STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING _____ B. WING _____	C 11/06/2023

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

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00420470. Complaint IN00420470 - Federal/state deficiencies related to the allegations are cited at F604. Survey dates: November 6, 2023 Facility number: 000052 Provider number: 155124 AIM number: 100290340 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 6 Medicaid: 51 Other: 14 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 15, 2023.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not	F 604		

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

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F 604	Continued From page 1 required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure residents' self-releasing seat belts (used to keep a resident positioned properly in their wheelchair) were secured in a manner which allowed the residents to freely release the belts for 2 of 4 residents reviewed for physical restraint (Residents B and C). The deficient practice was corrected on 10/24/23, prior to the start of the survey, and was therefore past noncompliance. Finding includes: An Indiana Department of Health (IDOH)	F 604	Past noncompliance: no plan of correction required.	

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F 604	Continued From page 2	F 604		

reportable incident document, dated 10/24/23 at 11:15 a.m., indicated it had been reported that Certified Nursing Aide (CNA) 8 had used tape to secure the self-releasing seat belts of Resident B and Resident C, which removed the ability of the residents to self-release the seat belts. The facility's internal investigation was initiated. The CNA was immediately re-educated by the Assistant Director of Nursing (ADON) and was suspended from work, pending the results of the investigation.

During an initial observation of the Expressions (memory care) unit, on 11/6/23 at 10:05 a.m., Residents B and D were observed sitting in the activity lounge participating in a morning activity. Both residents were observed with self-releasing seat belts in place. At the same time, Resident D was able to release her belt when requested. Resident B refused to release her belt and shook her head no.

On 11/6/23 at 10:10 a.m., Resident C was observed in his room asleep in his wheelchair, with his seatbelt in place and intact.

During an interview, on 11/6/23 at 10:18 a.m., Activities Assistant 3 indicated she worked on the unit specifically and had heard from other staff about someone putting tape on the seat belts of Residents B and C. She was not working when the incident happened.

During an interview, on 11/6/23 at 10:25 a.m., CNA 4 indicated she had been told about the tape being placed on the seat belts of Resident B and C. She had never witnessed anything like this before. All of the residents who had the self-releasing belts were able to remove them

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F 604	Continued From page 3	F 604		

when asked to.

During an interview, on 11/6/23 at 10:36 a.m., Qualified Medication Aide (QMA) 5 indicated she was working on the unit and south hall on the day the incident had allegedly occurred but had only heard about it from other staff. She had not ever seen any issues with the self-releasing belts when she worked on the unit.

During an interview, on 11/6/23 at 10:45 a.m., CNA 6 indicated she was working on a different unit of the facility on the date the incident supposedly happened. She did not see it firsthand but was told about it by other staff. She had never seen any tape on the self-releasing belts in the past.

During an interview, on 11/6/23 at 10:51 a.m., the former Director of Nursing (DON) indicated on the date of the incident one of the high school Helping Hands (student from the local high school who observe CNAs and assist with non-hands on activities), who was in the facility working alongside CNA 8, had seen the tape on the seat belts. The student reported it to the charge nurse, Register Nurse (RN) 13.

On 11/6/23 at 10:58 a.m., the Administrator (ADM) provided the facility's internal investigation documentation for review. At the same time, she indicated they had completed a full investigation of the allegations and sent the incident in as a reportable to IDOH. The CNA had been terminated following the investigation. There had not been any further incidents since this had been resolved.

During an interview, on 11/6/23 at 11:37 a.m.,

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F 604	Continued From page 4	F 604		

Laundry Aide 11 indicated she had observed the tape on Resident C's seatbelt and had told CNA 8 that she could not do that because they were not allowed to restrain the residents. There was also a volunteer helper with the CNA at the time. She indicated CNA 8 acknowledged that she knew it was not allowed, but never made any attempt to remove the tape. The Laundry Aide indicated she told the QMA who was on duty on that hallway about what she had seen and what the CNA had said. She was unsure what happened after that. She gave the DON and the ADM her statement when they were investigating.

Review of the facility's investigation documentation, included, but were not limited to the following:

a. A statement from the former Director of Nursing (DON), dated 10/24/23, indicated the incident had been noticed by a high school student in the Helping Hands program and brought it to the attention of the nurse. A second statement indicated the facility had notified Resident B's family of the incident.

b. An undated investigative interview statement, signed by the Administrator indicated CNA 9 had worked the day shift on 10/22/23. She noted that CNA 8 was on duty but had not provided toileting assistance to her residents. CNA 9 indicated she had gone into assist Resident C to the bathroom and noticed there was tape on his self-releasing seat belt.

c. An undated handwritten statement, signed by Laundry Aide 11, indicated CNA 8 had told her that she had taped Resident C's seat belt because he would not stay in his wheelchair. The

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F 604	Continued From page 5	F 604		

Laundry Aide observed the tape on the resident's seat belt. She then explained to CNA 8 that what she had done would get her into trouble. At that time, she indicated the Helping Hands student asked why it would get CNA 8 into trouble, and CNA 8 told the student that it was considered abuse to the resident, and they were not allowed to do that.

