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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VERMILLION PLACE	449 MAIN ST ANDERSON, IN 46016

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00396133, IN00396340 and IN00397461. Complaint IN00396133 - Unsubstantiated due to lack of evidence. Complaint IN00396340 - Substantiated. State deficiencies related to the allegations are cited at R0144. Complaint IN00397461 - Substantiated. State deficiencies related to the allegations are cited at R0274. Survey dates: January 3, 4, and 5, 2023 Facility number: 011970 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 10, 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 February 25, 2023. This building respectfully requests consideration for paper compliance from this Plan of Correction.	
R 0086 Bldg. 00	410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control;			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Tompkins	Administrator	01/24/2023

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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	of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on interview and record review, the facility failed to ensure timely renewal of the Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver (a waiver that allows facilities to perform waived laboratory tests on human specimens). This deficiency had the potential to affect 5 of 8 residents who receive blood glucose tests. Review of an undated facility document titled "Residents with Special Care Needs and/or Contracted Services," provided by Co-Director 2 on 1/3/23 at 2:30 p.m., indicated five residents required assistance with blood glucose testing. During an interview, on 1/4/23 at 10:01 a.m., Co-director 2 indicated the CLIA waiver expired in March. A copy of the CLIA Certificate of Waiver, provided by Co-director 2 on 1/4/23 at 2:33 p.m., indicated the expiration date was 3/17/21. During an interview, on 1/5/23 at 1:57 p.m., Co-Director 2 indicated she had called to renew the CLIA waiver but had to leave a voicemail. She indicated she did not have a policy about the CLIA waiver renewal.	R 0086	1. A renewal application for our CLIA Certificate of Waiver was submitted on January 12, 2023. We are awaiting a payment coupon to make payment for the renewal. When this is completed, we will have a current CLIA Waiver. 2. An audit was done on all other residents and there were no other residents identified as having the potential to be affected by the alleged deficient practice. 3. All business mail, renewals of licenses, etc. will be given to the Executive Director, or their designee, so they will be aware of renewal dates of licenses, etc. They will give all renewals for licenses, etc. to Accounts Payable so payment can be made timely, to prevent any expirations. 4. The Executive Director, or their designee, will note when the CLIA Waiver is due to expire. If a renewal form is not received timely, they will contact the State Office responsible for sending the renewals, to ensure the renewal is received. The Administrator, or their designee, will monitor to ensure the CLIA Waiver is renewed timely and does not expire.	02/25/2023

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R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure quarterly fire drills were conducted on each shift. Findings include: During an interview, on 1/4/23 at 10:01 a.m., Co-director 2 indicated she did not have documentation of fire drills for the past year. She did not believe the previous maintenance man completed any fire drills. Review of a facility document, provided by	R 0092	1. Quarterly fire drills will be done on each shift, for a total of 12 fire drills per year. 2. All residents had the potential to be affected by the alleged deficient practice. 3. The maintenance director has been inserviced on the proper fire drill procedure. The maintenance director, or their designee, are to ensure that quarterly fire drills are done on each shift for a total of 12 fire drills per year. If for some	02/25/2023

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	Co-Director 2 on 1/5/23 at 1:24 p.m. and indicated as a fire drill policy, was a blank fire drill report form outlining procedure for a fire drill. During an interview, on 1/5/23 at 1:24 p.m., Co-Director 2 indicated she did not have any additional policies to provide.		reason the maintenance director is unable to conduct a timely fire drill, they are to inform the Executive Director's Assistant, or their designee, for completion. 4. The Executive Director's Assistant, or their designee, will monitor the quarterly fire drills on each shift for a total of 12 fire drills per year, to ensure they are done timely. If for any reason a fire drill has not been conducted as required, they will conduct that fire drill ASAP. The Executive Director's Assistant, or their designee, will audit all fire drills monthly for 6 months, then quarterly for 6 months to ensure fire drills are being completed as required. The Administrator will be notified if any issues with conducting timely fire drills is found, for their correction.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (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 and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to obtain criminal background checks upon hire for new employees for 3 of 3 newly hired employees records reviewed (Qualified Medication Aide (QMA) 51, Maintenance	R 0116	1. The facility will obtain criminal background checks upon hire for all new employees. 2. All residents had the potential to be affected by the alleged	02/25/2023

