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	10/22/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 15, 16, 17, 18, 21, and 22, 2024 Facility number: 000274 Provider number: 155810 AIM number: 100271660 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicaid: 48 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 4, 2024.	F 0000	This Plan of Correction is being prepared and executed because it is required by the provisions of state regulation, and not because Vernon Health and Rehabilitation agrees with the allegations and citations listed on the statement of deficiencies. Vernon Health and Rehabilitation maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Vernon Health and Rehabilitation's written credible allegations of compliance. This plan of correction Is not meant to establish any standard of care contract, obligation or position, and Vernon Health and Rehabilitation reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction 12/14/24, as the facility's credible allegation of compliance. We respectfully request paper compliance.	
F 0550 SS=D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Bates	HFA	11/30/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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Bldg. 00	Based on observation, record review, and interview, the facility failed to ensure privacy was provided during incontinence care for 2 of 3 residents reviewed for dignity (Resident 38 and Resident 39). Findings include. 1. During a random observation, on 10/17/24 at 1:29 p.m., Resident 39 was visible from the room door window as a new brief was applied by CNA 6. The resident's privacy curtain had not been pulled. During an interview, on 10/17/24 at 1:46 p.m., Certified Nurse Assistent (CNA) 6 indicated she would typically pull the curtain around the resident for privacy during care. She was in a hurry and had not done so for Resident 39. Resident 39's clinical record was reviewed on 10/21/24 at 4:48 p.m. Diagnoses included need for personal assistance with care. A quarterly Minimum Data Set (MDS) assessment, completed on 9/18/24, indicated Resident 39 was dependent on the staff for upper and lower body dressing, toileting hygiene, personal hygiene, and for rolling left to right. 2. During a random observation, on 10/17/24 at 1:36 p.m., CNA 6 assisted Resident 38 in his wheelchair to his room. She pulled the privacy curtain of the first bed beside the door to nearly the edge of the first bed. Resident 38's foot of the bed including his feet were fully visible from the door window. His privacy curtain was not pulled around him. He was visible to the occupant of the first bed and the occupant of the bed against the	F 0550	**1. What corrective action will be accomplished for those residents found to have been affected by the accepted deficient practice:** The CNAs involved were immediately in-serviced on ensuring resident privacy during incontinence care. Residents 38 and 39 did not have any negative outcomes related to the alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident who requires incontinence care has the potential to be affected by the alleged deficient practice. **3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** CNA's involved in providing incontinence care have been re-educated on providing privacy during resident care. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON/Designee will conduct random observations of staff providing incontinence care to	12/14/2024

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	wall throughout his incontinence care. During an interview, on 10/17/24 at 1:46 p.m., CNA 6 indicated she had pulled the curtain near the door so Resident 38 could not be seen from the door. She had not pulled the privacy curtain around him to provide him with privacy from the other residents in the room. Resident 38's clinical record was reviewed on 10/21/24 at 4:41 p.m. Diagnoses included need for assistance with personal care. A quarterly MDS assessment, completed on 9/16/24, indicated Resident 38 was dependent on the staff for upper and lower body dressing, toileting hygiene, personal hygiene, and for rolling left to right. During an interview, on 10/21/24 at 2:47 p.m., CNA 7 indicated the privacy curtain should be pulled around a resident when care was provided for said resident. During an interview, on 10/21/24 at 2:55 p.m., CNA 8 indicated she would pull the privacy curtain around the resident when performing resident care. During an interview, on 10/21/24 at 3:38 p.m., the Director of Nursing (DON) indicated privacy should be provided when resident care was done. During an interview, on 10/21/24 at 4:19 p.m., the DON indicated the facility did not have a policy on providing privacy during resident care. 3.1-3(t)		ensure privacy is provided to 3 residents 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks then monthly for 3 months. Observation reports will be reviewed by the QAPI committee monthly until substantial compliance is achieved as determined by the committee.	

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F 0600 SS=E Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on observation, record review, and interview, the facility failed to provide adequate supervision and intervention to prevent physical resident-to-resident abuse for 4 of 4 residents reviewed for resident-to-resident abuse (Resident 19, Resident 21, Resident 43, and Resident 44). Findings include: 1. During an observation, on 10/15/24 at 9:15 a.m., Resident 43 stood up from her wheelchair, grabbed the nurses' desk to steady herself, her foot caught behind the wheelchair pedal, and she continued to lean forward to attempt to ambulate toward facility visitors. CNA 10 attempted to assist the resident to sit down in the wheelchair. Resident 43 declined and continued to ambulate toward the visitors with the assistance of CNA 10. Resident 43 reached out and attempted to grab a visitor's drink. CNA 10 redirected the resident by offering her a soda if she would sit down in the wheelchair. The resident agreed. During an observation, on 10/16/24 at 9:03 a.m., Resident 43 sat in her wheelchair beside the nurses' station near the administrator's office and facility's front entrance doors. During an observation, on 10/16/24 at 1:35 p.m., the resident sat in her wheelchair at the doorway of the administrator's office and facility's front entrance doors. During an observation, on 10/18/24 at 8:50 a.m., the resident sat in her wheelchair beside the nurses' station near the administrator's office.	F 0600	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Care plan and behavioral interventions for residents 19, 21, 43 and 44 were reviewed and updated to ensure appropriate for each individual's current plan of care. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Residents with targeted behaviors will be reviewed for appropriate care plan interventions. Nursing staff will be educated on where to find each residents' interventions as well as abuse policy and procedures. **4. How the corrective action will be monitored to ensure the deficient practice will not recur?** Director of Nursing or designee will audit 3 residents with targeted behaviors care plan for appropriate	12/14/2024

