STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Recertification and State Licensure Survey. Survey dates: June 8, 9, 10,11, 12 and 15, 2015. Facility number: 000274 Provider number: 155810 AIM number: 100271660 Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 2 Medicaid: 75 Total: 77 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1	F 0000	This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law. Plan of Compliance is effective: July 15, 2015	
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify the physician of a change in condition for 1 of 14 reviewed for significant changes. (Resident #10) Findings include: The clinical record for Resident #10 was reviewed on 6/10/15 at 1:57 p.m. The resident had diagnoses which included,	F 0157	**F 157 Notification of Changes** **Corrective action for residents identified:** Resident #10 was reassessed and physician notified of the previous low	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	but were not limited to, infantile cerebral palsy, dysphagia, quadriplegic, aphasia, convulsions, and intellectual disabilities. The review of nurse's notes for Resident #10 indicated, on 6/5/15 at 4:04 a.m., his blood pressure was 88/55. The nurse's note indicated "Pt's [Patient's] B/P [blood pressure] running low at this time..." No physician notification of the low blood pressure was indicated. A current care plan titled "Cognitive Loss/Dementia" for Resident #10 indicated "...keep my family and physician notified of any changes in my condition..." The clinical record lacked documentation of physician notification regarding the resident's low blood pressure on 6/5/15. It also indicated Resident #10's systolic blood pressure normally ran between the110's to 120's. The Director of Nursing was interviewed on 6/10/15 at 4:01 p.m. She indicated no physician notification of Resident #10's low blood pressure had been done on 6/5/15. She indicated the blood pressure was out of the resident's normal range. A current facility policy titled "Notification of Changes", dated		blood pressure reading. **Identification of others at risk:** All residents have the potential to be affected. Review of nurse notes for changes of condition for the past seven days reveal no areas of concerns. **Measures to ensure this deficient practice does not recur:** The nursing staff were re-educated on change of condition and notification of physician. Residents will be reviewed during morning meeting, verbal report and with 24 hour report to assist with ensuring notification of physician with change in condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9/10/2013, provided by the Nurse Consultant on 6/10/15 at 3:57p.m., indicated the following: "Purpose: Communicate to the resident, physician and resident's legal representative or interested family member when change in condition occurs. Notification occurs when: ...A significant change in the residents physical [,] mental or psychosocial status... ...A need to alter treatment significantly (need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)... ...A decision to transfer or discharge the resident from the facility.... Procedure: 1. Assess resident's change in condition: vital signs, mental status, functional status... 2. Notify the physician of condition change. ...4. Document symptoms, assessment, treatment, notifications, etc...."		**Monitoring of corrective action:** The Director Of Nursing (DON) or designee will conduct a records audit on 5 residents, 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, 2 time weekly for 4 weeks and then 1 time weekly for 6 months to ensure all residents with significant changes in condition have been assessed and physician notified. The results of the audits will be reviewed during the morning managers meeting. These audits will be ongoing with the results reported and further recommendations given as indicated through the Quality Assurance Committee (QAC) monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155810		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.5-1(a)(2)			
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to utilize restraints for only medical symptoms for 3 of 3 residents reviewed for restraints. (Resident #21, 2, 84) Findings Include: 1. On 6/9/15 at 2:22 p.m., Resident #21 was seated in his wheelchair in his room. A seatbelt was secured across his lap and a lap tray was secured to his wheelchair. There were no items on the tray. On 6/11/15 at 10:28 a.m., Resident #21 was seated in his wheelchair in the main dining room in front of the TV. A seatbelt was secured across his lap and a lap tray was secured to his wheelchair. There were no items on the tray. On 6/15/2015 at 8:20 a.m., Resident #21 was seated in his wheelchair in his room.	