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	Employee 53 and Housekeeper 52). Findings include: Employee record review, completed on 1/5/23 at 1:48 p.m., indicated criminal background checks were not obtained for QMA 51 on 1/5/23, for Maintenance Employee 53 on 1/4/23, and for Housekeeper 52 on 1/5/23. During an interview, on 1/5/23 at 1:53 p.m., Co-Director 3 indicated she had not been able to complete criminal background checks as needed. She would look at MyCase and other sources such as Facebook when a new application was received. She had just printed them off for the employee record review and had not been in the employee record prior to the employee record request. During an interview, on 1/5/23 at 1:55 p.m., Co-Directors 2 and 3 both indicated criminal background checks were not done prior to the hiring of new employees.		deficient practice. The facility will obtain criminal background checks upon hire for all new employees. 3. When an applicant has been approved for hire and before they begin work a criminal background check will be done. The employee will not begin work until a criminal background check has been done. The Executive Director's Assistant has been inserviced on the need for obtaining criminal background checks. The Executive Director's Assistant, or their designee, will monitor all new hires to ensure that criminal background checks are done. They will audit all new hires monthly for 6 months then quarterly for 6 months to ensure criminal background checks are done on all new hires. A list of all new hires and the date of their criminal background check will be given to the Administrator, or their designee, monthly for 6 months then quarterly for 6 months. If at any time the Executive Director's Assistant, or their designee, has any issues obtaining the criminal background check, they are to notify the Administrator, or their designee, for assistance. 4.The Executive Director's Assistant, or their designee, will monitor all new hires to ensure that criminal background checks are done. They will audit all new hires monthly for 6 months then quarterly for 6 months to ensure	

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			criminal background checks are done on all new hires. A list of all new hires and the date of their criminal background check will be given to the Administrator, or their designee, monthly for 6 months then quarterly for 6 months. If at any time the Executive Director's Assistant, or their designee, has any issues obtaining the criminal background check, they are to notify the Administrator, or their designee, for assistance.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (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 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			

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	they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a staff member was first aid and cardiopulmonary resuscitation (CPR) certified for 21 of 21 shifts scheduled. Findings include: During an interview, on 1/5/23 at 10:40 a.m., Co-Director 2 indicated she did not know where the CPR and first aid certifications for employees were located. Employee records, provided by Co-Director 2 on 1/5/23 at 12:24 p.m., were reviewed and lacked CPR and first aid certifications. Co-Director 2 indicated, when providing the employee records, if the records were not there, then the facility did not have them. During an interview, on 1/5/23 at 1:24 p.m., Co-Director 2 indicated there was no facility policy for CPR or first aid. During an interview, on 1/5/23 at 3:23 p.m., the Director of Nursing (DON) indicated CPR and first aid classes had been completed more than two years ago. Since then, they had hired new employees and neither CPR nor first aid training had been provided by the facility. According to the American Red Cross website, retrieved from https://www.redcross.org/take-a-class/lp/cpr-first-aid-aed-certification-new-hero, accessed on 1/6/23 at 8:02 a.m., first aid and CPR certifications are valid for two years.	R 0117	1. Staff will be trained in CPR/First Aid. At least one staff person on each shift shall be on site trained and certified in CPR/First Aid. Classes in CPR/First Aide are currently being scheduled to ensure we have adequately trained staff on each shift. 2. All residents had the potential to be affected by the alleged deficient practice. Staff will be trained in CPR/First Aid. At least one staff person on each shift shall be on site trained and certified in CPR/First Aid. Classes in CPR/First Aide are currently being scheduled to ensure we have adequately trained staff on each shift. CPR/first aide classed have been scheduled for February 26 and March 5, 2023. 3. The Executive Director's Assistant, or their designee, will keep a file with all nursing staffs, (and other staff, if desired) CPR/first aid information, including expiration dates. New employees' information will be add as needed. The Executive Director, or their designee, will schedule annual or semi-annual certification classes, based on need, to ensure at least one person on each shift shall be on site trained and certified in CPR/first aide. 4.The Executive Director's Assistant, or their designee, will keep a file will all nursing staff,	03/05/2023

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			(and other staff, if desired) CPR/first aid information. This information will be audited by the Executive Director, or their designee, once a month for 6 months, the quarterly for 6 months. If any issues are found the Executive Director, or their designee, will notify the Administrator, or their designee for correction.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (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. (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			

