

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 01/07/2016
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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 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00190182.</p> <p>Complaint IN00190182 - Substantiated. Federal/state deficiencies related to the allegation are cited at F282 and F309.</p> <p>Survey dates: January 6 and 7, 2016.</p> <p>Facility number: 000274 Provider number: 155810 AIM number: 100271660</p> <p>Census bed type: SNF: 77 Total: 77</p> <p>Census payor type: Medicare: 3 Medicaid: 74 Total: 77</p> <p>Sample: 6</p> <p>These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on January 11, 2016.</p>	F 0000	<p>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: January 26, 2016</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 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents with physician orders for Ankle Foot Orthoses (AFO) (Resident B and C), hand splints and torso splint (Resident F), received those services as ordered by the physician and/or care plan.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 1/7/16 at 8:35 a.m. Diagnoses for the resident included, but were not limited to, quadriplegic cerebral palsy, profound intellectual disability, dysphagia, epilepsy and tracheostomy. The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/3/15, indicated Resident B was dependent on staff for transfers, dressing and eating. Resident B also had upper and lower Range of Motion (ROM) limitations.</p> <p>During an observation on 1/6/16 at 9:30</p>	F 0282	<p>F 282 Services By Qualified Persons/per care plan</p> <p>Corrective Actions for Resident Identified: DONre-educated staff on applying hand splints /torsosplints, and Ankle Foot Orthoses (AFO) for residents B, C and F and other residents, asordered by the physician and/orcare plan.</p> <p>Identification of others at risk: Residentswho require splints and AFOs havethe potential to be at risk. An auditwas conducted to ensure AFOs and splintswere applied to these residents as orderedby the physician and/or care plan.</p> <p>Measures to ensure this deficient practice does not occur: Staffwere re-educated on</p>	01/26/6016
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	<p>a.m., Resident B was in his wheelchair and was not wearing any AFO's.</p> <p>On 1/6/16 at 10:52 a.m., Resident B was observed seated in his wheelchair and he was not wearing any AFO's.</p> <p>A review of a Physician's order, dated 6/13/15, indicated the resident had an order that included, "Resident to wear AFO's in shoes daily when up in bld [building] & up in chair".</p> <p>A review of Resident B's current restorative health plan, revised December 2015, indicated: "Staff will apply bilateral AFO's in shoes daily when in the building and in chair."</p> <p>2. The clinical record for Resident C was reviewed on 1/6/16 at 3:10 p.m. Diagnoses for the resident included, but were not limited to, cerebral palsy, profound intellectual disability, dysphagia, anoxic brain injury and tracheostomy. The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/27/15, indicated Resident C was dependent on staff for transfers, dressing and eating. Resident C also had upper and lower Range of Motion (ROM) limitations.</p> <p>On 1/6/16 at 10:45 a.m., Resident C was</p>		<p>following and implementing the residents plan of care.</p> <p>Monitoring of Corrective Actions: The Director of Nursing or designee will monitor 10 residents requiring splints/AFOs or other adaptive devices weekly for 3 months and then monthly for 6 months to determine that care plan interventions are implemented accordingly. Results of the resident audits will be ongoing with the results reported through the Quality Assurance Committee monthly for further review and recommendation.</p> <p>Compliance Date: January 26, 2016</p>	

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	<p>observed seated in his wheelchair and he was not wearing any AFO's. Resident C was wearing only bunny boots.</p> <p>On 1/7/16 at 11:05 a.m., Resident C was observed in his wheelchair. Resident C was not wearing any AFO's.</p> <p>On 1/7/16 at 12:10 p.m., Resident C was observed in his wheelchair. Resident C was not wearing any AFO's.</p> <p>A review of a Physician's order, dated 11/23/15, indicated to "hold right AFO" related to a fluid filled blister on his heel. A physician's order, dated 11/30/15, indicated to resume the right AFO.</p> <p>A review of Resident C's current restorative health plan, revised December 2015, indicated: "...Bilateral AFO's will be applied when up in chair...."</p> <p>Review of Resident C's health care plan, initiated 2/4/10 and revised 12/23/15, indicated: "Resident is at risk for pressure ulcers R/T [related to] immobility from CP [cerebral palsy], Contractures and incontinence." Interventions included, but were not limited to, "complete my treatments as ordered by my physician and up in my adapted wheelchair daily as tolerated."</p>			

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	<p>3. The clinical record for Resident F was reviewed on 1/7/16 at 11:25 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, profound intellectual disability, aphasia, traumatic brain injury, quadriplegia and epilepsy. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/4/15, indicated Resident F was dependent on staff for transfers, dressing and eating. Resident F also had upper and lower Range of Motion (ROM) limitations.</p> <p>On 1/6/16 at 12:30 p.m., Resident F was seated in her wheelchair. Resident F was not wearing any braces or AFO's.</p> <p>During an observation on 1/6/16 at 2:05 p.m., Resident F was still seated in her wheelchair. Resident F was not wearing any braces or AFO's.</p> <p>During an observation on 1/7/16 at 10:24 a.m., Resident F was in her wheelchair, at the nurse's station. Resident F did not have any hand or torso braces or AFO's on.</p> <p>A review of a physician's order, dated 8/19/15, indicated "Torso vest to be worn when up in chair." Another physician's order, dated 6/17/15, indicated "bilat [bilateral] hand splints & torso splint to be worn when up in chair."</p>			

