

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15A014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/13/2013
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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 a Recertification and State Licensure Survey.</p> <p>Survey dates: August 5, 6 ,7 ,8, 12, and 13, 2013</p> <p>Facility number: 000274 Provider number: 15A014 AIM number: 100271660</p> <p>Survey team : Linn Mackey RN TC August 5, 6, 8, 12, and 13 Toni Maley BSW Karen Koeberlein RN Angela Selleck RN August 6, 7, 8, 12, and 13</p> <p>Census Bed Type: NF: 94 Total: 94</p> <p>Census payor type: Medicaid: 94 Other: 0 Total: 94</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p>	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute and admission or agreement of the facts alleged or conclusions set forth in this statement of deficiencies. The facility maintains that 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. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 3, 2013	

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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	Quality Review completed by Debora Barth, RN.				

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F000159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview, observation and record review, the facility failed to offer evening banking hours for residents to access their personal funds. This affected 1 of 3 residents interviewed with a personal funds account and potentially affected 5 residents in the facility with a personal funds account. (Residents #76)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Resident #76 was interviewed on 8/6/13 at 1:28 p.m. regarding his ability to have access to his personal funds at the facility. Resident #76 stated, "When the Business Manager is not here, I can't get my money."</li> </ol> <p>A sign was observed on 8/7/13 at 2:55 p.m., posted outside of the Business Manager's Office that indicated facility banking hours were Monday through Friday from 10:00 a.m. to 11:30 a.m. and 3:00 p.m. to 4:00 p.m., Saturday and Sunday were 10:00 a.m. to 2:00 p.m."</p>	F000159	F 159 Action taken for resident's identified as potentially affected Resident # 76 was re-educated regarding the process to obtain money after business hours and on week-ends from the lock box located at the 200 hall nurses station. (Exhibit 1) Identification and corrective action for other residents with the potential to be affected: Five residents were identified to have the potential of being affected. All were educated on the procedure to obtain money after business hours and on week-ends from the lock box located at the 200 hall nurses station.(Exhibit 2) Measures that will be put into place to prevent recurrence. LPN # 3 and all other nurses were educated on the process to obtain money after business hours and on week-end from the lock box located at the nurses station on 200 hall. Money per regulation and policy is maintained in the lock box. (Exhibit 3) A Resident File Maintenance Report form is printed and placed in the box showing funds available for each resident and updated weekly. A receipt book is kept in the lock	09/03/2013	

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	<p>During an interview with LPN #3 on 8/8/13 at 10:40 a.m., she stated "If the office manager is not here, which is only the weekends she works, then the resident is unable to get to the funds. We as staff do not have access to the funds. If the resident makes the request before the day or the weekend then the resident can get to the money. Management takes turns coming in on the weekends, but are unable to get to the resident funds.</p> <p>"Money is in the [Narcotic] box for change only. There is between 15 to 20 dollars available for change for instance, if a resident already has money and needs change such as for the vending machine or big bills.</p> <p>Resident #76 will forget to let us know that he needs funds out and he will say that's ok and will just call his aunt. His Aunt will place his order for food and then she just pays for it with her debit/credit card."</p> <p>During an interview with the Business Manager on 8/12/13 at 3:53 p.m., she indicated that "the residents who are cognitively able to request money from their personal funds account are Residents #98, 77, 89, 106 and 76...</p>		<p>box to identify who obtains funds. BOM reconciles funds on days of work and replenishes funds as needed.(Exhibit 4) How will the facility monitor and who is responsible: ED/Designee will complete random interviews of residents and staff to ensure understanding regarding availability of money. ED/Designee will complete weekly reviews of audits completed by BOM . Results of interviews and audits will be taken to Quality Assurance Committee(QAC) for review and recommendation monthly for 6 months. With continued ongoing monthly reports to facility and regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>		

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	<p>...An amount of 20 dollars is kept in the nursing [medication] carts. If residents need more than 20 dollars, the resident needs to request it in advance."</p> <p>Record Review of the "Resident Personal Funds Policy," dated 2/10/2013, indicated "Personal funds for residents will be maintained by the Central Business Office (CBO). The facility business office and CBO will work together to safeguard, manage, and account for residents' personal funds. Residents shall make deposits..., withdraw funds..., and receive quarterly statements."</p> <p>The "Petty Cash" Policy dated 02/04/2013 provided by the Administrator on 8/13/13 at 8:50 a.m., indicated "Disbursements of Petty Cash will be limited to \$50.00 at one time...."</p> <p>3.1-6 (d) 3.1-6 (e) 3.1-6 (f)(1)</p>			