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	During an observation, on 10/18/24 at 12:11 p.m., the resident sat in her wheelchair beside the nurses' station. During an observation, on 10/18/24 at 1:00 p.m., the resident reached out and grabbed at Activity Aide 13 during lunch. Activity Aide 13 indicated she would sit with Resident 43 during the meal. Resident 43's clinical record was reviewed on 10/17/24 at 3:59 p.m. Diagnoses included spastic quadriplegic cerebral palsy, post-traumatic stress disorder, depression, adjustment disorder with mixed anxiety and depressed mood, hallucinations, generalized anxiety disorder, and suspected adult sexual abuse. The current physician's orders included venlafaxine extended release (antidepressant) 37.5 milligrams (mg) daily, alprazolam (antianxiety) 0.5 mg every 8 hours, and ziprasidone (antipsychotic) 40 mg twice a day. A quarterly Minimum Data Set (MDS) assessment, completed on 4/26/24, indicated the resident was unable to complete the interview to determine cognitive status. The resident had long and short-term memory impairment, and her cognitive decision making skills were severely impaired. She had hallucinations. She exhibited physical symptoms directed at others 1 to 3 days of the assessment period. She exhibited other behavioral symptoms not directed toward others daily. A quarterly Minimum Data Set (MDS) assessment, completed on 7/24/24, indicated the resident was unable to complete the interview to determine cognitive status. The resident had long and short-term memory impairment, and her		interventions 5 times weekly for four weeks, then 3 times weekly for four weeks; then 1 time weekly for 4 weeks, and then 1 resident monthly for three months to ensure compliance.	

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	cognitive decision making skills were severely impaired. She had hallucinations. She exhibited other behavior symptoms not directed toward others 4 to 6 days of the assessment period but not daily. A care plan for verbal aggression indicated the resident would sometimes use curse words (initiated 5/8/24 and last revised/reviewed 10/15/24). Interventions included encourage resident to use positive language, redirect conversation, and redirect to different activity such as a movie. Interventions were initiated 5/8/24 and last revised/reviewed 10/15/24. A care plan for a target behavior for putting up her middle finger to others was initiated on 5/8/24 and last revised/reviewed on 10/15/24. Interventions included encourage resident to not be inappropriate, engage in conversation, and redirect to an activity such as a movie or jukebox. Interventions were initiated 5/8/24 and last revised/reviewed 10/15/24. A care plan for a target behavior of self-injurious behavior (SIB), initiated on 9/11/23 and last revised/reviewed on 9/3/24, indicated the resident sometimes hit herself. Interventions included offer a snack or drink, offer a movie, and redirect to a baby doll or musical device. Interventions were initiated 9/11/23 and last revised/reviewed 9/3/24. A care plan for food seeking, initiated on 9/9/23 and last revised/reviewed on 9/3/24, indicated the resident would sometimes try to take food from others. Interventions included direct attention to a sensory device like her dolls or telephone, offer snacks frequently, and offer to sing with her. Interventions were initiated on 9/9/23 and last revised/reviewed on 9/3/24.			

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A care plan for the behavior of inappropriate sexual comments was initiated on 5/25/23 and last revised/reviewed on 9/3/24. Interventions included change conversation, educate on appropriateness, and offer snack. Interventions were initiated on 5/25/23 and last revised/reviewed on 9/3/24.

A care plan for post traumatic stress disorder was initiated on 5/8/24 and last revised/reviewed on 9/3/24. Interventions included ensure immediate safety and that of others, gently redirect or reorient as needed, and observe for stressors in the environment and provide a quiet, non-stimulating environment. Interventions were initiated on 5/8/23 and last revised/reviewed on 9/3/24.

A care plan for a target behavior of aggression as evidenced by hitting, biting, and scratching was initiated on 5/5/23 and last revised/reviewed on 10/11/24. Interventions included 15-minute checks for 72 hours (initiated 10/11/24), redirect resident away from nurses' station when appropriate or needed (initiated 1/5/24), educate resident she could hurt someone (initiated 9/15/23), offer snack, coffee, or soda (initiated 5/8/23), give cool down period (initiated 5/5/23), and play music (initiated 5/5/23). Interventions were last /revised/reviewed on 10/11/24.

A progress note, dated 1/5/24 at 3:41 p.m., indicated Resident 43 made contact with another resident.