F 0221	**F 221 Restraints** **Corrective action for affected resident**: Residents # 2, #21, #84 were reassessed to ensure devices remain necessary. In addition, care plans, physician orders and informed consents were reviewed and updated if needed. **Identification of others at risk**: All residents with positioning devices have the potential to be affected. Current residents with these devices will be	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A seatbelt was secured across his lap and a lap tray was secured to his wheelchair. There were no items on the tray. Resident #21's clinical record was reviewed on 6/12/15 at 9:10 a.m. Resident #21's diagnoses included, but were not limited to, cerebral palsy, quadriplegia, profound intellectual disabilities, and aphasia. There was a current physician's order for a manual adapted wheelchair with seat belt to promote proper body positioning/alignment. There were no physician's orders for use of a lap tray. Resident #21 had a current, 4/7/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident rarely or never understood others, was sometimes understood by others, made poor daily decisions, and was totally dependent on staff for transfers and locomotion. Resident #21 had current, 4/6/15, "Physical Device Evaluations", which indicated the seatbelt and lap tray were required for a history of falls and quadriplegia. The evaluation indicated the resident could not utilize the device, nor remove it upon command. Resident #21 had a current, 4/2/15, care		assessed to ensure interventions remain appropriate. Care plans, physician orders and informed consents will be updated. **Measures to ensure this deficient practice does not recur:** Staff education regarding positioning device assessments, physician orders, informed consents and appropriate interventions CNA assignment sheets reviewed to ensure devices are listed appropriately. Residents with devices will be reviewed upon admission, quarterly and annually to ensure the devices are appropriate and all informed consents, care plans and physician orders have been obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan problem/need regarding a risk for falls. Approaches to this problem included, but were not limited to, applying a seatbelt and a lap tray with side wings when in a chair. An interview, on 6/15/15 at 12:50 p.m., was conducted with the Director of Nursing and MDS Coordinator. It was indicated Resident #21 used the seatbelt due to his tendency to scoot forward in his chair. They both indicated the lap tray was used for positioning. During an interview on 6/15/15 at 12:55 p.m., the Activities Director indicated Resident #21's lap tray was used as a positioning device and not for activities. 2. On 6/9/15 at 2:43 p.m., Resident #84 was seated in his wheelchair in his room. A shoulder harness was secured across his chest and a seatbelt was secured across his lap. On 6/10/15 at 11:39 a.m., Resident #84 was seated in his wheelchair in his room. A shoulder harness was secured across his chest and a seatbelt was secured across his lap. On 6/12/15 at 10:06 a.m., Resident #84 was seated in his wheelchair in his room. A shoulder harness was secured across		**Monitoring of corrective action:** The licensed nurses and manager's will monitor/observe residents to ensure the plan of care is being followed. An audit tool will be completed with the monitoring rounds 5 times a week for 1 month, 3 times weekly for 1 month, 2 times weekly for 1 month and monthly thereafter for 6 months. Audits will be ongoing with the results reported and further recommendations given as indicated through the Quality Assurance Committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	his chest and a seatbelt was secured across his lap. On 6/15/15 at 9:17 a.m., Resident #84 was seated in his wheelchair in his room. A shoulder harness was secured across his chest and a seatbelt was secured across his lap. Resident #84's clinical record was reviewed on 6/10/15 at 10:41 a.m. Resident #84's diagnoses included, but were not limited to, cerebral palsy, profound intellectual disability, and epilepsy. There were no physician's orders for use of a shoulder harness or seatbelt while in the wheelchair. Resident #84 had a current, 5/13/15, quarterly, MDS assessment which indicated the resident rarely or never understood others, rarely or never made daily decisions, and was totally dependent on staff for transfers and locomotion. Resident #84 had current, 3/16/15, "Physical Device Evaluations", which indicated the shoulder harness and seatbelt were required for cerebral palsy, seizures, contractures, and mental retardation. The evaluation indicated the resident could not utilize the device, nor remove the device on command.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #84 had a current, 3/16/15, care plan problem/need regarding a risk for falls. The approaches included, but were not limited to, applying seatbelt when in chair for proper hip positioning. During an interview on 6/15/15 at 12:52 p.m., the DON and MDS Coordinator indicated Resident #84 required a shoulder harness and seatbelt for positioning due to spasticity and for safety. 