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F000201 SS=D	<p>483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who were involuntarily discharged by the facility were given 30 days notice prior to discharge for 2 of 2 residents reviewed for involuntary discharge (Residents #86 and #87).</p>	F000201	F 201 Action taken for resident's identified as potentially affected Resident # 86 went on therapeutic leave of absence with family on 8/11/13 and returned to facility on 8/17/13. Resident #86 previously has been on therapeutic leaves since her admission. The therapeutic leaves occurred on 06/09/2013 to	09/03/2013			

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	<p>Findings include:</p> <p>1.) During an 8/12/13, 11:30 a.m. interview, Resident #86's family indicated she had been called by the facility and asked to come get her loved one and take her home for 4 days until the Indiana State Department of Health survey was completed. The family indicated she did not feel she had a choice and must come get her loved one. The family member indicated the facility had told her Resident #86 was being over-stimulated by the survey process. RN #1 was the nurse who made this call. Resident #86's family indicated taking Resident #86 home for an unscheduled visit had been a hardship because she did not have people lined up to supervise Resident #86 when she could not be with her. She indicated Resident #86 needed 24 hour supervision due to her medical needs and behavioral issues.</p> <p>During an 8/7/13, 2:35 p.m. interview, Resident #86's family member indicated Resident #86 was in the facility for 120 days for the purpose of assessment. She indicated the goal was to determine if the resident would be best suited in a long term care or group home setting. The family was</p>		<p>6/22/2013 and 07/11/2013 to 7/17/13 (Exhibit 5). The family of resident # 86 had agreed on 8/9/13 to therapeutic leave due to over stimulation by unfamiliar people in the facility. Resident #86 was not discharged from the facility. Resident # 87 is no longer at the facility. Identification and corrective action for other residents with the potential to be affected: All residents who had been discharged or on therapeutic leave of absence LOA for the last 90 day were reviewed. No other residents were indentified to have the potential to be affected. What measures will be put into place to prevent recurrence. Facility management staff were re-educated on 8/13/13 by Director of Operations on regulations and policy and procedure regarding notice for resident discharge. (Exhibit 6) Documentation for all potential discharges will be reviewed at the morning meeting to assure discharge planning and documentation has been completed and discharge audit documentation completed. (Exhibit 7) How will the facility monitor and who is responsible: Results of the discharge record audits will be taken to Quality Assurance Committee for review and recommendation monthly for 6 months. With continued ongoing monthly reports to facility and regional Quality</p>		

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	<p>seeking a permanent therapeutic home where Resident #86 could live. Living with the family again was not part of the future plans.</p> <p>Resident #86's record was reviewed on 8/7/13 at 11:00 a.m.</p> <p>Resident #86's current diagnoses included, but were not limited to, cerebral palsy, impulse control disorder and unspecific intellectual disability.</p> <p>Resident #86 had a, 5/20/13, Preadmission Screening which indicated she had been approved for a short term 120 day placement in a long term care facility.</p> <p>Resident #86 had a current, 7/9/13, care plan problem/need which indicated she aggressively hugged others and open mouthed kiss which could result in injury. This problem originated in May 2013.</p> <p>During an 8/5/13, 10:30 a.m. observation, Resident #86 aggressively hugged Resident #59 from behind tightly around the neck.</p> <p>During an 8/6/13, 9:07 a.m., observation, Resident #86 shoved folders and books off the top of the</p>		Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.				

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	<p>middle station nursing desk then giggled. Resident #86 then tried to hug Resident #107 around the neck. Resident #107 put her hand out to keep Resident #86 away. The Maintenance Supervisor intervened and gently but firmly pulled Resident #86 away from Resident #107. While being pulled away, Resident #86 opened her mouth and acted as if she would bite Resident #107's hand.</p> <p>During an 8/8/13, 9:50 a.m. observation, Resident #86 hugged Resident #59 aggressively around the neck from behind. RN #1 firmly peeled Resident #86's arms from around Resident #59's neck.</p> <p>During an 8/12/13, 11:50 a.m. interview, the Administrator indicated Resident #86's family had been called and asked to take the resident home for a few days due to over stimulation. The Administrator indicated she was aware Resident #86 was in the facility to determine what future placement would be best for the resident. She indicated she did not know how the resident would develop skills for group living if she was requested to return home every time she experienced over-stimulation.</p> <p>During an 8/12/13, 3:05 p.m.</p>			

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	<p>interview, RN #1 indicated she had called Resident #86's family and asked her to take the resident home due to over-stimulation. She indicated Resident #86 had gone home for previous overnight visits. She also indicated the other visits had been arranged by the family not completed at the request of the facility.</p> <p>2.) Resident #87's record was reviewed on 8/12/13 at 9:45 a.m.</p> <p>Diagnoses included, but were not limited to, Hunters Syndrome.</p> <p>An attempted observation of Resident #87 in his room on 8/12/13 at 9:30 a.m., found the resident was not present and Resident # 87's name was no longer on the door.</p> <p>When LPN #5 was asked about Resident # 87's location, LPN #5 stated Resident #87 had been discharged on the previous day.</p> <p>Review of Resident #87's admission evaluation and interim care plan, indicated that Resident #87 was admitted for respite care on 8/2/13 at 1:30 p.m. and was to stay in the facility for two weeks until released to the family.</p>						