A resident-to-resident investigation for 1/5/24, provided by the Administrator on 10/18/24 at 1:12 p.m., indicated Resident 43 made contact with Resident 21 in the face with an open hand as she

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	approached Resident 21. Both residents were in their wheelchairs. The contact resulted in a small scratch on Resident 21's face. A progress note, dated 2/6/24 at 4:08 p.m., indicated the resident made contact with another resident with a slight pat to the face. A resident-to-resident investigation for 2/6/24, provided by the Administrator on 10/18/24 at 1:12 p.m., indicated Resident 43 made slight contact with Resident 19's nose with an open hand. The investigation determined the actions of Resident 43 were not intended to harm Resident 19. The staff indicated Resident 43's behavior of lightly tapping the nose was common when expressing feeling of friendship. A progress note, dated 2/9/24 at 9:50 a.m., indicated the resident shook her finger aggressively towards another resident. She was removed from the situation by the staff. A progress note, dated 2/14/24 at 6:55 p.m., indicated the resident had a verbal altercation with another resident. She was moved to a safe area. A progress note, dated 3/6/24 at 4:53 p.m., indicated the resident made contact with another resident. A resident-to-resident investigation for 3/6/24, provided by the Administrator on 10/18/24 at 1:12 p.m., indicated Resident 21 was witnessed to have a small mark on her forehead and a small scratch on her nose. Resident 43 was witnessed to be sitting beside Resident 21. Staff witnessed no contact between the residents. A progress note, dated 3/27/24 at 7:01 a.m.,			

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	indicated Resident 43 approached the provider and requested a hug while the provider was in a male resident's room. The staff reminded the resident it was not appropriate to enter the male resident's room, and the provider would exit when finished. The resident expressed verbal frustration and cursed at the provider. A progress note, dated 4/12/24 at 9:05 a.m., indicated an aggressive outburst was reported to the provider. The resident threw a carton of feeding at another resident for pointing at her. A progress note, dated 4/16/24 at 4:09 p.m., indicated contact was made by another resident with Resident 43. The other resident put Resident 43 in a headlock and was biting her. A resident-to-resident investigation for 4/16/24, provided by the Administrator on 10/18/24 at 1:12 p.m., indicated Resident 43 approached Resident 21. Resident 21 grabbed Resident 43's hair and made contact with Resident 43. A progress note, dated 5/2/24 at 4:42 p.m., indicated contact was made by another resident. Resident 43 had a small red mark on her left cheek. A resident-to-resident investigation for 5/2/24, provided by the Administrator on 10/18/24 at 1:12 p.m., indicated Resident 43 sat at the nurses' station in her wheelchair when Resident 21 grabbed Resident 43's hair and attempted to bite Resident 43's left check. Small red area noted to Resident 43's left cheek. Resident 21 was moved to a different hall to prevent future incidents between the two residents. A progress note, dated 5/3/24 at 6:47 p.m., indicated Resident 43 was cursing at another			

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	resident in the hallway. She flipped her middle finger up at the other resident. Resident 43 was assisted to her room. A progress note, dated 5/6/24 at 5:53 p.m., indicated Resident 43 took another resident's soda off his tray. She flipped her middle finger up at the other residents in the dining room without provocation. A progress note, dated 5/8/24 at 6:45 p.m., indicated Resident 43 went over to another resident's table, took the resident's plate, held it up to her mouth, and licked the plate. When staff attempted to intervene Resident 43 cursed, yelled, and flipped her middle finger up at the staff. A progress note, dated 7/16/24 at 6:09 p.m., indicated Resident 43 threw her shoe at another resident. She smacked herself then blamed the other resident for hitting her. A progress note, dated 8/25/24 at 10:47 a.m., indicated Resident 43 put herself on the floor from her wheelchair multiple times. She was difficult to redirect. She shook her fist and flipped her middle finger up numerous times at other residents. A progress note, dated 8/25/24 at 10:02 p.m., indicated Resident 43 made contact with another resident. A resident-to-resident investigation for 8/25/24, provided by the Administrator on 10/18/24 at 1:12 p.m., indicated the CNA heard a commotion in the hallway between Resident 19 and Resident 43. Resident 19 had scratches on her upper extremities. Resident 43 was placed on 15-minute checks and was moved to another hall.			

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	A resident-to-resident investigation for 10/11/24, provided by the Administrator on 10/18/24 at 1:12 p.m., indicated Resident 43 was at the front entrance doors when Resident 44 crouched down in front of her face and asked where she was going. Resident 43 made contact with Resident 44's nose with an open hand. Resident 44 made contact with Resident 43's face with an open hand. Resident 44 had a small open area to the bridge of his nose from his glasses. During an interview, on 10/21/24 at 12:43 p.m., the Social Services Director (SSD) indicated Resident 43 was redirected often with coffee and food. When Resident 43 would go to the unit in the back hall she had to be closely monitored because Resident 19 and Resident 21 do not get along with her (Resident 43). During an interview, on 10/21/24 at 2:55 p.m., Certified Nurse Assistant (CNA) 8 indicated she was uncertain what the specific interventions were for Resident 43 as she had been recently hired. She said she would look them up on the care plan to see Resident 43's behaviors and triggers. During an interview, on 10/21/24 at 3:07 p.m., LPN 14 indicated Resident 43 was mostly verbal. She would make eye contact with the resident and tell her what she was doing was not appropriate. If the resident was really upset, she would remove her from the situation and talk to the resident on the resident's level. During an interview, on 10/21/24 at 4:19 p.m., the DON indicated Resident 43 had been doing much better since she had moved to the front hall. The incident on 10/11/24 was the first one that had occurred since the move.			