3. On 6/10/2015 at 11:25 a.m., Resident #2 was observed in the main dining room sitting in her wheel chair with a seat belt fastened across her abdomen. On 6/10/2015 at 1:14 p.m., Resident #2 was observed in her room sitting in her wheel chair with a seat belt fastened across her abdomen. She was moving her arms and feet around, the TV was on but the resident was not watching it. On 6/10/2015 at 3:55 p.m., Resident #2 was observed in her room sitting in her wheel chair with a seat belt fastened across her abdomen. On 6/11/2015 at 10:34 a.m., Resident #2 was observed in her room sitting in her wheel chair with a seat belt fastened across her abdomen.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During a 6/10/2015, 4:07 p.m., interview, the Director of Nursing (DON) indicated direct care staff released the positioning enabler every 2 hours and as needed. The DON indicated staff used a 1 finger looseness to check the tightness of the positioning enabler. During a 6/10/2015, 4:13 p.m., interview, Certified Nurse Aide (CNA) #1 indicated the CNA's did bed checks every two hours and document in the group # ADL's book. During a 6/11/2015, at 10:36 a.m., interview, CNA #2 indicated the buckle seat belt was used to keep the resident from falling out of her chair. CNA #2 indicated the CNA's removed the seat belt every 2 hours to lay the resident down to change her incontinence briefs. Resident #2's clinical record was reviewed on 6/10/2015 at 3:00 p.m. The resident's current diagnoses included but were not limited to, mental retardation, cerebral palsy, dysphagia, convulsions, constipation, gastrostomy, profound intellectual disabilities. Resident #2 had a current, 4/14/15, Minimum Data Set assessment which indicated the resident was rarely or never			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	understood and was totally dependent on staff for all mobility and activities of daily living. There was no indication for use of restraints. The "PHYSICAL DEVICE EVALUATION SHEET", dated 1/20/15, indicated the seat belt was used as a positioning device, to help with upper body alignment and fall precautions. The device was to be used while the resident was in her wheel chair and removed every two hours and prn (as needed). The resident was unable to bear weight or transfer self with or without seatbelt. No further updates or quarterly reviews noted. The care plan, dated 5/14/15, indicated Resident #2 had limited independent mobility and used an adapted wheel chair with a seat belt, as recommended by professional evaluation. A goal, target dated for 7/8/15, indicated the resident was to be in the least restrictive device and would be evaluated at least quarterly for any changes needed. The approach, start date of 1/2/15, indicated "...use a set belt to assist...with proper hip position. Release this when I am being checked and changed and as needed for care." Resident was unable to verbalize wants and needs to be checked every two hours for incontinent needs.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155810		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current facility policy titled "Restraints", provided by the DON on 612/15 at 2:25 p.m., indicated the following: "Purpose: Guide the appropriate and safe management of residents who may utilize restraints. Restraint use should be limited to circumstances in which the resident has medical symptoms that warrant use. ...4. Medical symptoms that warrant the use of restraints should be documented in the residents medical record, ongoing assessment and care plans..." 3.1-26(o)			
F 0241 SS=E Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. A. Based on observation and interview, the facility failed to provide care for residents in a dignified manner for 2 of 14 residents reviewed. (Resident #10 and #37)	F 0241	**F 241 Dignity** **Corrective action for affected**	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B. Based on observation, record review and interview, the facility failed to serve and feed 14 of 37 residents eating in the main dining room in a dignified manner. Findings include: A1. The clinical record for Resident #10 was reviewed on 6/10/15 at 1:57 p.m. The resident had diagnoses which included, but were not limited to, infantile cerebral palsy, dysphagia, quadriplegic, aphasia, convulsions, and intellectual disabilities. During an observation of Resident #10 on 6/8/15 at 2:36 p.m., the resident was in bed and had brown/white dried debris on his lower lip. During an observation of Resident #10 on 6/10/15 at 11:45 a.m., the resident was observed in the hallway with a thin line of dried white debris across the bottom of his lower lip. Agency nurse #13 was observed talking directly to the resident at that time. During an interview with LPN #8 on 6/10/15 at 1:15 p.m., she indicated Resident #10 was with activity staff at Wal-Mart.		