STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF NEW WHITELAND	532 COUNTRY GATE DRIVE NEW WHITELAND, IN 46184

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00461532. Complaint IN00461532 - State deficiencies related to the allegations are cited at R0052. Survey date: July 1, 2025 Facility number: 016046 Residential Census: 70 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 2, 2025.	R 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Vita of New Whiteland respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed. This deficient practice resulted in a resident being left on the floor for multiple hours. (Resident B) Findings include: During an interview on 7/1/25 at 8:45 a.m., CNA 1 indicated Resident B's daughter had come into the facility, on 6/14/25, and showed CNA 1 a video from inside Resident B's room. On the video, CNA 1 observed Resident B on the floor at approximately 12:30 a.m. CNA 3 walked in the room and threw a pillow and then took Resident B's blanket off her bed and threw it at her. CNA 3 left the room with Resident B still on the floor.	R 0052	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B care plan shall be updated with increased rounds by staff confirming fall interventions in place are effective. Involved staff educated and separated from community. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:**	07/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Holder	Executive Director	07/16/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Resident B remained on the floor for approximately five hours. During an interview on 7/1/25 at 9:01 a.m., Family Member 1 indicated she had never seen anyone treated the way Resident B was treated. At that time, Family Member 1 became tearful and indicated she had a camera in Resident B's room and the entire incident between Resident B and CNA 3 was recorded. Family Member 1 attempted to contact the facility to tell them Resident B was on the floor, on 6/14/25 at 12:50 a.m., 12:57 a.m., and 1:21 a.m., but there was no answer. On 7/1/25 at 9:05 a.m., Family Member 1 provided her personal cell phone with security camera footage of Resident B's room. A review of the security camera footage indicated: - On 6/14/25 at 12:54 a.m., Resident B was wearing a shirt and brief. Resident B was lying on her left side, on a fall mat next to her bed. Resident B sat up and leaned against the bed. Resident B remained on the floor. - On 6/14/25 at 1:25 a.m., Resident B was still sitting on the floor approximately 3 feet away from her bed and was facing her bed (away from camera view). CNA 3 entered Resident B's room, threw a pillow on the floor, then took Resident B's blanket off of her bed and threw it at her while she was sitting up on the floor. CNA 3 left Resident B's room and loudly said bullsh*t. Resident B was still on the floor. Resident B laid her head on the pillow and covered herself. - On 6/14/25 at 4:42 a.m., Resident B was lying on the floor. CNA 3 walked into Resident B's room indicated to Resident B, it looks like you lost your pillow, then CNA 3 walked into Resident B's		All residents in the Memory Care area sustaining a fall who require assistance to recover from fall have the potential to be affected by the alleged deficient practice. An audit of care plans for Memory Care residents to be reviewed and/or updated by DNS/Designee for resident fall interventions with walking rounds to confirm in place. Care Staff to do room rounds every 2 hours to ensure fall interventions are effective. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ED/Designee will complete an inservice with all staff to ensure staff education on resident right to be free of abuse/neglect completed by 7/16/25. DNS/Designee will complete an inservice with nursing staff to ensure staff education on rounding every 2 hours on night shift completed on 7/9/25. Care Staff to do room rounds every 2 hours to ensure fall interventions are effective. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED/Designee will be responsible for Residents Rights QA tool weekly x 4 weeks then monthly x	

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	bathroom. - On 6/14/25 at 4:42 a.m., CNA 3 walked out of Resident B's bathroom with a brief. CNA 3 walked over to Resident B, pulled the blanket off of Resident B, and unfastened the brief that Resident B was wearing. - On 6/14/25 at 4:45 a.m., Resident B was still lying on the floor. A soiled brief was lying on the floor. CNA 3 was assisting Resident B to put on her pants. - On 6/14/25 at 5:13 a.m., Resident B was still lying on the floor. CNA 3 and another CNA entered Resident B's room. CNA 3 walked up to Resident B and quickly pulled the blanket off of her. Resident B was startled. CNA 3 and the other CNA assisted Resident B off the floor and into her wheelchair. During an interview on 7/1/25 at 10:08 a.m., CNA 3 indicated she wasn't sure how long Resident B was left on the floor. Resident B was lying on her fall mat, not on the floor. During an interview on 7/1/25 at 10:16 a.m., Qualified Medication Aide (QMA) 1 indicated she was working on the secured memory care unit, on 6/14/25 for night shift. CNA 3 did not make QMA 1 nor CNA 2 aware that Resident B had fallen and was on the floor. Finally, CNA 2 made QMA 1 aware that Resident B had a fall after the two CNA's had assisted her up to her wheelchair. The clinical record for Resident B was reviewed on 7/1/25 at 11:35 a.m. The diagnoses included, but were not limited to, Lewy body dementia, Parkinsonism, and obstructive sleep apnea. Resident B required a secured memory care unit.		5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	On 7/1/25 at 9:40 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Neglect, and Financial Exploitation Prevention, dated 2/2021, and indicated this was the current policy used by the facility. A review of the policy indicated residents have the right to be free from abuse and neglect. This citation relates to Complaint IN00461532			