident B was lying in bed on 11/25/25. The audio was recorded from the time the CNAs had entered the resident's room and through out their stay. The conversation consisted of foul language with the frequency of the usage of f***. Residents and their families			

	that reside in the facility were discussed by name that included the residents' finances, their aggravation with the residents and laughing while making fun of residents inabilities and face appearances while eating. The recorded conversation document between the CNAs included but was not limited to the following statements: there should be an "old people's jail," a resident identified by name was "crazy," another resident was identified by name was "irritating as f***,"I hope they take his a**," and stated a significant other of one of the CNAs in the room was on "house arrest." During the conversation, the CNAs had stated they were going to close the exterior door to the resident's room. Through out the conversation between CNA 1 and CNA 2, Resident B had repeatly attempted to sit up and/or get out of bed, but was told to lay back down by the CNAS. One attempt, the resident had voiced she wanted to get up and sit in the chair for awhile. One of the CNAs responded to Resident B, "I want you to stay in bed, cuz it's almost 3:00 in the morning and you be fallin. Let's lay back down, it's so early and then in one hour we gonna get you changed and cleaned up closer when day shift, [CNA 3] gets here, okay." Resident B responded "okay." Another			

attempt by the resident to get up she was told by one of the CNAs "what are you doing? what are you doing?" Resident B responded, "sitting up." CNA stated, " No ma' ma you are unsteady on your feet, we are not doing that. You don't want to fall and then you will have to go to the hospital. Do you want to be at the hospital on Thanksgiving? Resident B responded, "oh no!" CNA responded, then relax your legs..." The CNAs conversation was continued until they had exited the resident's room.

The investigation did not include interviews conducted with the alleged staff members accused of the incident, interviews with witnessed staff members, and/or any interviews with other residents related to the incident.

An interview was conducted with CNA 1 on 12/19/25 at 10:23 a.m. She indicated the management staff had not discussed with her the reason why she had been investigated. She was not asked to provide a statement of what occurred in Resident B's room on 11/25/25. She had not signed any documentation while she was in the office with the RDO.

An interview was conducted with CNA 3 on 12/19/25 at 12:15 p.m. He indicated on the morning of 11/25/25, Resident B

	had reported first thing that morning there had been two CNAs in her room sitting and talking in her living room on night shift. The resident was "offended" and "angry" about what happened that night. The resident had stated one CNA was sitting in the chair and the other CNA was sitting on the sofa. Resident B had tried to get out of bed to see who was in her living room due to darkness in the apartment, but was told by the CNAs to lay back down. The resident at times does get confused, but he believed her what she was saying what happened. She was very adamant that it happened. Resident B was not the first resident that had made statements about night staff "hanging out" in their apartments at night. He had reported to the Qualified Medication Aide (QMA) that morning and Resident B's Representative. An interview was conducted with the RDO on 12/18/25 at 3:27 p.m. She indicated she did not have written statements that had been conducted with CNA 1 nor CNA 2 during the investigations. During an interview with CNA 1 about the incident, she had become irate and physical. The police was notified, and they had to address the situation. CNA 1 and CNA 2 are not allowed back			

	on the property. She believed CNA 3's statement was not necessary to include in the investigation file. It was reported to her CNA 3 was told CNA 1 and CNA 2 had only been sleeping in Resident B's living room on night shift of 11/25/25. An abuse policy was provided by the RDO on 12/18/25 at 2:22 p.m. It indicated, "...It is the policy of this facility to ensure that all residents are free from abuse, neglect, involuntary seclusion, and misappropriation of property in accordance with Indiana State regulations... and ISDH [Indiana State Department of Health] guidelines...Definitions:...Verbal abuse is the use of oral, written, or gestured language containing disparaging, derogatory, or disrespectful remarks directed toward a resident or their family, regardless of the individual's age, cognitive ability, or disability. This includes threats, inappropriate jokes, or demands...Procedures...Investigations into allegations of abuse, neglect, or misappropriation are conducted thoroughly and promptly. The Abuse Coordinator or Executive Director collects information, interviews involved parties and reviews all relevant documentation or evidence. A written report of the investigation is completed and retained in corrective action,			

	which may include termination of employment and reporting to applicable state registries..." This citation is related to Intake 466367.			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure injectable medications were administered by licensed staff for 3 of 5 residents reviewed for medication administration (Residents K, L, and N). Findings include: 1 a. The clinical record for Resident K was reviewed on 12/18/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, diabetes. A physician's order, dated 10/9/25, indicated she was to receive Ozempic (semaglutide - used in adults to control blood sugar levels when combined with diet and exercise) 2 units injected subcutaneously (under the skin) every Wednesday. The investigation file of QMA 10 working outside of her scope of	R 0245		01/05/2026