**resident**: Residents #10, #12, #36, #37,#43, #61, #69, were assessed by nursing staff and no adverse effects noted. **Identification of others at risk**: All residents have the potential to be effected. Review of the nurses notes for the past 7 days reveal no change in conditions noted **Measures to ensure this deficient practice does not recur:** Staff were educated on treating all residents with dignity and respect. Specific education with staff regarding dignified interaction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation of Resident #10 on 6/10/15 at 3:13 p.m., he was observed in his power wheelchair between the 300 hall nurse's station and the main dining room. The resident had a thin line of dried white debris across the bottom of his lower lip. CNA #14 was observed talking directly to the resident at that time. A moment later, CNA #6 was observed talking directly to the resident at that time. During an observation of Resident #10 on 6/10/15 at 3:25 p.m., the resident was observed in the hallway with a thin line of dried white debris across the bottom of his lower lip. Agency nurse #13 was observed talking directly to the resident at that time. A few minutes later, Agency nurse #13 was observed seated at the nurse's station without having provided any care to Resident # 10. During an observation of Resident #10 on 6/10/15 at 3:47 p.m., the resident was observed by the main dining room with a thin line of dried white debris across the bottom of his lower lip. The Social Service Assistant was observed talking directly to the resident at that time. During an observation on 6/10/15 at 4:58 p.m. with the Director of Nursing present, the resident was observed in the		with residents during care and mealtimes. **Monitoring of corrective action:** During mealtimes and manager rounds the licensed nurses and managers will ensure that dignity is maintained for all residents. If an area of concern is noted, the manager will immediately intervene to re-educate the appropriate staff member. Audits of mealtimes and rounds will be conducted by department managers 5 times a week for 4 weeks, 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, then monthly thereafter for 6 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assisted dining room with dried white debris in the corners of his mouth. During an interview with the Administrator on 6/10/15 at 5:20 p.m., she indicated she had observed a thin line of dried white debris across the bottom of Resident #10's lower lip and had wiped it off prior to the observation at 4:58 p.m. The Administrator indicated she did not realize the debris had been on the bottom of the resident's lower lip all day. A. 2. On 6/10/15 at 10:35 a.m., Resident #37 was seated in his wheelchair in his room. Resident #37's mouth was open, with his tongue protruding, and saliva running from the left side of his mouth. On 6/10/15 at 11:41 a.m., Resident #37 was seated in his wheelchair in his room. Resident #37's mouth was open, with his tongue protruding, and saliva continued to run from the left side of his mouth to his chin. On 6/10/15 at 1:17 p.m., Resident #37 was seated in his wheelchair in his room. Resident #37's mouth was open, with his tongue protruding, and white, frothy saliva running from the left side of his mouth and chin, and onto his shirt. A white bath towel was placed across his chest from his left shoulder to his right		Assurance Committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hip. On 6/10/15 at 2:23 p.m., Resident #37 was seated in his wheelchair in his room. Resident #37's mouth was open, his tongue protruding, and white, frothy saliva continued to run from the left side of his mouth to his chin and onto his shirt. The white bath towel was on the floor next to his wheelchair. On 6/10/15 at 3:10 p.m., Resident #37 was seated in his wheelchair in his room. Resident #37's mouth was open, his tongue protruding, and white, frothy saliva continued to run from the left side of his mouth to this chin and onto his shirt and left shirt sleeve. White, chalky film was observed on the right side of resident's mouth. Resident #37's clinical record was reviewed on 6/10/15 at 11:50 a.m. Resident #37's diagnoses included, but were not limited to, cerebral palsy, quadriplegia, epilepsy, severe intellectual disabilities, and expressive language disorder. Resident #37 had a current, 4/28/15, annual Minimum Data Set (MDS) assessment which indicated: the resident was rarely or never understood and totally dependent on staff for personal			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hygiene. During an interview, on 6/11/15 at 10:51 a.m., LPN #7 indicated Resident #37 required oral care four times daily by a nurse and as needed by a CNA. LPN #7 indicated residents were checked on by staff at least every 2 hours. B. 1. During