STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VERMILLION CONVALESCENT CENTER	1705 S MAIN ST CLINTON, IN 47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00405579. Complaint IN00405579 - No deficiencies related to the allegations are cited. Survey dates: June 11, 12, 13, 14, and 15, 2023 Facility number: 000052 Provider number: 155124 AIM number: 100290340 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 7 Medicaid: 52 Other: 9 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 23, 2023.	F 0000	**Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law.** **Please accept this Plan of Correction as our credible allegation of compliance.** **Please find enclosed this Plan of Correction for this survey.** **Due to the low scope and severity of the survey findings, the Facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.**	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Melissa Gum | Administrator | 07/06/2023

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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	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review, and interview, the facility failed to ensure the Code Status/Advanced Directive document matched the physician's order for code status for 1 of 24 residents reviewed for	F 0578	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient***	07/17/2023

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	advanced directives (Resident 1). Finding includes: Resident 1's record was reviewed on 6/15/23 at 9:00 a.m. The physician's order, dated 10/25/22, indicated the resident was a full code (preferred to have CPR [cardio-pulmonary resuscitation] performed, if needed as a life-saving measure). The Indiana Physician Orders for Scope of Treatment (Post), document, signed 9/6/22, indicated the resident preferred to be a no code (did not prefer to have CPR performed as a life-saving measure). A document posted on the door of the chart rack at the nurse's station, indicated the resident was a full code. A care plan, dated 9/5/22, and reviewed on 5/8/23, indicated the resident's code status had been designated as a no code. During an interview, on 6/15/23 at 9:26 a.m., Licensed Practical Nurse (LPN) 10 indicated there was a listing of the residents' code status on the door of the chart rack at the nurse's station. The staff could also see the information in the residents' chart or in the computer system by their name. During an interview, on 6/15/233 at 9:29 a.m., Director of Nursing (DON) indicated she had never seen the document posted on the rack of the nurse's station and was not an approved document by her. She indicated the staff should have used the computer or chart to check residents' code status. During an interview, on 6/15/23 at 9:55 a.m., DON		***practice?*** There were no residents negatively affected by the alleged deficient practice. Resident #1's code status was reviewed with Physician and Resident/Responsible Party. The code status/advanced directive order was changed to match the code status/advanced directive document to reflect Resident wishes. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were negatively affected by the alleged deficient practice; however, all residents have the potential to be affected. All residents' code status/advanced directive documents have been audited to ensure that all match the code status/advanced directive orders in accordance with resident wishes and plan of care. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Code Status" has been reviewed and no changes are indicated at this time. The nursing staff have been re-educated regarding the facility	

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	indicated a unit manager had created the code status document at the nurse's station to try to be helpful so that staff could find the information more readily. The DON indicated the code status on the computer and on the document at the nurse's station do not match the post form in Resident 1's chart. On 6/15/23 at 9:57 a.m., the DON provided a document, dated 10/2014, titled. "Code Status", and indicated it was the policy currently being used by the facility. The policy indicated, "... The facility requires all physicians to address code status for each resident to delineate if resuscitative measures should be initiated. This enables nursing personnel to readily and clearly ascertain how to treat the resident in the event of an emergency ...." 3.1-4(1)(4)		policies and expectations regarding ensuring code status orders accurately match code status/advanced directive orders on record. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure that all residents code status orders accurately reflect and match the code status/advanced directive documents on record at all times. Code status audits will occur on at least 20 residents weekly for 4 weeks, and then on 20 of the residents every other week for 4 weeks and then at least 20 residents monthly. Should a concern be found, immediate corrective action will occur. Results of these audits and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp			