	practice was provided by the RDO on 12/18/25 at 11:30 a.m. The investigation file included a Pass Med Report, generated on 11/4/25. The report indicated QMA 10 had administered Resident K's Ozempic, 1 mg subcutaneously on 9/10/25. 1 b. The clinical record for Resident L was reviewed on 12/18/25 at 1:40 p.m. The resident's diagnosis included, but was not limited to, diabetes. A physician's order, dated 7/23/24, indicated he was to receive Humalog (type of insulin) three times a day per sliding scale before meals. The investigation file of QMA 10 working outside of her scope of practice was provided by the RDO on 12/18/25 at 11:30 a.m. The investigation file included a Pass Med Report, generated on 11/4/25. The report indicated QMA 10 had administered Resident L's Humalog subcutaneously on 10/22/25, 10/26/25, and 10/27/25. 1c. The clinical record for Resident N was reviewed on 12/18/25 at 2:00 p.m. The resident's diagnosis included, but was not limited to, diabetes.			

	A physician's order, dated 9/25/25, indicated she was to receive Lantus Solostar (type of insulin) 15 units subcutaneously daily. On 12/18/25 at 11:30 a.m., the Regional Director of Operations (RDO) provided an incident report, submitted to the Indiana Department of Health on 11/4/25 at 2:28 p.m. The incident report indicated that Qualified Medication Aide (QMA) 10 had worked outside of her scope of practice. The investigation file of QMA 10 working outside of her scope of practice was provided by the RDO on 12/18/25 at 11:30 a.m. The investigation file included a Pass Med Report, generated on 11/4/25. The report indicated QMA 10 had administered Resident N's Lantus Solostar subcutaneously on 11/3/25. During an interview on 12/19/25 at 10:36 a.m., QMA 10 indicated she had administered insulin and Ozempic to residents at the facility. She was not insulin certified but had taken the insulin administration class. She had not passed the test for certification. QMA 10 indicated she had given the insulin, despite not being certified, because no one else was around to give the insulin. Based on interview and record			

review, the facility failed to ensure injectable medications were administered by licensed staff for 3 of 5 residents reviewed for medication administration (Residents K, L, and N).

Findings include:

1 a. The clinical record for Resident K was reviewed on 12/18/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, diabetes.

A physician's order, dated 10/9/25, indicated she was to receive Ozempic (semaglutide - used in adults to control blood sugar levels when combined with diet and exercise) 2 units injected subcutaneously (under the skin) every Wednesday.

The investigation file of QMA 10 working outside of her scope of practice was provided by the RDO on 12/18/25 at 11:30 a.m. The investigation file included a Pass Med Report, generated on 11/4/25. The report indicated QMA 10 had administered Resident K's Ozempic, 1 mg subcutaneously on 9/10/25.

1 b. The clinical record for Resident L was reviewed on 12/18/25 at 1:40 p.m. The resident's diagnosis included, but was not limited to, diabetes.

A physician's order, dated 7/23/24, indicated he was to

receive Humalog (type of insulin) three times a day per sliding scale before meals.

The investigation file of QMA 10 working outside of her scope of practice was provided by the RDO on 12/18/25 at 11:30 a.m. The investigation file included a Pass Med Report, generated on 11/4/25. The report indicated QMA 10 had administered Resident L's Humalog subcutaneously on 10/22/25, 10/26/25, and 10/27/25.

1c. The clinical record for Resident N was reviewed on 12/18/25 at 2:00 p.m. The resident's diagnosis included, but was not limited to, diabetes.

A physician's order, dated 9/25/25, indicated she was to receive Lantus Solostar (type of insulin) 15 units subcutaneously daily.

On 12/18/25 at 11:30 a.m., the Regional Director of Operations (RDO) provided an incident report, submitted to the Indiana Department of Health on 11/4/25 at 2:28 p.m. The incident report indicated that Qualified Medication Aide (QMA) 10 had worked outside of her scope of practice.

The investigation file of QMA 10 working outside of her scope of practice was provided by the RDO on 12/18/25 at 11:30 a.m. The investigation file included a

	Pass Med Report, generated on 11/4/25. The report indicated QMA 10 had administered Resident N's Lantus Solostar subcutaneously on 11/3/25. During an interview on 12/19/25 at 10:36 a.m., QMA 10 indicated she had administered insulin and Ozempic to residents at the facility. She was not insulin certified but had taken the insulin administration class. She had not passed the test for certification. QMA 10 indicated she had given the insulin, despite not being certified, because no one else was around to give the insulin.			
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal.	R 0306		01/05/2026

(5) The amount disposed of.