a dining observation on 6/11/15 at 11:38 a.m., CNA #11 was observed talking over residents to CNA #2, who was across the dining room and assisting to feed another resident. CNA #11 indicated to CNA #2 it was her day off and her bed was calling her name. During a dining observation on 6/11/15 at 11:50 a.m., CNA #3 was observed not interacting with the resident she assisted to feed. She offered a bite of food to the resident and then continued to look away from the resident until the next bite of food was offered. B. 2. During the dining observation on 6/08/15 at 11:13 a.m. in the main dining room, the following was observed: Resident #69 was observed to have pureed food running from his mouth to his chin and onto his clothing protector while LPN #9 was assisting in feeding him. RN #12 approached LPN #9 while she was still assisting Resident #69 and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	placed a vial of insulin into her hand. RN #12 and LPN #9 discussed a date issue with the medication while LPN #9 then continued to offer bites of food to Resident #69. Resident #69 continued to have pureed food on his mouth and chin. LPN #9 wiped Resident #69's face with a napkin at the end of his meal. During the dining observation on 6/11/15 at 11:36 a.m., LPN #8 was observed feeding Resident #12 while standing in front of his wheelchair. B3. During a dining observation on 6/08/2015 at 12:13 p.m., CNA #2 did not interact with Resident #43 while she assisted the resident to eat. During a dining observation on 6/11/2015 at 11:19 a.m., CNA #3 did not wipe Resident 36's face when food rolled out onto her chin. The food stayed on the resident's face for at least three more bites before CNA #3 wiped the resident's face. CNA #3 did not interact with the resident while she assisted the resident to eat. During a dining observation on 6/11/2015 at 11:26 a.m., CNA #4 did not interact with Resident #61 while she assisted the resident to eat. During the meal CNA #4 talked to other staff.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155810		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During a dining observation on 6/11/2015 at 11:38 a.m., CNA #4 did not wipe Resident #61's face when food stuck to both corners of the resident's mouth and chin. CNA #4 did not interact with the resident while she assisted the resident to eat. During a dining observation on 6/11/2015 at 11:46 a.m., LPN #8 did not wipe Resident #12's face when red liquid rolled down the resident's chin. The liquid stayed on his face for several more bites before being wiped off. LPN #8 did not interact with the resident while she assisted the resident to eat. LPN #8 was talking to other staff. Review of a policy, "Resident's Right Training", obtained from the Administrator on 6/15/15 at 2:13 p.m., indicated the following: "...Every resident has the right to be treated with consideration, respect, and with full recognition of his/her dignity and individuality...." 3.1-3(t)			
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide activities in the resident's room according to his care plan for 1 of 2 residents reviewed for activity needs (Resident #37). Findings Include: On 6/10/15 at 10:34 a.m., Resident #37 was seated in his wheelchair in his room. The resident's eyes were closed. The room was quiet with the exception of a roommate's TV with the sound low. On 6/10/15 at 11:41 a.m., Resident #37 was seated in his wheelchair in his room in the same location. The resident's eyes were closed. The room was quiet. On 6/10/15 at 1:17 p.m., Resident #37 was seated in his wheelchair in his room in the same location. The resident was awake. The room was quiet. On 6/10/15 at 2:23 p.m., Resident #37 was seated in his wheelchair in his room in the same location. The resident was awake. The room was quiet	F 0248	**F 248 Activities** **Corrective action for affected resident**: Activity preferences reviewd for Resident #37 and careplan updated **Identification of others at risk**: Activity preferences for all residents reviewed and care plan updated if needed **Measures to ensure this deficient practice does not recur:** Staff re-educated on honoring all resident choices and	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/11/15 at 10:25 a.m., Resident #37 was in bed with the curtain pulled around his bed. The resident was awake. The room was quiet. On 6/11/15 at 1:12 p.m., Resident #37 was seated in his wheelchair in his room. The resident was awake. The room was quiet. On 6/11/15 at 12:12 p.m., Resident #37 was seated in his wheelchair in his room. The resident was awake. The room was quiet with the exception of a roommate's TV. On 6/12/15 at 8:22 a.m., Resident #37 was in bed with the curtain pulled around his bed. The resident was awake. The room was quiet. On 6/12/15 at 10:08 a.m., Resident #37 was in bed with the curtain pulled around his bed. The resident was awake. The room was