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	<p>Review of progress notes from 8/9/13 at 12:20 p.m., stated that on 8/8/13 at 10:30 a.m., RN #1 spoke to Resident #87's parent by phone and expressed concern about Resident #87's behaviors.</p> <p>On 8/12/13 at 12:30 p.m., a phone call was placed to Resident #87's father to ask about the circumstances surrounding the early discharge.</p> <p>During an 8/12/13, 12:40 p.m. interview, Resident #87's family indicated Resident #87 had been in the facility for a respite stay while the family left the state for a vacation. The family member indicated the facility had called on Thursday and told him Resident #87 was unplugging other resident's gastrostomy pumps. The request was firm but not forceful. The family was vacationing out of state. The facility was the only facility the family had ever located who could provide respite care for Resident #87's special needs. The family felt they had to cut their visit short and come home or they would lose the possibility of any future respite stays. The family felt they were being asked to take Resident #87 home early because the inspection process would be easier without Resident #87 in the facility.</p>				

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	<p>Review of a current, facility policy titled "Termination of Agreement", which was provided by the Administrator on 8/12/13 at 9:55 a.m. indicated the following,</p> <p>" If Vernon Manor Children's Home decides to involuntarily transfer or discharge a resident, it shall give the resident at least thirty (30) days written notice except in the following situations:</p> <p>(a) The safety or health of individuals in the Community would be endangered;</p> <p>(B) The residents health improves sufficiently to allow a more immediate transfer or discharge;</p> <p>(ac) Immediate transfer is needed because of the resident's urgent medical needs;</p> <p>(d)The resident has not resided in the Community for thirty (30) days.</p> <p>3.1-12(a)(7)</p>				

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>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.</p> <p>Based on observation, interview and record review the facility failed to ensure residents who had potential restraints in place, had orders for the device and had assessments for the use of the device for 2 of 3 residents reviewed for potential restraint use in a sample of 15 residents who met the criteria for restraints. (Residents #13 and#19)</p> <p>Findings Include:</p> <p>Resident #13 was seated in a wheelchair with a wheelchair seat belt in place during the following dates and times: 8/5/13, 1:45 p.m., 8/6/13, 9:30 a.m. 8/8/13, 9:53 a.m.</p> <p>Resident #13's record was reviewed on 8/8/13 at 8:40 a.m.</p> <p>Resident #13's current diagnoses included, but were not limited to, cerebral palsy and severe mental retardation.</p>	F000221	<p>F 221 What Corrective actions have been taken for the identified Resident? A safety device/restraint assessment was completed on resident #13 and resident # 19. Physician orders were obtained and care plan updated to reflect current status of resident related to device.</p> <p>(Exhibit 8) How are you going to identify other residents that could be potentially affected by this deficiency? Current residents were assessed and identified residents had a safety device/restraint assessment completed. Physician orders and care plans were updated to reflect current status of identified residents. What measures will be put into place to prevent recurrence. Nursing staff were educated on the safety device/restraint process. Safety device/restraint assessments will be completed upon initiation of a device, quarterly and as needed for condition changes. How will the facility monitor and who is responsible: Director of Nursing / Designee will perform safety device/restraint process audits 5 times a week for 4 weeks, then 5 times biweekly for 2 months, then</p>	09/03/2013

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	<p>Resident #13's record lacked an order for a wheelchair seat belt, an assessment for the use of a potential restraint and an assessment reflecting the seat belt was the least restrictive means available to treat a medical symptom or condition.</p> <p>During a 8/8/13, 2:30 p.m., interview, the Administrator indicated the facility had not obtained orders nor completed assessments for safety devices which were potentially restraining in nature if the device was used for positioning.</p> <p>2. During an 8/6/13, 1:12 p.m., observation Resident #19 was in the dining room in a tilt back wheelchair with a waist seat belt on.</p> <p>During an 8/12/13, at 9:00 a.m., observation, Resident #19 was in her room, sitting up in a tilt back wheelchair with a waist seat belt on.</p> <p>Resident # 19's record was reviewed on 8/12/13 at 9:30 a.m.</p> <p>Resident # 19's current diagnoses included, but were not limited to microcephalic, multiple congenital abnormalities, osteoporosis, gastritis, seizures, and spastic quadriplegia.</p>		<p>weekly for 3 months. The results of the audits will be reviewed for recommendations by the QAC monthly times 6 months, with continued ongoing monthly reports to facility and regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>				

