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	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
1019 SENIOR LIVING 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. Survey dates: August 6 and 7, 2024 Facility number: 011970 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 9, 2024.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective September 7, 2024. ="" span="" _september="" 7th,="" 2024_____.<="">="" p="">	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed by residents or their representative for 7 of 7 residents reviewed for services plans. (Residents 4, 27, 29, 100, 101, 31, and 37) Findings include: 1. Resident 29's clinical record was reviewed on 8/6/24- at 1:55 p.m. Current diagnoses included hypertension and bipolar disorder. The resident's current 4/22/24 service plan was not signed by the resident or a representative. 2. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m.. Diagnoses at the time of discharge included hypertension, anxiety	R 0217	="" p="">R217 ="" p="">"> It is the practice of 1019 Senior Living Vermillion Place to ensure that service plans are signed by residents or their respective resident representatives. ="" p="">"> What corrective action will be accomplished for those residents found to have been affected by the deficient practice? ="" p="">"> Residents 4, 27, 29, 31 and 37 all	09/07/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zoe Kesler	RCA	08/27/2024

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	and depression. The resident's most current 2/13/24 service plan was not signed by the resident or a representative. 3. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. Current diagnoses included major depressive disorder and hypertension. The resident's current 5/20/24 service plan was not signed by the resident or a representative.4. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. Diagnoses included left hemiparesis and end stage renal disease. A current service plan, dated 7/2/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 5. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. Diagnoses included right hemiparesis and diabetes mellitus type 2. A current service plan, dated 7/5/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 6. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD) and pulmonary emphysema. A current service plan, dated 3/29/24, indicated the resident was alert, required use of a walker for ambulation, and required oxygen. The service plan lacked a resident or resident representative signature. 7. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. Diagnoses included hypertension and peripheral neuropathy. A service plan, dated 1/27/24, indicated the resident was alert and oriented, was independent with		have current service plans that have been reviewed and signed. Residents 100 and 101 no longer reside at this facility. ="" p=""> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? ="" p=""> All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing has completed resident file audits. All residents now have current signed service plans in place. Moving forward, the Administrator and/or designee will audit all new admission service plans to ensure that all documentation is obtained as required. ="" p=""> What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ="" p=""> All staff responsible for completion of service plans have been educated on facility policy for service plans. Moving forward, the Administrator and/or designee will audit all new admission service plans to ensure that all documentation is obtained as	

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	transfers, and required use of a walker for ambulation. The service plan lacked a resident or resident representative signature. During an interview, on 8/8/24 at 1:55 p.m., the Administrator indicated she could not locate the signed service plans for the residents in question. A current facility policy, dated 12/23, titled "Resident Service Plan", and provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "... 5. Upon initial review and subsequent changes, members of the community care team that contributed to the Resident Service Plan, including the Executive Director, Wellness Director, or designee, and the resident/legally responsible party should sign the Resident Service Plan...."		required. The administrator and/ or designee will sign off on all new admission service plans to ensure that the service plan is complete. This will allow for any corrections to be made in a timely manner. ="" p=""> How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ="" p=""> The DON will audit the service plans monthly for three months, then quarterly thereafter. ="" p=""> Date of Compliance: Sep 7, 2024 ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	
R 0410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance			

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Bldg. 00	Based on interview and record review, the facility failed to ensure residents had either a tuberculin skin test completed within three months prior to admission or upon admission, or for residents who did not have a documented negative tuberculin skin test result during the preceding twelve (12) months, a baseline tuberculin skin testing using the two-step method for 3 of 3 residents reviewed for TB screening upon admission. (Residents 101, 4, 27, and 100) Findings include: 1. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m. The resident was admitted to the facility on 2/11/24. The clinical record lacked proof of a tuberculin skin test completed within 3 months prior to admission, a two- step skin test upon admission, or a history of a TB skin test within 12 months prior to admission. 2. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. The residents admission date was 7/2/24. The record lacked documentation of a 2-step TB test. 3. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. The residents admission date was 7/5/24. The record lacked documentation of a 2-step TB test. 4. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. The residents admission date was 1/15/24. The record lacked documentation of a 2-step TB test. During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional documentation to provide showing TB testing results or TB testing for new admissions.	R 0410	R 410 ="" p="">> It is the practice of 1019 Senior Living Vermillion Place to ensure that all newly admitted residents have the 2-Step TB Test completed ="" p="">> What corrective action will be accomplished for those residents found to have been affected by the deficient practice? ="" p="">> Residents 4 and 27 have received a new 1st TB Test. Resident 4 and 27 are both scheduled to receive the 2nd Step TB Test. ="" p="">> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? ="" p="">> All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing has completed resident file audits. All new admissions now have received a new 1st Step TB and are scheduled to receive the 2nd Step TB Test. Moving forward, the Administrator and/or designee will audit all new admission upon	09/07/2024