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	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 dementia training and a job-specific orientation completed for 3 of 3 newly hired employees of 5 employee records reviewed (Qualified Medication Aide (QMA) 51, Maintenance Employee 53 and Housekeeper 52). Findings include: A 1/5/23 employee record review indicated the following employees lacked documentation of dementia training and job-specific orientation: QMA 51, Maintenance Employee 53 and Housekeeper 52. During an interview, on 1/5/23 at 12:24 p.m., Co-Director 2 indicated she had no additional employee records. During an interview, on 1/5/23 at 1:24 p.m., Co-Director 2 indicated she had no additional inservice training available.	R 0119	1. All employees will receive dementia training per ISDH guidelines. New hires will receive 6 hours of dementia training with in 6 months of hire and other employees will have 3 hours annual dementia training. All new hires will receive job-specific orientation. This will be done within a reasonable length of time, depending on the new hires scheduled hours and the extend of the orientation. Employees: QMA 51, Maintenance 53, Housekeeper 52 will receive the dementia training that is required within 6 months of hire and their job-specific orientation will be completed. 2. All residents had the potential to be affected by the alleged deficiency. All employees will receive dementia training per ISDH guidelines. New hires will receive 6 hours of dementia training with in 6 months of hire and other employees will have 3 hours annual dementia training. All new hires will receive job-specific orientation. This will be done within a reasonable length of time, depending on the new hires	02/25/2023

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			schedule. d hours and the extend of the orientation. Employees: QMA 51, Maintenance 53, Housekeeper 52 will receive the dementia training that is required within 6 months of hire and their job-specific orientation will be completed. 3.The Executive Director's Assistant, or their designee, will schedule the 6-hour dementia training once every 6 months to ensure that all new hires receive the training. They will also schedule 3 hours of annual dementia training. The Executive Director's Assistant, or their designee, will also audit all new employee's files to ensure that the job-specific orientation is completed timely. If they have not been completed the person responsible for the orientation will be notified for completion. 4. The Executive Director's Assistant or their designee, will report to the Executive Director, or their designee, the schedule for the 6-hour and annual 3-hour dementia training. The Executive Director will monitor this schedule to ensure the dementia training is completed as required. The Executive Director, or their designee, will audit the new employee files once a month for 6 months, then once a quarter for 6 months to ensure that all required records are completed. If the Executive Director, or their	

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			designee, notes any issues with the employees records they will report this to the Administrator, or their designee for correction.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (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 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.			

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	(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 observation 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 employees reviewed for annual dementia training (Director of Nursing (DON) and Certified Nurse Aide (CNA) 54). A 1/5/23 employee record review indicated the DON and CNA 54 lacked documentation of annual dementia training. During an interview, on 1/5/23 at 12:24 p.m., Co-Director 2 indicated she had no additional employee records. During an interview, on 1/5/23 at 1:24 p.m., Co-Director 2 indicated she had no additional in-service training available.	R 0120	1. The facility will conduct 3 hours of annual dementia training for employees who have been employed for greater than one year. The DON and CNA 54 will be given 3 hours of dementia training. 2. All residents had the potential to be affected by the alleged deficient practice. The facility will conduct 3 hours of annual dementia training for employees who have been employed for greater than one year. The DON and CNA 54 will be given 3 hours of dementia training. 3. The Executive Director's Assistant, or their designee, will schedule 3 hours of dementia training annually for all employees who have been employed for more than one year. The Executive Director, or their designee, will assist as needed. 4. The Executive Director, or their designee, will monitor the scheduling and conducting of the 3-hour annual dementia training. They will audit all employee files every 6 months for one year for employees who have been employed for more than one year to ensure they have received the required training. If the Executive Director, or their designee, will	02/25/2023

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			notify the Administrator, or their designee, if there are any issues in the completion of the 3-hour training for her assistance in correction.3. The Executive Director's Assistant, or their designee,	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (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			

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	a diagnosis. (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 interview and record review, the facility failed to ensure employees were screened for tuberculosis (TB) upon hire for 3 of 3 newly hired employees (Qualified Medication Aide (QMA) 51, Maintenance Employee 53 and Housekeeper 52) and annually for 2 of 2 employees employed greater than one year (Director of Nursing (DON) and Certified Nurse Aide (CNA) 54). Findings include: A 1/5/23 employee record review indicated the following employees lacked TB screening upon hire: QMA 51, Maintenance Employee 53 and Housekeeper 52. The DON and CNA 54 also lacked annual TB screening. During an interview, on 1/5/23 at 10:40 a.m., Co-Director 2 indicated the facility was unable to get the serum to give the TB test. They were unable to get a physician to write an order for the TB test serum. The nurse should have completed annual TB risk assessments with the employees. During an interview, on 1/5/23 at 3:23 p.m., the DON indicated TB tests and annual TB risk assessments were not done.	R 0121	1. A TB skin test using the Mantoux method, unless they have a documented previously positive reaction, will be required of all new employees prior to hire. A annual TB screening will be done on all employees who have been employed more than one year. QMA 51, Housekeeper 52 and Maintenance employee 53 will be required to obtain a current TB skin test using the Mantoux method, unless they have documented a previously positive reaction. The DON and CNA 34 will have an annual TB screening completed.2. All residents had the potential to be affected by the alleged deficiency. 1. A TB skin test using the Mantoux method, unless they have a documented previously positive reaction, will be required of all new employees prior to hire. A annual TB screening will be done on all employees who have been employed more than one year. QMA 51, Housekeeper 52 and Maintenance employee 53 will be required to obtain a current TB skin test using the Mantoux	02/28/2023

