

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  03/24/2015
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NAME OF PROVIDER OR SUPPLIER  VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00168216.</p> <p>Complaint IN00168216 - Substantiated. Federal/state deficiency related to the allegation is cited at F282.</p> <p>Survey dates: March 23 and 24, 2015.</p> <p>Facility number: 000274 Provider number: 155810 AIM number: 100271660</p> <p>Survey team: Shelley Reed, RN TC</p> <p>Census bed type: SNF: 77 Total: 77</p> <p>Census payor type: Medicare: 1 Medicaid: 76 Total: 77</p> <p>Sample: 5</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited.</p> <p>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.</p> <p><b>Plan of Compliance is effective:</b> April 17, 2015</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 282 SS=D Bldg. 00	<p>Quality review completed on March 25, 2015 by Randy Fry RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure the Plan of Care was followed for 1 of 1 resident's care plan reviewed for 15 minute monitoring. (Resident B)</p> <p>Findings Include:</p> <p>1. The clinical record of Resident B was reviewed on 3/23/15 at 9:00 a.m. The record indicated the resident's diagnoses included, but were not limited to: psychosis with grandiosity, anxiety, depressive disorder, dysphagia, seizure disorder and moderate intellectual disability.</p> <p>During an observation on 3/23/15 from 11:40 a.m. to 12:00 p.m. and 1:40 p.m. to 2:00 p.m., Resident B was not check on</p>	F 282	<p><b>F 282</b></p> <p><b>Corrective Actions for Resident Identified:</b></p> <p>The care plan for Resident B was reviewed</p> <p>and updated for on 3.27.15 by the Interdisciplinary team and the 15 minute checks were discontinued. The plan of care was compared to resident B to determine that all care plan interventions were implemented with no other issues</p>	04/17/2015

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	<p>by any staff member. He was in his room, asleep.</p> <p>Review of a Behavior Tracking Record dated 2/22/15, indicated Resident B hit another resident in the face. Resident B stated the other resident ran into him with his wheelchair. Resident B was redirected to his room. Both residents were assessed.</p> <p>The Care Plan, dated 2/12/15, indicated, " Behavioral Symptoms- I have had incidents of physical aggression." The care plan interventions included, one on one while awake and monitored every 15 minutes while asleep until the Interdisciplinary Team (IDT) meets in three days." The Care Plan was updated on 3/3/15 with Resident B having a problem with aggression. The intervention included 15 minute checks.</p> <p>Review of a Social Service Progress Note dated 3/3/15, indicated IDT decided to place Resident B on 15 minute checks.</p> <p>Review of the Behavior Data History Sheet indicated Resident B had 2 behaviors in January and 34 behaviors in February. The behaviors included, but were not limited to: aggression, delusions and wandering. Resident B had 1 behavior in March.</p>		<p>identified.</p> <p><b>Identification of others at risk:</b></p> <p>The Interdisciplinary team reviewed care plans and all residents to determine that care plan interventions were implemented as per the plan of care.</p> <p><b>Measures to ensure this deficient practice does not occur:</b></p> <p>Staff were re-educated on following and implementing the residents plan of care.</p> <p>The Director of Nursing or designee will audit 10 resident care plans and the resident weekly x2 months and then monthly x6 months to determine</p>	

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	<p>During an interview on 3/23/15 at 8:30 a.m., CNA #1 indicated Resident B was still on 15 minute checks. She stated CNA's were supposed to document every 15 minutes and the nurses were supposed to document every 1 hour.</p> <p>During an interview on 3/24/15 at 9:33 a.m., LPN #2 stated Resident B was on 1:1 checks, then every 15 minutes and then every 1 hour. He had not been on any other monitoring since then.</p> <p>During an interview on 3/24/15 at 11:25 a.m., the Director of Nursing (DON) was asked to provide the 15 minute monitoring sheets for Resident B. Several sheets were pulled from an accordion file in no certain order. The initial sheet was date 2/22/15 with one on one monitoring until the resident was discharged to the hospital. Resident B returned on 2/23/15 and 15 minute monitoring was started. She stated she was not sure if the resident was still on every 15 minute monitoring.</p> <p>She was asked to provide the 15 minute monitoring sheets from 3/24/15. The nurse for Resident B was questioned by the DON as to what CNA had Resident B. The nurse indicted CNA #3 was assigned to Resident B, but she had</p>		<p>that care plan interventions are implemented accordingly.</p> <p><b>Monitoring of Corrective Actions:</b></p> <p>Results of the care plan/resident and behavior audits will be ongoing with the results reported through the Quality Assurance Committee monthly for further review and recommendation.</p> <p><b>Compliance Date:</b> April 17, 2015</p>	

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	<p>already left for the day. The DON called CNA #3 at home to ask if she had filled out the sheet from earlier. Per the DON, the CNA indicated she was not aware Resident B was still on 15 minute checks and she did not fill out the monitoring sheet.</p> <p>The DON was asked who was auditing the monitoring for Resident B and she stated "I need to get organized and I should have been monitoring that it was done."</p> <p>Review of the Daily 15 Minute Check sheets indicated monitoring started on 2/22/15 at 6:00 p.m. until 3/6/15 at 6:00 a.m. The daily 15 minute checks were re-started on 3/23/15 at 9:15 a.m. until 3/23/15 at 10:00 p.m. One on one monitoring was noted on 2/24/15 thru 2/27/15. No additional monitoring was provided.</p> <p>2. A review of the policy titled "Behavior Assessment and Management, dated 4/15/13, was provided by the DON on 3/24/15 at 12:25 p.m., and indicated the following:</p> <p><u>"Care planning of resident behaviors:</u></p> <p>Understanding the nature....Once behaviors have been assessed, the next</p>			

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	<p>step is to develop a resident-specific care plan based directly....If behaviors place the resident or others at risk for harm, immediate action is required to prevent any harm. The focus of the care plan should be to address the underlying cause or causes, reversing the daily display of troubling behaviors, and preventing any harm from occurring."</p> <p>This Federal tag is related to Complaint IN00168216.</p> <p>3.1-35(g)(2)</p>				