d. An interview statement from Resident B, dated 10/24/23, indicated she did not know of anyone who had harmed her. She did not feel afraid or unsafe and felt everyone treated her very nice.

e. A document titled, "Possible or Potential Mental Anguish Assessment," dated 10/24/23, indicated Resident B had no signs or symptoms of potential mental anguish.

f. A PHQ-9 (a depression assessment module, which scores each of the 9 depression diagnostic criteria as "0" [not at all] to "3" [nearly every day]) document, dated 10/24/23, indicated Resident B scored a 6 (mild depression).

g. An interview statement for Resident C, dated 10/24/23, indicated the resident was not able to remember any incidence when anyone had mistreated or harmed him. He told the interviewer he felt fine, and he did not have any fear or feel unsafe.

h. A document titled, "Possible or Potential Mental Anguish Assessment," dated 10/24/23, indicated Resident C had no signs or symptoms of potential mental anguish.

i. A PHQ-9 (a depression assessment module, which scores each of the 9 depression diagnostic

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F 604	Continued From page 6	F 604		

criteria as "0" [not at all] to "3" [nearly every day]) document, dated 10/24/23, indicated Resident C scored a 11 (moderate depression).

j. Nursing in-service sign-in sheets, dated 10/24/23, indicated education titled, "Restraints, Self-release belt alarm," was provided as part of the investigation documentation. The DON had provided the education which covered the policy titled, "Alarm, Position Change."

k. Nursing in-service sign-in sheets, dated 10/24/23, for education titled, "Mood/Behavior Management and CNA/Helping Hand Job Description," was provided as part of the investigation documentation. The DON had provided the education which covered the policies on Mood and Behavior and Abuse Prohibition. Signed copies of documents, titled, "Abuse Prohibition/Know Your Role," had been signed by each staff person in attendance.

l. A facility investigation document, dated 10/27/23, and signed by the ADM, indicated she had called CNA 8, into the facility, to discuss the incident. The CNA told her that she knew better than to put tape on the seat belt, but the resident just kept getting up from his chair, and she had done it to keep him safe. The Abuse policy was reviewed with the CNA. The CNA was terminated due to corporal punishment, involuntary seclusion, and unreasonable confinement. The CNA had never been back into the facility after her suspension, except to sign her termination paperwork.

1. Resident B's record was reviewed on 11/6/23 at 1:51 p.m. The resident diagnoses included, but were not limited to, dementia (the loss of

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F 604	Continued From page 7	F 604		

cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), and mood disorder (a mental health condition that primarily affects a person's emotional state).

An admission Minimum Data Set (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 9/15/23, indicated the resident had severe cognitive deficit.

A care plan, dated 9/19/23 and revised 10/22/23, indicated the resident had multiple risk factors for falls. Interventions included, but were not limited to, seat belt alarm.

A physician's order, dated 10/9/23, indicated resident may use self-release belt to promote safety awareness. Utilization of self-release belt does not inhibit voluntary movement.

An initial physical restraint assessment, dated 10/9/23, indicated the resident had a self-release seat belt and was able to release the belt upon command.

2, Resident C's record was reviewed on 11/6/23 at 2:41 p.m. The resident's diagnoses included, but were not limited to, dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and frontotemporal dementia (a group of disorders that occur when nerve cells in the frontal and temporal lobes of the brain are lost).

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F 604	Continued From page 8	F 604		

A comprehensive Minimum Data Set (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 10/27/23, indicated the resident had severe cognitive deficit.

A care plan, dated 7/21/23 and updated on 11/3/23, indicated the resident had multiple risk factors for falls. Interventions included, but were not limited to, seat belt alarm to wheelchair.

A physician's order, dated 10/6/23, indicated resident may use self-release belt to promote safety awareness. Utilization of self-release belt does not inhibit voluntary movement.

An initial physical restraint assessment, dated 10/2/23, indicated the resident was able to release the belt upon command.

On 11/6/23 at 2:14 p.m., the Nurse Consultant provided a document, with a revised date of 6/2023, titled, "Abuse Prohibition, Reporting and Investigation," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: The facility shall prohibit and prevent abuse...This includes but is not limited to...any physical or chemical restraint...Physical abuse...Includes...controlling behavior through corporal punishment...which is physical punishment, is used to correct or control behavior...."

The deficient practice was corrected by 10/24/23, after the facility implemented a systemic plan that included the following actions: provided a complete investigation of the incident;

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F 604	Continued From page 9 assessment of the physical, mental and emotional status of the residents involved; provided re-education to all nursing staff of restraints and the use of self-releasing seat belts along with mood and behavior management and abuse prohibition, reporting, and investigation policies and procedures; and termination of the staff responsible. The deficient practice was corrected on 10/24/23, prior to the start of the survey, and was therefore past noncompliance. This citation relates to complaint IN00420470. 3.1-3(w)	F 604		