

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 07/29/2014
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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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F000000	<p>This visit was for the Investigation of Complaint IN00152864.</p> <p>Complaint IN00152864-Substantiated. State deficiency related to the allegations are cited at 9999.</p> <p>Survey date: July 29, 2014.</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: 85 Total: 85</p> <p>Census payor type: Medicaid: 84 Other: 1 Total: 85</p> <p>Sample: 3</p> <p>This deficiency reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute and admission or agreement by Vernon Manor Children's Home of the facts alleged or conclusions set forth in this statement of deficiencies. The facility maintains the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of correction and specific corrective actions are prepared and/or executed in compliance with the state and federal laws.</p> <p>Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance 8/12/14</p>	

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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F009999	<p>State Findings:</p> <p>The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Immediately informing the division by telephone, followed by written notice within (24)twenty-four hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents....</p> <p>This state rule was not met as evidence by:</p> <p>Based on record review and interview, the facility failed to ensure the Administrator reported an incident related to a resident (Resident B) making physical contact with another resident (Resident C) to the ISDH in accordance</p>	F009999	<p>F9999</p> <p>The administrator of this facility is responsible for and reports reportable unusual occurrences that directly threaten the welfare, safety or health of residents in accordance with the Indiana State Department of Health, Long Term Care Division's Reportable Incident Policy.</p> <p><u>Corrective action for identified resident's</u> Residents B and C were assessed and care plans updated to reflect current resident status.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u> Based on resident observations no other residents were affected. The Administrator and Director of Nursing were re-educated regarding the reporting of unusual occurrences as defined in state tag F9999 by the Director of Operations on 8/11/14.</p> <p><u>Measures to prevent recurrence:</u></p>	08/12/2014
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	<p>with state regulation and facility policy.</p> <p>Findings include:</p> <p>1). During an interview with the Director of Nursing (DoN) on 7/29/14 at 8:00 a.m., information was requested related to the last ISDH reportables since the most recent annual survey.</p> <p>The ISDH reportables were provided by the DoN and reviewed on 7/29/14 at 11:30 a.m.</p> <p>The clinical record for Resident (B) was reviewed on 7/29/14 at 10:30 a.m. Diagnoses for the resident included, but were not limited to, seizure disorder, aspiration pneumonia, mental retardation with delusional behaviors, aphasia, anxiety and Lennox-Gastaut Syndrome.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 7/8/14, indicated Resident (B) was severely cognitively impaired. Resident (B) received the following Activities of Daily Living (ADL) assistance; transfer and ambulation- independent, dressing and bathing-supervision only. Resident (B) made self understood usually and had the ability to usually understand others.</p> <p>During record review on 7/29/14 at 10:30</p>		<p>The Administrator will report unusual occurrences as defined in state tag F9999 and as outlined in the ISDH Reportable Incident Policy.</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>The administrator of this facility is responsible and will report reportable unusual occurrences that directly threaten the welfare, safety or health of residents in accordance with the Indiana State Department of Health, Long Term Care Division's Reportable Incident Policy. Resident incidents will be reviewed in the facility Morning Managers Meeting and will be reviewed through the facility Quality Assurance Committee monthly for 6 months to assure incidents involving resident harm or meeting the criteria for ISDH Reportable Incident Policy are reported appropriately.</p>				

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	<p>a.m., progress notes, dated 7/6/14 at 8:05 p.m., indicated Resident (B) was sitting at the back nurse's station without his helmet on. The nurse attempted to give Resident (B) his helmet and he then threw his helmet to the floor and stated "I don't want it and you can't make me." A CNA then came out from another room and attempted to pick up and give Resident (B) his helmet. Resident (B) picked up the helmet again and threw it across the room. Resident (B) was removed from the area. The incident was reported to the DoN and Executive Director on 7/6/14 at 8:15 p.m.</p> <p>Review of the July, 2014 mood and behavior sheets, Resident (B) had several episodes of behavior on 7/6/14 and 7/7/14. On 7/6/14, Resident (B) was observed at 8:05 p.m. and 9:20 p.m. without his helmet on. On 7/7/14, he was again observed without his helmet on. On 7/6/14 at 9:30 p.m., Resident (B) was observed opening windows. The interventions for the behaviors included, but were not limited to, do not argue with him, explain why his helmet is important and reproach after a few minutes.</p> <p>During an interview on 7/29/14 at 2:30 p.m., SSD indicated Resident (B) did have behaviors in July. She indicated she would put a care plan in place if more</p>			

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	<p>than 1 behavior occurred related to throwing his helmet or aggression.</p> <p>2). The clinical record for Resident (C) was reviewed on 7/29/14 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, infantile cerebral palsy, moderate intellectual disability, dysphagia, anemia, colostomy and retro vaginal fistula.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 6/25/14, indicated Resident (C) was severely cognitively impaired. Resident (C) was non-verbal, but able to give gestures. Resident (C) received the following Activities of Daily Living (ADL) assistance; transfer-dependent with one person assist and dressing, bathing and hygiene-extensive assistance with one person assist.</p> <p>During record review on 7/29/14 at 9:00 a.m., progress notes indicated, on 7/6/14 at 7:45 p.m., Resident (C) was seated at the nurses' station and was struck in the face with a helmet that was thrown by another resident during a behavior. A skin assessment indicated a red mark that measured 2.0 cm x 0.5 cm was noted to the left side of the nose. The DoN and Physician were notified.</p>				

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	<p>During an interview on 7/29/14 at 12:00 p.m., the DoN indicated the incident was not reported to ISDH because it was unintentional.</p> <p>During an interview on 7/29/14 at 3:35 p.m., the Administrator indicated the incident was not reported because Resident (B) did not intend on hitting Resident (C) with his helmet. She indicated the resident was mad and just threw his helmet and it hit Resident (C).</p> <p>Review of a current facility policy dated 8/8/13, titled "ABUSE, NEGLECT, AND MISAPPROPRIATION OF PROPERTY", which was provided by the Administrator on 7/29/14 at 8:40 a.m., indicated the following:</p> <p>"Purpose: Prevent abuse, neglect and misappropriation of property.</p> <p>Procedure: ...Protection: 1. All residents will be protected from harm."</p> <p>This Federal tag relates to Complaint IN00152864.</p>						