

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Vermillion Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 S Main St Clinton, IN 47842	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident was assessed and a physician order was obtained prior to utilizing an audible bed and chair alarm for 1 of 2 residents reviewed for falls (Resident B). Findings include: On 6/17/26 at 12:35 p.m. during an initial observation and interview, Resident B sat in the main dining room with her husband. She was alert with some confusion noted during the interview. The resident indicated she had some falls but had not been hurt any of the times she fell. The resident was sitting in her wheelchair on a black air filled cushion and an incontinent pad. No anti-skid material was observed in the wheelchair. Observed anti-tip bars to the lower bottom of the wheelchair. The bars were upside down. No alarm observed on the chair. The husband indicated there was an alarm on the bed and usually there was a chair alarm and indicated the staff must have forgotten to put the chair alarm back on when they had gotten her up earlier. On 6/17/26 at 1:35 p.m., during an interview, the Occupational Therapist indicated Resident B did not have anti-skid material in the wheelchair seat because she no longer required it. She indicated the anti-tip bars were on the wheelchair incorrectly, but they had been fixed since she was made aware. She did not know who had placed them on incorrectly. On 8/18/26 at 10:00 a.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but was not limited to, end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), muscle weakness, and difficulty walking. Review of the nurses progress notes indicated the resident had fallen three times. On 2/11/26 the resident slid out of a wheelchair. On 3/21/26 the resident fell walking to the bathroom. On 4/8/26 the resident slid out of wheelchair in the bathroom. No injuries were noted during any of the falls. A care plan, dated 8/5/26, indicated falls. The resident had multiple risk factors for falls. Interventions included, on 4/8/26 Dycem (anti-skid material) to wheelchair, check for placement every shift; on 3/31/26 Non-skid socks when in bed; on 1/19/26 remind resident and husband to call for assistance with transfers; on 11/17/2025 anti-rollbacks to wheelchair; on 8/15/25 hang orange reminder sign in room to call for assistance; on 8/7/25 non-skid strips at bedside. The record lacked documentation of bed or chair alarm as an intervention and lacked documentation of anti-tip bars to wheelchair as an intervention. A quarterly Minimum Data Set Assessment (MDS) assessment, dated 5/7/26, indicated the resident had mild cognitive impairment and required assistance with daily care needs. On 6/18/26 at 11:55 a.m., during a phone interview, the resident's representative indicated she was concerned about the falls and indicated the resident was to have both a chair alarm and bed alarm, but when she had visited the alarm was not on or it had been turned off. At 12:20 p.m., during an interview Licensed Practical Nurse (LPN) 4 indicated the resident did have a chair alarm and a bed alarm. She indicated the reason for the alarm was because the resident would get up on her own or the husband would help her and not ask staff for assistance. The LPN indicated the facility required a physician order for an alarm and acknowledged the record lacked a physician order for either a chair or bed alarm. On 6/18/26 at 12:30 p.m., during an observation of the resident's bed. A bed alarm was on the bed but not (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attached to the alarm box. The resident was not in the facility at the time of the observation. The resident's husband indicated the alarm was placed on her chair before she left for dialysis and the staff had disconnected the bed alarm when they made the bed. On 6/18/26 at 1:46 p.m., during an interview, the Regional Nurse Consultant indicated the alarms were placed at one time as a nursing measure and should have been removed. She indicated since the resident had not had a fall for a while she no longer needed the alarm. On 6/18/26 at 2:00 p.m., the Regional Nurse Consultant provided a document titled Alarm position change, dated 9/17 and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: While position change alarms may be implemented to monitor a resident's movements, for some residents, the use of position change alarms that are audible to the resident(s) may have the unintended consequence of inhibiting freedom of movement.Procedure.2. Should a position change alarm be deemed appropriate intervention by the team, a physician's order shall be obtained. This citation relates to Intake 3024588. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(w)410 IAC (Indiana Administrative Code) 16.2-3.1-26(a)410 IAC (Indiana Administrative Code) 16.2-3.1-26(b)		