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	04/24/2024

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 the Investigation of Complaints IN00432997 and IN00433003. Complaint IN00432997 - Federal/state deficiencies related to the allegations are cited at F604. Complaint IN00433003 - No deficiencies related to the allegations are cited. Survey dates: April 23 and 24, 2024. Facility number: 000274 Provider number: 155810 AIM number: 100271660 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicaid: 49 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 2, 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 5/23/24, as the facility's credible allegation of compliance. We respectfully request paper compliance.	
F 0604 SS=D	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica McKinley	Executive Director	05/23/2024

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	§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review, and interview, the facility failed to ensure a resident was free from a physical restraint for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: On 4/23/24 at 4:03 a.m., Resident B was observed laying on a bed in his room.	F 0604	*1) What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* Resident B no longer resides in the facility 2) *How will other residents having the potential to be affected by the*	05/23/2024

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	On 4/23/24 at 4:26 a.m., Resident B was observed scooting down the hallway on his buttocks. QMA 4 assisted Resident B off of the floor and sat Resident B in a chair in the dining room. QMA 4 walked down to Resident B's room, retrieved a helmet, and placed it on Resident B's head. On 4/23/24 at 4:57 a.m., Resident B was ambulating independently in the hallway with a soft helmet on. He wandered into an all-male resident room. On 4/23/24 at 11:23 a.m., Resident B was lying on a bare mattress in his room. On 4/24/24 at 7:15 a.m., Resident B was scooting on his buttocks in the hallway. On 4/24/24 at 7:42 a.m., Resident B was laying in a female resident's bed while she occupied it, in a room across from the nurse's station. On 4/24/24 at 8:12 a.m., Resident B was ambulating independently near the nurse's station, naked from the waist down. On 4/24/24 at 12:39 p.m., Resident was being guided by his hand, by LPN 34, out of the dining room. Resident B's clinical record was reviewed on 4/23/24 at 7:20 a.m. Diagnoses included, but were not limited to, pervasive developmental disorder, profound intellectual disabilities, dysphagia, oropharyngeal phase, other lack of coordination, need for assistance with personal care, muscle weakness, diplegia of upper limbs, and insomnia. The current physician's orders included, but were not limited to, benazepril (treat high blood		*same alleged deficient practice be identified and what corrective action(s) will be taken?* All residents have the potential to be affected by this alleged deficient practice. Audit completed to ensure residents utilizing assigned wheelchairs. No negative findings noted. *3) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* In-service completed by DON/designee on 4/16/24 with all staff regarding Abuse, Neglect, Device and Restraint Policy, Resident Rights, and Care Plans. Failure to abide by the policy to result in further disciplinary action up to and including termination. *4) How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* The DON or designee will complete random audits of 5 residents to ensure all are free from physical restraints 5 days a week x 4 weeks, then 3 days a week x 4 weeks, then 1 day a week x 4 weeks, then once a month for 4	

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	pressure) 2.5 mg daily, lacosamide (treat seizures) 100 mg twice daily, metoprolol tartrate (treat high blood pressure) 25 mg twice daily, Novolog (short acting insulin) FlexPen per sliding scale, primidone (treat seizures) 250 mg daily, and 30 minute checks from 7:00 p.m. to 7:00 a.m., pressure reducing cushion to wheelchair, he may wear a protective helmet and he had a targeted behavior of crawling out of bed. At end of each shift mark the frequency (how often behavior occurred), the intensity (how resident responded to redirection) and the intervention (ensure his safety, ensure his was positioned correctly in bed, or assess him for injury). A quarterly Minimum Data Set (MDS) assessment, dated 4/10/24, indicated Resident B was rarely/never understood. Resident B had an impairment to his bilateral upper and lower extremities. Resident B used a wheelchair. Resident B had other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) that occurred daily. A care plan, dated 7/14/23, indicated Resident B was at risk of falls related to weakness, gait and balance deficits, use of medications which may cause dizziness, change in normal routine, and environment. Resident B's interventions included, but were not limited to, 30-minute checks while he was in bed at night (3/1/24). A behavior care plan, dated 9/11/23, indicated Resident B enter other resident's rooms. Resident B's interventions included, but were not limited to, offer to assist him to lay down (9/11/23), redirect		months to ensure substantial compliance. The results of these audits will be reviewed in the 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 as indicated.	