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	§483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation, and record review, the facility failed to ensure the temperature and palatability of food served for 1 of 1 test tray reviewed for temperature and palatability and 2 of 26 residents reviewed for food palatability (Residents 30 and 14). Findings include: During an interview, on 6/12/23 at 9:40 a.m., Resident 30 indicated she ate meals in her room and the food was often cold when she got it. The food cart sat on the hallway. It was not passed out in a timely manner from the staff and the food got cold before she received her food tray. During an interview, on 6/12/23 at 11:52 a.m., Resident 14 indicated she ate meals in her room and the food was cold when she got the food tray. During an interview, on 6/15/23 at 11:23 a.m., the Dietary Manager (DM) indicated food temperatures should be taken when food came out of the oven, after being placed onto the steam table, and prior to being plated. The hall food trays would be placed into the hall carts with the food plate covered with a plastic lid and plastic base.	F 0804	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident # 30 and #14 were not negatively impacted by the test tray's food temperature. Resident # 30 and #14 were served food immediately upon food arriving to the unit. The Residents on the unit were assessed by staff to ensure the temperature and palatability was satisfactory, corrective action immediately occurred as warranted. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were negatively affected by the alleged deficient; however, all residents receiving room trays have the potential to be affected. An evaluation of all residents receiving room trays has been completed to ensure that;	07/14/2023

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	During a kitchen observation, on 6/15/23 at 11:23 a.m., the lunch meal food temperatures were taken after placement onto the steam table by Cook 16. The cube steak measured at 191 degrees Fahrenheit (F), the broccoli measured at 162 F, the brown gravy measured at 165 F, the mashed potatoes measured at 165 F. On 6/15/23 at 12:28 p.m., test tray food temperatures were measured by the Dietary Manager (DM). The cubed steak temperature measured at 136 F, the mashed potatoes temperature measured at 135 F, and the cooked broccoli temperature measured at 100 F. The DM indicated all cooked food should have been at least 135 F and the broccoli was not warm enough. On 6/15/23 at 12:50 p.m., DM provided and identified a document as a current facility policy, titled, "Food Temperature on Service Line," dated 05/2018. The policy indicated, "...Policy: Foods will be served at proper temperature to ensure food safety...Procedure: ...4. Acceptable service temperatures are: ...Meat, Entrees, Eggs > or = (greater than or equal to) 135 degrees Fahrenheit (F)...Potatoes, pasta > or = 135 F...Vegetables > or = 135 F...." 3.1-21(a)(2)		room trays are passed timely once delivered to the units, and temperature and palatability of food satisfactory to the residents and in accordance with facility policy. Corrective action if any required were immediately conducted. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "food temperature" has been reviewed and no changes are indicated at this time. The dietary staff and Nursing staff have been re-educated on the policy with a focus on ensuring the food prepared for floor trays are delivered and served at accurate temperatures, including serving on the unit timely upon delivery. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DM and DON or designee will be responsible for completing the monitoring tool to ensure that all residents receiving room trays are promptly delivered a tray with	

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			acceptable temperature and palatability of food (according to policy) . The audits shall be completed on scheduled work days as follows: Two times weekly for two weeks, then weekly for two weeks, then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the cleanliness and sanitation of the kitchen and food preparation and storage areas for 2 of 2 kitchen observations with the potential to effect 67 of 68 residents who received food prepared in the kitchen, and the facility failed to ensure sanitary food handling when assisting residents with eating in the assisted dining room for 1 of 2 dining observations (Residents 6 and 54). Findings include: 1. On 6/11/23 at 10:52 a.m., during an initial tour of the kitchen with the Dietary Manager (DM), the following was observed: a. The flooring throughout the kitchen, dry storage room, walk-in refrigerator and walk-in freezer were observed soiled, and littered with small, dried food particles, fresh food items, small pieces of paper debris: including condiment packets and paper towel pieces. The flooring had heavy soilage buildup with a black residue at the cove bases, around the floor drains, under the wheeled storage cabinets, under the food preparation area, under the storage shelving units, and underneath, as well as, behind the appliances. b. A soiled and hairy mop head hung on a cart, that held eight metal pots, next to the kitchen sink. c. An onion box was stored on top of a box full of banana on a kitchen countertop.	F 0812	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #6 and #54 were not negatively affected by the alleged deficient practice. There were no residents negatively affected by the alleged deficient practice. The flooring through- out the kitchen was promptly cleaned to remove spoilage, debris and build-up. The mop head was removed from the cart and stored properly. The onion box was removed and stored properly. Items in the walk-in refrigerator were checked and promptly labeled, dated and or discarded if warranted. The exhaust hood over the stove was cleaned to remove greasy build-up. The ice machine was cleaned to remove residue and lime build-up. The Dietary Aide was educated and instructed to place a hair net on before walking in to kitchen and proper storage of personal items. The CNA was re-educated on the use of gloves as indicated and hand sanitation practices according to policy when assisting a resident with meal or with feeding a resident.	07/14/2023