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			method, unless they have documented a previously positive reaction. The DON and CNA 34 will have an annual TB screening completed. 3. All new hires will have a TB skin test using the Mantoux methos, unless they have a documented previously positive reaction, before beginning work. All current employees. who have been employed more than one year, files will be audited to ensure they have current TB screenings. 4. Executive Director's Assistant, or their designee, will ensure all new hires have a TB skin test using the Mantoux method, unless they have a documented previously positive reaction, prior to hire. A list of all new hires with the date of their TB skin test, unless they have a documented previously positive reaction, will be given to the Executive Director, or their designee, for audit once a month for 6 months, then quarterly for 6 months. If there are any issues regarding the prior to employment Mantoux screening the Administrator will be notified for assistance in correction. The DON, or their designee, will audit all current employees who have more than one year employment for current TB screenings. If any staff is found without a current TB screening, one will be completed. The DON, or their designee, will audit all current employees file	

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			who have been employed more than one year, for a TB screening. The DON, or their designee will report their findings to the Executive Director, or their designee, monthly for 6 months, then quarterly for 6 months. If any issues are found, that cannot be corrected, the Executive Director, or their designee, will report the findings to the Administrator, or their designee for help in correcting the issues.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (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 ensure the facility was maintained in a clean and homelike manner (1st and 2nd floor). Findings include: During the initial tour of the facility on 1/3/23 at 10:16 a.m., the following was observed: Near the door of room 212 was large dark brown/black stain the size of a two footballs end to end. In front of room 210 was a dark brown/black stain the size of two basketballs side by side. Between rooms 217 and 219 was a dark brown/black stain slightly larger than the size of a basketball.	R 0144	1. The various stains, spots, spills, etc. on the carpet will be corrected. The current carpet is going to be removed. New carpet squares are going to be laid to replace the old carpet. The missing ceiling tile will be replaced with new tile. 2.. All residents have the potential to be affected by the alleged deficient practice. The various stains, spots, spills, etc. on the carpet will be corrected. The current carpet is going to be removed. New carpet squares are going to be laid to replace the old carpet. The missing ceiling tile will be replaced with new ceiling tile. 3. The old carpet is being removed and replaced with new carpet	04/01/2023

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	Near room 220 was a dark brown/black stain the size of two basketballs side by side. Near room 224 was a reddish stain the size of a basketball and a large dark brown/black stain the size of a car tire. Near room 228 was a dark brown/black stain the size of a football. In front of room 232 was a reddish stain slightly larger than the size of a basketball. Between rooms 120 and 121 were six softball sized stains that were dark brown/black. Near the first floor laundry room was a dark brown/black stain the size of a basketball. Two missing ceiling tiles had been observed, on 1/3/23 at 10:00 a.m., upon exiting the elevator onto the second floor which created a draft of cooler air. During an interview, on 1/3/23 at 2:33 p.m., Co-director 2 indicated she didn't know why the tiles were missing. During an observation, on 1/4/23 at 8:10 a.m., the two ceiling tiles on the second floor remained missing. The facility maintenance log was provided by Co-Director 2, on 1/5/23 at 12:24 p.m., and lacked a carpet cleaning task. The facility cleaning task list was provided by Co-Director 2, on 1/5/23 at 1:24 p.m., and lacked a carpet cleaning task. During an interview with the DON, on 1/5/23 at 2:51 p.m., she indicated the carpets had been		squares. The carpet pattern has been picked out and they measured the floor on 1/20/2023. I do not yet have a date on when we can expect delivery and installation of the carpet squares. The policies on daily cleaning, cleaning of carpet spills are being reviewed. A policy on carpet cleaning will be developed based on what is recommended for the new carpet squares. The prompt replace of ceiling tiles has been discussed with the Maintenance Director. 4. The Executive Director, or their designee, is to do a daily walk through of the building, five days a week. They will report any spills, spots on carpet or any other issue needing cleaning or repair to the proper department, housekeeping or Maintenace, for correction. The Executive Director, or their designee, will keep a record of the daily walk throughs and if an issue is not corrected timely, she will discuss it with the proper dept. to find out why it has not been corrected. The Executive Director or their designees, will review the daily walk throughs with the Administrator. or their designee weekly, for any needed actions or corrections.	