(6) The method of disposition.

(7) The date of the disposal.

(8) The signature of the person conducting the disposal of the drug.

(9) The signature of a witness, if any, to the disposal of the drug.

Based on interview and record review, the facility failed to ensure a resident received a narcotic medication as ordered by the physician for 1 of 1 resident reviewed for medication errors (Resident J).

Findings include:

The clinical record for Resident J was reviewed 12/18/25 at 12:45 p.m. The resident's diagnosis included, but was not limited to, hypertension.

A service plan, dated 9/5/25, indicated Resident J needed medication assistance. The goal was for the resident to receive medications timely and safely per the physician's orders. The intervention was for staff to assist the resident with medication administration as needed per physicians orders.

A physician's order, dated 10/20/25, indicated the resident was to receive morphine sulfate (narcotic pain medication) ER

(extended release) 30 milligram (mg) take 1 tablet by mouth three times daily at 8:00 a.m., 2:00 p.m., and 10:00 p.m.

A nurse's note, dated 11/3/25 at 5:31 p.m., indicated Resident J's medical providers office was made aware of a medication error. A new order was received to hold any sedating medications and to hold the 10:00 p.m. dose of morphine. A mediation reconciliation was done. Staff will monitor mental status and respiratory status every 30 minutes throughout the night.

During an interview on 12/18/25 at 3:25 p.m., the Regional Nurse Consultant (RNC) indicated a medication error had occurred on 11/3/25 at 3:00 p.m., when Resident J was given an extra dose of morphine sulfate 30 mg. The 2:00 p.m. dose of morphine sulfate had been given but not signed off as given on the Medication Administration Record. The second shift Qualified Medication Aide thought the dose had been missed and administered a dose of Morphine Sulfate ER 30mg. The error was discovered and the Director of Nursing was immediately notified.

During an interview on 12/19/25 at 10:06 a.m., Resident J indicated he did get too much of a medication once, but it had

not happened again.

On 12/19/25 at 11:00 a.m., the Director of Nursing provided the Narcotics Policy, last revised November 2025, that read "...To ensure safe storage, administration, tracking, and disposal of controlled substances and to reduce the risk of diversion, misuse, or medication errors...Every dose removed is documented on the CRS[sic], including: date and time, Resident Name, Medication name, strength, and dose administered, Quantity remaining, Staff initials or signature. Each administered dose is also documented on the Medication Administration Record [MAR], including time, dose, route, and staff initials..."

This Residential tag relates to Intake 466443.

Based on interview and record review, the facility failed to ensure a resident received a narcotic medication as ordered by the physician for 1 of 1 resident reviewed for medication errors (Resident J).

Findings include:

The clinical record for Resident J was reviewed 12/18/25 at 12:45 p.m. The resident's diagnosis included, but was not limited to, hypertension.

A service plan, dated 9/5/25,

indicated Resident J needed medication assistance. The goal was for the resident to receive medications timely and safely per the physician's orders. The intervention was for staff to assist the resident with medication administration as needed per physicians orders.

A physician's order, dated 10/20/25, indicated the resident was to receive morphine sulfate (narcotic pain medication) ER (extended release) 30 milligram (mg) take 1 tablet by mouth three times daily at 8:00 a.m., 2:00 p.m., and 10:00 p.m.

A nurse's note, dated 11/3/25 at 5:31 p.m., indicated Resident J's medical providers office was made aware of a medication error. A new order was received to hold any sedating medications and to hold the 10:00 p.m. dose of morphine. A mediation reconciliation was done. Staff will monitor mental status and respiratory status every 30 minutes throughout the night.

During an interview on 12/18/25 at 3:25 p.m., the Regional Nurse Consultant (RNC) indicated a medication error had occurred on 11/3/25 at 3:00 p.m., when Resident J was given an extra dose of morphine sulfate 30 mg. The 2:00 p.m. dose of morphine sulfate had been given but not signed off as given on the

Medication Administration Record. The second shift Qualified Medication Aide thought the dose had been missed and administered a dose of Morphine Sulfate ER 30mg. The error was discovered and the Director of Nursing was immediately notified.

During an interview on 12/19/25 at 10:06 a.m., Resident J indicated he did get too much of a medication once, but it had not happened again.

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This Residential tag relates to Intake 466443.

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