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	<p>A review of Resident F's current restorative health plan, revised December 2015, indicated: "Staff will apply Torso vest for 4 hours during day when in chair and Bilateral hand splints will be applied when in my chair daily."</p> <p>The CNA daily sheets, provided by the Director of Nursing (DON) on 1/7/16 at 12:20 p.m., indicated the following: [name of Resident B, "...bilat AFO's when in w/c [wheelchair] and in bldg [building]"; [name of Resident C], "...bilat AFO's when up"; and [name of Resident F], "bilat hand splints & torso splints-on while in w/c; bilat AFO's on when in w/c, right knee brace with AFO's when in chair."</p> <p>During an interview on 1/7/16 at 9:25 a.m., Physical Therapist #4 indicated they had a recent in-service for staff related to AFO's. He indicated there was a binder with pictures of the splints, braces and AFO's at the nurses' station for a reference for staff.</p> <p>During an interview on 1/7/16 at 12:15 p.m., CNA #1 indicated she had both Resident C and Resident F today. She indicated she usually had time to put on their AFO's, but not today with the death of a resident earlier that morning. At</p>			

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F 0323 SS=D Bldg. 00	<p>12:15 p.m., CNA #1 stated she was going to ask therapy if they had Resident C's AFO's. At 12:20, CNA #1 asked the Unit Manager if Resident F had been cleared to start wearing her splints and braces since she had been sick.</p> <p>During an observation and interview on 1/7/16 at 2:10 p.m., both CNA #2 and CNA #3 were on the 300 Hall. They indicated they were going room to room, checking to see who had what splint, brace or AFO in their rooms.</p> <p>No further information was provided at exit on 1/7/16.</p> <p>This Federal tag relates to Complaint IN00190182.</p> <p>3.1-35(g)(1) 3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure</p>	F 0323	F 323D Free of Accident Hazards	01/26/2016			

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	<p>residents who were transferred using a mechanical lift were transferred with sufficient staff assistance to prevent accident and injury for 1 of 1 residents reviewed for transfers (Resident D).</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 1/7/16 at 8:07 a.m. Diagnoses for the resident included, but were not limited to, profound intellectual disability, quadriplegic cerebral palsy, epilepsy and aphasia.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/9/15, indicated Resident D was severely cognitively impaired. Resident D received the following Activities of Daily Living (ADL) assistance; transfer-total assist with two person assist, dressing, bathing, eating and hygiene-dependant with one person assist.</p> <p>During an observation and interview on 1/6/16 at 11:15 a.m., Resident D was observed from the hall, up in a Hoyer sling, slightly off to the side of the bed. Upon entering the open door room, CNA #5 was observed to be transferring Resident D by herself. She had already started to move Resident D over to her wheelchair. As she lowered Resident D</p>				<p>Corrective action for affected residents: ResidentF was assessed with no findingsnoted</p> <p>Identification of others at risk: Residentstransferred with hoyertype lift have the potentialto be affected.</p> <p>Measures to ensure this deficit practice does not recur: DONreeducated staff along withreturn demonstration onlifting and transferring proceduressusing a hoyer type lift.</p> <p>Monitoring of corrective action: TheDON or designee will monitor toensure lifting and transferring proceduresare followed including two people present during residentstransfers, 5 times weekly for3 months, 3 times weekly for 1month, 2 times weekly for1 month and then 1 weekly for 3months, then continued monthly thereafteras part of the facilities ongoing Quality Assurance program. Results ofthis monitoring will be reported throughthe Quality Assurance Committeemonthly for further recommendtions.</p>		

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	<p>into the wheelchair, she indicated she sometimes moved residents by herself when they were short staffed.</p> <p>During an interview on 1/6/16 at 11:25 a.m., the Director of Nursing (DON) was notified of the single person Hoyer transfer.</p> <p>During an interview on 1/6/16 at 11:48 a.m., the DON indicated CNA #5 had been suspended. She indicated the CNA was just in-serviced related to the mechanical lift policy.</p> <p>A health care plan problem, initiated 8/12/13 and revised 1/5/16, indicated "Devices-I have the diagnosis CP [cerebral palsy]...non-weight bearing...I depend on others for chair and bed mobility." Intervention included, but were not limited to, "Transfer me to my adapted wheelchair with the use of mechanical lift."</p> <p>Review of a physician's order, indicated "Transfer w/use of mechanical lift to adapted w/c [wheelchair]." The order was dated 6/24/15.</p> <p>A facility policy, dated 1/22/12, titled "MECHANICAL LIFT" was provided by the DON on 1/6/16 at 11:46 a.m., indicated the following:</p>		<p>Compliance Date: January 26, 2016</p>				

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	<p>"Purpose: Transfer a dependent resident safely. Procedure: ..7. Continue raising....As applicable, one person guide sling and reassure resident while other person pushed and directs movement of lift base."</p> <p>Review of a "TRANSFERS VIA MECHANICAL LIFT" in-service, provided by the DON on 1/16/16 at 11:46 a.m., indicated the following:</p> <p>"By signing below: ...I understand that two staff members must actively participate in raising/lowering the resident in the lift or moving it from surface to surface."</p> <p>CNA #5 signed the form on 12/3/15.</p> <p>This Federal tag relates to Complaint IN00190182.</p> <p>3.1-45(a)(2)</p>			