

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/02/2023
NAME OF PROVIDER OR SUPPLIER 1019 SENIOR LIVING VERMILLION PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 449 MAIN ST, ANDERSON, , 46016		
(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 a State Residential Licensure Survey. Survey dates: October 31, November 1, and November 2, 2023. Facility number: 011970 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 9, 2023.	R 0000	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 December 24, 2023. This building respectfully requests consideration for paper compliance from this Plan of Correction.	
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references	R 0116	R116 It is the practice of Vermillion Place to obtain criminal background checks and references for all newly hired employees.	12/24/2023

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

and any convictions in accordance with IC 16-28-13-3.

Based on record review and interview, the facility failed to obtain criminal background checks upon hire for 3 of 3 newly hired employees record reviewed (Qualified Medication Aide (QMA) 3, Dietary Aide 4, Certified Nursing Aide (CNA) 5) and failed to obtain references upon hire for 2 of 3 newly hired employees record reviewed (QMA3 and Dietary Aide 4).

Findings include:

Employee record review, completed 11/2/23 at 10:00 a.m., indicated criminal background checks were not obtained for QMA 3 (hire date 7/18/23), Dietary Aide 4 (hire date 9/6/23), and CNA 5 (hire date 6/9/23).

References were not obtained for QMA 3 or Dietary Aide 4.

During an interview, on 11/2/23 at 9:30 a.m., Co-director 2 indicated Dietary Aide 4 did not get a background check due to her age, as she was a minor at the time of hiring. QMA 3 and CNA 5 were re-hired employees and new references were not obtained. She had no further information to provide.

During an interview, on 11/2/23 at 10:49 a.m., Co-director 1 and

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

All residents have the potential to be affected by the alleged deficient practice. All employee files have been audited at this time and the facility has obtained criminal histories and references on all current employees.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?

All residents have the potential to be affected by the alleged deficient practice. The Business Office Assistant has completed employee file audits. All current employees have a criminal history and references. Moving forward, the Business Office Assistant and/or designee will audit the new employee files and ensure that all documentation is obtained as required.

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

Co-director 2 indicated the facility had no policy for employee records.

Based on record review and interview, the facility failed to obtain criminal background checks upon hire for 3 of 3 newly hired employees record reviewed (Qualified Medication Aide (QMA) 3, Dietary Aide 4, Certified Nursing Aide (CNA) 5) and failed to obtain references upon hire for 2 of 3 newly hired employees record reviewed (QMA3 and Dietary Aide 4).

Findings include:

Employee record review, completed 11/2/23 at 10:00 a.m., indicated criminal background checks were not obtained for QMA 3 (hire date 7/18/23), Dietary Aide 4 (hire date 9/6/23), and CNA 5 (hire date 6/9/23).

References were not obtained for QMA 3 or Dietary Aide 4.

During an interview, on 11/2/23 at 9:30 a.m., Co-director 2 indicated Dietary Aide 4 did not get a background check due to her age, as she was a minor at the time of hiring. QMA 3 and CNA 5 were re-hired employees and new references were not obtained. She had no further information to provide.

During an interview, on 11/2/23 at 10:49 a.m., Co-director 1 and

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

The Business Office Assistant will complete an employee file audit on all new employees' files using a checklist which includes all required documentation. The Executive Director will sign off on all new employee files once the Business Office Assistant ensures that the file is complete. This will allow for any corrections to be made in a timely manner.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

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

	Co-director 2 indicated the facility had no policy for employee records.		The Business Office Assistant will bring the initial employee audit as well as any new employee file audits to the monthly QAPI committee meeting for further review and recommendations. The QAPI team will continue to monitor the completion of employee files on an ongoing basis. The Business Office Assistant is responsible for the implementation and monitoring of this plan.	
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly	R 0117	R117 It is the practice of Vermillion Place to ensure at least one staff member with first aid and cardiopulmonary resuscitation shall always be on site. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. All nursing employee files have	12/24/2023

receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on record review and interview, the facility failed to ensure a staff member was first aid and cardiopulmonary resuscitation (CPR) certified for 16 of 21 shifts scheduled.

Findings include:

Review of employee schedules, provided by Co-director 2 on 11/1/23 at 10:55 a.m., were reviewed on 11/2/23 at 10:00 a.m., and indicated the following shifts lacked a staff member certified in first aid and CPR:

10/25/23: second and third shifts

10/26/23: first and third shifts

10/27/23: all shifts

10/28/23: second and third shifts

10/29/23: second and third shifts

10/30/23: all shifts

10/31/23: second and third

been audited at this time and the facility has begun to obtain CPR and first aid certification for all nursing staff.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?