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	<p>Review of the current, 7/12/13 physician's orders, did not indicate an order for the waist seat belt or tilt back chair.</p> <p>Review of a current, 7/2/13, care plan did not address the resident's tilt back wheelchair or the waist seat belt.</p> <p>Review of a Safety Device/ Restrictive Assessment completed by the facility on 6/26/13, indicated the type of safety device/ restrictive device was wheelchair and waist belt.</p> <p>During a 8/12/13 9:05 a.m. interview, CNA # 4 indicated Resident # 19 wore a seat belt.</p> <p>During a 8/12/13 9:10 a.m. interview, LPN # 5 indicated Resident # 19 wore a seat belt.</p> <p>Review of a current, facility policy titled "Restraint Usage" which was provided by the administrator on 8/12/13 at 10:30 a.m., indicated the following: "Purpose: Restraint will be used only for medical conditions to prevent injury to the resident.... Procedure: 1. Restraints are applied only upon proper physician's order stating type of restraint ...and reason for restraint.... 6. The interdisciplinary</p>						

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	<p>team shall monitor and review each restrained resident for least restrictive restraint method possible restraint reduction or elimination and report to at least quarterly the facility Quality Assurance committee."</p> <p>3.1-26(b) 3.1-26(r)</p>			

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F000250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a behavior management plan which addressed the prevention of behaviors and documented to occurrence of behaviors for 3 of 3 residents reviewed for behavior management. (Residents #86, #83, #87)</p> <p>Findings include:</p> <p>1.) During an 8/5/13, 10:30 a.m. observation, Resident #86 aggressively hugged Resident #59 from behind tightly around the neck. Resident #86's arms were peeled gently but firmly from around Resident #59's neck by an unidentified nursing staff member. Resident #86 was instructed not to touch others. Resident #59 indicated she was not hurt. After the event, Resident #86 was redirected away from Resident #59. She was not offered any form of recreational, diversionary materials, nor was she assisted to a meaningful activity.</p>	F000250	F 250 What Corrective actions have been taken for the identified Resident? Behavior management plans for residents #83, #86 and #87 were reviewed by interdisciplinary team (IDT) and revised as indicated to reflect current resident status. The nursing staff were educated on the behavior management plans. (Exhibit 10). How are you going to identify other residents that could be potentially affected by this deficiency? Current residents were reviewed. Any identified residents had a behavior management plan updated to reflect current resident status. What measures will be put into place to prevent recurrence. Nursing staff re-education on the policy and procedures for behavior management was completed on 8/16/13 (Exhibit 11). The Social Services Director will review behavior binders at each nurses station and nurses notes for residents with documented behaviors prior to the morning meeting. The IDT will review the behavior management plan to validate reflection of current resident status. (Exhibit 12) How will the facility monitor and who is	09/03/2013			

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	<p>During an 8/6/13, 9:07 a.m., observation, Resident #86 shoved folders and books of the top of the middle station nursing desk then giggled. Resident #86 then tried to hug Resident #107 around the neck. Resident #107 put her hand out to keep Resident #86 away. The Maintenance Supervisor intervened and gently but firmly pulled Resident #86 away from Resident #107. While being pulled away, Resident #86 opened her mouth and acted as if she would bite Resident #107's hand. After the event, Resident #86 was simply away from Resident #107. She was not offered any form of recreational, diversionary materials, nor was she assisted to a meaningful activity.</p> <p>During an 8/6/13, 10:20 a.m. observation, Resident #86, who could ambulate, was seated in someone's wheelchair wheeling herself about the hallways. An unidentified nursing staff member then stated "I see you've found yourself another wheelchair."</p> <p>During an 8/7/13, 10:45 a.m., observation, Resident #86 was wheeling herself around the hallway in someone's wheelchair. An unidentified staff member was heard</p>		<p>responsible: Social Service Director / Designee will complete audits on 5 residents with behavior management plans per week for 4 weeks, then monthly times 5 months. Behaviors will be reviewed at monthly behavior management meeting. Results of the audits and minutes of monthly behavior management meeting will be reviewed by the QAC monthly times 6 months, with continued ongoing monthly reports to facility and regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>				

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	<p>stating "I see [Resident #86] has a wheelchair again."</p> <p>During an 8/8/13, 9:50 a.m. observation, Resident #86 hugged Resident #59 aggressively around the neck from behind. RN #1 firmly pealed Resident #86's arms from around Resident #59's neck. Resident #59 indicated she was not hurt. RN #1 verbally insisted Resident #86 must go to her room. Resident #86 sat down on the floor. Resident #86 resisted RN #1's efforts. RN #1 picked Resident #86 up from the floor and firmly walked Resident #86 to her room. After the event, Resident #86 was not offered any recreational materials nor was she directed to a meaningful activity.</p> <p>During observations on 8/5/13 from 10:00 a.m. to 2:30 p.m., on 8/6/13 from 8:30 a.m. to 3:00 p.m., and on 8/7/13 from 8:30 a.m. to 3:00 p.m., Resident #86 roamed up down and about hallways. She was not assisted by staff to engage in meaningful activities when she was roaming. She was not given games, toys, books or manipulative devices.</p> <p>Resident #86's record was reviewed on 8/7/13 at 11:00 a.m.</p>				