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	cleaned, maybe a year ago. They were just stained and the facility was going to have them replaced sometime. This Residential Tag relates to Complaint IN00396340.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure a self administration of medication assessment and physician's orders were followed for 1 of 5 residents observed during medication pass (Resident 7). Findings include: During a medication administration observation, on 1/3/23 at 11:29 a.m., Qualified Medication Aide (QMA 51) was unable to locate an albuterol (medicine used to relax the smooth muscles in the airways) inhaler for Resident 7 in the medication cart. She indicated, during the observation, the resident probably had the inhaler in her room with	R 0216	1. The facility will ensure that resident's self-administration of medication assessment and the physicians orders are followed. Resident 7 has a physician's order to keep their albuterol inhaler at the bedside per the resident's request. 2. There are no other residents identified as being potentially affected by the alleged deficent practice. 3. The DON, or their designee, will monitor all resident's medication and the resident's self-administration assessments	02/25/2023

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	her. After giving the resident her oral medications, QMA 51 asked the resident if she had the inhaler. The resident indicated she kept the inhaler with her and used it. Resident 7's clinical record was reviewed on 1/3/23 at 3:25 p.m. The resident's current physician's orders included an order for albuterol inhaler - inhale two puffs by mouth every four hours with a start date of 7/26/22. The physician's orders lacked a may self administer medications order. Resident 7's "Self Administration of Medication Assessment," completed on 10/15/22, indicated they were deemed unable to safely administer medications and the staff continued to administer all medications. During an interview, on 1/5/23 at 9:40 a.m., Co-Director 2 indicated the resident should not have had the inhaler in her room. During an interview, on 1/5/23 at 1:24 p.m., Co-Director 2 indicated she was unable to locate a facility policy about administration of medications.		to ensure there will be no medications left at the resident's bedside without a physician's order. The DON, or their designee, will audit all resident's medication records monthly for 6 months and quarterly for 6 months to ensure the proper orders and assessments are in place. If any issues are noted they will notify the Executive Director, or their designee for assistance in correction. 4.The DON, or their designee, will monitor all resident's medication and the resident's self-administration assessments to ensure there will be no medications left at the resident's bedside without a physician's order. The DON, or their designee, will audit all resident's medication records monthly for 6 months and quarterly for 6 months to ensure the proper orders and assessments are in place. If any issues are noted they will notify the Executive Director, or their designee for assistance in correction.	
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (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			

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	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 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 observation, interview, and record review, the facility failed to employ a qualified food services director. Findings include: During a sanitation tour of the kitchen, on 1/3/23 at 9:46 a.m., Dietary Aide 7 indicated she was not the person in charge and didn't think they had a dietary manager or supervisor.	R 0274	1 All residents have the potential to be affected by the alleged practice. Staff has been enrolled in classes then they do not follow through. We hired a CDM but they did not work out. I have recently spoken to a CDM. She assured me she is interested in our position. She is to come in and fill out an application and if all references check out she will be	02/25/2023

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	Review of the Employee Record Form completed by the facility on 1/4/23 at 10:01 a.m., contained no individual listed as the Food Services Supervisor. During an interview, on 1/4/23 at 10:04 a.m., Co-Director 2 indicated they did not have a dietary manager, dietician, nor anyone with certification. There had been someone with a certificate for the Certified Dietary Manager course, but she had only worked at the facility for 2-3 weeks. Her last day employed was 12/28/22. Prior to this, it had been months since the facility had a dietary manager. Review of the facility's job description, titled "JOB DESCRIPTION - Certified Dietary Manager," dated 7/11/22 and provided by Co-Director 2 on 1/5/23 at 1:24 p.m., indicated the following: "...REQUIREMENTS: *Registration as a dietetic technician or CDM/CFPP certificate *ServSafe Certification...." This Residential tag relates to Complaint IN00397461.		hired. THe Executive Director's Assistant, or their designee and the HFA, or their designee, will be responsible for the dietary department until a CDM is hired. The HFA is also an RN. There is no one else on staff that meet the requirements of a CDM. The Board of Director's Chairman, the Executive Director, the Executive Director's Assistant and the Administrator or their designees, will continue to try to hire a CDM. They will all put forth an ongoing effort to get a CDM hired as soon as possible. There has been no negative outcome for the allegedly affected residents. 2.1 All residents have the potential to be affected by the alleged practice. Staff has been enrolled in classes then they do not follow through. We hired a CDM but they did not work out. I have recently spoken to a CDM. She assured me she is interested in our position. She is to come in and fill out an application and if all references check out, she will be hired. The Executive Director's Assistant, or their designee and the HFA, or their designee, will be responsible for the dietary department until a CDM is hired. The HFA is also an RN. There is no one else on staff that meet the requirements of a CDM. The Board of Director's Chairman, the Executive Director, the Executive Director's Assistant and the	