All residents have the potential to be affected by the alleged deficient practice. The Business Office Assistant has completed employee file audits on the nursing employee files. All nursing staff will obtain CPR and first aid certification before December 24, 2023. Moving forward, the Business Office Assistant and/or designee will audit the new employee files and ensure that nursing employees have CPR and first aid certification as required.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

The Business Office Assistant

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

	shifts During an interview, on 11/2/23 at 9:30 a.m., Co-director 1 indicated there were no additional employee certifications to provide. During an interview, on 11/2/23 at 11:48 a.m., Co-director 1 and Co-director 2 indicated there were no facility policies for first aid or CPR. Based on record review and interview, the facility failed to ensure a staff member was first aid and cardiopulmonary resuscitation (CPR) certified for 16 of 21 shifts scheduled. Findings include: Review of employee schedules, provided by Co-director 2 on 11/1/23 at 10:55 a.m., were reviewed on 11/2/23 at 10:00 a.m., and indicated the following shifts lacked a staff member certified in first aid and CPR: 10/25/23: second and third shifts 10/26/23: first and third shifts 10/27/23: all shifts 10/28/23: second and third shifts 10/29/23: second and third shifts		will complete an employee file audit on all new employees' files using a checklist which includes all required documentation. The Executive Director will sign off on all new employee files once the Business Office Assistant ensures that the file is complete. This will allow for any corrections to be made in a timely manner. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Business Office Assistant will bring the initial employee audit as well as any new employee file audits to the monthly QAPI committee meeting for further review and recommendations. The QAPI team will continue to monitor the completion of employee files on an ongoing basis. The Business Office Assistant is responsible for the implementation and monitoring of this plan.	
--	--	--	--	--

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

	10/30/23: all shifts 10/31/23: second and third shifts During an interview, on 11/2/23 at 9:30 a.m., Co-director 1 indicated there were no additional employee certifications to provide. During an interview, on 11/2/23 at 11:48 a.m., Co-director 1 and Co-director 2 indicated there were no facility policies for first aid or CPR.			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility.	R 0119	R119 It is the practice of Vermillion Place to have all newly hired employees' complete job-specific orientation. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. All employee files have been audited at this time and the facility has completed a job-specific orientation on all current	12/24/2023

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

	(2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure newly hired employees had job-specific orientation completed for 2 of 3 employee records reviewed (Qualified Medication Aide (QMA) 3 and Certified Nurse Aide (CNA) 5). Findings include: Employee record review,		employees. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. The Business Office Assistant has completed employee file audits. All current employees have a job-specific orientation. Moving forward, the Business Office Assistant and/or designee will audit the new employee files and ensure that all documentation is obtained as required. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Business Office Assistant will complete an employee file audit on all new employees' files using a checklist which includes all required documentation. The Executive Director will sign off on all new employee files	
--	--	--	--	--

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

completed 11/2/23 at 10:00 a.m., indicated the following employees lacked documentation of job specific orientation: QMA 3 (hire date 7/18/23) and CNA 5 (hire date 6/9/23).

During an interview, on 11/2/23 at 9:30 a.m., Co-director 2 indicated she had provided all the information the facility had for employee records.

During an interview, on 11/2/23 at 11:48 a.m., Co-director 1 and Co-director 2 indicated there were no facility policy for job-specific orientation.

Based on record review and interview, the facility failed to ensure newly hired employees had job-specific orientation completed for 2 of 3 employee records reviewed (Qualified Medication Aide (QMA) 3 and Certified Nurse Aide (CNA) 5).

Findings include:

Employee record review, completed 11/2/23 at 10:00 a.m., indicated the following employees lacked documentation of job specific orientation: QMA 3 (hire date 7/18/23) and CNA 5 (hire date 6/9/23).

During an interview, on 11/2/23 at 9:30 a.m., Co-director 2 indicated she had provided all the information the facility had

once the Business Office Assistant ensures that the file is complete. This will allow for any corrections to be made in a timely manner.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Business Office Assistant will bring the initial employee audit as well as any new employee file audits to the monthly QAPI committee meeting for further review and recommendations. The QAPI team will continue to monitor the completion of employee files on an ongoing basis.

The Business Office Assistant is responsible for the implementation and monitoring of this plan.

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

	for employee records. During an interview, on 11/2/23 at 11:48 a.m., Co-director 1 and Co-director 2 indicated there were no facility policy for job-specific orientation.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of	R 0120	R 120 It is the practice of Vermillion Place to ensure yearly dementia inservice training is conducted for all staff. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. All employee files have been audited at this time and the facility is in the process of obtaining the required dementia training. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?	12/24/2023

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

	cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure employees who had been employed for greater than one year, had three hours of annual dementia training for 2 of 2 employee reviewed for annual dementia training (Certified Nurse Aide (CNA) 6 and Qualified Medication Aide (QMA) 7). Findings include: Employee record review, completed 11/2/23 at 10:00 a.m., indicated CNA 6 and QMA 7 lacked annual dementia training. During an interview, on 11/2/23		All residents have the potential to be affected by the alleged deficient practice. The Business Administrator has completed employee file audits and is in the process of obtaining the required documentation. Moving forward, the Business Office Assistant and/or designee will audit the new employee files and ensure that all documentation is obtained as required. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Business Office Assistant will complete an employee file audit on all new employees' files using a checklist which includes all required documentation. The Executive Director will sign off on all new employee files once the Business Office Assistant ensures that the file is complete. This will allow for any corrections to be made in a timely manner. How the corrective action will be monitored to ensure the deficient practice will not	
--	--	--	---	--

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

at 9:30 a.m., Co-director 2 indicated she had provided all the information the facility had for employee records.

During an interview, on 11/2/23 at 11:48 a.m., Co- director 1 and Co-director 2 indicated they did not have a facility policy for annual dementia training.

Based on record review and interview, the facility failed to ensure employees who had been employed for greater than one year, had three hours of annual dementia training for 2 of 2 employee reviewed for annual dementia training (Certified Nurse Aide (CNA) 6 and Qualified Medication Aide (QMA) 7).

Findings include:

Employee record review, completed 11/2/23 at 10:00 a.m., indicated CNA 6 and QMA 7 lacked annual dementia training.

