

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 02/19/2014
--	---	--	---

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
F000000	<p>This visit was for the Investigation of Complaint IN00144322 and Complaint IN00144729.</p> <p>Complaint IN00144322-Substantiated. Federal deficiencies related to the allegations are cited at F 328.</p> <p>Complaint IN00144729-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: February 17, 18 and 19, 2014.</p> <p>Facility number: 000274 Provider number: 15A014 AIM number: 100271660</p> <p>Survey team: Shelley Reed, RN TC</p> <p>Census bed type: SNF: 81 Total: 81</p> <p>Census payor type: Medicaid: 81 Total: 81</p> <p>Sample: 5</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 March 14, 2014.	

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.

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 02/19/2014
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	
F000328 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure respiratory medication was administered in a timely manner for 1 of 5 residents reviewed for medication administration. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident (C) was reviewed on 2/17/14 at 1:45 p.m. Diagnoses for the resident included, but were not limited to, infantile cerebral palsy, developmental delay,</p>	F000328	F 328 Treatment/Care for Special Needs What Corrective actions have been taken for the identified resident? Resident C no longer resides in the facility. How are you going to identify other residents that could be potentially affected by this deficiency? Residents receiving medication or treatments have the potential to be affected by the alleged deficiency. No corrective action is indicated for these residents however medication administration audits will be completed by the Director of Nursing as part of the Quality Assurance program. What measures put into place ensure the cited deficient practice does	03/14/2014	

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 02/19/2014
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	
	<p>seizure disorder, tracheostomy and gastrostomy tube.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 11/7/13, indicated Resident (C) indicated Resident (C) was severely cognitively impaired. Resident (C) received the following Activities of Daily Living (ADL) assistance; transfer-total dependence with one person assist, ambulation-did not occur, hygiene and bathing-total dependence with one person assist, range of motion-impairment of both upper and lower extremities.</p> <p>During record review, a nursing note, dated 1/26/14 at 2:30 p.m., indicated LPN #10 walked into Resident (C)'s room to administer his respiratory medications. Resident (C) was found to be lethargic, oxygen saturation of 84%, heart rate of 146, respiration 27 and a blood pressure was unable to be obtained. Resident (C)'s skin was cold and clammy. The note indicated the physician was notified and the resident was sent to the local hospital.</p> <p>A late entry, posted after a 1/27/14, 5:00 a.m. notation, post-dated 1/26/14 at 2:30 p.m., indicated</p>		<p>not occur? Individual coaching has been provided to LPN #10. Staff education has been provided with licensed nurses and respiratory therapist related to medication administration and documentation. Medication administration audits and annual individual staff medication administration competency assessment will be conducted to assure compliance. What monitoring system will be put in place to the effectiveness of the corrective actions? Director of Nursing or designee will perform medication administration audits weekly for 4 weeks, then biweekly for 2 months, and monthly thereafter. The results of these audits will be reported monthly to the QA committee. Date of Compliance: March 14, 2014.</p>		

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 02/19/2014
--	---	--	---

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
	<p>Resident (C) was placed on 6L oxygen via trach and saturation came up to 98%. The note indicated breathing remained shallow and suctioning was not needed.</p> <p>During review on the Medication Administration Record (MAR) for the month of January,2014, the MAR indicated Resident (C) received Albuterol (bronchodilator) 0.083% four times daily at 7 a.m., 1 p.m., 7 p.m. and 1 a.m.</p> <p>During review of the respiratory care record, dated 1/26/14, Resident (C) received Albuterol at 1 a.m., 7 a.m. and 1 p.m. The respiratory assessment, dated 1/26/14 at 7 a.m., indicated Resident (C) had a heart rate of 138 pre and 115 post treatment, respirations 18 pre and post treatment and oxygen of 97 % pre and post treatment. The respiratory assessment, dated 1/26/14 at 1:00 p.m., indicated Resident (C) had an oxygen rate of 88% pre and 84% post treatment, heart rate 146 pre treatment and 138 post treatment, respiration 20 pre treatment and 27 post treatment.</p> <p>During an interview on 2/18/14 at 2:20 p.m., LPN #10 indicated she</p>			

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 02/19/2014
--	---	--	---

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
	<p>was behind on her breathing treatments when she walked into Resident (C)'s room and noticed he did not look well. She indicated she started his Albuterol treatment and went to get a nurse who was more familiar with his baseline health. LPN #10 had LPN #4 assess Resident (C). LPN #4 indicated to LPN # 10 there was a need to call the physician and ask to send him out for evaluation.</p> <p>During the interview, she indicated she charted prior to the time of the treatment by 15 minutes, the resident was on room-air and the cool mist was off. She indicated she did not circle her initials and write on the back of the MAR the medication was administered late. She indicated staff have one hour prior and one hour post to give the ordered medication. She had given the 1:00 p.m. medication at 2:15 p.m.</p> <p>A health care plan problem, dated 8/16/13, indicated Resident (C) had a tracheostomy. Some of the approaches for the problem indicated "perform trach care per facility policy", "observe for signs or symptoms of obstructed airway" and "suction as needed".</p>			

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 02/19/2014
--	---	--	---

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
	<p>Review of a current facility policy, dated 9/9/09, provided by the Corporate Nurse on 2/19/14 at 11:24 p.m., titled "Respiratory/Nursing", included, but was not limited to, the following:</p> <p>"POLICY: The Respiratory therapist/nurse are to give respiratory treatments as ordered by a physician...."</p> <p>This Federal tag relates to Complaint IN00144322.</p> <p>3.1-47(a)(6)</p>			