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	<p>Resident #86's current diagnoses included, but were not limited to, cerebral palsy, impulse control disorder and unspecific intellectual disability.</p> <p>Resident #86 had a current, 7/9/13, care plan problem/need which indicated she aggressively hugged others and open mouthed kiss which could result in injury. Approaches to this problem included, but were not limited to, monitor her activities, encourage her to slow down, encourage her to attend activities, encourage her not to touch others, provide her with hand held objects, offer theraband (therapy exercise band) and offer a baby doll.</p> <p>Resident #86's record and the behavior monitoring log lacked documentation of the 8/5/13, 8/6/13, and 8/8/13 aggressive hugging events and the 8/6/13 and 8/7/13 borrowing of wheelchairs.</p> <p>During a 8/12/13, 9:20 a.m. interview, the Social Services Director indicated it was imperative all behaviors be documented in the behavior book. The nurses may also document in the clinical record. The behavior log documentation was used to determine if behavior management</p>				

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	<p>programs were effective or modifications were needed. The behavior management program would not work if behaviors were not documented. The behavior log also had a form to document new behaviors that could need a plan. She indicated she was unaware Resident #86 had been aggressively hugging and that borrowing wheelchairs was a new behavior. Lastly she indicated she had completed a staff inservice on 7/25/13 regarding the behavior management program and the importance of all staff documenting all behaviors.</p> <p>2.) Resident #87's record was reviewed on 8/7/13 at 9:00 a.m.</p> <p>Resident #87's current diagnoses included, but were not limited to, Hunters Syndrome.</p> <p>Resident #87 had a current, 8/2/13, care plan regarding behaviors due to wandering and entering others rooms. Approaches to this problem included, but were not limited to, redirection, offer healthy snack, guide away from doors, and explain that he can't enter unless invited.</p> <p>During an 8/7/13, 1:48 p.m. observation, the resident was observed running and punching walls,</p>						

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	<p>opening the fire extinguisher door, entering the back entrance to the kitchen, turning off facility lights, and closing fire doors. Staff was present and attempted no interventions as described in Resident #87's behavior careplan.</p> <p>During an interview with the Social Services Director on 8/12/13 at 11:35 a.m., when questioned about the care plan in place for Resident #87's behaviors, and why observed behaviors were not documented, the SSD stated "I know." When questioned about the care plan interventions, and why they were not used when behaviors were observed, she stated, "I don't know how to answer that question."</p> <p>3. Resident #83's record was reviewed on 8/7/13 at 2:50 p.m. Current diagnoses included, but were not limited to, impulse control disorder, mental retardation and generalized anxiety disorder.</p> <p>A care plan review for Resident #83 on 8/7/13 at 1:54 p.m., indicated "I will disrobe." The care plan was dated 7/20/13.</p> <p>The interventions indicated, "immediately provide privacy (protect</p>						

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	<p>from public view), replace clothing, encourage to participate in redressing, check for personal needs, if/when unsuccessful maintain appropriate dress direct to private area to ensure privacy and encourage to participate in choice of two activities."</p> <p>The record review for Resident #83 was reviewed on 8/8/13 at 3:30 p.m.</p> <p>"The Behavior Tracking Record on Disrobing," dated August 2013, indicated "one behavior of disrobing in the hall on 8/5/13 at 2:00 p.m."</p> <p>During an interview with the Social Service Director on 8/12/13 at 11:07 a.m., she indicated "no other documentation to provide related to behaviors for Resident #83. I have just the one stripping this month...."</p> <p>During an 8/5/13, 1:20 p.m. observation, Resident #83 sat on the floor in the hallway. She removed her top and exposed her bare breasts. While exposed, she sat on the floor in the hallway. An unidentified staff member assisted Resident #83 to her room where she was redressed in the top she had removed.</p>			

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	<p>During an 8/7/13, 1:48 p.m. observation, Resident #83 was standing in the hallway. She then removed her top exposing bare breasts. While exposed, she walked down the hallway toward the nursing station. An unidentified staff member then walked her to her room. At 2:05 p.m. Resident #83 was wearing a one piece rear closing outfit.</p> <p>4. The content of a 7/25/13 facility inservice was provided by the Social Service Director on 8/12/13 at 9:30 a.m. The inservice content included, but was not limited to, the following:</p> <p>"If ANY resident has an unusual behavior that is not already a part of their behavior plan, please fill out a behavior sheet."</p> <p>"Behavior Management: It is the policy of VMHC [Vernon Manor Health Care] that residents who exhibit behavior problems will be included in the behavior management and monitoring program...</p> <p>A Behavior Monitoring Record (facility specific) will be used to document each observed episode of targeted behaviors. It will reflect the following information: Date</p>				