During an interview, on 11/2/23 at 9:30 a.m., Co-director 2 indicated she had provided all the information the facility had for employee records.

During an interview, on 11/2/23 at 11:48 a.m., Co- director 1 and Co-director 2 indicated they did not have a facility policy for annual dementia training.

recur, i.e., what quality assurance program will be put into place?

The Business Office Assistant will bring the initial employee audit as well as any new employee file audits to the monthly QAPI committee meeting for further review and recommendations. The QAPI team will continue to monitor the completion of employee files on an ongoing basis.

The Business Office Assistant is responsible for the implementation and monitoring of this plan.

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

R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.	R 0121	R121 It is the practice of Vermillion Place to obtain tuberculosis (TB) testing and health screenings for all newly hired employees. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. All employee files have been audited at this time, and the facility has ensured that tuberculosis screenings and health	12/24/2023
--------	--	--------	--	------------

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

(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.

Based on record review and interview, the facility failed to ensure employees were screened for tuberculosis (TB) and obtained completed health screenings upon hire for 3 of 3 newly hired employees (Qualified Medication Aide (QMA), Dietary Aide 4, and Certified Nurse Aide (CNA) 5).

Findings include:

Employee record review, completed 11/2/23 at 10:00 a.m., indicated the following employees lacked TB screening and completed health screening upon hire: QMA 3 (hire date 7/18/23), Dietary aide 4 (hire date 9/6/23), and CNA 5 (hire date 6/9/23).

Employee health screen records, provided by Co-director 2 on 11/2/23 at 9:30 a.m., lacked a signature from the facility nurse/physician reviewer.

During an interview on 11/2/23

screenings have been obtained for all current employees.

How other residents having the potential to be affected by the same deficient practice will be

identified and what corrective actions will be taken?

All residents have the potential to be affected by the alleged deficient practice. The Business Office

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

at 10:49 a.m., Co-director 1 and Co-director 2 indicated they did not have a facility policy for TB testing.

During an interview on 11/2/23 at 12:30 p.m., Co-director 1 and Co-director 2 indicated the last TB testing done in the facility was back in 2018 and new hires were currently sent to a local healthcare clinic to receive TB testing. Some of the new hires could have up to date testing from recent employment with other healthcare positions, but they had not asked for these results.

Based on record review and interview, the facility failed to ensure employees were screened for tuberculosis (TB) and obtained completed health screenings upon hire for 3 of 3 newly hired employees (Qualified Medication Aide (QMA), Dietary Aide 4, and Certified Nurse Aide (CNA) 5).

Findings include:

Employee record review, completed 11/2/23 at 10:00 a.m., indicated the following employees lacked TB screening and completed health screening upon hire: QMA 3 (hire date 7/18/23), Dietary aide 4 (hire date 9/6/23), and CNA 5 (hire date 6/9/23).

Employee health screen records, provided by Co-director

Assistant has completed employee file audits. All current employees have tuberculosis (TB) testing and health screenings. Moving forward, the Business Office Assistant and/or designee will audit the new employee files and ensure that all documentation, including the signature from our facility nurse/physician reviewer, is obtained as required per State Guidelines.

What measures will be put into place and what systemic changes will be made to ensure that the

deficient practice does not recur?

The Business Office Assistant will complete an employee file audit on all new employees' files using a checklist which includes all required documentation. The Executive Director will sign off

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

2 on 11/2/23 at 9:30 a.m., lacked a signature from the facility nurse/physician reviewer.

During an interview on 11/2/23 at 10:49 a.m., Co-director 1 and Co-director 2 indicated they did not have a facility policy for TB testing.

During an interview on 11/2/23 at 12:30 p.m., Co-director 1 and Co-director 2 indicated the last TB testing done in the facility was back in 2018 and new hires were currently sent to a local healthcare clinic to receive TB testing. Some of the new hires could have up to date testing from recent employment with other healthcare positions, but they had not asked for these results.

on all new employee files once the Business Office Assistant ensures at the file is complete. This will allow for any corrections to be made in a timely manner.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what

quality assurance program will be put into place?

The Business Office Assistant will bring the initial employee audit as well as any new employee file

audits to the monthly QAPI committee meeting for further review and recommendations. The QAPI

team will continue to monitor the completion of employee files on an ongoing basis.

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

			The Business Office Assistant is responsible for the implementation and monitoring of this plan.	
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for	R 0123	R123 It is the practice at Vermillion Place to have all newly hired employees complete job descriptions. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. All employee files have been audited at this time and the facility has completed job descriptions on all current employees. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?	12/24/2023

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

separation. Based on record review and interview the facility failed to ensure newly hired employees had signed job descriptions for 2 of 3 newly hired employee records reviewed (Qualified Medication Aide (QMA) 3 and Certified Nurse Aide (CNA) 5). Employee record review, completed 11/2/23 at 10:00 a.m., indicated the following employees lacked documentation of signed job descriptions: QMA 3 (hire date 7/18/23) and CNA 5 (hire date 6/9/23). During an interview, on 11/2/23 at 9:30 a.m., Co-director 2 indicated she had provided all the information the facility has for employee records. During an interview, on 11/2/23 at 11:48 a.m., Co- director 1 and Co-director 2 indicated there was no facility policy for signed job descriptions. Based on record review and interview the facility failed to ensure newly hired employees had signed job descriptions for 2 of 3 newly hired employee records reviewed (Qualified Medication Aide (QMA) 3 and Certified Nurse Aide (CNA) 5). Employee record review, completed 11/2/23 at 10:00	All residents have the potential to be affected by the alleged deficient practice. The Business Office Assistant has completed employee file audits. All current employees have a job description. Moving forward, the Business Office Assistant and/or designee will audit the new employee files and ensure that all documentation is obtained as required. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Business Office Assistant will complete an employee file audit on all new employees' files using a checklist which includes all required documentation. The Executive Director will sign off on all new employee files once the Business Office Assistant ensures that the file is complete. This will allow for any corrections to be made in a timely manner. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality	
---	---	--

