STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155810	A. BUILDING 00 B. WING	08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VERNON HEALTH & REHABILITATION	1955 S VERNON ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 26, 27, 28, 29 and August 1, 2022. Facility number: 000274 Provider number: 155810 AIM number: 100271660 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicaid: 55 Other: 1 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 8, 2022.	F 0000	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.***	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review and interview, the facility failed to ensure the MDS (Minimum Data Set) assessment accurately identified a resident's leg wounds for 1 of 4 residents reviewed for wounds (Resident 9). Findings include:	F 0641	**The facility respectfully requests paper compliance for this citation.** **1) Immediate actions taken for those residents identified:** **It is the policy of this facility to ensure resident assessments accurately reflect the residents'**	08/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	During an observation, on 7/27/22 at 1:20 p.m., Resident 9 was sitting in recliner with his legs elevated, his heels were resting on pillows separating his feet and his right leg was resting over his left leg. During a wound observation accompanied by LPN 7 and RN 5, on 7/29/22 at 9:11 a.m., the resident was lying on his back on a shower bed, an open wound was visible to his right calf area, the open area was the length of a dime and the width of a pencil eraser. Calcium alginate (absorbent dressing) was applied to the wound that was covered by a padded dressing and secured with a gauze wrap. His clinical record was reviewed on 7/27/22 at 1:47 p.m. Diagnoses included, but were not limited to, traumatic brain injury and profound intellectual disabilities. A 5/17/22 quarterly MDS assessment indicated he was risk for the development of pressure ulcers, did not have any pressure ulcers and did not have any venous or arterial wounds. A current care plan for an open area to his lower right posterior leg, dated 3/28/22, indicated the goal was for area to heal without complications within the review date, the target date was 9/29/22. A current care plan for a right posterior calf lesion, dated 4/27/22, indicated he was at risk for complications. The goal, with a target date of 7/29/22, indicated the wound would heal without complications and remain intact. A wound assessment, dated 7/26/22 at 12:15 a.m., indicated an arterial ulcer to his right posterior, medial calf with an onset date on 4/27/21. The		**status. Resident 9's assessment was modified and submitted to CMS.** **2) How the facility identified other residents:** **All residents with altered skin integrity have the potential to be affected by the alleged deficient practice. All residents with altered skin integrity have been audited for accuracy; any discrepancies identified have been corrected and re-submitted to CMS. In-service was provided to MDS to ensure accuracy of all assessments prior to submission.** **3) Measures put into place/System changes:** **MDS or designee will complete a random audit of 3 residents for accurate coding on the MDS related to wounds 3 days a week x 4 weeks, then two days a week x 4 weeks, then one day a week x 4 weeks, then once a month for 3 months to ensure substantial compliance.** **Any concerns noted will be addressed and corrected.** **Results of the audits will be reviewed at the monthly QAPI meetings.** **Action Plan will be written by the QAPI Committee, if any patterns/trends/non-compliance identified.** **4) How the corrective actions will be monitored:**	

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	wound had closed over the week prior and would continue to be monitored. A wound assessment, dated 7/26/22 at 12:19 p.m., indicated an arterial ulcer to his right lower calf with an onset date of 3/29/22. The wound measured 0.75 cm (centimeter) in length and 0.4 cm in width and had no measurable depth. Treatment continued per wound clinic orders. During an interview, on 8/1/22 at 11:22 a.m., the Administrator indicated they used a consulting company to complete their MDS assessments. During an interview, on 8/1/22 at 1:58 p.m., the DON indicated they did not have a policy for MDS assessments, they referred to the RAI (Resident Assessment Instrument) manual.		**The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure interventions to aid in pressure relief were consistently in place	F 0686	**The facility respectfully requests paper compliance for this citation.**	08/30/2022