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			Administrator or their designees, will continue to try to hire a CDM. They will all put forth an ongoing effort to get a CDM hired as soon as possible. There has been no negative outcome for the allegedly affected residents. 3. The Executive Director's Assistant or their designee will again run ads for a CDM, they will also contact the Indiana Unemployment Office for any available candidates. This will be done weekly until a CDM is hired. Once a CDM is hired every effort will be made to continue their employment. Applications will be gone through, and current employees assessed to see if anyone is appropriate to send to school to become a CDM. The CEO and the Board of Directors will also be asked to assist in the search for a CDM. 4. The Executive Director or their designee will review all dietary applications to see if an appropriate CDM can be identified or a candidate to begin enrolment in training to become a CDM. The Executive Director or their designee and the Executive Director's Assistant, or their designee will meet weekly to review where they are on obtaining a CDM. The results of these meetings will be shared with the Administrator, or their designee, if they have not attended the meeting. The Administrator or their	

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			designee will assist the staff in obtaining a CDM and will meet with all appropriate applicants/hires to assist them in any way possible to ensure they continue their employment.	
R 0328 Bldg. 00	410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (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 Activities Director. Findings include: Review of a document, titled "List of Administrative Employees", provided by Co-Director 2 on 1/4/23 at 10:01 a.m., indicated for the Activity Director had been "Hired then she decided to retire permanently." During an interview, on 1/4/23 at 4:32 p.m., the Administrator indicated the facility did not currently have an Activity Director. She was unsure, but thought the position had been vacant since summer. Currently, the facility had volunteers in for BINGO every week. During an interview, on 1/5/23 at 10:40 a.m., Co-Director 2 indicated they did not have an Activities Director. They utilized volunteers and other employees for BINGO, puzzles, cards, and	R 0328	1. The facility will hire a qualified Activity Director or someone who will be enrolled in an Activity Director's course and will be complete the course within one year. 2. All residents have the potential to be affected by the alleged deficient practice. The facility will hire a qualified Activity Director or someone who will be enrolled in an Activity Director's course and will be complete the course within one year. 3. The Executive Director's Assistant or their designee will again run ads for an Activity Director. They will also contact the Indiana Unemployment Office for any available candidates. This will be done weekly until an Activity Director is hired. Once an Activity	02/28/2023

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	an ice cream social. Review of a current job description, provided by Co-Director 2 on 1/5/23 at 1:24 p.m., indicated the following: "...If the employee has not completed an Activity Director's course, the C.E.O. would have to give approval for the hiring of the employee, as an Activity Consultant will have to be hired until the employee completes the state approved course...."		Director is hired every effort will be made to continue their employment. Applications will be gone through, and current employees assessed to see if anyone is appropriate to send to school to become an Activity Director. 4. The Executive Director or their designee will review all applications to see if an appropriate Activity Director can be identified or a candidate to begin enrolment in training to become an Activity Director. The Executive Director or their designee and the Executive Director's Assistant, or their designee, will meet weekly to review where they are on obtaining an Activity Director. The results of these meetings will be shared with the Administrator, or their designee, if they have not attended the meeting. The Administrator or their designee will assist the staff in obtaining an Activity Director and will meet with all appropriate applicants/hires to assist them in any way possible to ensure they will remain employed.	
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on			

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	needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. Based on interview and record review, the facility failed to ensure a resident diagnosed with bipolar disorder, who participated in the Medicaid program, had a mental health individual needs assessment completed prior to admission in the clinical record and was referred to a mental health care provider for 1 of 7 residents clinical records reviewed (Resident 31). Findings include: Resident 31's clinical record was reviewed on 1/4/23 at 3:27 p.m. The resident's admitting diagnoses included bipolar disorder and anxiety. His medications included clonazepam (used for anxiety) 1 milligram (mg) daily started on 9/28/22, quetiapine (antipsychotic) 200 mg every day at bedtime started on 9/28/22, and venlafaxine extended release (antidepressant) 150 mg daily started on 9/28/22. The clinical record lacked a mental health individual needs assessment and mental health care provider consultation notes. During an interview, on 1/5/23 at 12:25 p.m., Co-Director 2 indicated the facility was unaware the resident had bipolar disorder prior to	R 0379	1. All residents who receive Medicaid or Federal SSI and have a major mental health diagnosis will be referred to a mental health service provider for consultation and treatment if needed. Resident 31 will be referred to a mental health provider for a consultation and to obtain treatment if indicated. 2. All other residents who receive Medicaid or Federal SSI and have a major mental health diagnosis have the potential to be affected by the alleged deficient practice. All resident" s medical records will be audited to identify any other residents who may need mental health services. If any residents are identified as needing mental health services due to a major mental illness diagnosis, they will be referred to a mental health service provider for consultation and treatment if indicated. 3. The DON, or their designee, will note any major mental illness on all new admissions. If the admission receives Medicaid or	02/25/2023