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

	a.m., indicated the following employees lacked documentation of signed job descriptions: QMA 3 (hire date 7/18/23) and CNA 5 (hire date 6/9/23). During an interview, on 11/2/23 at 9:30 a.m., Co-director 2 indicated she had provided all the information the facility has for employee records. During an interview, on 11/2/23 at 11:48 a.m., Co-director 1 and Co-director 2 indicated there was no facility policy for signed job descriptions.		assurance program will be put into place? The Business Office Assistant will bring the initial employee audit as well as any new employee file audits to the monthly QAPI committee meeting for further review and recommendations. The QAPI team will continue to monitor the completion of employee files on an ongoing basis. The Business Office Assistant is responsible for the implementation and monitoring of this plan.	
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain the facility in a clean sanitary manner regarding carpet stains for 2 of 2 floors in the facility (first and second floor). This deficient practice had the potential to impact 24 of 24 residents, who resided in the	R 0144	R144 It is the practice of Vermillion Place to ensure the facility was maintained in a clean and homelike manner. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the	12/24/2023

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

FORM APPROVED

OMB NO. 0938-0391

facility.

Findings include:

During an environmental tour on 10/31/23, staining was noted to the hallway carpet on both the first and second floors, which included the following areas:

In the hallway, in front of room 118 to 119, there were nine dark stains on the carpet range in size from 1-inch circles, to 3-inch circles, to a 2-foot long by 1-inch straight line stain in front of room 119.

A large 4-foot long by 1-foot wide splash pattern stain outside room 121.

In the hallway from 123 to 130, there were multiple stains ranging from 1-inch circles to 3-inch circles.

Outside of room 124, there were approximately nine 1-inch circle shaped stains.

Outside the kitchen door, there was a large approximately 2-foot by 4-foot patch of darkly discolored carpet.

The elevator located outside of the kitchen had a carpet with stains and discoloration over three-quarters of the surface.

alleged deficient practice. The various stains, spots, spills, etc. on the carpet will be corrected. The current carpet is going to be cleaned and the Executive Director will determine if the spots have been removed. Upon the carpet cleaning being completed, the Executive Director will decide if the carpet in the areas mentioned needs replaced.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?

All residents have the potential to be affected by the alleged deficient practice. The entire hallway carpeting is being cleaned. Upon cleaning, the Executive Director will decide if the carpet in the areas mentioned needs replaced.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

The policies on daily cleaning,

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

Outside room 206, in front of the desk, there were multiple 3-inch circle shaped stains. In the hallway between rooms 201 and 203, the carpet was dark and discolored close to the baseboard. In front of room 215, there were multiple circle shaped stains ranging from 2-inch circles to 4-inch circles. Across from room 226, there was a large splash pattern stain, approximately 3 feet by 2 feet. Outside room 222, there were multiple 1-inch circle shaped stains. In the hallway from room 226 to 224, the carpet by the baseboard was dark and discolored. Outside room 228, across from the desk, there were multiple 1-inch circle shaped stains. Outside room 232, there was a 3-inch by 3-inch stain. The elevator located by the laundry room had stains and discolorations cover approximately three-quarters of the floor surface. During an interview on 11/2/23 at 11:18 a.m., Resident 2 indicated she had observed multiple stains on the carpets in		cleaning of carpet spills is being reviewed. A policy on carpet cleaning will be developed based on what is recommended for the carpeting. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Executive Director and/or designee is to do a daily walk through of the building five days a week. They report any spills, spots on the carpet or any other issues needing cleaning or repair to the proper department, housekeeping, or Maintenance for correction. The Executive Director and/or designee will keep a record of the daily walkthroughs. The Executive Director and/or designee will review the daily walkthroughs with the housekeeping department and Maintenance for any needed actions or corrections.	
---	--	---	--

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

the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:36 a.m., Resident 20 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:37 a.m., Resident 17 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:38 a.m., Resident 14 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:39 a.m., Resident 10 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a

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

manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:40 a.m., Resident 19 indicated he had observed multiple stains on the carpets in the hallway. He believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:52 a.m., Co-Director 1 indicated many of the discolorations and spots on the carpets must be stains, because the carpet was professionally cleaned in February 2023.

Review of an undated facility document titled "Facility Cleaning Task List", provided by Co-Director 1 on 11/2/23 at 9:32 a.m., indicated the following:
"...vacuum the front entry way.....vacuum lobby... Vacuum, ...in break room...Clean elevator...Vacuum inside...All Common Areas:...Vacuumed..."

Based on observation and interview, the facility failed to maintain the facility in a clean sanitary manner regarding carpet stains for 2 of 2 floors in the facility (first and second floor). This deficient practice had the potential to impact 24 of 24 residents, who resided in the facility.

