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	01/12/2024

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 IN00423877 and IN00425880. Complaint IN00423877 - No deficiencies related to the allegations are cited. Complaint IN00425880 - Federal/State deficiencies related to the allegations are cited at F760. Survey dates: January 11 and 12, 2024. Facility number: 000274 Provider number: 155810 AIM number: 100271660 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 2 Medicaid: 46 Other: 2 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 17, 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 2/1/24, as the facility's credible allegation of compliance. We respectfully request paper compliance.	
F 0760 SS=D	483.45(f)(2) Residents are Free of Significant Med Errors			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica McKinley	HFA	02/01/2024

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	The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident with a brain injury was free from a significant medication error related to repeated missed doses of a muscle relaxer for 1 of 3 residents reviewed for medication availability. (Resident B) Findings include: Resident B's clinical record was reviewed on 1/11/24 at 8:32 a.m. Diagnoses included traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent encounter, diffuse traumatic brain injury with loss of consciousness of unspecified duration, subsequent encounter, spastic hemiplegic cerebral palsy, and other disorders of autonomic nervous system. His medications included dantrolene (treat muscle spasms) 50 milligrams (mg) three times daily (a.m., lunch and evening), amantadine (treat palsy like symptoms) 15 ml (milliliters) twice daily, Keppra (treat seizures) 5 ml twice daily, propranolol (treat blood pressure) 10 mg three times daily, and diazepam (antianxiety) 10 mg as needed (PRN) for seizure lasting five minutes, repeat every five minutes if seizure persists not to exceed six doses in a 24 hour period. An admission Minimum Data Set (MDS), dated 12/27/23, indicated he was rarely or never understood. His Medication Administration Record (MAR) indicated he did not receive an evening dose of	F 0760	F760 l) Immediate actions taken for those residents identified: Resident B is no longer in the facility. 2)How the facility identified other residents: All residents have the potential to be affected by this alleged deficient practice. 3)Measures put into place/System changes: In-service completed with licenses staff with emphasis on procedure for obtaining medications for late admission, Prior Authorization Process, and physician or nurse practitioner notification regarding directions on backordered or unavailable medications. 4)How the corrective actions will be monitored: The DON or designee will complete a random audit of 5 residents to ensure medications are available 3 days per week times 4 weeks, then 2 days per week times 4 weeks, then 1 day per week for 4 weeks, and finally once a month for 4 months to ensure substantial compliance. The results of these audits will be reviewed in the Quality Assurance	02/01/2024

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	dantrolene on 12/20/23. His Medication Administration Record (MAR) indicated he did not receive an a.m. dose of dantrolene on 12/21/23. A nurses note, dated 12/21/23 at 9:50 am, indicated it was requested from the pharmacy for his medications to be brought immediately to the facility. The pharmacy indicated when a resident was admitted after hours the facility needed to contact the after-hours tech to receive medications in a timely manner. His Medication Administration Record (MAR) indicated he did not receive a lunch dose of dantrolene on 12/21/23. A nurses note, dated 12/21/23 at 1:10 p.m., indicated the pharmacy was contacted due to dantrolene not covered by insurance. The pharmacy would send the medication and an alternative was not needed. Pharmacy was still working on sending his medication to the facility. A Nurse Practitioner (NP) note, dated 12/27/23 at 9:44 a.m., indicated the prior authorization for dantrolene was completed on a medication website. His Medication Administration Record (MAR) indicated he did not receive an a.m. dose of dantrolene on 12/29/23. A nurses note, dated 12/29/23 at 8:35 a.m., indicated the pharmacy was notified regarding the need of dantrolene and they informed the facility it needed a prior authorization. The NP was notified.		Meeting monthly for 6 months or until 100% compliance is achieved for 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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	His Medication Administration Record (MAR) indicated he did not receive a lunch or an evening dose of dantrolene on 12/29/23. His Medication Administration Record (MAR) indicated he did not receive an a.m. lunch or an evening dose of dantrolene on 12/30/23. His Medication Administration Record (MAR) indicated he did not receive an a.m., lunch, or an evening dose of dantrolene on 12/31/23. His Medication Administration Record (MAR) indicated he did not receive an a.m. dose of dantrolene on 1/1/24. A nurses note, dated 1/1/24 at 10:06 a.m., indicated the pharmacy was contacted regarding the dantrolene medication. The facility was covering a two-day supply until the prior authorization was addressed. The pharmacy was to send a two-day supply to the facility. His Medication Administration Record (MAR) indicated he did not receive a lunch dose of dantrolene on 1/1/24. A nurses note, dated 1/1/24 at 2:01 p.m., indicated Resident B displayed facial grimacing, he was moaning loudly and thrashed himself in bed. He had noticeable muscle spasms to his bilateral upper and lower extremities. Staff had made several attempts throughout the shift to provide comfort to him while awaiting his medication to be delivered to facility. NP 2 was notified regarding his condition and to check on status of the prior authorization for dantrolene and she was updated regarding the facility covering a two-day supply which was to be delivered to facility stat. NP 2			

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	indicated the prior authorization had been filled out and returned to pharmacy and she would contact the pharmacy herself to inquire as to why medication had not been delivered. A one-time order was received for baclofen (muscle relaxer) 10 mg to be administered via g-tube (gastric tube). A nurses note, dated 1/1/24 at 2:20 p.m., indicated a one time dose of baclofen was given to the resident. A nurses note, dated 1/2/24 at 2:52 p.m., he had slight tremors off and on, but otherwise, in good spirits. He was resting in his wheelchair with his eyes closed and displayed no signs or symptoms of discomfort. The pharmacy was called to follow up on the medication refill, billing had gone through, and the medication was expected to arrive in the evening of 1/3/24. A nurses note, dated 1/2/24 at 3:43 p.m., indicated pharmacy indicated dantrolene was to be delivered this evening from an alternative pharmacy. A nurses note, dated 1/3/24 at 1:19 p.m., indicated he was alert to himself, he had slight facial grimacing and twitching of his upper extremity. A nurses note, dated 1/4/24 at 2:40 a.m., indicated he was neuro storming (a hyperactive response of the nervous system). His fan was turned on bedside his bed, his TV volume was turned down, and his lights were turned off. A nurses note, dated 1/4/24 at 8:59 a.m., indicated an as needed (PRN) diazepam was given to him, due to neuro storming. He had increased respirations, sweating, rigidity in arms and legs, and pointing toes downward.			