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	him back to his own room (9/11/23), and redirect to him to the common area (9/11/23). A behavior care plan, dated 4/22/24, indicated Resident B got into other resident's beds and/or chair. Resident B interventions included, but were not limited to, offer him an activity of choice (4/22/24), offer him his chair (4/22/24), and redirect him to his room (4/22/24). Review of nurses notes indicated the following: On 3/1/24 at 3:15 a.m., Resident B was in bed with blood on his clothing, face, and head. There was blood on the floor in the middle of his bedroom. He was assessed and given a shower to be cleaned off. His blood sugar was 46 mg/dL. A bolus of orange juice was given. He was sent to the emergency room for evaluation and treatment. On 3/01/24 at 6:19 a.m., Resident B returned from the emergency room with four staples to the middle of his forehead. On 3/12/24 at 9:34 a.m., Resident B was assessed during a shower and had new discoloration to his left shoulder measuring 20.1 cm length (centimeters) x 8.5 cm width. The discoloration went from the back of the shoulder to the front of the shoulder. A knot was present in the middle of collar bone area. He was able to move his arm up and put his hand behind his head. He had some discomfort when his shoulder area was palpated. The nurse practitioner was notified and a new order for an x-ray was obtained. On 3/12/24 at 1:10 p.m., the results from the mobile x-ray indicated there was no evidence of a fracture or dislocation. .			

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	On 3/17/24 at 5:04 a.m., Resident B had been up and down all night, restless and wandering in halls. He was redirected several times but kept getting up. On 3/18/24 at 2:06 a.m., Resident B slept in short spans and then was back up, scooting in hallway. Redirection (snack and drinks) was not helpful. Day shift reported that he didn't sleep on that shift either. On 3/19/24 at 4:43 a.m., Resident B was awake most of the shift. Staff assisted the resident back into his bed and he got right back up and scooted down the hallway. Staff gave him snacks and fluids, his brief was dry. He had no signs or symptoms of pain or discomfort displayed. He repeatedly went into other resident's room. Staff continuously re-directed him but was ineffective in getting him to remain in his own room and his own bed. A nurse practitioner note, dated 3/20/24 at 7:29 a.m., indicated Resident B had not been sleeping well per night shift nursing staff. The plan was to increase his melatonin to 4 mg for insomnia and to monitor him closely due to recent falls. On 3/21/24 at 4:57 a.m., Resident B slept about an hour and a half after melatonin was given the awoke and wandered the halls. He was redirected many times and was ineffective. On 3/22/24 at 12:21 a.m., Resident B slept approximately one hour after receiving melatonin and then was back up scooting down the hallway, attempting to go into other resident's room per his usual. A nurse practitioner note, dated 3/22/24 at 7:02			

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	a.m., indicated Resident B was only sleeping about one hour after starting melatonin. There was a concern about increasing the dose, given his small stature and recent falls. On 3/23/24 at 4:50 a.m., Resident B did not sleep at all this shift. He had been scooting up and down the halls all night per his usual. Staff redirected him back to his room several times and he would get right back up. He received fluids, snack, and his brief was changed as needed. On 3/24/24 at 4:35 a.m., Resident B had been awake the entire shift, scooting and walking through the hallway. He was assisted to bed and made sure all needs were met. He was directly noted back in hallway, attempting to enter other's rooms and scooting around. On 3/25/24 at 4:41 a.m., Resident B slept approximately two hours. He slept in his bed and in the dining room in a chair. On 3/28/24 at 2:36 a.m., Resident B received 2 mg of melatonin for insomnia. The dose had not had any notable effect on him. He was up out of bed and wandering the halls at night. He was redirected back to bed and was ineffective. He also wandered into other rooms. He scooted on the floor and sat in the dining room chairs. He rested but rarely slept. He had a history of falls. He wore a protective helmet. On 3/29/24 at 3:04 a.m., the melatonin continued to be ineffective for Resident B and he had been awake the entire shift, scooted up and down the hallway, going into other residents' room and crawling into occupied beds. Staff continued to redirect him back into his room and into his bed and he repeatedly got right back up and scooted			

