

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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NAME OF PROVIDER OR SUPPLIER VERMILLION PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 449 MAIN ST ANDERSON, IN 46016
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint #IN00194277.</p> <p>Complaint #IN00194277 - Substantiated. State deficiency related to the allegations is cited at R091.</p> <p>Survey Dates: March 7, 2016</p> <p>Facility Number: 011970 Provider Number: 011970 AIM number: N/A</p> <p>Census Bed Type: Residential: 36 Total: 36</p> <p>Census Payor Type: Medicaid: 23 Other: 13 Total: 36</p> <p>Sample: 3</p> <p>This state finding is cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on March 7, 2016.</p>	R 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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R 0091 Bldg. 00	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (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 request. Based on record review and interview, the facility failed to ensure physician orders were received and signed by a licensed nursing personnel. This deficient practice had the potential to effect 36 of 36 residents currently living within the facility.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 3/7/16 at 11:15 a.m. Diagnoses included, but were not limited to, history of cerebralvascular accident, hypertension, depression, renal insufficiency and peripheral neuropathy.</p> <p>Review of Resident B's physician orders for March 2016 indicated the orders were not signed as having been reviewed by</p>	R 0091	<p>R000 Preparation and/or execution of this Plan of Correction in general or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Vermillion Place of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and the specific corrective actions are prepared and/or executed solely because of provisions of state laws. Vermillion Place desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective March 25, 2016. This building respectfully requests consideration for paper compliance from the Plan of Correction. R0091 1. Residents B,C,D medical records have been</p>	03/25/2016

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	<p>licensed nursing personnel. The orders were signed by a Qualified Medication Aide (QMA).</p> <p>2. The clinical record for Resident C was reviewed on 3/7/16 at 11:06 a.m. Diagnoses included, but were not limited to, vertigo, colonic diverticulosis, fibromyalgia, hypothyroidism and narcolepsy.</p> <p>Review of Resident C's physician orders for March 2016 indicated the orders were not signed as having been reviewed by licensed nursing personnel. The orders were signed by a Qualified Medication Aide (QMA).</p> <p>3. The clinical record for Resident D was reviewed on 3/7/16 at 12:40 p.m. Diagnoses included, but were not limited to, memory deficit, malaise, arthritis, hypokalemia and venous stasis atrophic vaginitis.</p> <p>Review of Resident D's physician orders for March 2016 indicated the orders were not signed as having been reviewed by licensed nursing personnel. The orders were signed by a Qualified Medication Aide (QMA).</p> <p>During an interview on 3/7/16 at 10:02 a.m., the Administrative Assistant</p>		<p>reviewed by a licensed nurse. There was no negative outcome found for any resident. All rewrites have been reviewed by a licensed nurse. All verbal and telephone orders are being taken by a licensed nurse 2 All 36 residents had the potential to be effected There was no negative outcome for any potentially effected resident All rewrites have been reviewed by a licensed nurse. All verbal and telephone orders are being taken by a licensed nurse 3. All rewrites are being reviewed by a licensed nurse. All telephone or verbal orders are being taken by a licensed nurse The facility current updated policy titled "Content of the Medical Record" and the Nurse Practice Act have been reviewed by the Administrator and the Director of Nursing to ensure no deficient practices occur The Administrative Assistant has been inserviced on physicians telephone calls and the proper handling of these calls 4. The Director of Nursing, or their Designee, will monitor the Resident rewrites, physician telephone and verbal orders every 2 weeks for 3 months, then monthly for 3 months. Random monitoring as needed will occur after that. They will report any issues to the Administrator 5 Date of Compliance ,March 25, 2016</p>				

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	<p>indicated she took phone calls from the physician offices and would take a detailed message and relayed it to the nurse. "If it doesn't have to do with patient care like medications, I would take the information and pass it on."</p> <p>During an interview on 3/7/16 at 10:29 a.m., the Director of Nursing indicated she had been unaware the Administrative Assistant was taking messages from the physician offices. The Director of Nursing indicated only licensed nursing personnel should be taking orders from the physician offices. The Director of Nursing also indicated the QMA checked to make sure the orders were current on the monthly physician orders and signed them after they had been checked. The Director of Nursing or the Assistant Director of Nursing were responsible for making any changes found by the QMA.</p> <p>Review of a current undated policy titled "Content of the Clinical Record", indicated the following: "...g. Physician's Verbal Orders: All physicians' verbal and telephone orders shall include the date, time, physician's order, signature of licensed nurse or pharmacist, therapist (for therapy orders) and dietitian (for diet orders) accepting the order and the name of the physician giving the order...."</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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