PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> C		COMPL	(3) DATE SURVEY COMPLETED 08/07/2024	
NAME OF PROVIDER OR SUPPLIER 1019 SENIOR LIVING VERMILLION PLACE		-	449 MA	ADDRESS, CITY, STATE, ZIP COD NIN ST RSON, IN 46016			
(X4) ID PREFIX TAG R 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
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 00	000	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	failed to ensure ser residents or their residents reviewed 4, 27, 29, 100, 101 Findings include: 1. Resident 29's cli 8/6/24- at 1:55 p.m hypertension and becurrent 4/22/24 ser resident or a representation of the series of t	vand record review, the facility vice plans were signed by expresentative for 7 of 7 for services plans. (Residents, 31, and 37) nical record was reviewed on a. Current diagnoses included ipolar disorder. The resident's vice plan was not signed by the	R 02	217	="" p="">R217 ="" p=""> It is the practice of 1019 Senic Living Vermillion Place to ensithat service plans are signed by residents or their respective resident representatives. ="" p=""> What corrective action will be accomplished for those reside found to have been affected by deficient practice? ="" p=""> Residents 4, 27, 29, 31 and 35	ure by ents y the	09/07/2024

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

TITLE

(X6) DATE

Zoe Kesler **RCA** 08/27/2024

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.

State Form Event ID: BMLI11 Facility ID: 011970 If continuation sheet Page 1 of 9

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
			B. W	B. WING			2024
				_			
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
				449 MA			
1019 SE	NIOR LIVING VERI	MILLION PLACE		ANDER	RSON, IN 46016		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		ne resident's most current			have current service plans tha	t	
	_	n was not signed by the			have been reviewed and signe		
	resident or a repres				Residents 100 and 101 no lon		
	lesident of a repres	onar, c.			reside at this facility.	gei	
	3 Resident 37's cli	nical record was reviewed on			="" p="">		
		. Current diagnoses included			- μ- /		
		isorder and hypertension. The			How other residents having th		
		/20/24 service plan was not			potential to be affected by the		
		ent or a representative.4.			same deficient practice will be		
		ll record was reviewed on 8/6/24			identified and what corrective		
		oses included left hemiparesis			actions will be taken?		
		disease. A current service			="" p="">		
	_	indicated the resident was alert			- μ- /		
	_	as independent with transfers.			All regidents have the notantic	ul to	
		cked a resident or resident			All residents have the potentia		
	_				be affected by the alleged defi		
	representative signs	ature.			practice. The Director of Nursi	-	
	5 Dasidant 27kg ali	nical record was reviewed on			has completed resident file au		
		Diagnoses included right			All residents now have current	-	
	_	abetes mellitus type 2. A			signed service plans in place.	_4	
	_	n, dated 7/5/24, indicated the			Moving forward, the Administr		
	_	nd oriented and was			and/or designee will audit all n		
					admission service plans to ensthat all documentation is obtain		
	_	ransfers. The service plan				nea	
		resident representative			as required.		
	signature.				="" p="">		
	6 Pasidont 211s ali	nical record was reviewed on			What magazines will be not into		
		i. Diagnoses included chronic			What measures will be put into		
		_			place and what systemic chan	<u> </u>	
	_	ary disease (COPD) and ema. A current service plan,			will be made to ensure that the		
		cated the resident was alert,			deficient practice does not rec	ur?	
					="" p="">		
	_	alker for ambulation, and			All staff reapensible for as well	otion	
	required oxygen. The service plan lacked a resident or resident representative signature.				All staff responsible for comple	zuOH	
	resident or resident	representative signature.			of service plans have been		
	7 Desident 1001	limical magand rates were items 4			educated on facility policy for	41	
		linical record was reviewed on			service plans. Moving forward		
	_	Diagnoses included			Administrator and/or designee		
		eripheral neuropathy. A			audit all new admission servic	е	
	_	1/27/24, indicated the resident			plans to ensure that all		
	was alert and orien	ted, was independent with			documentation is obtained as	l	