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	down the hall into other resident's room. He had received fluids, snacks, brief had been changed as needed. On 4/2/24 at 11:22 a.m., the melatonin was discontinued for Resident B by the nurse practitioner. On 4/3/24 at 4:21 a.m., Resident B had been awake all night. He scooted in the halls and walked at times and entered other rooms/empty beds. On 4/9/24 at 5:05 p.m., Resident B sat in the dining room/chair. He had no signs of discomfort. He had a padded helmet on. He had a fall per verbal report. No injuries were noted. On 4/9/24 at 11:39 p.m., Resident B scooted in the hall several times. He was redirected back to his room and tucked into bed. He stayed awhile then got back up. He left his helmet on for short periods of time then took it off. He was given snacks and drinks taken. There were no signs of discomfort or injury due to the fall. A MDS ARD (Assessment Reference Date) note, dated 4/11/24 at 11:48 a.m., indicated he was currently on behavior plans for crawling out of bed and entering other's rooms. According to staff documentation and interview, he had 83 behaviors in the seven-day reference period. He was non-verbal and could not display that he could read small or large print. His eyes did follow objects when presented to him. He did not appear to recall his birthday or where he currently lived. He could not provide self-care or manage his own medications. He communicated by using body language and facial expressions. On 4/16/24 at 6:31 a.m., a CNA found Resident B			

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	in another resident's wheelchair, with both a chest harness and a seat belt secured. The Administrator, Nurse Practitioner and on-call nurse were notified. He did not appear to have any psychosocial discomfort at that time. He was up and walking around per his normal. On 4/16/24 at 7:30 a.m., Resident B was assessed for pain with no discomforts noted. His range of motion was within normal limits. There were no new discolorations or abrasions. On 4/16/24 at 10:40 a.m., Resident B was observed for psychosocial well-being. He walked around and acted per his normal behavior. He had not shown any signs or symptoms of discomfort. On 4/17/24 at 12:34 a.m., Resident B was up and ambulated/wandered in the halls. He acted per his normal. He was redirected to bed several times, stayed for short spans, then was back up. He was given additional drinks/snack given. No symptoms of discomfort and no latent injuries were observed. On 4/17/24 at 3:33 p.m., Resident B was observed for psychosocial well-being. He walked around the hallway and he acted per his normal behavior. He did not show any signs or symptoms of discomfort. A nurse practitioner note, dated 4/18/24 at 2:00 p.m., indicated Resident B was seen for an acute visit for the incident that occurred on 4/16/24. Staff reported a CNA found him seat belted with chest harness on, in another resident's wheelchair. They denied any psychosocial discomfort from the incident. Resident B was observed walking around in the hallway. He was non-verbal and unable to answer any questions purposefully. He			

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	did not appear to be in any psychosocial distress during assessment as he was walking in hallway and acted per his baseline. Staff denied any changes to his sleep pattern. He was not showing any signs of discomfort. Staff would continue to monitor his mood and behavior. The facility investigation was reviewed on 4/23/24 at 8:16 a.m. A typed timeline indicated the following: On 4/15/24 at 5:00 p.m., CNA 17 came on to the unit. Resident B was in bed until 8:00 p.m. or 9:00 p.m. At approximately 9:00 p.m., CNA 17 saw Resident B in a wheelchair, with a seat belt buckled. He did not have a chest harness on. CNA 17 asked about the chair. RN 6 said there was a physician's order that if Resident B wouldn't stay in bed, he needed to be in his chair. CNA 17 took him out of the wheelchair to change his brief and put him in bed. At 10:00 p.m., CNA 17 saw Resident B in the hallway without his helmet on. She got his helmet and put it on him then guided him back to bed. At 10:30 p.m., CNA 17 observed RN 6 with Resident B in a wheelchair, with a seat belt buckled. He did not have a chest harness on. RN 6 propelled the resident to his room. Between 11:00 p.m. to 1:00 a.m. QMA 4 saw Resident B at the nurses station in a wheelchair that was not his. He did not check to see if he had a seat belt on. CNA 8 saw Resident B in a regular wheelchair sitting at the nurses station. Shortly afterwards, Resident B got out of the chair and scooted across the floor.			