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	<p>Time Behavior Precipitating events Staff interventions Outcome..."</p> <p>"Behavior Assessment and Management-It is important to understand causes of behavior problems in our residents. ... Causes of those behaviors can be internal or external factors that combine to make a behavior happen or keep happening."</p> <p>The review of the "Behavior Management" policy last updated 1/07 on 8/13/13 at 3:35 p.m., indicated ..."residents who exhibit behavior problems will be included in the behavior management and monitoring program. This program is designed to accommodate individual needs and maintain resident's dignity while managing behavior symptoms...</p> <p>...A Behavior Monitoring Record...will be used to document each observed episode of the targeted behavior. It will reflect the following information: date, time, behavior, precipitating events, staff intervention and outcome.</p>				

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	<p>Behavior monitoring records will be maintained in a log ...at Nurse's stations..."</p> <p>3.1-34(a) 3.1-34(a)(1) 3.1-34(a)(2)</p>			

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F000282 SS=D	<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 G-tube (gastrostomy tube) services were provided in a manner to ensure residents were given medications and feedings as ordered for 2 of 5 residents reviewed for G-tubes (Resident #81 and Resident #83).</p> <p>Findings include:</p> <p>1.) During an 8/8/13, 12:30 p.m., lunch meal observation, RN #1 fed Resident #81 her meal through her G-tube. After the meal was completed, Resident #81 was taken back to the nurses station in her wheelchair.</p> <p>Resident #81's record was reviewed on 8/8/13 at 12:45 p.m.</p> <p>Resident #81's diagnoses included, but were not limited to, seizures, constipation, and GERD (gastrointestinal reflux disease).</p> <p>Resident #81 had a current treatment</p>	F000282	<p>F 282 What Corrective actions have been taken for the identified Resident? Records for Resident # 81 and Resident # 83 were reviewed for accuracy. Resident #83's order for Risperdal was immediately clarified with ordering physician and corrected on the medication administration record. RN #1 and LPN #3 were immediately re-educated on the procedure of following the residents written plan of care. (Exhibit 13) Resident #81 and #83 were assessed with no findings. How are you going to identify other residents that could be potentially affected by this deficiency? All residents who have medication orders have the potential to be affected by this alleged practice. No other resident with feeding tubes had the potential to be affected. What measures will be put into place to prevent recurrence. Licensed nursing staff have been re-educated on the procedure for following each residents plan of care.(Exhibit 14) Physician orders will be reviewed at the morning meeting by the IDT. Director of Nursing or Designee will verify orders have been transcribed as written to</p>	09/03/2013	

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	<p>order, dated 7/21/13, for staff to check bowel sounds in all four quadrants (abdomen) after feedings.</p> <p>During an interview on 8/8/13 at 2:08 p.m., RN #1 was asked if she was aware that bowel sounds were to be checked after feedings. RN #1 stated, "I listened for gurgling before."</p> <p>2.) The clinical record for Resident #83 was reviewed on 8/7/13 at 2:50 p.m.</p> <p>The diagnoses for Resident #83 included, but were not limited to: impulse control disorder and generalized anxiety disorder.</p> <p>The August 2013 Physician orders for Resident #83, indicated Risperdal 0.5 milliliters (0.5 milligrams) to be given by gastrostomy tube at bedtime for</p>		<p>medication and treatment sheets. Observation of nurses providing medications and feedings as ordered for G-tube residents will be completed by the Director or Nursing or Designee . (Exhibit 15) How will the facility monitor and who is responsible: Director of Nursing / Designee will perform audits on the procedure for following written plan of care 5 times a week for 4 weeks, then 5 times bi-weekly for 2 months, then monthly times three months. The audits will include observation of nurses providing medications and feedings for G-tube residents. The results of the audit will be reviewed by the QAC for 6 months, with continued ongoing monthly reports to facility and regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>		