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/07/2024			
	PROVIDER OR SUPPLIER NIOR LIVING VERM		449 MA	STREET ADDRESS, CITY, STATE, ZIP COD 449 MAIN ST ANDERSON, IN 46016				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF transfers, and requir ambulation. The ser resident representat During an interview Administrator indic signed service plans A current facility po "Resident Service F Administrator on 8/ following: " 5. Up subsequent changes care team that contr Plan, including the Director, or designed	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION red use of a walker for rvice plan lacked a resident or	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) required. The administrator are designee will sign off on all neadmission service plans to enthat the service plan is completed to be made in a timely manner entry. How the corrective action will monitored to ensure the deficit practice will not recur, i.e., when quality assurance program will put into place? Entry permy The DON will audit the service plans monthly for three months then quarterly thereafter. Entry permy Entry permy	DATE and/ or ew sure ete. ons r. be ient at II be ens,			
R 0410	410 IAC 16.2-5-12 Infection Control -							

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/07/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 449 MAIN ST ANDERSON, IN 46016				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
Bldg. 00	failed to ensure resists in test completed admission or upon a who did not have a tuberculin skin test twelve (12) months testing using the two residents reviewed admission. (Resident Findings include: 1. Resident 101's converted admitted to the facility reviewed on 8/7/24 admitted to the facility record lacked proof completed within 3 two-step skin test within admission. 2. Resident 27's climate a TB skin test within admission date was documentation of a series and completed within 3. Resident 27's climate a 18/6/24 at 2:23 p.m. was 7/5/24. The reconverted a 19/7/24 at 1:22 p.m. was 1/15/24. The reconverted a 2-step TB test. During an interview DON indicated she documentation to proceed the skin test within a 19/7/24 at 1:20 p.m. was 1/15/24. The reconverted a 2-step TB test.	nical record was reviewed on The residents admission date ord lacked documentation of a inical record was reviewed on The residents admission date becord lacked documentation of	R 0410	R 410 ="" p=""> It is the practice of 1019 Senic Living Vermillion Place to ensithat all newly admitted resider have the 2-Step TB Test completed ="" p=""> What corrective action will be accomplished for those reside found to have been affected by deficient practice? ="" p=""> Residents 4 and 27 have rece a new 1st TB Test. Resident 4/27 are both scheduled to rece 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 be affected by the alleged defination. The Director of Nursich has completed resident file aud All new admissions now have received a new 1st Step TB at are scheduled to receive the 2 Step TB Test. Moving forward Administrator and/or designed audit all new admission upon	ents ents y the ents ived and ive e al to icient ing idits. e nd end end end the		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/07/2024			
NAME OF PROVIDER OR SUPPLIER 1019 SENIOR LIVING VERMILLION PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 449 MAIN ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	"TB testing - Resid Administrator on 8	olicy, revised 5/24 and titled ent", provided by the /7/24 at 2:05 p.m., indicated the equired tuberculosis test shall		admission and on day 21 to ensure that all documentation obtained as required. ="" p="">	is			
	(PPD); or, if the inc	p Mantoux test for purified protein derivative dividual has a documented ant Mantoux test, PPD reactor;		What measures will be put int place and what systemic char will be made to ensure that th deficient practice does not rec ="" p="">	nges e			
				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 Administrand/or designee will audit all radmitted resident records to ensure 2nd Step TB Tests are obtained as required. The Administrator and/or designe audit all new admits at 21 day after admittance to ensure the Step TB has been administered This will allow for any correctito be made in a timely manne =""" p="""> How the corrective action will monitored to ensure the deficition practice will not recur, i.e., who quality assurance program wi	rator new e e will rs e 2nd ed. ons or. be ient at			
				put into place? The DON will audit the reside records in accordance to 2 St TB Tests weekly for four weel monthly for three months, the quarterly thereafter. ="" p="">	nt ep ks,			