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

Findings include:

During an environmental tour on 10/31/23, staining was noted to the hallway carpet on both the first and second floors, which included the following areas:

In the hallway, in front of room 118 to 119, there were nine dark stains on the carpet range in size from 1-inch circles, to 3-inch circles, to a 2-foot long by 1-inch straight line stain in front of room 119.

A large 4-foot long by 1-foot wide splash pattern stain outside room 121.

In the hallway from 123 to 130, there were multiple stains ranging from 1-inch circles to 3-inch circles.

Outside of room 124, there were approximately nine 1-inch circle shaped stains.

Outside the kitchen door, there was a large approximately 2-foot by 4-foot patch of darkly discolored carpet.

The elevator located outside of the kitchen had a carpet with stains and discoloration over three-quarters of the surface.

Outside room 206, in front of the desk, there were multiple 3-inch circle shaped stains.

In the hallway between rooms

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

201 and 203, the carpet was dark and discolored close to the baseboard.

In front of room 215, there were multiple circle shaped stains ranging from 2-inch circles to 4-inch circles.

Across from room 226, there was a large splash pattern stain, approximately 3 feet by 2 feet.

Outside room 222, there were multiple 1-inch circle shaped stains.

In the hallway from room 226 to 224, the carpet by the baseboard was dark and discolored.

Outside room 228, across from the desk, there were multiple 1-inch circle shaped stains.

Outside room 232, there was a 3-inch by 3-inch stain.

The elevator located by the laundry room had stains and discolorations cover approximately three-quarters of the floor surface.

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

During an interview on 11/2/23 at 11:18 a.m., Resident 2 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:36 a.m., Resident 20 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:37 a.m., Resident 17 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:38 a.m., Resident 14 indicated she had observed multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet.

During an interview on 11/2/23 at 11:39 a.m., Resident 10 indicated she had observed

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

	multiple stains on the carpets in the hallway. She believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet. During an interview on 11/2/23 at 11:40 a.m., Resident 19 indicated he had observed multiple stains on the carpets in the hallway. He believed the facility needed to correct the problem either by cleaning in a manner to remove the stains or replacing the carpet. During an interview on 11/2/23 at 11:52 a.m., Co-Director 1 indicated many of the discolorations and spots on the carpets must be stains, because the carpet was professionally cleaned in February 2023. Review of an undated facility document titled "Facility Cleaning Task List", provided by Co-Director 1 on 11/2/23 at 9:32 a.m., indicated the following: "...vacuum the front entry way.....vacuum lobby... Vacuum, ...in break room...Clean elevator...Vacuum inside...All Common Areas:...Vacuumed..."			
R 0269	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(b) (b) The menu or substitutions, or	R 0269	R269 It is the practice of Vermillion Place to ensure menus	12/24/2023

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

both, for all meals shall be approved by a registered dietitian. Based on interview and record review, the facility failed to ensure menus and/or their substitutions were approved by a registered dietitian. This deficient practice had the potential to impact 24 of 24 residents who received meals in the facility. Findings include: Review of the menus provided by Co-Director 1 on 10/31/23 at 2:00 p.m., indicated the following: The menus lacked portion size guidance. The menus lacked indication they had been approved by a registered dietitian. During an interview on 11/1/23 at 10:00 a.m., Co-Director 1 indicated the facility had not employed a consultant registered dietitian for approximately 4 years. During an interview on 11/1/23 at 12:17 p.m., Co-Director 1 indicated the current facility menus had not been approved by a registered dietitian. Based on interview and record review, the facility failed to ensure menus and/or their	and/or their substitutions were approved by a registered dietitian and that the menus provide portion size guidance. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. Vermillion Place has acquired a program called Grove Menus that will provide menus approved by a registered dietitian. The program will also allow for the dietary manager to make changes and for those changes to be approved by a registered dietitian. Portion size guidance will also be a part of this program. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. The	
---	---	--

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

substitutions were approved by a registered dietitian. This deficient practice had the potential to impact 24 of 24 residents who received meals in the facility.

Findings include:

Review of the menus provided by Co-Director 1 on 10/31/23 at 2:00 p.m., indicated the following:

The menus lacked portion size guidance.

The menus lacked indication they had been approved by a registered dietitian.

During an interview on 11/1/23 at 10:00 a.m., Co-Director 1 indicated the facility had not employed a consultant registered dietitian for approximately 4 years.

During an interview on 11/1/23 at 12:17 p.m., Co-Director 1 indicated the current facility menus had not been approved by a registered dietitian.

Grove Menus will provide menus approved by a registered dietitian and will also provide portion size guidance.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

All dietary staff will be trained on the Grove Menu Program and how to serve appropriate portion sizes related to the guidance provided.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Executive Director and/or designee will observe at least one meal daily to verify five times a week for a month, then weekly for two weeks, then monthly for 90 days to verify that meals are being served that are dietitian approved and meet the portion guidelines recommended. Results of the audit will be reported to the QAPI committee for review. There must be at least three

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

			consecutive months with no findings to discontinue the audit.	
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food	R 0274	R274 It is the practice of Vermillion Place to employ a dietary manager/food services supervisor or a consultant registered dietician. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. The Executive Director has hired a dietary manager who has training and experience in food service supervision and management and who will be supervised by a dietician on a regularly scheduled basis. Vermillion Place will also contract a dietician to meet the state requirements.	12/24/2023

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

service management.

(E) An individual with training and experience in food service supervision and management.