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	2. During an observation, on 10/21/24 at 3:37 p.m., Resident 21 wheeled herself out of the Director of Nursing (DON)'s office. She was smiling as she moved her arms spastically. Resident 21's clinical record was reviewed on 10/21/24 at 9:04 a.m. Diagnoses included spastic quadriplegic cerebral palsy, profound intellectual disabilities, and mixed receptive-expressive language disorder. A quarterly MDS assessment, completed 8/21/24, indicated the resident was rarely or never understood and rarely or never understood others. Her cognitive decision-making skills were severely impaired. She exhibited physical behavioral symptoms directed at other 1 to 3 days during the assessment period and other behavioral symptoms not directed at others 4 to 6 days, but less than daily during the assessment period. A care plan for behavioral symptoms indicated the resident could only propel her wheelchair by using her left hand on the wheels of her chair. The resident leaned side to side, was very spastic and would inadvertently bump into others with her head/mouth. The resident would move her wheelchair in front of people walking in the halls and block doors. The resident had a behavior of unsafe wheelchair mobility. The care plan was initiated 5/31/16 and last revised/reviewed on 9/12/24. Interventions included educate the resident their behavior was unsafe, redirect to an activity, and report any behaviors to the nurse. All interventions were initiated on 6/3/16 and last revised/reviewed on 9/12/24. A care plan for aggression indicated the resident			

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	would bite or reach out and grab/hit others or bite them. The care plan was initiated on 6/3/16 and last revised/reviewed on 10/3/24. Interventions included encourage therapeutic rest following any outside activity as needed (initiated 9/6/18), educate it was not nice to hit others (initiated 4/21/17), and promptly respond to her to decrease her behavior of grabbing/hitting/biting when she wanted attention (initiated 6/3/16). All interventions were last revised/reviewed on 10/3/24. A progress note, dated 1/5/24 at 3:47 p.m., indicated the resident had contact with another resident. A red scratch on her left cheek from the contact was 4 cm (centimeters) long by 0.1 cm wide. A progress note, dated 3/6/24 at 8:38 p.m., indicated the resident was in an altercation with another resident earlier in the day resulting in pink marks to the resident's right check and above the right eye. A progress note, dated 4/16/24 at 3:59 p.m., indicated the resident made contact to another resident. There was no documentation regarding injury. A progress note, dated 5/2/24 at 4:29 p.m., indicated the resident made contact with another resident. There was no documentation regarding injury. 3. During an observation, on 10/17/24 at 6:03 p.m., Resident 19 smiled at staff and wheeled herself down the hallway to the dining room and back to her room. Resident 19's clinical record was reviewed on			

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	155810	A. BUILDING 00 B. WING	10/22/2024

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	10/21/24 at 11:01 a.m. Diagnoses included severe intellectual disabilities, impulse disorder, and oppositional defiant disorder. An annual MDS assessment, completed on 9/9/24, indicated the resident rarely or never understood others and was rarely or never understood by others. Her cognitive skills for decision making were severely impaired. A progress note, dated 2/6/24 at 4:14 p.m., indicated contact was made by another resident. The resident was smiling and no injuries were identified. A progress note, dated 8/25/24 at 10:11 p.m., indicated the resident made contact with another resident. Multiple surface level scratches were noted to face, chest and left thigh. 4. During an observation, on 10/15/24 at 11:27 a.m., Resident 44 ambulated down the hallway with his cane smiling at other residents and staff members. During an observation, on 10/17/24 at 4:28 p.m., Resident 44 sat outside the facility's front entrance, smiled, and indicated he was enjoying the weather. Resident 44's clinical record was reviewed on 10/21/24 at 10:22 a.m. Diagnoses included anxiety disorder, major depressive disorder, and visual hallucinations. A quarterly MDS assessment, completed 8/26/24, indicated the resident was cognitively intact. He exhibited no behaviors. A resident-to-resident investigation for 10/11/24,			

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	provided by the Administrator on 10/18/24 at 1:12 p.m., indicated Resident 43 was at the front entrance doors when Resident 44 crouched down in front of her face and asked where she was going. Resident 43 made contact with Resident 44's nose with an open hand. Resident 44 made contact with Resident 43's face with an open hand. Resident 44 had a small open area to the bridge of his nose from his glasses. During an interview, on 10/18/24 at 4:32 p.m., the Administrator indicated she had been in her office right in the immediate vicinity of Resident 43's and Resident 44's resident-to-resident interaction. The interaction had happened very quickly without warning. During an interview, on 10/21/24 at 4:19 p.m., the DON indicated she believed Resident 44 bent down and was in Resident 44's face causing her to react out of fight or flight mode when she hit him. She believed he also reacted instinctively when he hit her back. A facility policy, dated 3/5/24, provided by the Administrator on 10/15/24 at 11:32 a.m., titled "Abuse and Neglect Policy," indicated "...All residents will be protected from harm...." 3.1-27(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure interventions were implemented as ordered for a resident experiencing an acute medical decline for 1 of 2 residents reviewed for hospitalizations (Resident 18)	F 0684	**1. What corrective action will be accomplished for those residents found to have been affected by the accepted deficient practice:** Resident #18 has returned to the	12/14/2024