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	A current facility policy, revised 5/24 and titled "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...The required tuberculosis test shall include the two-step Mantoux test for tuberculosis using purified protein derivative (PPD); or, if the individual has a documented history of a significant Mantoux test, PPD reactor; a chest x-ray...."		admission and on day 21 to ensure that all documentation is obtained as required. ="" p=""> What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ="" p=""> All staff responsible for the completion of 2 Step TB Tests have been educated on facility policy for 2 Step TB Testing. Moving forward, the Administrator and/or designee will audit all new admitted resident records to ensure 2nd Step TB Tests are obtained as required. The Administrator and/ or designee will audit all new admits at 21 days after admittance to ensure the 2nd Step TB has been administered. This will allow for any corrections to be made in a timely manner. ="" p=""> How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON will audit the resident records in accordance to 2 Step TB Tests weekly for four weeks, monthly for three months, then quarterly thereafter. ="" p="">	

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

FORM APPROVED
OMB NO. 0938-039

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			Date of Compliance: Sep 7, 2024 ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure residents who had resided in the facility for longer than one year had either annual TB (tuberculosis) risk assessments or annual TB skin tests completed for 3 of 4 residents reviewed	R 0412	R 412 ="" p=""> It is the practice of 1019 Senior Living Vermillion Place to ensure	09/07/2024

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	for annual TB screening. (Residents 29, 37, and 31) Findings include: 1. Resident 29's clinical record was reviewed on 8/6/24 at 1:55 p.m. The resident was admitted to the facility on 4/4/19. The clinical record lack an annual TB test and/or annual risk assessment. 2. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. The resident was admitted to the facility on 6/13/22. The clinical record lack an annual TB test and/or annual risk assessment.3. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. The resident admitted to the facility on 12/26/22. The clinical record lacked an annual TB risk assessment or testing. During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional information to provide for annual TB screenings or testing. A current facility policy, revised 5/24, titled, "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...Policy: Residents will be asked to provide proof of a negative TB test prior to move-in. Thereafter, the test will be performed at least once every 12 months or per State regulations...."		that all residents who have resided within the facility for longer than 1 year have received a TB Skin Test or Annual TB Risk Assessment if TB Skin Test is contraindicated. ="" p="">"> What corrective action will be accomplished for those residents found to have been affected by the deficient practice? ="" p="">"> Residents 29, 37, and 31 have received a TB Skin Test or Annual TB Risk Assessment if TB Skin Test is contraindicated. ="" p="">"> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? ="" p="">"> All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing has completed resident file audits. All residents have received an Annual TB Skin Test or Annual TB Risk Assessment if TB Skin Test is contraindicated. Moving forward, the Administrator and/or designee will audit resident records to ensure that all documentation is obtained as required. ="" p="">">	

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			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ="" p="">"> All staff responsible for the completion of Annual TB Skin Tests or Annual TB Risk Assessments if contraindicated have been educated on the facility policy for Annual TB Testing. Moving forward, the Administrator and/or designee will audit all resident records to ensure all required TB Tests or Annual Risk Assessments are obtained and complete. ="" p="">"> How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON will audit the resident records in accordance monthly for three months, then quarterly thereafter. Any discrepancies will be documented and reported to the Administrator. ="" p="">"> Date of Compliance: Sep 7, 2024 ="" p="">"> ="" p="">">	

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