State Form Event ID: BML111 Facility ID: 011970 If continuation sheet Page 5 of 9

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	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPL 08/07/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 449 MAIN ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
				Date of Compliance: Sep 7, 20 ="" p="">	024			
R 0412 Bldg. 00	410 IAC 16.2-5-12 Infection Control -		R 0412	R 412		09/07/2024		
	failed to ensure resi facility for longer th TB (tuberculosis) ri	dents who had resided in the nan one year had either annual sk assessments or annual TB of 6 of 4 residents reviewed	K U412	e"" p=""> It is the practice of 1019 Senic Living Vermillion Place to ensu		09/07/2024		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		ONSTRUCTION	(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
			B. WING			08/07/2024		
		<u> </u>		CTD DET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIEF	8		449 MA				
1010 85	NIOR LIVING VER	ALL LON DLACE						
IUIS SEI	NIOR LIVING VERI	WILLION FLAGE		ANDER	RSON, IN 46016			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	for annual TB scree	ening. (Residents 29, 37, and			that all residents who have res	sided		
	31)				within the facility for longer tha	ın 1		
					year have received a TB Skin			
	Findings include:				or Annual TB Risk Assessmer	nt if		
					TB Skin Test is contraindicate	d.		
		nical record was reviewed on			="" p="">			
	_	The resident was admitted to						
	-	9. The clinical record lack an						
	annual TB test and/	or annual risk assessment.			What corrective action will be			
					accomplished for those reside			
		nical record was reviewed on			found to have been affected by	y the		
		. The resident was admitted to			deficient practice?			
		22. The clinical record lack an			="" p="">			
		or annual risk assessment.3.						
		al record was reviewed on			Residents 29, 37, and 31 have			
		. The resident admitted to the			received a TB Skin Test or An			
	-	. The clinical record lacked an			TB Risk Assessment if TB Skin			
	annual TB risk asse	essment or testing.			Test is contraindicated.			
					="" p="">			
	_	v, on 8/8/24 at 1:55 p.m., the						
		had no additional information			How other residents having the	е		
	to provide for annu	al TB screenings or testing.			potential to be affected by the			
		1			same deficient practice will be			
		olicy, revised 5/24, titled, "TB			identified and what corrective			
	_	provided by the Administrator			actions will be taken?			
	_	m., indicated the following:			="" p="">			
	•	s will be asked to provide proof						
		st prior to move-in. Thereafter,			All residents have the potentia			
	-	formed at least once every 12			be affected by the alleged defi			
	months or per State	regulations"			practice. The Director of Nursi	-		
					has completed resident file au All residents have received an			
					Annual TB Skin Test or Annua Risk Assessment if TB Skin Te			
					is contraindicated. Moving for			
					the Administrator and/or desig will audit resident records to	nee		
					ensure that all documentation	ie		
					obtained as required.	ıə		
					="" p="">			
					- P- /			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	e survey pleted 7/2024
	ROVIDER OR SUPPLIE		449 MA	ADDRESS, CITY, STATE, ZI AIN ST RSON, IN 46016	IP COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
				What measures will place and what syst will be made to ensu deficient practice do ="" p="">	emic changes ure that the	
				All staff responsible completion of Annual TB Assessments if cont have been educated policy for Annual TB Moving forward, the and/or designee will resident records to e required TB Tests of Assessments are obtained to be complete.	al TB Skin Risk traindicated d on the facility 3 Testing. Administrator l audit all ensure all r Annual Risk	
				How the corrective a monitored to ensure practice will not recurquality assurance proput into place? The DON will audit to records in accordant three months, then of the	the deficient ur, i.e., what rogram will be the resident ce monthly for quarterly repancies will	
				Date of Compliance ="" p="">	: Sep 7, 2024	
				="" p="">		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/07/2024	
	PROVIDER OR SUPPLIE		•	449 MA	ADDRESS, CITY, STATE, ZIP COD NIN ST RSON, IN 46016	•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
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