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	Findings include: Resident 18's clinical record was reviewed on 10/17/24 at 3:44 p.m. Diagnoses included spastic quadriplegic cerebral palsy, severe intellectual disabilities, idiopathic epilepsy and epileptic syndromes, hyperglycemia (elevated blood sugar), and chronic kidney disease. A care plan, revised on 10/15/24 at 4:01 p.m., indicated the resident was unable to independently change positions, feed self, toilet self, or transfer self. He was dependent on staff for all needs to be met with routine, anticipatory care. A revision of his care plan, dated 9/17/24 at 12:47, included the addition of enhanced barrier precautions (EBP) because he had an indwelling device (suprapubic catheter) which placed him at higher risk for infection. Lab results, dated 10/10/24, indicated the resident's blood glucose level was 456 mg/dL (milligrams per deciliter). (Normal blood glucose levels run between 70 mg/dL and 100 mg/dL.) On 10/10/24, at 1:50 p.m., a nurse practitioner's note indicated an order for 10 units of Novolog insulin (a rapid acting insulin), 10 units daily of Lantus insulin (a long-acting insulin), and a hemoglobin A1C (HbgA1c) to be performed one week later (measures average glucose levels for the previous 3 months). The NP indicated the resident's low sodium level was likely related to elevated blood sugars. The plan was to follow glucose levels closely and get repeat labs in a week. A review of lab results in the clinical record between 10/10/24 and 10/20/24 indicated no HbgA1c had been performed.		facility from hospital at baseline status. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident has the potential to be affected by the alleged potential practice. **3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** Licensed staff have been re-educated to ensure all interventions are implemented as ordered. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON/Designee will conduct random audit of 3 residents 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks then monthly for 3 months to ensure interventions are implemented as ordered. Audits will be reviewed by the QAPI committee monthly until substantial compliance is achieved as determined by the committee.	

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	A progress note, dated 10/11/24 at 1:53 a.m., indicated nursing checked Resident 18's blood glucose due to issues from earlier in the day. (The issues were not specified). The NP was notified of a blood glucose of 330 mg/dL. The NP advised the nurse to recheck blood glucose at 4:00 a.m. There was no documentation in the resident's clinical record to indicate the blood glucose level was obtained at 4:00 a.m. on 10/11/24, as ordered. Vital signs on 10/11/24, at 10:30 a.m., indicated the resident's blood glucose was now 502 mg/dL. A progress note, dated 10/20/24, at 1:29 p.m., indicated the resident's blood glucose was 373 mg/dL. His respiratory rate was 32 (per minute) and heart rate was 122 beats per minute (bpm). His oxygen saturation was 87% on room air. He required 4 liters of oxygen via nasal cannula to maintain an oxygen saturation of 91%. The NP ordered a stat CBC (complete blood count), with differential, a stat BMP (basic metabolic panel), a stat magnesium level, a stat chest x-ray, a stat UA (urinalysis), an additional 15 units of Novolog, and 2 grams IM (intramuscular injection) of Rocephin (antibiotic). The note indicated the Rocephin was pulled from the emergency drug kit at that time. A progress note, dated 10/20/2024 at 1:47 p.m., indicated the resident's oxygen saturation was 86%. A breathing treatment was administered at that time. His heart rate was 121 bpm, respiratory rate was 28 bpm and shallow, and breath sounds were clear but diminished on the left side. Slight rhonchi (gurgling or bubbling sounds) were heard on the right side. After the breathing treatment, his heart rate was 125 bpm, respirations were 32			

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	bpm and shallow, breath sounds were unchanged. He was placed on 4 liters of oxygen via nasal cannula, resulting in an oxygen saturation of 91%, heart rate of 125 bpm, and respirations had increased to 40 bpm, still shallow. Nursing was to continue to monitor. On 10/20/24, at 2:23 p.m., a progress note indicated the resident's supplemental oxygen had to be increased to 5 liters because his oxygen saturation levels had decreased to 90%. His respiratory rate continued at 40 bpm. The resident would continue to be monitored. On 10/20/24 at 2:25 p.m., a progress note indicated the nurse called the resident's representative to give an update on the resident's status. The representative requested the resident be sent out to a local hospital to be evaluated. The note indicated, as of the time of departure, the Rocephin had not been administered. On 10/20/24, at 11:41 p.m., a progress note indicated the nursing facility received a call from the local hospital. The resident had to be intubated (a breathing tube was inserted into the resident's airway) and was transferred to a larger, regional hospital. During an interview with LPN 5 on 10/21/24 at 3:47 p.m., she indicated the regional hospital had called with an update. The resident was intubated and was septic (a life threatening condition involving the body's response to an infection). During an interview with the NP on 10/21/24 at 2:26 p.m., she indicated when she talked to nursing on 10/20/24 at 1:21 p.m., she asked the LPN 5 to get the resident's vital signs, which indicated Resident 18 was meeting sepsis criteria.			

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	Prior to this, she had only had his glucose levels reported to her. She ordered 2 grams of Rocephin to be administered immediately. At 2:32 p.m., the nurse called to tell the NP the Rocephin had not been given because the nurse could not find a 1-inch needle with which to administer the antibiotic. The NP told LPN 5 at that time how critical it was for antibiotics to be administered at the first signs of sepsis. The risk of sepsis increased 10% every hour without antibiotics. During an interview with the Director of Nursing (DON), on 10/21/24 at 3:54 p.m., she indicated she had received a report from the regional hospital. The resident was septic and had a urinary tract infection (UTI). The resident had a history of declining rapidly when sick. During an interview with LPN 5, on 10/21/24 at 4:54 p.m., she indicated she called the NP at 7:00 a.m. on 10/20/24 to tell her the resident's blood glucose was high. At 9:30 a.m., she called the NP with blood glucose levels. At 1:30 p.m., she contacted the NP and received orders for insulin, stat labs, chest x-ray, and 2 grams of Rocephin. She could not find a 1-inch needle to administer the Rocephin. When she told the NP that she had not given the Rocephin, the NP was fine with it. LPN 5 had been busy with other needs, residents, and tasks on the unit. The resident did not appear to be in distress. LPN 5 had been monitoring and reporting the resident's vitals regularly since first contacting the NP at 7:00 a.m. on 10/20/24. The resident had a history of declining rapidly when sick. Resident 18's hospital progress notes, dated 10/20/24 indicated the resident was seen by intensivist services for septic shock. The resident was transferred from his facility to the emergency			