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A nurses note, dated 1/4/24 at 10:02 a.m., the diazepam was effective. He was calmer and resting quietly.

A nurses note, dated 1/4/24 at 10:49 a.m., indicated he started neuro storming again. A PRN diazepam was given.

A NP note, dated 1/4/24 at 11:36 a.m., NP 2 indicated nursing reported he had been having increased seizure activity through the morning. He subsequently received two PRN diazepam with improvement in symptoms. However, he started to spasm once again and appeared uncomfortable. Upon physical exam, he was lying in bed, appeared chronically ill, pale, and uncomfortable. He was alert. He had jerky movements of hands and feet continuously during exam and subtle horizontal nystagmus (repetitive, uncontrolled eye movements).

A nurses note, dated 1/4/24 at 2:31 p.m., indicated he continued with intermittent posturing (rigid body movements from brain injury).

A nurses note, dated 1/4/24 at 4:03 p.m., indicated he was sent to a local hospital for neuro storming and posturing.

A hospital assessment and plan, dated 1/5/24, indicated he was admitted for possible status epilepticus, it was unclear of the etiology, although a differential diagnosis included seizures as well as autonomic storming secondary to dantrolene withdrawal and potential contributory of hydrocephalus.

A nurses note, dated 1/6/24 at 4:43 p.m., indicated he remained intubated (tube placed for mechanical

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	breathing) at the hospital with continuous EEG (Electroencephalography) monitoring and minimal seizure activity had been seen since arrival to the hospital. The plan was to monitor brain activity for now to determine a plan moving forward. A nurses note, dated 1/7/24 at 9:52 p.m., indicated he remained intubated in the hospital, his EEG was negative, and the CT (Computerized Tomography) of his head showed ventriculomegaly (build-up of cerebrospinal fluid). A spinal tap was done with negative findings for infection. Neuro storms continued. During an interview with the Administrator, on 1/11/24 at 10:47 a.m., she indicated when Resident B was first admitted to the facility, his mom provided an insurance card. The facility paid for 24 capsules of 25 mg of dantrolene and 9 doses of 50 mg of dantrolene on 12/21/23. Then on 1/1/24 mom provided a different insurance card and that's how they got the medications from an outside source on 1/1/24 and 1/2/24. During an interview with NP 15, on 1/11/24 at 4:51 p.m., indicated she was on call for NP 2. She completed the prior authorization for the dantrolene. She saw Resident B on 12/21/23 and on 12/27/23. On 12/27/23, she had a notice for the prior authorization needed to be completed, it was in the NP/physician folder at the facility, she was not aware the prior authorization needed completed prior to 12/27/23. The nurse on duty indicated to her that he was not out of the dantrolene yet. She did not receive any calls from the facility after 12/27/23 and she was not aware of any partial or missed doses. If she would have been aware, she would have prescribed baclofen for him.			

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	During an interview with RN 13, on 1/12/24 at 10:01 a.m., she indicated when she came to work on Monday, 1/1/24, he had not had the dantrolene over the weekend. She called the nurse on call and the pharmacy. The pharmacy indicated to her they were awaiting the prior authorization for the dantrolene. The NP indicated she had signed the prior authorization and sent it in. The facility paid for a two-day supply and delivered the medication. After Monday, he was very jerky, more than his normal, he arched his back a few times, and he was more fidgety, making fast movements, which she didn't notice prior. It wasn't seizure activity she had seen before. She reached out to the NP to see if they could get any other medication for him until his dantrolene arrived. The NP gave a one-time dose of baclofen. During an interview with DON, on 1/12/24 at 10:33 a.m., she indicated the pharmacy normally faxed prior authorizations to the providers. The facility got a prior authorization notice, not the actual prior authorization for medications. Initially, they had the dantrolene medication and ran out. The nurses contacted the NP and the pharmacy. The pharmacy did not have the medication on hand and had to retrieve the medication from an outsourced pharmacy. The nurses were diligent about contacting the NP and the pharmacy. He was doing well without any issues. He neuro-stormed once and they gave him baclofen. The day he was sent to the hospital he received two doses of diazepam. He had a neuro-storming episode before coming to the facility and was sent to the hospital. He did not receive dantrolene on 12/29/23, 12/30/23 and 12/31/23. The documentation on the medication administration record for the evening of 12/30/23 and 12/31/23 was a mistake, he did not receive the dantrolene. Those medications were not given, they tried to			

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	go into the system to correct it, but the system would not allow them to amend it. During an interview with the DON, on 1/12/24 at 12:34 p.m., she indicated when medications were unavailable, they would check the emergency drug kit (EDK), and contact the NP and the pharmacy. A current facility policy, titled "Notification of Changes Policy," provided by the Administrator, on 1/12/24 at 11:51 a.m., indicated the following: "...Notification occurs when...A need to alter treatment significantly (need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment) ...." This citation relates to Complaint IN00425880. 3.1-48(c)(2)			