quiet. On 6/15/15 at 8:23 a.m., Resident #37 was in bed with curtain closed around bed. The resident was dressed and awake. The room was quiet. Resident #37's clinical record was reviewed on 6/10/15 at 11:50 a.m. Resident #37's diagnoses included, but		activity preferences **Monitoring of corrective action:** Activity in individual rooms and groups will be monitored during manager rounds by department managers 5 times a week for 8 weeks, then monthly thereafter for 6 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to, cerebral palsy, quadriplegia, epilepsy, severe intellectual disabilities, and expressive language disorder. Current physician's orders indicated the resident might participate in activities and recreational programs. Resident #37 had a current, 4/28/15, annual Minimum Data Set (MDS) assessment which indicated: the resident was rarely or never understood and totally dependent on staff for locomotion on and off the unit. Resident #37 had a current, 4/21/15, "Activities Assessment" which indicated the resident could not verbalize his needs and preferences, enjoyed being read aloud to, indicated an interest in a variety of music, and he was interactive with movement and sound nearby. Resident #37 had a current, 4/23/15, care plan problem/need regarding activities involvement. Approaches to this problem included, but were not limited to, using his CD player to play music or a recorded story made by his family. During an interview, on 6/11/15 at 12:12 a.m., CNA #6 indicated she was not aware of any activities enjoyed by Resident #37.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 6/11/15 at 3:40 p.m., CNA #5 indicated she was not aware of any activities enjoyed by Resident #37. During an interview, on 6/1/15 at 9:50 a.m., the Activities Director indicated music or a recorded story should be playing for Resident #37 while he was in his room per his plan of care. 3.1-33(a)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to assess a change of condition related to a low blood pressure for 1 of 14 residents reviewed. (Resident #10). Findings include: The clinical record for Resident #10 was reviewed on 6/10/15 at 1:57 p.m. The resident had diagnoses which included,	F 0309	**F309 Assessments** **Corrective action for affected resident**: Resident #10 was reassessed. His physician was notified of the low blood pressure.	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	but were not limited to, infantile cerebral palsy, dysphagia, quadriplegic, aphasia, convulsions, and intellectual disabilities. The review of nurses' notes for Resident #10 indicated on 6/5/15 at 4:04 a.m., his blood pressure was 88/55. The nurse's note indicated "Pt's [Patient's] B/P [blood pressure] running low at this time...." No recheck of the low blood pressure was indicated. The clinical record lacked documentation of a recheck regarding the Resident's low blood pressure on 6/5/15. It also indicated Resident #10's systolic blood pressure normally ran between 110's to 120's. The Director of Nursing was interviewed on 6/10/15 at 4:01 p.m., she indicated no recheck of Resident #10's low blood pressure had been done on 6/5/15. She indicated the blood pressure was out of the resident's normal range of 110's to 120's. A current facility policy titled "Notification of Changes", dated 9/10/2013, provided by the Nurse Consultant on 6/10/15 at 3:57p.m., indicated the following: "Procedure:		**Identification of others at risk**: All residents have the potential to be affected. Review of nurse notes for the past seven days reveal no areas of concerns. **Measures to ensure this deficient practice does not recur:** Licensed nurses have been in-serviced on notifying physicians when an assessment indicates a possible change of condition. 24 hour reports, physician orders and verbal reports will be reviewed during morning clinical meetings to ensure appropriate assessment, documentation, physician notification and follow up have occurred. **Monitoring of corrective action:** The Director of Nursing (DON) or designee will conduct a records audit on 5 residents 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Assess resident's change in condition: vital signs, mental status, functional status... ...4. Document symptoms, assessment, treatment, notifications, etc... 5. Follow up nursing assessments continue until condition has stabilized...." 3.1-37(a)		time weekly for 3 months, and then 1 time monthly for 3 months to ensure appropriate assessment, documentation, physician notification and follow up. The results of the audits will be reviewed during morning clinical meeting. Results of these audits will be forwarded to the Quality Assurance Committee monthly for recommendations.	
