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	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermillion Convalescent Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48226 Based on observation, interview and record review, the facility failed to aid a resident in a manner that maintained or enhanced their dignity for 1 of 1 residents randomly observed for resident rights. (Resident 72). Findings include: On 7/18/24 at 10:00 a.m., observed Student Nurse Aide (4) transporting Resident 72 from the shower room to the resident's room while sitting in an open shower chair (a wheeled chair which provides support and stability to individuals who require assistance with bathing or using the restroom). The resident was wearing a blue long sleeve shirt and covered in the front with a light blanket. The back of the shower chair was uncovered, and the resident's buttocks was exposed. On 7/18/24 at 10:05 a.m., during an interview with Licensed Practical Nurse (LPN) 4 she indicated the resident should be completely covered before transporting in a shower chair. On 7/18/24 at 10:20 a.m., during an interview with Student Nurse Aide 4, she indicated the resident should have been covered prior to transporting the resident in a shower chair. On 7/18/24 at 1:30 p.m., the medical record of Resident 72 was reviewed. The resident was admitted with diagnosis including but not limited to, encephalopathy (damage or disease that affects the brain), altered mental status and cognitive communication deficit (trouble expressing needs using basic words and gestures). A care plan, dated 9/7/21, indicated the resident required assistance of one person for activities of daily living (ADL) care and transportation. An admission Minimum Data Set (MDS) assessment, dated 5/28/24, indicated the resident was not cognitively intact and she required maximum assistance of two persons for care needs. On 7/18/24 at 2:00 p.m., the Regional Nurse Consultant provided a document, titled, Resident Rights, dated 11/28/2016, and indicated it was the policy currently being used by the facility. The policy indicated, .Respect and Dignity. The resident has the right to be treated with respect and dignity 3.1-3(a)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 35317 Based on interview and record review, the facility failed to ensure documentation of a resident's transfer included information that the physician and family representative were notified of a resident being transferred to the hospital for 1 of 2 reviewed for hospitalization (Resident 17). Finding includes: During an interview, on 7/16/24 at 11:30 a.m., Resident 17 indicated she had recently been sent out to the hospital for a seizure and stayed overnight. Resident 17's record was reviewed on 7/22/24 at 10:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Epilepsy (group of non-communicable neurological disorders characterized by recurrent epileptic seizures [uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain]). A quarterly Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident was cognitively intact. Review of the Situation, Background, Assessment, and Recommendation (SBAR) form, dated 6/18/24, indicated Resident 17 was being transported to the emergency room . The form was not completed in its entirety and lacked documentation of physician notification and family representative notification. Reivew of a nurse's note, dated 6/18/24 at 11:15 p.m., the note indicated Resident 17 had complained to a certified nurse's assistant (CNA) that she was not feeling well. The CNA reported to the nurse the resident was unresponsive to verbal stimulation. The resident did regain consciousness, but her color was pale with flushed face. The resident had nausea and vomiting times 2. Emergency Medical Services (EMS) was called to assist with transport to the hospital. The resident was alert at the time of transport. The nurse's note lacked documentation of a physician or family representative being notified of the transfer to the hospital for Resident 17. During an interview, on 7/22/24 at 10:19 a.m., Licensed Practical Nurse (LPN) 13 indicated the nursing staff should complete a SBAR form when sending out residents to the hospital. The form was then placed in a binder at the nurse's station when completed. During an interview, on 7/22/24 at 11:13 a.m., the Regional Nurse Consultant indicated she was unable to find any documentation of where the physician or family representative was notified of Resident 17's transfer to the hospital. The nurse, who had completed the SBAR, was no longer employed with the facility. On 7/22/24 at 11:00 a.m., the Regional Nurse Consultant provided a document with a revised date of 11/15, titled, SBAR Communication Form, .2. The licensed nurse will ensure relevant aspects of pages one through three are completed prior to calling the physician or other Healthcare Professional (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24 at 11:12 a.m., the Regional Nurse Consultant provided a document with a revised date of 11/16, titled, Change in Resident Condition/Emergency Transfer to Acute Care Hospital, and indicated it was the policy currently being used by the facility. The policy indicated, .In the event a resident's condition changes warranting medical attention, the licensed nurse shall complete the SBAR communication form and contact the physician .The family/resident representative shall be notified of the change in condition and corresponding physician orders 3.1-12(a)(5)(A) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(vii) 3.1-12(a)(6)(B)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 34525 Based on observation, record review, and interview, the facility failed to ensure a resident's indwelling urinary catheter (catheter-a tube which is inserted into the bladder to drain urine) bag and tubing were kept from making contact with the floor for 1 of 1 residents reviewed for urinary catheters (Resident 36). Findings include: During the initial observation, on 7/16/24 at 2:03 p.m., Resident 36 was in his room sitting in a recliner. His catheter was attached to the lower portion of the recliner. The catheter urinary drainage bag (a bag attached to a indwelling urinary catheter to catch the urine) was in contact with the floor. During a random observation, on 7/17/24 at 1:16 p.m., the resident was in his room sitting in his wheelchair. The catheter tubing was observed in contact with the floor. During a random observation, on 7/18/24 at 2:13 p.m., the resident was sitting in his room in the recliner. His catheter was attached to the lower portion of his wheelchair next to the recliner. The catheter bag was observed in contact with the floor. During a random observation with the Assistant Director of Nursing (ADON), on 7/18/24 at 2:31 p.m., the resident was observed sitting in the recliner. The catheter bag was attached to the lower portion of his wheelchair sitting next to the recliner. The catheter bag was observed in contact with the floor. During a random observation, on 7/22/24 at 10:39 a.m., the resident was observed sitting on the side of his bed. The bed was in a very low position. A tub barrier, used to hold the catheter bag while the bed was in a low position, was flipped upside down and the catheter tubing was observed in contact with the floor. Resident 36's record was reviewed on 7/18/24 at 9:58 a.