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	<p>aggressive behavior, originally ordered on 6/20/13.</p> <p>The August 2013 MAR (medication administration record) for Resident #83 indicated the above medication was given daily.</p> <p>The clinical record for Resident #83 was reviewed on 8/8/13 at 3:30 p.m. A consultation report, dated 5/1/13, indicated a physician response: "I accept the recommendation(s) above with the following modification(s)... [Decrease] Risperdal 0.5 milligrams [one] by mouth every hour of sleep for one month then discontinue, dated 6/20/13."</p> <p>During an interview with LPN #3 on 8/12/13 at 3:43 p.m., LPN #3 stated "...I don't think I missed it. I don't remember seeing the consultation report with the order date of 6/20/13..."</p> <p>"...The previous Director of Nursing came and told me to decrease the Risperdal to 0.5 milligrams. She never stated that it was to be discontinued and I wrote the order."</p> <p>During an interview with the Director of Nursing on 8/12/13 at 4:03 p.m., she stated, "I spoke with the physician over the phone and got a</p>						

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	<p>clarification on the order for Risperdal dated 6/20/13. The physician indicated that she wanted the Risperdal 0.5 milligrams per gastrostomy tube discontinued now..."</p> <p>3.1-35(g)(2)</p>				

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to ensure G-tube (gastrostomy tube) services were provided according to physician's orders for 1 of 3 residents reviewed for G-tubes (Resident #81).</p> <p>Findings include:</p> <p>During an 8/8/13, 12:30 p.m., lunch meal observation, RN #1 fed Resident #81 her meal thru her G-tube. After the meal was completed, Resident #81 was taken back to the nurses station in her wheelchair.</p> <p>Resident #81's record was reviewed on 8/8/13 at 12:45 p.m.</p>	F000322	F 322 What Corrective actions have been taken for the identified Resident? Records for Resident #81 were reviewed. No discrepancy noted on the record. RN #1 was immediately re-educated on following physician orders related to G-tube services. Resident #81 was assessed with no findings. How are you going to identify other residents that could be potentially affected by this deficiency? Orders for all residents with gastrostomy tubes were reviewed. No other resident was found to have an order to check bowel sounds after feeding. No other resident had the potential to be affected. What measures will be put into place to prevent recurrence. Licensed nursing staff were re-educated on the	09/03/2013

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	<p>Resident #81's diagnoses included, but were not limited to, seizures, constipation, and GERD (gastrointestinal reflux disease).</p> <p>Resident #81 had a current treatment order, dated 7/21/13, for staff to check bowel sounds in all four quadrants (abdomen) after feedings.</p> <p>During an interview on 8/8/13, at 2:08 p.m., RN #1 was asked if she was aware that bowel sounds were to be checked after feedings. RN #1 stated, "I listened for gurgling before."</p> <p>3.1-44(a)(2)</p>		<p>policy for gastrostomy tubes feedings and following physician orders. (Exhibit 17) The Director of Nursing / designee observed all licensed nursing staff provide gastrostomy tube feedings. DON/Designee will complete gastrostomy tube feedings proficiency audits on all licensed nursing staff at least quarterly to ensure proficiency. How will the facility monitor and who is responsible: DON/Designee will present results of gastrostomy tube feeding proficiency audits to QAC for review and recommendations for 6 months, with continued ongoing monthly reports to facility and regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who was admitted using an antipsychotic medication had a diagnoses for the use of the medication and behavioral indicators for antipsychotic use for 1 of 5 residents reviewed for unnecessary medication (Resident #107).</p> <p>Findings include:</p> <p>Resident #107's record was reviewed</p>	F000329	F 329 What Corrective actions have been taken for the identified Resident? Record review was completed for resident #107. The physician order for the antipsychotic medication was immediately clarified with proper diagnosis obtained. RN #1 was re-educated on the antipsychotic medication protocol. How are you going to identify other residents that could be potentially affected by this deficiency? All Residents admitted with orders for antipsychotic medications have the potential to be affected.	09/03/2013	

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	<p>on 8/7/13 at 2:10 p.m.</p> <p>Resident #107's current diagnoses included, but were not limited to, hypertension, malnutrition and dementia.</p> <p>Resident #107 was admitted to the facility on 7/5/13.</p> <p>Resident #107 had an 7/5/13, admission order for Zyprexa (an anti-psychotic medication) 10 mgs two times daily.</p> <p>Resident #107's record lacked a diagnoses for the use of an antipsychotic medication or identified behavioral indicators for the use of an antipsychotic medication.</p> <p>Resident #107 had a 8/7/13 pharmacy recommendation that indicated the resident did not have a diagnoses for the use of the medication Zyprexa.</p> <p>During an 8/8/13, 11:04 a.m., interview RN #1 indicated she had completed the admission for Resident #107. She indicated a nurse did not review the medication to ensure each medication has a diagnosis for it's use. She indicated the facility relies on the pharmacy to review and</p>		<p>Any identified residents had a diagnosis for the use of the antipsychotic medication clarified. What measures will be put into place to prevent recurrence. All licensed nursing staff and social service staff have been re-educated on the psychotropic medication policy. (Exhibit 18) Medication regimen review forms(Exhibit 19) have been initiated and are sent to pharmacy for review with all new admission orders. New orders received for antipsychotic medications will be reviewed by the IDT at the morning meeting for proper diagnoses.(Exhibit 20) New residents admitted with psychotropic medications will be reviewed monthly by the behavior committee. How will the facility monitor and who is responsible: The Director of Nursing/designee will present results of audit for proper diagnosis for antipsychotic medication for review by the QAC for 6 months, with continued ongoing monthly reports to facility and regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>				