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to maintain range of motion for 1 of 3 residents reviewed related to the use of splints. (Resident #37) Findings Include: On 6/9/15 at 2:46 p.m., Resident #37 was seated in his wheelchair in his room. Resident #37's bilateral hands were positioned into fists with his thumbs inside the fist. No splints were present on his hands.	F 0318	**F 318 ROM** **Corrective action for affected resident**: Care plan reviewed and updated for Residents #37 to reflect current resident status.	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/10/15 at 10:35 a.m., Resident #37 was seated in his wheelchair in his room. No splints were present on his hands. On 6/10/15 at 1:17 p.m., Resident #37 was seated in his wheelchair in his room. No splints were present on his hands. On 6/11/15 at 11:24 a.m., Resident #37 was seated in his wheelchair in his room. No splints were present on his hands. On 6/11/15 at 3:40 p.m., Resident #37 was seated in his wheelchair in his room. No splints were present on his hands. Resident #37's clinical record was reviewed on 6/10/15 at 11:50 a.m. Resident #37's diagnoses included, but were not limited to, cerebral palsy, quadriplegia, epilepsy, severe intellectual disabilities, and expressive language disorder. Current physician's orders indicated bilateral thumb splints were to be applied every morning and to be removed every evening. Resident #37 had a current, 4/28/15, annual Minimum Data Set (MDS) assessment which indicated the resident had functional limitations of range of		**Identification of others at risk**: All residents have the potential to be affected by decreased range of motion. In addition to observations, care plans and physician orders were reviewed to ensure residents with limited range of motion receive appropriate services. **Measures to ensure this deficient practice does not recur:** Assessments, care plans, physician orders, restorative nursing programs and CNA assignment sheets reviewed and updated to reflect the current splinting devices for each resident. Nursing staff will be re-educated on the use of splinting devices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155810		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	motion to his bilateral upper extremities. Resident #37 had a current, 4/23/15, care plan problem/need regarding limited mobility. Approaches to this problem included, but were not limited to, application of bilateral thumb splints per therapy recommendation. During an interview, on 6/11/15 at 12:12 p.m., CNA #6 indicated Resident #37 should have thumb splints applied as described on the CNA assignment sheet. During an interview, on 6/11/15 at 3:40 p.m., CNA #5 indicated she removed Resident #37's thumb splints in the evenings if he was wearing them, but did not apply them if they were not on his hands. CNA #5 looked for Resident #37's thumb splints and indicated the splints were not in the resident's room. 3.1-42(a)(2)		**Monitoring of corrective action:** The MDS coordinator or designee will review restorative documentation for five residents five times a week for 4 weeks, then three times a week for 4 weeks, then two times a week for 4 weeks then monthly on an ongoing basis for 6 months. The results from the restorative audits will be discussed in the daily clinical meeting and during the monthly Quality Assurance Committee.	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, record review and interview, the facility failed to serve and prepare food in a sanitary manner for 37 of 77 residents who ate food served from the kitchen. Findings Include: 1. On 6/11/15 at 3:58 p.m., the Certified Dietary Manager (CDM) was observed in the facility kitchen without a hairnet or protective covering to her head. The CDM indicated a hairnet was in her pocket. The CDM then applied the hairnet to her head and washed her hands at the sink for 7 seconds before touching the food preparation table. 2. During dining observation on 6/08/15 at 11:13 a.m. in the main dining room, the following was observed: RN #12 approached LPN #9 while she was still assisting in feeding a resident and placed a vial of insulin into her left hand. LPN #9 placed the vial in her right hand while she read the vial, returned it to RN #12, then continued to offer bites of food to the resident. Following hand washing, CNA #10 applied a glove to her right hand after indicating she had a band aid on her thumb. She then approached a resident	F 0371	**F 371 Kitchen Sanitation** **Corrective action for affected resident:** Nurses notes reviewed for all residents and no change of condition noted related to infection control **Identification of others at risk**: All residents have potential for risk. Nurses notes reviewed for residents and no change of condition noted related to insufficient infection control practices **Measures to ensure this deficient** **practice does not recur:** Staff re-educated on wearing hair nets at all times in the	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and began to set his tray up. CNA #10 picked up a clothing protector