(2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis.

(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.

Based on interview and record review, the facility failed to employ a dietary manager/food services supervisor or a consultant registered dietitian. This deficient practice had the potential to impact 24 of the 24 residents who received meals in the facility.

Findings include:

During an interview on 10/31/23 at 10:45 a.m., Co-Director 1 indicated the facility did not currently employ a dietary manager/food services supervisor.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?

All residents have the potential to be affected by the alleged deficient practice. The Executive Director has hired a dietary manager who has training and experience in food service supervision and who will be supervised by a dietitian on a regularly scheduled basis. Vermillion Place will also contract a dietitian to meet the state requirements.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

[A Dietary Manager has been hired and a dietitian will be contracted to meet the state requirements. All dietary staff will be trained on a regular basis to ensure proper food preparation, serving and sanitation under the leadership of the dietary manager.](#)

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

Review of the facility completed "Employee Record" form provided by Co-Director 1 following the entrance conference on 10/31/23, no dietary manager/food services supervisor was listed on the form.

During an interview on 11/1/23 at 10:00 a.m., Co-Director 1 indicated the previous dietary manager/ food services director left her position as a dietary manager on 7/18/23 (over 3 months prior). The facility had not employed a consultant registered dietitian for approximately 4 years.

Based on interview and record review, the facility failed to employ a dietary manager/food services supervisor or a consultant registered dietitian. This deficient practice had the potential to impact 24 of the 24 residents who received meals in the facility.

Findings include:

During an interview on 10/31/23 at 10:45 a.m., Co-Director 1 indicated the facility did not currently employ a dietary manager/food services supervisor.

Review of the facility completed "Employee Record" form provided by Co-Director 1 following the entrance conference on 10/31/23, no

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

[In the event of a vacancy, the Executive Director will begin the recruitment process and retain a Dietary Manager. The Executive Director will work with the facility food service vendor to provide education to the dietary staff.](#)

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

	dietary manager/food services supervisor was listed on the form. During an interview on 11/1/23 at 10:00 a.m., Co-Director 1 indicated the previous dietary manager/ food services director left her position as a dietary manager on 7/18/23 (over 3 months prior). The facility had not employed a consultant registered dietician for approximately 4 years.			
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on interview and record review, the facility failed to ensure pharmacy recommendations were reviewed and addressed by the resident's physician for 1 of 2 residents reviewed with pharmacy recommendations (Resident 9). Findings include: Resident 1's clinical record was reviewed on 11/1/23 at 9:36 a.m. Current diagnoses included bipolar disorder, major depressive disorder with	R 0299	R299 It is the practice of Vermillion Place to ensure pharmacy recommendations were reviewed and addressed by the resident's physicians. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	12/24/2023

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

psychotic features, and post traumatic stress disorder.

The resident had a current physician's order dated 5/13/23 for risperidone (an antipsychotic medication) 0.25 mg twice daily as needed.

Resident 1 had a 6/27/23, "Consultant Report" from the consultant pharmacist which indicated they had an "as needed" order for an antipsychotic, which had been in place for greater than 14 days without a stop date: (Risperidone 0.25 mg twice daily). It was recommended to discontinue the medication.

Resident 1 had a 8/25/23, "Consultant Report" from the consultant pharmacist which indicated they had an "as needed" order for an antipsychotic, which had been in place for greater than 14 days without a stop date: (Risperidone 0.25 mg twice daily). It was recommended to discontinue the medication.

The clinical record lacked indication the two (2) pharmacy recommendations had ever been communicated to the resident's physician, nor had the physician addressed the recommendation on any other form of documentation.

During an interview on 11/2/23 at 9:45 a.m., Co-Director 1

Resident 9's pharmacy recommendations have been sent to their physician at this time. The doctor's response has been recorded and changes to the resident's medications were made accordingly.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?

All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing has reviewed the pharmacy recommendations with the consulting pharmacy to verify that all recommendations made have been followed up on by the physician. For any recommendations found that have not been responded to by the physician, the Director of Nursing will send them to the physician. The response will be recorded and changes to the residents' medications will be made accordingly.

What measures will be put into place and what systemic

indicated the facility had not been aware they needed to communicate recommendations to the resident's physician's for their review.

During an interview on 11/2/23 at 10:49 a.m., Co-Director 1 and Co-Director 2 indicated the facility lacked a policy regarding pharmacy recommendations.

Based on interview and record review, the facility failed to ensure pharmacy recommendations were reviewed and addressed by the resident's physician for 1 of 2 residents reviewed with pharmacy recommendations (Resident 9).

Findings include:

Resident 1's clinical record was reviewed on 11/1/23 at 9:36 a.m. Current diagnoses included bipolar disorder, major depressive disorder with psychotic features, and post traumatic stress disorder.

The resident had a current physician's order dated 5/13/23 for risperidone (an antipsychotic medication) 0.25 mg twice daily as needed.

Resident 1 had a 6/27/23, "Consultant Report" from the consultant pharmacist which indicated they had an "as needed" order for an antipsychotic, which had been in

changes will be made to ensure that the deficient practice does not recur?

The Director of Nursing and all nurses educated on the requirement for pharmacy recommendations to be reviewed by the physician monthly.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Director of Nursing and/or designee will review pharmacy recommendations monthly and send them to the physician as needed. The Executive Director will verify that the recommendations have been followed up on within 10 days of receiving the recommendations.