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	department with complaints of decreased level of consciousness and hyperglycemia (high blood glucose). In the emergency department, he was found to have signs of sepsis including tachycardia (elevated heart rate), hypotension (low blood pressure), and elevated lactic acid levels. Due to his decreased mentation, he was eventually intubated for airway protection and hypoxia (low oxygen levels). A current facility policy, provided by the DON on 10/22/24 at 10:27 a.m., titled "Change In A Resident's Condition or Status", indicated the following: "...6) The....nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status." 3.1-37(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff Based on observation, interview, and record review, the facility failed to ensure staff were qualified to perform GJ-tube care for 1 of 1 residents reviewed for feeding tubes. (Resident 42) Findings include: A clinical record review for Resident 42 was performed on 10/16/24 at 11:06 a.m. Diagnoses included anoxic brain damage, gastrostomy malfunction, lack of expected normal physiological development in childhood, artificial openings of the gastrointestinal tract, and a disorder of the autonomic nervous system which caused sympathetic storming (a condition which can occur with patients with severe brain injuries).	F 0726	**1. What corrective action will be accomplished for those residents found to have been affected by the accepted deficient practice:** QMA 12 has been re-educated on the scope of the QMA to include not changing enteral feeding tubing or hanging enteral feeding. Resident # 42 has had no negative findings from the alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	12/14/2024

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	Physician orders, dated 7/22/24, indicated the resident was to receive Pedia-Sure Enteral Formula through his gastrojejunostomy (GJ-tube). (A GJ-tube is a means of delivering food to someone who cannot eat by mouth.) The order specified 620 mils (milliliters)of Pedia-Sure combined with 340 mils of Pedialyte. The pump was to run at 42 ml/hour for 23 hours per day. The bag of formula was to be changed every 24 hours. A care plan, revised on 9/12/24 at 1:36 p.m., indicated the resident was at risk for gastrointestinal complications related to gastrostomy, jejunostomy, and enteral feeding. On 10/16/24, at 2:09 p.m., QMA 12 was observed providing GJ-tube care for Resident 42. QMA 12 transferred the resident from his play pen to his crib. During the observation, QMA 12 indicated she had already prepared his bag of formula and would be switching the old bag out with the new bag. She detached the tubing connected to GJ-tube and checked the placement of the tube by flushing it with 10 mils of normal tap water. The tube was not flushing properly and took some time to begin to flow. The QMA indicated she was not concerned with the slow draining of the syringe. Once the tube was flushing properly, she attached the tubing connected to the new bag of formula and discarded the old bag and tubing. She indicated, at that time, it was her practice to date the new bag of formula before hanging it or attaching it to the resident. A review of Resident 42's MAR (medication administration record) was performed on 10/17/24 at 9:36 a.m. The following dates indicate the days		Any resident who requires continuous enteral feeding has the potential to be affected by the alleged potential practice. An audit was completed with no negative findings noted. **3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** QMA staff have been re-educated to ensure they understand the scope of their job functions. QMA staff have been provided with reviewed and signed new orientation packets. Failure to adhere to the scope of practice will result in disciplinary action up to and including termination. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON/Designee will conduct random audit of 3 residents 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks then monthly for 3 months to ensure enteral feedings are only being administered and changed by licensed personnel. Audits will be reviewed by the QAPI committee monthly until substantial compliance is achieved as determined by the committee.	

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	in October 2024 when QMA 12 hung and attached a new bag of formula for Resident 42: 10/10/24, 10/16/24, and 10/17/24. These dates were documented under the order for the enteral feeding bag to be changed every 24 hours. During an interview with LPN 5 on 10/17/24 at 10:57 p.m., she indicated QMAs were allowed to spike the enteral feeding bags and program the pump for Resident 42. During an interview with the DON on 10/18/24 at 4:03 p.m., she indicated QMAs could clean around the GJ-tube site, but could not hang a new bag of formula, nor attach the new tubing to the GJ-tube site. A current facility document, titled "QMA Orientation", provided by the Administrator on 10/18/24 at 12:15 p.m., indicated QMAs were not oriented to hang enteral feeds or change the tubing accompanying a new bag.			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure shift to shift narcotic count and reconciliation was completed for 2 of 5 carts reviewed for medication reconciliation. (Kalor Hall and Timms Hall) Findings include: 1. During a medication storage observation of the Kalor Hall medication cart, on 10/21/24 at 1:21 p.m., accompanied by LPN 4, the "Narcotic Sheet Log/ Tracking Form" was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled	F 0755	**1. What corrective action will be accomplished for those residents found to have been affected by the accepted deficient practice:** No residents were affected by the alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident receiving a controlled substance has the potential to be	12/14/2024