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	<p>ensure each medication had a diagnoses for it's use. She additionally indicated, that due to the date of Resident #107 admission, it was one month before the review was completed. She indicated she could not find a diagnosis for the use of Zyprexa.</p> <p>During an 8/12/13, 9:49 a.m., interview LPN #2 indicated Resident #107 did not display negative behaviors that negatively impacted her quality of life or quality of care.</p> <p>During an 8/12/13, 10:13 a.m. interview, the Social Services Director indicated Resident #107 was still adjusting to the facility and doing well. Resident #107 had displayed some behavioral issues shortly after admission but was currently doing well. She additionally indicated all residents on antipsychotic medication should have both a diagnosis for it's use and behavioral indicators for use of an antipsychotic.</p> <p>Resident #107 was observed either seated calmly in her wheelchair, napping or resting calmly in her bed on the following dates and times: 8/5/13, 10:30 a.m., in bed, 8/6/13, 9:06 a.m., in wheelchair, 8/7/13, 10:00 a.m., in wheelchair, 8/7/13,</p>			

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	<p>10:50 a.m., in bed, 8/8/13, 8:30 a.m., in bed, 8/8/13, 9:40 a.m., in bed and 8/8/13, 10:40 a.m., in bed</p> <p>A current, 3/14/13, facility policy titled "Psychotropic Medication Protocol", which was provided by the Administrator on 8/12/13 at 2:49 p.m., indicated the following:</p> <p>"2. Supporting diagnosis shall be present in the clinical record... "7. Behavior Tracking: For those residents receiving medications to treat behavioral symptoms, qualitative and quantitative monitoring shall be completed and documented."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>						

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observations, record review, and interview, the facility failed to develop and implement appropriate plans of action to address behavior management, antipsychotic medications use without a diagnosis, involuntary discharge without notice, residents with seatbelts without restraint assessment or physician order, feeding administration with bolus feeding through gastrostomy tube, accessibility and bookkeeping</p>	F000520	F 520 What Corrective actions have been taken for the identified Resident? Residents # 13, 19, 76, 81, 83, 86, and 107 were assessed with no findings. Resident # 87 is no longer at the facility. Identification of other residents potentially affected and corrective actions Identified residents have had their re-education on obtaining funds, physician orders updated, plans of care updated, behavior management plans updated, and device assessments updated to	09/03/2013	

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	<p>principles on resident funds and not following physician orders were identified during the Annual Recertification and State Licensure survey. Residents #13, 19, 76, 81, 83, 85, 86, 87 and 107.)</p> <p>Findings include:</p> <p>During an 8/12/13 at 4:47 p.m., interview with the Administrator, the administrator was queried regarding QAA (Quality Assurance and Assessment) and the identified concerns of the annual survey as follows:</p> <ol style="list-style-type: none"> <li>1. Behavior Management for Residents #83, 86, and 87.</li> <li>2. Antipsychotic use without diagnoses for Resident #107.</li> <li>3. Involuntary discharge without notice for Residents #85 and 87.</li> <li>4. Seatbelt Restraints without assessment or physician order for Resident #13 and #19.</li> <li>5. Not following Physician order related to feeding administration with bolus</li> </ol>		<p>reflect current status as indicated. What measures will be put into place to prevent recurrence. The Executive Director and Director of Nursing have been educated by the Regional Director of Clinical Services on the Quality Assurance Program. Action plans and audits will be completed as scheduled in the plan of correction on behavior management, antipsychotic use without a diagnosis, involuntary discharge, device/restraints without assessment/physician order, following physician orders related to feeding administration via G-tube, discontinuation of medication and accessibility of funds. How will the facility monitor and who is responsible: The Executive Director and Director of Nursing will present the results of the audits to the QAC monthly for 6 months for review and further recommendations. The regional QAC will review facility audits and actions plans for further recommendations and validation of completion.</p>				

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	<p>feeding through gastrostomy tube for Resident #81. Discontinuation of medication for Resident #83.</p> <p>6. Accessibility and Book Keeping Principles of Resident Funds for Resident #76</p> <p>7. During an interview with the Administrator on 8/13/13 at 8:50 a.m., she indicated that the only concern that had been included in facility QAA program was Behavior Management, dated 4/4/13. She also indicated no action plans or evaluation of the other concerns had been included in the QAA program.</p> <p>3.1-52(b)(2)</p>						