from the floor and placed it in the soiled linen cart. She then proceeded to use hand sanitizer while wearing a contaminated glove on her right hand. CNA #10 then began feeding the resident with the contaminated gloved hand. CNA #11 washed her hands for 8 seconds, and then began to assist with feeding a resident. CNA #2 washed her hands for 12 seconds, and then took over with assisting a resident. CNA #2 then washed her hands for 9 seconds, and then assisted with feeding a resident. CNA #2 then washed her hands for 8 seconds, and then assisted with feeding a resident. During a dining observation on 6/11/2015 at 11:26 a.m.,CNA #4 washed her hands for 10 seconds, then fed Resident #61 her lunch. During a dining observation on 6/11/2015 at 11:30 a.m., the Dietary Manager (DM) washed her hands for 7 seconds, then donned gloves and peeled a banana		kitchen and proper hand washing procedures **Monitoring of corrective action:** The Director of Nursing (DON) or designee will observe 3 staff hand washing return demonstration 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, 1 time weekly for 3 months, and then 1 time monthly for 3 months The Executive Director (ED) or designee will observe dietary staff for appropriate infection control practices include, hand washing hairnets, with dietary staff 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, 1 time weekly for 4 weeks and then monthly for 6 months The results of the audits will be reviewed during morning clinical meeting and forwarded to the Quality Assurance Committee monthly for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155810		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON MANOR CHILDRENS HOME	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for Resident #6. A facility document "Hand Hygiene" was given on 6/15/15 at 1:32 p.m., by DON page 169 implementation step 3 g "...Perform hand hygiene using plenty of lather and friction for at least 15 to 20 seconds..." 3.1-21(i)(2)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to prevent the spread of infections regarding 1 of 3 direct care observations and linen handling in the laundry (Resident #6 and #37). Findings include: 1. The clinical for Resident #6 was reviewed on 6/11/15 at 4:50 p.m., who had diagnoses which included, but were not limited intellectual disabilities, dysphagia, gastrostomy. During an observation of Resident #6 on 06/11/2015 at 5:10 p.m., the resident was lying in bed receiving a tube feeding. LPN #7 bent down to check the position of the bed and placed her right gloved hand on the floor. After standing, she pushed her hair back with the same gloved hand. Without taking off her gloves and	F 0441	**F 441 Infection Control** **Corrective action for affected resident**: Resident #6, #37 was assessed with no signs or symptoms of infection noted. **Identification of others at risk**: Current residents were observed with no findings. **Measures to ensure this deficient practice does not**	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	washing her hands, LPN #7 reached for Resident #6's gastrostomy tube to disconnect it. During an interview on 6/11/2015 at 5:15 p.m., LPN #7 indicated she had placed her hand on the floor prior reaching to disconnect the gastrostomy tube. 2. During an observation of linen handling, on 6/10/15 at 1:15 p.m., Laundry Aide #15 dropped a blanket on the floor while stocking the 200 Hall linen closet. She then picked up the blanket, folded it, and placed it in the linen closet. A current facility policy "INFECTION CONTROL", provided by the DON on 6/8/15 at 10:49 a.m., indicated the following: "Purpose: Provide a safe sanitary and comfortable living environment to help prevent development and transmission of infection. ...2. Infection control program includes the following: a. Prevention, surveillance and control measures to protect residents...from heath-care associated infections. ...4. Facility staff to perform hand hygiene...."		**recur:** All nursing staff was educated on infection control, specifically on hand hygiene, glove usage and hand washing procedures while providing care to residents. Return demonstrations were preformed with staff during various resident care procedures and work tasks, observing each step to ensure proper hand washing/hand hygiene and glove usage. Staff was encouraged to ask questions during the return demonstrations to ensure that the policy was understood completely. **Monitoring of corrective action:** Managers, or designees will observe hand washing techniques and glove use while staff provide resident care on 5 staff per week times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-18(l)		4 weeks, 3 staff per week times 4 weeks, 1 staff weekly times 4 weeks and monthly thereafter for 6 months. The audit results will be discussed in morning meeting and in the monthly Quality Assurance Committee meeting for further recommendations.	