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

place for greater than 14 days without a stop date:
(Risperidone 0.25 mg twice daily). It was recommended to discontinue the medication.

Resident 1 had a 8/25/23, "Consultant Report" from the consultant pharmacist which indicated they had an "as needed" order for an antipsychotic, which had been in place for greater than 14 days without a stop date:
(Risperidone 0.25 mg twice daily). It was recommended to discontinue the medication.

The clinical record lacked indication the two (2) pharmacy recommendations had ever been communicated to the resident's physician, nor had the physician addressed the recommendation on any other form of documentation.

During an interview on 11/2/23 at 9:45 a.m., Co-Director 1 indicated the facility had not been aware they needed to communicate recommendations to the resident's physician's for their review.

During an interview on 11/2/23 at 10:49 a.m., Co-Director 1 and Co-Director 2 indicated the facility lacked a policy regarding pharmacy recommendations.

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

R 0328	Activities Programs - Noncompliance 410 IAC 16.2-5-7.1(c)(1-3) (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division. Based on interview and record review, the facility failed to employ an activity director. This deficient practice had the potential to impact 24 of 24 residents who resided in the facility. Findings include: During an interview on 10/31/23 at 10:45 a.m., Co-Director 1 indicated the facility did not currently employ an activity director. Review of the facility completed "Employee Record" form which was provided by Co-director 1 following the entrance conference on 10/31/23, no activity director or activity staff member was listed on the form.	R 0328	R328 It is the practice of Vermillion Place to employ a qualified Activity Director. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. The Executive Director has hired an Activity Director who will complete an activities director course within one year. requirements. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. The Executive Director has hired an Activity Director who will complete an activities director course within one year. requirements.	12/24/2023
---------------	--	---------------	---	-------------------

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

During an interview on 11/2/23 at 11:18 a.m., Resident 2 indicated the facility did not have an activity director or anyone in charge of activities. Volunteers came in to the facility and offered some activities. She would like more activities to be offered.

During an interview on 11/2/23 at 11:36 a.m., Resident 20 indicated the facility did not have an activity director. She would like more activities. The residents had developed some activities themselves.

During an interview on 11/2/23 at 11:37 a.m., Resident 17 indicated the facility did not have an activity director. She would like more activities. She believed the facility needed an ongoing activity program to encourage residents to come out of their rooms. People staying in their rooms alone a lot was not good for them.

During an interview on 11/2/23 at 11:38 a.m., Resident 14 indicated the facility did not have an activity director. She would like more activities.

During an interview on 11/2/23 at 11:39 a.m., Resident 10 indicated the facility did not have an activity director. She would like more activities.

During an interview on 11/1/23 at 2:23 p.m., Co-Director 1

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

An Activity Director has been hired. In the event of a vacancy, the Executive Director will begin the recruitment process and retain an Activity Director.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

In the event of a vacancy, the Executive Director will begin the recruitment process and retain an Activity Director.

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

indicated the last time the facility had someone directing the activity program was December 14, 2022.

Based on interview and record review, the facility failed to employ an activity director. This deficient practice had the potential to impact 24 of 24 residents who resided in the facility.

Findings include:

During an interview on 10/31/23 at 10:45 a.m., Co-Director 1 indicated the facility did not currently employ an activity director.

Review of the facility completed "Employee Record" form which was provided by Co-director 1 following the entrance conference on 10/31/23, no activity director or activity staff member was listed on the form.

During an interview on 11/2/23 at 11:18 a.m., Resident 2 indicated the facility did not have an activity director or anyone in charge of activities. Volunteers came in to the facility and offered some activities. She would like more activities to be offered.

During an interview on 11/2/23 at 11:36 a.m., Resident 20 indicated the facility did not have an activity director. She would like more activities. The

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

	residents had developed some activities themselves. During an interview on 11/2/23 at 11:37 a.m., Resident 17 indicated the facility did not have an activity director. She would like more activities. She believed the facility needed and ongoing activity program to encourage resident to come out of their rooms. People staying in their rooms alone a lot was not good for them. During an interview on 11/2/23 at 11:38 a.m., Resident 14 indicated the facility did not have an an activity director. She would like more activities. During an interview on 11/2/23 at 11:39 a.m., Resident 10 indicated the facility did not have an an activity director. She would like more activities. During an interview on 11/1/23 at 2:23 p.m., Co-Director 1 indicated the last time the facility had someone directing the activity program was December 14, 2022.			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the	R 0383	R383	12/24/2023

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

	resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to coordinate service plans related to mental health needs with the resident's mental health care provider for 2 of 2 residents reviewed for mental health services (Residents 9 and 1). Findings include: An undated/untitled facility document, provided by Co-Director 1 on 10/31/23 at 2:00 p.m., indicated the facility had four current residents with a major mental illness, including Residents 1 and 9. 1. Resident 9's clinical record was reviewed on 11/1/23 at 2:31 p.m. Current diagnoses included bipolar disorder, panic		It is the practice of Vermillion Place to coordinate service plans related to mental health needs with the resident's mental health provider. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 1 and 9's service plans have been reviewed by their mental health provider and a plan of care was developed in cooperation with the mental health provider. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The four residents identified as having major mental illness have the potential to be affected by the alleged deficient practice. All four residents service plans have been reviewed by their mental health provider and a plan of care was developed in cooperation with their mental health provider.	
--	--	--	--	--

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

disorder, and Parkinson's disease. The resident received medicaid services and received psychiatric services at a community-based service provider.