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	At 2:00 a.m., CNA 12 saw Resident B sitting at the nurses station in his wheelchair with no seat belt. At 3:00 a.m., RN 6 propelled Resident B in a wheelchair again, down the hallway. The seat belt was buckled. At 4:00 a.m., Resident B was in a wheelchair in his room, with the seat belt buckled. CNA 17 went to change his brief, but he was dry. Resident B remained in the wheelchair. At 4:20 a.m., RN 6 checked Resident B's blood sugar while the resident was seated in a wheelchair at the nurses station, without a seat belt buckled. At 4:30 a.m., CNA 12 saw Resident B on the floor scooting down the hall towards the dining room. At 6:30 a.m., CNA 25 found Resident B in the wheelchair with a seat belt and a chest harness on. A statement by CNA 17, dated 4/16/24 at 4:45 p.m., indicated she came onto the unit at 5:00 p.m., after getting report. Resident B was in his bed. After completing his care, the resident stayed in bed until 8:00 p.m. or 9:00 p.m. When the resident left his room, he scooted/walked around the hallway and the facility. At some point after that, the CNA saw him in the hallway in a wheelchair with a lap belt buckled. He did not have a chest strap on at that time. CNA 17 asked RN 6 about the chair. RN 6 said the resident had an order for a wheelchair when he wouldn't stay in bed. CNA 17 got the resident from the wheelchair and changed his brief. When the CNA was done, the resident stayed in his bed. The CNA saw Resident B			

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	approximately 30 minutes to an hour later, out in the hallway without his helmet. She put his helmet back on him and went on to other residents. A bit later in the hallway, CNA 17 saw RN 6 with Resident B, who was strapped into a wheelchair. RN 6 said the resident was making a regurgitating sound, and the nurse couldn't stand the sound anymore. Soon after, CNA 17 saw Resident B in a wheelchair in the hallway with a lap belt secured, but no chest harness. At approximately 3:00 a.m., RN 6 walked down the hallway pushing Resident B in a wheelchair with the lap belt buckled. CNA 17 went to Resident B's room to check his brief. The resident was in a wheelchair with the lap belt buckled. The resident's brief was dry, so she did not take him out of the wheelchair. That was the last time she saw him on that shift. An undated statement by QMA 4, indicated Resident B was seen, between the hours of 11:00 p.m. and 1:00 a.m., in a wheelchair near the nurses station. QMA 4 did not see if Resident B was buckled into the chair. QMA 4 was able to tell that it was an adapted wheelchair. QMA 4 was at the nurses station working on medication cart and did not look more than a passing glance. An undated statement by RN 6 indicated LPN 34 called her at 6:43 a.m., and told her about Resident B being found in an adaptive wheelchair with a lap belt and harness on. RN 6 last saw Resident B in a wheelchair at the nurses station for a blood sugar check at 4:20 p.m. The resident was not strapped into the wheelchair. An addition to the statement, on 4/19/24, indicated RN 6 had never seen Resident B in a chest harness. At 4:20 a.m., RN 6 checked Resident B's blood sugar while the resident sat in a regular wheelchair, near the medication cart. The resident was in the hallway scooting sometime after 4:20 a.m. RN 6 did not see			

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	him at all after that time and it was normal for him to be everywhere. RN 6 was not sure who would put the resident in the wheelchair. The bottom quarter of the paper with RN 6's statement on it was torn off. During an interview with QMA 4, on 4/23/24 at 4:16 a.m., he indicated he saw Resident B between the hours of 11:00 p.m. and 1:00 a.m., on 4/16/24, seated in a wheelchair that was not his. The QMA did not realize Resident B was buckled in, and did not think Resident B had a wheelchair of his own. Resident B was mobile and they had issues with him going into other resident's rooms. During an interview with CNA 12, on 4/23/24 at 4:59 a.m., she indicated, on 4/16/24 at 4:30 a.m., she did not see Resident B strapped into a wheelchair. She thought it was frustrating, removing Resident B from other resident's rooms all of the time. Resident B had been found in a female resident's bed, where he had a bowel movement in the bed. Most of the time, they found him in other resident's bathrooms, sitting on the toilet. During an interview with CNA 25, on 4/23/24 at 6:02 a.m., she indicated around 6:30 a.m. on 4/16/24, she was going to get Resident B ready for the day. He was in front of his TV, seated in another resident's adaptive wheelchair with a chest harness (one strap that went across his chest) and a lap belt on. He was awake and not trying to get up. She took him out of the wheelchair and told LPN 34. She had not gotten report from CNA 17. Resident B scooted around the facility on his bottom, roamed into other resident's room, and was in everybody else's bed but his own. She didn't think he was aware of what he was doing.			