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	d. The walk-refrigerator contained two undated and unlabeled containers of food. e. The exhaust hood over the stove had a yellowish-brown greasy build-up. f. The inside of the ice machine had a dark residue and a heavy buildup of lime. g. Dietary Aide 17 walked into the kitchen without wearing a hairnet and placed a styrofoam cup and a plastic bag onto a kitchen cart. The DM, on 6/11/23 at 11:22 a.m., indicated the kitchen was cleaned weekly and the flooring, including the storage room and walk-in refrigerator/freezer should be swept and mopped daily, and the mop head should never have been hung on a cart in the kitchen, but stored in the kitchen utility closet. The box of onions should have never been stored on top of the box of bananas. All containers placed in the refrigerators should be dated and labeled with the name of the food item. The stove hood and ice machine are soiled and should be checked daily and deep cleaned monthly. No one should enter the kitchen without wearing a hairnet and staff are not to bring their personal items into the kitchen area. On 6/11/23 at 11:30 a.m., the DM provided the June kitchen cleaning schedule log with four tasks initialed as completed, on 6/1/23, 6/3/23, 6/5/23, and 6/7/23. The DM indicated daily staff should clean all of the kitchen and initial after completing the tasks. On 6/12/23 at 10:15 a.m., the DM provided and identified a document as a current facility policy titled, "Storage of Dry Foods," dated 05/2018. The policy indicated, "...Policy: A proper handling		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient; however, all residents have the potential to be affected. Deep cleansing of the kitchen area has been completed to ensure that entire kitchen cleaned in accordance with professional standards for food service safety and in accordance with facility policies. Food storage areas have been assessed to ensure all items labeled and dated according to policy. All discrepancies, if any noted, were immediately corrected. Dietary staff and nursing staff immediately educated on wearing hair net, storage of personal items, and hand sanitation, proper food handling. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "food storage, food handling, and sanitary conditions in kitchen" has been reviewed and no changes are indicated at this time. The dietary and nursing staff have been re-educated on the facility policies with a focus on ensuring kitchen is	

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	procedure for dry food safely lessens the risks of acquiring foodborne diseases...Procedure: ...Dry food storage areas are kept dry, clean...." At the same time, the DM provided and identified another document as a current facility policy titled, "Storage of Foods under Sanitary Conditions," dated 05/2018. The policy indicated, "...It is the policy of this facility that food shall be stored according to acceptable sanitation standards...All food items stored in the refrigerator must be labeled and dated if NOT scheduled to be served at the next meal...." The DM provided and identified a third document as a current facility policy, titled, "Cleaning Hood Filter," dated 05/2018. The policy indicated, "...Policy: It is necessary to maintain clean hoods and filters...Procedure: Weekly...." The DM provided and identified a fourth document as a current facility policy, titled, "Sanitizing Ice Machine & Scoops," dated 05/2018. The policy indicated, "...Policy: It is necessary to clean and sanitize the ice machine...Procedure: Clean unit a minimum of once a month...." 2. On 6/15/23 at 10:41 a.m., during an observation of the food puree process with the Dietary Manager (DM) and Cook 16 in the kitchen, the kitchen floor appeared to be swept, but the flooring had a heavy soilage buildup with black residue at the cove bases, around the floor drains, under the wheeled storage cabinets, under the food preparation area, under the storage shelving units, and underneath, as well as, behind the appliances. The DM indicated the floor had been swept but needed to be stripped and cleaned. The housekeeping supervisor cleaned the flooring		cleansed according to policy with professional standards for food service safety, storage of dry foods completed according to facility policy, cleaning of exhaust hood, and ice machine according to facility policy, wearing hair net and storage of personal items, and proper handling of resident food when serving and assisting with feeding residents. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DM and DON or designee will be responsible for completing the monitoring tool to ensure that kitchen is cleansed according to policy with professional standards for food service safety, storage of dry foods completed according to facility policy, cleaning of exhaust hood, ice machine according to facility policy, wearing hair net and storage of personal items, and proper handling of resident food when serving and assisting with feeding residents. The audits will be completed on working days twice weekly for 4 weeks, and then weekly for 4 weeks, then every other week for 4 weeks, and then monthly. Should a concern be noted, immediate corrective action will occur. Results of these reviews and any corrective actions	