The resident had a most current signed , 9/18/23 service plan, which lacked a plan of care developed in cooperation with their mental health services provider.

2. Resident 1's clinical record was reviewed on 11/1/23 at 9:36 a.m. Current diagnoses included bipolar disorder, major depressive disorder with psychotic features, and post traumatic stress disorder. The resident received medicaid services and received psychiatric services at a community-based service provider.

The resident had a most current signed, 10/16/23 service plan, which lacked a plan of care developed in cooperation with their mental health services provider.

Based on interview and record review, the facility failed to coordinate service plans related to mental health needs with the resident's mental health care provider for 2 of 2 residents reviewed for mental health services (Residents 9 and 1).

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

The Director of Nursing and/or their designee will note any major mental illness on all current residents and new admissions. If any are noted, they will be referred to a mental health services provider for consultation and treatment if indicated.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Executive Director and/or their designee will monitor all current residents and any new admissions for a diagnosis of major mental illness, to ensure they are referred to a mental health service provider for consultation and treatment if indicated, monthly for 6 months, then quarterly for 6 months. The Executive Director will inform the Director of Nursing and/or designee if there are any issues

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

Findings include:

An undated/untitled facility document, provided by Co-Director 1 on 10/31/23 at 2:00 p.m., indicated the facility had four current residents with a major mental illness, including Residents 1 and 9.

1. Resident 9's clinical record was reviewed on 11/1/23 at 2:31 p.m. Current diagnoses included bipolar disorder, panic disorder, and Parkinson's disease. The resident received medicaid services and received psychiatric services at a community-based service provider.

The resident had a most current signed , 9/18/23 service plan, which lacked a plan of care developed in cooperation with their mental health services provider.

2. Resident 1's clinical record was reviewed on 11/1/23 at 9:36 a.m. Current diagnoses included bipolar disorder, major depressive disorder with psychotic features, and post traumatic stress disorder. The resident received medicaid services and received psychiatric services at a community-based service provider.

The resident had a most current signed, 10/16/23 service plan, which lacked a plan of care

noted in their audits.

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

	developed in cooperation with their mental health services provider.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure an infection control program was developed to include employee in-service education on infection prevention and the offering of information to residents regarding infection transmission and immunizations. This deficit practice had potential to impact 24 of 24 residents who reside in the facility.	R 0407	R407 It is the practice of Vermillion Place to ensure an infection control program is developed to include employee inservicing on infection prevention and offering of information to residents regarding infection transmission and immunizations. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. All staff have been inserviced on infection prevention. All residents have been provided information related to infection transmission and immunizations. How other residents having the potential to be affected	12/24/2023

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

Findings include:

Review of the facility Infection Control binder, on 11/1/23 at 9:47 a.m., indicated a lack of education or policies for standard precautions, isolation practices, hand hygiene, infection prevention, and immunizations.

Review of the facility In-service binder, provided by QMA 3, on 11/2/23 at 10:20 a.m., indicated the last employee in-service was held in 2020.

During an interview, on 11/2/23 at 10:49 a.m., Co- Director 1 and Co-Director 2 indicated they did not have education for residents regarding immunizations.

During an interview, on 11/2/23 at 11:48 a.m., Co-Director 2 indicated in-services had not been held since the COVID-19 infection presentations and education in 2021.

by the same deficient practice will be identified and what corrective actions will be taken?

All residents have the potential to be affected by the alleged deficient practice. All staff have been inserviced on infection prevention. All residents have been provided information related to infection transmission and immunizations.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

The Executive Director has created a yearly inservice schedule that consists of the required trainings which includes infection prevention. The Director of Nursing and nursing staff have been trained on the requirements on education of residents and will educate residents moving forward on infection transmission and immunizations.

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

A current, undated, facility policy titled, "Infection Control," provided by QMA 3 on 11/1/23 at 2:34 p.m., indicted the following: "...Staff shall be given training at least annually on infection control practices, including universal precautions....Residents will be offered information related to infection transmission and immunizations at least annually...."

Based on record review and interview, the facility failed to ensure an infection control program was developed to include employee in-service education on infection prevention and the offering of information to residents regarding infection transmission and immunizations. This deficit practice had potential to impact 24 of 24 residents who reside in the facility.

Findings include:

Review of the facility Infection Control binder, on 11/1/23 at 9:47 a.m., indicated a lack of education or policies for standard precautions, isolation practices, hand hygiene, infection prevention, and immunizations.

Review of the facility In-service binder, provided by QMA 3, on 11/2/23 at 10:20 a.m., indicated the last employee in-service

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Executive Director and/or their designee will audit employee files to ensure that infection prevention training is provided yearly for staff. The Director of Nursing and/or designee will audit resident files monthly for the required education to residents regarding infection transmission and immunizations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

was held in 2020.

During an interview, on 11/2/23 at 10:49 a.m., Co- Director 1 and Co-Director 2 indicated they did not have education for residents regarding immunizations.

During an interview, on 11/2/23 at 11:48 a.m., Co-Director 2 indicated in-services had not been held since the COVID-19 infection presentations and education in 2021.

A current, undated, facility policy titled, "Infection Control," provided by QMA 3 on 11/1/23 at 2:34 p.m., indicted the following: "...Staff shall be given training at least annually on infection control practices, including universal precautions....Residents will be offered information related to infection transmission and immunizations at least annually...."

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