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	During an interview with LPN 34, on 4/23/24 at 6:19 a.m., she indicated CNA 25 reported to her that Resident B was in another resident's adaptive wheelchair with a chest harness and seat belt on. The pommel (a device/cushion between the user's legs, as they were seated in a wheelchair to prevent the user from sliding forward in the seat) was up. LPN 34 called the Administrator and reported it. She completed a head-to-toe assessment on Resident B and assessed his vital signs. On 4/23/24 at 6:30 a.m., CNA 25 indicated which wheelchair Resident B had been found in on 4/16/24. The adaptive wheelchair was observed to have a footbox for the resident's feet, a pommel device for between the legs, a cushioned seat, a lap belt with a metal buckle with a push button release (similar to a car seatbelt), a padded chest strap with a plastic buckle, and a padded head rest. During an interview with the Administrator, on 4/23/24 at 11:08 a.m., she indicated CNA 25 found Resident B in an adaptive wheelchair when she went in to do his care. The DON collected all the witness statements as well as other staff, through in-person and telephone interviews. She could not identify who put him in the wheelchair with the chest harness and seat belt. Resident B was mobile and took off his own helmet. Resident B was eating, drinking, and had shown no mood or behavior changes. The Administrator suspended the nurse because she was the one in charge of the residents. No one admitted to putting Resident B into the wheelchair. The Administrator knew the resident could get himself up into the adaptive wheelchair and buckle the lap belt. Resident B got himself on the toilets and she had			

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	seen him "perched like a bird" on the dining room chairs. During an interview with the Administrator, on 4/23/24 at 12:00 p.m., she indicated the torn off part of RN 6's statement was just notes that did not pertain to the statement. During an interview with LPN 29, on 4/24/24 at 8:08 a.m., she indicated Resident B absolutely would not be able to get up in an adaptive wheelchair by himself and buckle himself in the wheelchair. He usually sat in the brown chairs in the dining room. During an interview with CNA 21, on 4/24/24 at 8:10 a.m., she indicated Resident B would not be able to get up in an adaptive wheelchair or be able to buckle a seatbelt and especially around his chest. During an interview with CNA 28, on 4/24/24 at 8:26 a.m., she indicated Resident B would not be able to get into an adaptive wheelchair by himself, nor buckle or unbuckle a seatbelt. During an interview with the Director of the Therapy Department with Physical Therapist 2 present, on 4/24/24 at 8:35 a.m., the Director indicated Physical Therapist 2 completed an evaluation on Resident B per the request of the Administrator and Corporate Management. Both the Director and Physical Therapist 2, indicated Resident B could not buckle or unbuckle a seatbelt on command. The Director felt that Resident B may have been able to climb into the adaptive wheelchair by himself because she had seen him climb into beds that were at waist height. Physical Therapist 2 felt that if Resident B tried to climb into the adaptive wheelchair, it would tip if			

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	he stepped on the footbox. During an interview with the ADON, on 4/24/24 at 9:21 a.m., she indicated Resident B would not be able to get into the adaptive wheelchair by himself due to the footbox and the pommel. He might be able to get in a wheelchair that was open with no foot pedals and the brakes were locked. He would not be able to buckle or unbuckle a seatbelt and definitely not a chest harness. She did not see him sitting in the dining room chairs by himself, he was normally led by staff to sit in the dining room chairs. During an interview with CNA 22, on 4/24/24 at 9:37 a.m., she indicated Resident B would not be able to get into an adaptive chair by himself and there was no way he would be able to buckle a seatbelt or harness. She had not seen him get into a dining room chair by himself unless he was led by staff. During an interview with RN 6, on 4/24/24 at 10:13 a.m., she indicated Resident B went into other resident's rooms. There was not a physician's order to be in a wheelchair if he couldn't stay in his bed or room. The last she saw Resident B, on 4/16/24, was when she took his blood sugar at 4:20 a.m. at the nurses station and he was in his own wheelchair. She had not pushed him down the hall in an adaptive chair. He was his own wheelchair and it did not have a seatbelt on it. She did not consider it being abusive if a resident was in someone else's wheelchair with a seatbelt on. If a resident couldn't undo a seatbelt, she would consider it a restraint. A current facility policy, dated 2/11/22 and titled, "Restraint and Device Use Policy," provided by the DON on 4/23/24 at 11:40 a.m., indicated the			

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	following: "...Purpose: The purpose of this policy is for each resident to attain and maintain his/her highest practicable well-being in an environment that: Prohibits the use of physical restraints for discipline or convenience; Prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity...." This citation relates to Complaint IN00432997. 3.1-3(w)			