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	medications: October 2024- lacked a narcotic card, liquid, and/or bottle count: 10/8 on day shift and night shift 10/9 on day shift and night shift 10/10 on day shift 10/11 on day shift October 2024- lacked a shift-to-shift narcotic reconciliation signatures: 10/12 on day shift and night shift 10/15 on day shift 10/18 on day shift During an interview, at the time of the observation, LPN 4 indicated the narcotic count was completed by the oncoming nurse and offgoing nurse during shift change. 2. During a medication storage observation of the Timms Hall medication cart, on 10/21/24 at 1:21 p.m., accompanied by LPN 4, the "Narcotic Sheet Log/ Tracking Form" was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: October 2024- lacked a narcotic card, liquid, and/or bottle count: 10/11 on day shift and night shift 10/14 on night shift October 2024- lacked a shift-to-shift narcotic reconciliation signatures: 10/16 on night shift		affected by the alleged potential practice. An audit was completed with none noted. **3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** DON/Designee re-educated the licensed staff on the proper way to complete the controlled substance shift to shift count sheet. Failure to complete the form will result in disciplinary action up to and including termination. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON/Designee will audit 3 med carts 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then 1 time a week x 4 week then monthly x 4 months to ensure the controlled substance shift to shift count sheet is completed. Audits will be reviewed by the QAPI committee monthly until substantial compliance is achieved as determined by the committee.	

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	During an interview, at the time of the observation, LPN 4 indicated the narcotic count was completed by the oncoming nurse and offgoing nurse during shift change. During an interview, on 10/18/24 03:37 p.m., the DON indicated staff was to complete the narcotic sheet log after every shift. A current facility policy, titled "Controlled Medication Storage," provided by the DON on 10/18/24 at 3:37 p.m., indicated the following: ... "At change of custody, a physical inventory of all controlled medications is conducted by 2 licensed/ certified personnel and is documented ...." 3.1- 25(b)(3)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on observation, interview, and record review, the facility failed to ensure monitoring of vital signs parameters as ordered for 1 of 1 residents randomly reviewed for parameters during medication administration. (Resident 27) Findings include: Resident 27's clinical record was reviewed on 10/21/24 at 8:35 a.m. Diagnoses included autistic disorder, essential hypertension (high blood pressure), hypothyroidism due to medicaments and other exogenous substances, and iron deficiency anemia. Current orders included atenolol (antihypertensive) 25 milligram (mg) tablet once daily with parameters of holding the medication if	F 0757	**1. What corrective action will be accomplished for those residents found to have been affected by the accepted deficient practice:** Resident #27 medications were reviewed by the physician and parameters were removed from the order. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident who requires an assessment to be completed prior to the administration of medication has the potential to be affected by	12/14/2024

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(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
	systolic blood pressure (top number) was less than 110 millimeters of mercury (mmHg) and/or heart rate was less than 55. A Medication Administration Report (MAR) for October 2024 indicated the resident received atenolol without obtaining blood pressure or pulse as follows: on 10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16. 10/17, 10/18, 10/19, 10/20, and 10/21. During a medication administration observation, on 10/21/24 at 8:17 a.m., LPN 4 was observed administering atenolol 25 mg without obtaining Resident 27's vital signs before administration. During an interview, on 10/21/24 at 8:34 a.m., LPN 4 indicated she did not check resident's blood pressure or heart rate before administering his atenolol. During an interview, on 10/21/24 at 9:22 a.m., the DON indicated vital signs were not completed before the administration of atenolol. Staff should be following the physician's order. During an interview, on 10/21/24 at 10:03 a.m., the MDS Coordinator indicated the need to check the medication parameters before administering the medication per physician orders. Review of a current facility policy, titled "Medication Administration," provided by the DON on 10/21/24 at 9:28 a.m., indicated the following: " ...Medications are administered in accordance with written orders of the physician/prescriber ...."		the alleged deficient practice. An audit was completed with no negative findings noted. **3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not happen again:** Licensed staff were re-educated on following physician orders and completing assessments prior to the administration of medications as ordered. Failure to do so will result in disciplinary action up to and including termination. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON/Designee will conduct random audit of 3 residents 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks then monthly for 3 months to ensure assessments are being completed prior to administering medications as ordered. Audits will be reviewed by the QAPI committee monthly until substantial compliance is achieved as determined by the committee.	

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	155810	A. BUILDING 00 B. WING	10/22/2024

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F 0759 SS=D Bldg. 00	3.1-48(a)(2) 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% related to medications not being administered according to orders for 2 of 36 opportunities of medication administration, resulting in a medication error rate of 5.56%. Findings include: During a medication administration observation, on 10/21/24 at 8:17 a.m., Licensed Practical Nurse (LPN) 4 was observed preparing mediations for Resident 27. The following was observed: LPN 4 prepared atenolol (high blood pressure) 25 milligram (mg) daily with parameters of holding the medication if systolic blood pressure was less than 110 millimeters of mercury (mmHg) and/or heart rate less than 55. Blood pressure and pulse were not obtained before administering the medication. LPN 4 prepared levothyroxine (hypothyroidism) 88 micrograms (mcg) daily. The medication was administered with eleven other medications, including but not limited to, famotidine (antacid) 20 mg twice daily, and ferrous sulfate (iron supplement) 325 mg daily. During an interview, on 10/21/24 at 8:34 a.m., LPN 4 indicated she did not check the resident's blood pressure or heart rate before administering the atenolol. During an interview, on 10/21/24 at 9:49 a.m., LPN	F 0759	**1. What corrective action will be accomplished for those residents found to have been affected by the accepted deficient practice:** No negative findings were noted from the alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident who receives medications has the potential to be affected by the alleged deficient practice. An audit was completed to ensure medications are administered after completing assessments per physician orders and per manufacture guidelines for thyroid hormones. Orders and administration times were adjusted as needed. **3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not happen again:** Licensed staff were re-educated following physician orders and manufacture guidelines when administering thyroid hormone medications. Failure to do so will result in disciplinary action up to	12/14/2024