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), unspecified hydronephrosis (a condition where one or both kidneys become stretched and swollen as the result of a build-up of urine inside them), retention of urine, and urinary tract infection (UTI). An admission Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident had no cognitive deficit, required extensive assistance of two plus with transfers and toileting, and had an indwelling urinary catheter. A care plan, dated 6/25/24, and revised 7/5/24, indicated the resident had obstructive uropathy and had a catheter. Intervention included, but were not limited to, observed for signs and symptoms of infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 7/9/24, with a stop date of 7/12 24, indicated to administer one amoxicillin-potassium clavulanate (a drug used to treat bacterial infections), 875-125 milligrams (mg) tablet, every 12 hours for urinary tract infection (UTI). During an interview, on 7/18/24 at 10:55 a.m., the resident indicated he was aware that he had been taking an antibiotic for a UTI. They had given him a new catheter, a week or so ago, because he had a UTI. He had only taken the antibiotic for 3 days or so and it ended about a week ago. During an interview, on 7/18/24 at 2:31 p.m., the ADON indicated catheter bags and the tubing should never be in contact with the floor. On 7/18/24 at 9:40 a.m., the Regional Nurse Consultant provided a document, with a revision date of 1/2020, titled Urinary Drainage Bag Maintenance, and indicated it was the policy currently being used by the facility. The policy indicated, .Rule: .Urinary drainage bag should not be allowed to touch the floor. Use the following procedure to secure the drainage bag: .2. Explain to the resident the following: .Do not allow the urinary drainage bag or tubing to touch the floor 3.1-41(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48226 Based on observations and interview, the facility failed to ensure medication were labeled and stored properly for 2 of 2 medication carts and 1 of 2 medication treatment carts reviewed for medication storage (Residents 72, 63 and 5). Findings include: On 7/18/24 at 11:00 a.m., during a medication cart observation. Lantus insulin pen (an injection device that you can use to deliver preloaded insulin into your subcutaneous tissue, the innermost layer of skin in your body) with the name of Resident 72 written on the side of the pen was observed. A pharmacy prescription label was not on the pen and there was no indication of when the insulin pen had been opened. Resident 72's Lantus insulin vial (a small glass bottle, used to store medication in the form of liquids) prescription label did not indicate the date it was opened. Resident 63's Lantus insulin pen pharmacy prescription label indicated the dispense date was 5/30/24. The label did not indicate the date it was opened. Resident 5's Novolog insulin pen prescription label indicated the dispense date was 5/1/24. The prescription label did not indicate the date it was opened. Resident 5's Aspart insulin pen prescription label indicated it was dispensed on 2/4/24. The label did not indicate the date it was opened. On 7/18/24 at 11:05 a.m., during an interview with Licensed Practical Nurse (LPN) 4, the nurse indicated every insulin vial and insulin pen should be dated when opened and be discarded after 16 to 30 days. On 7/19/14 at 9:35 a.m., during initial observation of north back hall treatment medication cart. Numerous prescribed ointments and topical medications were loose in the drawer, no medications were bagged, and several medications had no prescription labels. On 7/19/24 at 11:00 a.m., during an interview with the Assistant Director of Nursing, she indicated the treatment medications should be separated in individual bags in the treatment carts. On 7/18/2024 at 2:20 p.m., the Regional Nurse Consultant provided a document, titled Medication storage, Storing Drugs, dated 12/2017, and indicated it was the policy currently being used by the facility. The policy indicated, Procedures . 1.Each drug must be kept and stored in the labeled dispensing container .12. All drug storage areas must be clean, well lit, and free of clutter at all times (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/2024 at 2:00 p.m., the Regional Nurse Consultant provided a document, titled, Medication Expiration, dated 9/2017, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure .1 . d. Multiple dose injections, such as insulin will expire 28 days after opening unless otherwise noted by manufacturer .2. Facility staff shall date the label of any multiuse vial when the vial is first accessed . 3.1-25(j)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34525 Based on record review and interview, the facility failed to ensure medications administered to a resident had been documented for 1 of 5 residents reviewed for unnecessary medication (Resident 39). Findings include: Resident 39's record was reviewed on 7/17/24 at 2:32 p.m. The profile indicated the resident's diagnoses included, but were not limited to, overactive bladder (causes sudden urges to urinate that may be hard to control), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), anxiety disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), and hyperlipidemia (elevated fats in the blood). A physician's order, dated 11/1/23, indicated to administer 1 tablet of oxybutynin chloride (used to treat symptoms of overactive bladder) 5 milligrams (mg) twice daily. The July 2024 Medication Administration Record (MAR) lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician's order, dated 12/28/23, indicated to administer 1 tablet of galantamine (used to treat the symptoms of Alzheimer's disease [a type of dementia]), 4 mg two times daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician's order, dated 1/24/24, indicated to administer 1 tablet of lorazepam (used to treat anxiety) 0.5 mg one time daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician order, dated 2/29/24, indicated to administer 1 tablet of atorvastatin (drug to lower the amount of fats in the blood) 20 mg once daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician's order, dated 6/26/24, indicated to administer 1 tablet of memantine (used to treat dementia) 10 mg two times daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. During an interview, on 7/18/24 at 1:45 p.m., the Regional Clinical Nurse indicated the expectation was that nurses would document the administered of a medication when the drug was administered. On 7/18/24 at 2:00 p.m., the Regional Nurse Consultant provided a document, with a revision date of 4/2017, titled, Medication Administration, and indicated it was the policy currently being used by the facility. The policy indicated, .Guidelines for Medication Administration .21. Always record the dose of the medication on the MAR after the resident consumption 3.1-48(c)(2)