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	with the scrubber as requested from the dietary department and the floor needed to be done, because it had been a while since the floor was scrubbed. 3. During an observation of the assisted dining area, on 6/11/23 at 12:28 p.m., Certified Nursing Aide (CNA) 7 was assisting Resident 6 and Resident 54 with their lunch meal. At the request of Resident 6, the CNA handed the resident her diet card holder. She then pulled the resident's tray toward her, and grabbed the resident's bread with her bare hands. No hand sanitation was observed prior to the CNA touching the resident's bread. After putting butter on Resident 6's bread, the CNA handed the bread to the resident, turned toward Resident 54, grabbed the underside of the table and pulled her chair closer to Resident 54. After pulling Resident 54's tray closer to her, she picked up a spoon and began to assist the resident with her meal. No hand sanitation was observed prior to the CNA assisting the resident. During an interview, on 6/11/23 at 2:04 p.m., CNA 7 indicated she was aware that she had touched Resident 6's bread with her bare hands. She understood she should not have done so without sanitizing her hands first. On 6/12/23 at 2:23 p.m., the Regional Nurse Consultant provided a document, dated 5/2018, titled, "Glove Use and Meal Service," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure...4. Employees may not touch...foods with bare hands...." 3.1-21(i)(3)		will be discussed during the facility's quarterly QA meetings on an ongoing basis. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0839 SS=D Bldg. 00	483.70(f)(1)(2) Staff Qualifications §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on record review, and interview, the facility failed to ensure that all licensed employees had an active Indiana license for 1 of 69 licensed employees. Finding includes: During review of employee records, on 6/15/23 at 11:15 a.m., a Licensed Practical Nurse (LPN) 15 was noted to have an expired Indiana nursing license. The nurse's license had been expired since 10//31/22. The nurse was noted to be an employee at the facility since 2014. Review of the nursing schedule, on 6/15/23 at 11:20 a.m., LPN 15 had been working during the week of the annual survey and at least the month prior. During an interview, on 6/15/23 at 11:28 a.m., Regional Nurse Consultant indicated that they were made aware of the expired license on 6/14/23 and the nurse was immediately taken off the schedule. She indicated LPN 15 had paid to renew her license on 10/31/22, but the state of Indiana had not renewed her license. The nurse owed money in back taxes. The nurse consultant indicated the facility nor the nurse had not realized her licensed was not renewed.	F 0839	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** LPN #15 was immediately removed from the schedule and not allowed to work until her licensed renewed and in good standing by the state of Indiana. LPN #15 was promptly notified of the expired license and the reason her licensed was not renewed. There were no residents negatively affected by the deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient; however, all residents have the potential to be affected. An audit of all license held by staff was immediately conducted to ensure all license/certifications/qualifications are in good standing and not	07/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 00 B. WING	06/15/2023

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	On 6/15/23 at 12:20 p.m., the Regional Manager provided a document, dated 2023, titled, "Job Description," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Must be a graduate of a School of Nursing and hold a current license by the State of Indiana in good standing ...." 3.1-14(s)		expired. Any discrepancies, if noted was corrected immediately, ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Licensed staff and job descriptions" has been reviewed and no changes are indicated at this time. The nursing staff and Human Resource staff have been re-educated on the facility policies with a focus on ensuring that all staff holding license, certification or qualification are renewed and updated and remain in good standing at all times and not expired. Staff will not be allowed to work if license/certification/qualifications are not in good standing. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The Administrator or designee will be responsible for completing the monitoring tool to ensure that all staff holding license, certification or qualification are renewed and updated and remain in good standing at all times and not expired. The audits will be	

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			completed on working days twice weekly for 4 weeks, then weekly for 4 weeks, then every other week for 4 weeks and then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	