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	5 indicated the need to check the physician's orders before administering medications. It would show under the physician's order if there were any medication parameters. Levothyroxine should be administered separately. During an interview, on 10/21/24 at 9:56 a.m., the Director of Nursing (DON) indicated the facility did not have an order to administer levothyroxine with other medications. During an interview, on 10/21/24 at 10:03 a.m., the MDS Coordinator indicated any medication parameters were in the physician's order. If the levothyroxine medication did not specify directions, one would go off the preference of the resident. During an interview, on 10/21/24 at 10:24 a.m., the DON indicated medication administration times were reviewed as part of the pharmacy medication reconciliation review. Resident 27's medications were reviewed in August, September, and October 2024 without any recommendations. Review of a current facility policy, titled "Medication Administration," provided by the DON on 10/21/24 at 9:28 a.m., indicated the following: " ...Medications are administered in accordance with written orders of the physician/prescriber ...." The National Institute of Medicine, Medline Plus document titled "Levothyroxine," dated 2/15/2019, was retrieved on 10/21/24 from https://medlineplus.gov/druginfo/meds/a682461.html. The guidance included: " ...if you take ferrous sulfate (iron supplement), take it at least 4 hours before or 4 hours after you take levothyroxine ...."		and including termination. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON/Designee will conduct random audit of 3 residents 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks then monthly for 3 months to ensure assessments are being completed prior to administering medications as ordered. Audits will be reviewed by the QAPI committee monthly until substantial compliance is achieved as determined by the committee.	

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F 0847 SS=E Bldg. 00	3.1-48(c)(1) 483.70(n)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements Based on record review and interview, the facility failed to provide an arbitration agreement that granted the resident or their representative the right to rescind the agreement within 30 days of signing it for 3 of 3 current residents reviewed who were admitted after 2/1/24 (Resident 26, Resident 44, and Resident 97). Findings include: During an interview conducted in conjunction with the entrance conference on 10/15/24 at 9:37 a.m., the Administrator indicated the facility offered arbitration agreements in the admission agreement packet. The sample admission agreement packet, provided as indicated above, was reviewed on 10/21/24 at 2:39 p.m. The admission/arbitration agreement packet lacked mention of the resident's or resident's representative's right to rescind the arbitration agreement within 30 days of signing the agreement. 1. Resident 44's 2/25/24, Admission Agreement document indicated section 8.7 addressed an agreement "not to elect a trial by jury of any fact trialable by a jury." The resident initialed "agree." The form lacked mention of the resident's or resident's representative's right to rescind the agreement within 30 days of signing the agreement. 2. Resident 97's 10/14/24, Admission Agreement document indicated section 8.7 addressed an	F 0847	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents 26,44 and 97 were provided with an updated admission agreement in which the arbitration agreement was removed. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents were found to be affected. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The arbitration agreement was removed from the admission agreement and new admission agreements were reviewed and obtained from residents and/or responsible parties. **4. How the corrective action will be monitored to ensure the deficient practice will not recur?** The Executive Director, or designee will audit the admission agreements for 3 new residents	12/14/2024

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	agreement "not to elect a trial by jury of any fact trialable by a jury." The resident's representative initialed "agree." The form lacked mention of the resident's or resident's representative's right to rescind the agreement within 30 days of signing the agreement. 3. Resident 26's 8/15/24, Admission Agreement document indicated section 8.7 addressed an agreement "not to elect a trial by jury of any fact trialable by a jury." The resident's representative initialed "agree." The form lacked mention of the resident's or resident's representative's right to rescind the agreement within 30 days of signing the agreement. During an interview, on 10/21/24 at 2:50 p.m., the Administrator indicated the Social Services Director (SSD) went over the arbitration agreement during the admission process and explained the resident/resident's representative could change their minds about arbitration within 30 days of signing the agreement. During an interview, on 10/21/24 at 2:57 p.m., the SSD indicated she explained during the admission process what arbitration was and the resident/resident's representative could change their minds about arbitration within 30 days if they changed their mind. She did not know where the admission/arbitration agreement indicated the resident could rescind the arbitration agreement. During an interview, on 10/21/24 at 3:32 p.m., the Administrator indicated the admission agreement containing the arbitration agreement lacked mention of the ability for the resident/resident's representative to rescind the arbitration agreement within 30 days of signing the agreement.		weekly for four weeks and then 3 admissions monthly for 5 months to ensure compliance.	

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	During an interview, on 10/21/24 at 3:50 p.m., the Administrator indicated the facility did not have a policy on arbitration.			