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	during random observations for 2 of 4 residents reviewed for pressure injuries (Residents 7 and 32). Findings include: 1. On 7/26/22 at 10:17 a.m., Resident 7 was in bed, laying on a low air loss mattress, which was unplugged from the wall. A mechanical lift pad was at the foot of the mattress. On 7/26/22 at 2:02 p.m., she was in bed. The mattress was unplugged from the wall and the resident was sinking into mattress. During an interview, at the time of the observation, LPN 50 indicated the mattress must have come unplugged when the bed was moved during cares. An observation of the underside of the bed indicated the cord was wrapped around the leg of the bed. During a wound care observation, on 7/28/22 at 8:48 a.m., a wound to her left buttock was dimpled in, with an opening approximately the diameter of a pencil. The wound was deep enough to require LPN 50 to apply approximately one-half length of a pencil of packing strip gauze into the wound (per physician order). Resident 7's clinical record was reviewed on 7/26/22 at 12:21 p.m. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, diabetes with nephropathy, profound intellectual disabilities, cauda equina syndrome, and stage four pressure injury to left buttock. Current physician orders included, but were not limited to, plain packing strip (gauze bandage) soaked with Dakin's solution, then wrung out so it		**1) Immediate actions taken for those residents identified:** **It is the policy of this facility to ensure resident assessments accurately reflect the residents' status. Resident 9's assessment was modified and submitted to CMS.** **2) How the facility identified other residents:** **All residents with altered skin integrity have the potential to be affected by the alleged deficient practice. All residents with altered skin integrity have been audited for accuracy; any discrepancies identified have been corrected and re-submitted to CMS. In-service was provided to MDS to ensure accuracy of all assessments prior to submission.** **3) Measures put into place/System changes:** **MDS or designee will complete a random audit of 3 residents for accurate coding on the MDS related to wounds 3 days a week x 4 weeks, then two days a week x 4 weeks, then one day a week x 4 weeks, then once a month for 3 months to ensure substantial compliance.** **Any concerns noted will be addressed and corrected.** **Results of the audits will be reviewed at the monthly QAPI meetings.** **Action Plan will be written by**	

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	remained damp, pack wound, and cover with a dressing daily and check function of low air loss mattress twice daily. A 5/10/22, quarterly, Minimum Data Set (MDS) assessment indicated she was rarely/never understood and rarely/never understood others. She required extensive assistance for bed mobility and was dependent for transfers. She had one unhealed pressure injury. During an interview, on 8/1/22 at 10:34 a.m., the Wound Nurse indicated she would expect the low air loss mattress to be functioning at all times. 2. During a wound observation, on 7/28/22 at 9:11 a.m., Resident 32 was in bed. He had a reddened, open surface wound to his upper right back area to back, approximately the size of ping pong ball. His outer left ear presented with a scabbed area and redness. During the observation, LPN 71 indicated the resident had a tendency to lay on his left ear due to spacticity and his natural positioning; he used pillows to offset pressure to the area. During a random observation, on 7/29/22 at 10:18 a.m., he was up in his wheelchair in his room. His ear was directly against his head rest and his ear pillow was not in place. During an observation, on 7/29/22 at 10:45 a.m., he remained in the wheelchair, with his left ear directly against his head rest. During an interview, at the time of the observation, LPN 75 indicated he should have had a pillow in place between the head rest and his ear. The pillow may have been soiled and taken to the laundry. During an observation at the time of		**the QAPI Committee, if any patterns/trends/non-compliance identified.** **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	the interview, LPN 75 assisted the resident to lift his head. His left ear was dark red in color. Resident 32's clinical record was reviewed on 7/27/22 at 9:18 a.m. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, profound intellectual disabilities, failure to thrive, cauda equina, and stage two pressure injuries to his left ear and right lateral back. Current physician orders included, but were not limited to, cover fragile area to right upper flank with foam once daily, low air loss mattress, cut out pillow to left ear when in bed and or in recliner and wheelchair, and waffle cushion for left ear. A 6/14/22, quarterly, MDS assessment indicated he was rarely/never understood and rarely/never understood others. He was dependent for bed mobility and transfers. He had an unhealed pressure injury. During an interview, on 8/1/22 at 10:36 a.m., the Wound Nurse indicated the resident only had one of the type of pillow used for his ear when he was up in his wheelchair. Review of a current facility policy titled "Skin Condition Policy," dated 5/19/21 and provided by the DON on 8/1/22 at 1:15 p.m., indicated the following: "...Purpose: To provide a system for evaluation of skin to identify risk and individual interventions to address risk and process for care on changes/interruptions in skin integrity...Potential resident interventions to prevent skin impairments/assist in healing may include: Specialty mattress...individual repositioning...." 3.1-40(a)(2)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions were consistently implemented for 1 of 2 residents reviewed for falls (Resident 51). Findings include: On 7/27/22 at 1:19 p.m., Resident 51 was sitting in her low bed, with her legs and feet partially on the bedside mat. On 7/28/22 at 8:26 a.m., she was sitting in her low bed, on her knees and elbows, playing with a fidget toy. On 7/29/22 at 10:17 a.m., she was in her bed, laying on her side. The bed was raised to approximately knee height. During an interview, on 7/29/22 at 10:33 a.m., the Activity Director indicated the bed should have been low, but she didn't know how low. The resident's care plan would show how her bed should kept, and she lowered the resident's bed to floor level. Resident 51's clinical record was reviewed on 7/27/22 at 8:35 a.m. Diagnoses included, but were	F 0689	**The facility respectfully requests paper compliance for this citation.** **1) Immediate actions taken for those residents identified:** **It is the policy of this facility to ensure resident assessments accurately reflect the residents' status. Resident 9's assessment was modified and submitted to CMS.** **2) How the facility identified other residents:** **Residents with altered skin integrity have the potential to be affected by the alleged deficient practice. Residents with altered skin integrity have been audited for accuracy; any discrepancies identified have been corrected and re-submitted to CMS. In-service was provided to MDS to ensure accuracy of all assessments prior to submission.** **3) Measures put into place/System changes:** **MDS or designee will**	08/30/2022

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	not limited to, Down syndrome, developmental disorder of speech and language, and scoliosis. A 6/24/22, quarterly, Minimum Data Set (MDS) assessment indicated she was rarely/never understood and rarely/never understood others. She required extensive assistance with bed mobility, limited assistance with transfers, and supervision when walking in her room. She was not steady when moving from seated to standing, and required human assistance to stabilize. She had a current care plan problem, revised/reviewed on 6/21/22, of would sit down on the floor. Interventions included, but were not limited to, direct to activity and provide a safe environment. She had a current care plan problem, reviewed/revised on 7/26/22 for risk for falls related to history of falling, unsteady gait, scoliosis, G- tube use, incontinence, and diabetes with hypoglycemia at times. Interventions included, but were not limited to, mats on floor to both sides of bed and bed to be kept in lowest position at all times except during care. Review of 4/12/22 orthopedics note indicated she had recurrent hip dislocations due to a known dysplastic right acetabulum (the ball and socket joint was not as deep as it should be) and her left hip also showed acetabular dysplasia but not as severe. Review of a current facility policy titled "Fall Management," dated 5/19/21 and provided by the DON on 8/1/22 at 1:15 p.m., indicated the following: "...Fall prevention is achieved through an interdisciplinary approach of managing risk factors and implementing appropriate		**complete a random audit of 3 residents for accurate coding on the MDS related to wounds 3 days a week x 4 weeks, then two days a week x 4 weeks, then one day a week x 4 weeks, then once a month for 3 months to ensure substantial compliance.** **Any concerns noted will be addressed and corrected.** **Results of the audits will be reviewed at the monthly QAPI meetings.** **Action Plan will be written by the QAPI Committee, if any patterns/trends/non-compliance identified.** **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	interventions to reduce risk for falls...." 3.1-45(a)(2)			