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		A. BUILDING 00 B. WING	01/05/2023

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	admittance. He had been residing at home. She was unaware of any requirements for screening or referrals to mental health care providers. She did not think a mental health screening or referral to a mental health care provider had been provided. During an interview, on 1/5/23 at 1:24 p.m., Co-Director 2 indicated she did not believe the facility had a policy on residents with major mental illness. During a telephone interview, on 1/5/23 at 3:23 p.m., the Director of Nursing (DON) indicated she was unaware of any requirements for mental health screenings for those with major mental illness.		federal SSI they will be referred to a mental health services provider for consultation and treatment if indicated. 4, The Executive Director, or their designee, will monitor all new admissions for a diagnosis of a 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, or their designee, will inform the Administrator, or their designee, if there are any issues noted in her audits. for their assistance is correcting the issues.	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the 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 develop a comprehensive care plan with a	R 0383	1. The facility will develop a comprehensive care plan with a	02/25/2023

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	mental health service provider for a resident diagnosed with bipolar disorder, who participated in the Medicaid program, for 1 of 1 residents reviewed for mental illness (Resident 31). Resident 31's clinical record was reviewed on 1/4/23 at 3:27 p.m. The resident's admitting diagnoses included bipolar disorder and anxiety. His medications included clonazepam (used for anxiety) 1 milligram (mg) daily started on 9/28/22, quetiapine (antipsychotic) 200 mg every day at bedtime started on 9/28/22 and venlafaxine extended release (antidepressant) 150 mg daily started on 9/28/22. The clinical record did not include a care plan or consultation notes from a mental health service provider. During an interview, on 1/5/23 at 12:25 p.m., Co-Director 2 indicated the facility was unaware the resident had bipolar disorder prior to admittance. He had been residing at home. She was unaware of any requirements for residents with major mental illness. The facility did not develop care plans. During an interview, on 1/5/23 at 1:24 p.m., Co-Director 2 indicated she did not believe the facility had a policy on residents with major mental illness. During a telephone interview, on 1/5/23 at 3:23 p.m., the Director of Nursing (DON) indicated no care plan had been developed for Resident 31 as far as she knew.		mental health service provider for resident 31. 2, Any resident with a major mental health illness diagnosis is at a potential to be affected by the alleged deficient practice. All current resident's medical records will be audited for major mental health diagnosis. Any resident identified as having a major mental illness who does not currently have a mental health service provider will be referred to a mental health service 3. The DON, 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. 4, The Executive Director, or their designee, will monitor all current residents and new admissions for a diagnosis of a 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, or their designee, will inform the Administrator, or their designee, if there are any issues noted in her audits.	
R 0407	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance			

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Bldg. 00	(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 interview and record review, the facility failed to ensure a system was in place to analyze patterns of infections for 28 of 28 residents residing in the facility. Findings include: During an interview, on 1/4/23 at 1:36 p.m., the Administrator indicated she had not discussed infection control surveillance with the current Director of Nursing (DON) much and was uncertain how communicable diseases were tracked. The tracking may have been in the DON office in a binder. Co-Director 3 managed COVID-19 infection tracking. During an interview, on 1/5/23 at 10:49 a.m., Co-Director 3 produced a notebook tracking COVID-19, but no other infections. She only followed COVID-19 infections and was uncertain if the DON tracked other infections. Review of a facility binder, on 1/5/23 at 11:14 a.m., titled "Infection Control" and located in the DON office, indicated the most recent documented infection surveillance was completed on 3/24/22.	R 0407	1. The facility will continue to ensure that a system is in place to analyze patterns of infections. The facility will track all new infections in the 28 residents, as we have the Covid-19 infections. 2. All residents have the potential to be affected by the alleged deficient practice. The facility will continue to ensure that a system is in place to analyze patterns of infections. The facility will track all new infections in the 28 residents, as we have the Covid-19 infections. 3. The DON, or their designee, will track patterns of infectious symptoms. The forms will be kept in binder in the DON's office and will be divided by months. The nursing staff is to inform the DON, or their designee, of all new infections, for tracking, by filling out a form and turning it in to the DON, or their designee. 4. The DON, or their designee, is to audit all residents for new	02/25/2023

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	During an interview, on 1/5/23 at 3:23 p.m., the DON indicated the Qualified Medication Aides (QMAs) were supposed to fill out a form whenever a resident was on an antibiotic. She did not know where the binder with those forms was located. During an interview, on 1/5/23 at 3:33 p.m., the Administrator indicated she looked through the binder marked infection control and the most recent tracking sheet was from 3/2022. A current facility policy, provided by Co-Director 3 on 1/5/23 at 2:00 p.m., indicated the following: "...The Nursing Supervisor or her designee shall track patterns of infectious symptoms...."		infections. When a new infection is found the DON, or their designee is to report these findings to the Executive Director or their designee, monthly for 6 months then quarterly for 6 months. If there are any issues with reporting or tracking infections the Executive Director, or their designee, is to report it to the Administrator for assistance in correcting the issue.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete			

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	a diagnosis. Based on interview and record review, the facility failed to ensure a resident received a two-step tuberculosis test (TB) upon admission for 1 of 1 recently admitted residents reviewed for TB tests. Resident 31's clinical record was reviewed on 1/4/23 at 2:37 p.m. Admission TB tests were not included in the clinical record. During an interview, on 1/5/23 at 10:40 a.m., Co-Director 2 indicated the facility was unable to get the serum to give the TB test. They were unable to get a physician to write an order for the TB test serum. During an interview, on 1/5/23 at 3:23 p.m., the Director of Nursing (DON) indicated TB tests had not been given for some time.	R 0410	1. All new admissions will receive a TB skin test completed within the last 3 months prior to admission or upon admission and read at 48-72 hours. For residents who do not have a documented negative TB skin test in the preceding 12 months, the baseline TB skin testing will employ the two-step method. If the first step is negative a second step will be performed with in one to three weeks. 2. Any new admission has the potential to be affected by the alleged deficient practice. All new admissions will receive a TB skin test completed within the last 3 months prior to admission or upon admission and read at 48-72 hours. For residents who do not have a documented negative TB skin test in the preceding 12 months, the baseline TB skin testing will employ the two-step method. If the first step is negative a second step will be performed with in one to three weeks. 3. All new admissions will be referred to their family physician for administration of the Mantoux TB skin test prior to admission. If a two=step is required, the resident will see their family physician in 1-3 weeks to obtain the second step TB skin test. 4. All new admissions will be monitored by the DON, or their designee, to ensure they have	02/25/2023

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			received the required Mantoux TB skin testing prior to admission. The DON, or their designee, will monitor all new admissions monthly for 6 months, the quarterly for 6 months to ensure they have received their Mantoux TB testing prior to admission. The DON, or their designee, will report their findings to the Executive Director, or their design.	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on record review and interview, the facility failed to ensure annual Tuberculosis (TB) risk assessments had been completed for 6 of 6 residents reviewed for annual health assessments(Residents 18, 12, 9, 30, 2 and 3). Findings include: 1. Resident 18's clinical record was reviewed on 1/3/23 at 2:40 p.m. His last TB risk assessment was completed on 5/14/21.	R 0412	1.The facility will continue to do annual TB risk assessments on all residents. Residents 18, 12, 9, 30, 2 and 3 will have new TB risk assessments completed. 2. All residents have the potential to be affected by the alleged deficient practice. All current resident's medical records will be audited and any resident who does not have a current TB risk assessment will have one completed. 3. The DON, or their designee,	02/25/2023

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	2. Resident 12's clinical record was reviewed on 1/3/23 at 3:01 p.m. His last TB risk assessment was completed on 8/21/21. 3. Resident 9's clinical record was reviewed on 1/3/23 at 3:35 p.m. Her last TB risk assessment was completed on 10/20/21. 4. Resident 30's clinical record was reviewed on 1/4/23 at 2:40 p.m. His last TB risk assessment was completed on 4/27/21.5. Resident 2's clinical record was reviewed on 1/3/23 at 3:40 p.m. His last TB risk assessment was completed on 2/3/21. 6. Resident 3's clinical record was reviewed on 1/4/23 at 2:42 p.m. Her last TB risk assessment was completed on 2/28/20. During an interview with the Co-Director 2, on 1/5/23 at 10:40 a.m., she indicated the TB assessments were supposed to be completed by the nurse on admission and annually. During a telephone interview with the DON, on 1/5/23 at 3:23 p.m., she indicated the TB test and risk assessments had not been completed.		will keep a binder with all residents annual TB risk assessments. The assessments will be kept in monthly order, in the order they are due to be completed. The assessments will then be completed monthly in the order they are due. 4.The DON, or their designee, will report monthly for 6 months, then quarterly for 6 months. to the Executive Director, or their designee, the TB assessments that have been completed for the month. If any assistance is needed, the Executive Director, or their designee, will notify the Administrator, or their designee, for assistance.	