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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00300036. Complaint IN00300036 - Substantiated. Federal/State deficiency related to the allegation is cited at F684. Survey dates: July 25 and 26, 2019 Facility number: 000274 Provider number: 155810 AIM number: 100271660 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 3 Medicaid: 65 Other: 1 Total: 69 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 31, 2019.	F 0000	**Facility requesting a desk review for this plan of correction.** **This plan of correction constitutes the facility's written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by State and Federal law.**	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to complete bowel monitoring and ensure the treatment for constipation for 3 of 3 residents reviewed for bowel monitoring (Residents B, C and D). Findings include: 1. The closed clinical record for Resident B was reviewed on 7/25/19 at 8:31 a.m. The resident was admitted to the facility on 3/20/1988 and discharged to another facility on 5/30/19. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, profound intellectual disability, abdominal distension and retained cholelithiasis following cholecystectomy. The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/15/19, indicated the resident was severely cognitively impaired. The resident was incontinent of bowel and bladder. A health care plan, dated 2/2/10, indicated the resident had chronic constipation and bloating related to a history of constipation, cerebral palsy, dysphagia and being dependent on others for all fluids. Interventions included, but were not limited to, auscultate abdomen for any signs of constipation, document my stools for frequency and amount and notify the physician if the interventions were not effective. Resident B had the following prescribed medications for constipation to have been given as needed: a. Cleansing enema if sodium phosphate enema not effective.	F 0684	F684 It is the Policy of Vernon Health and Rehabilitation to complete bowel monitoring and ensure treatment for constipation is provided. **Step 1** Resident B no longer resides at the facility. Resident C and Resident D were assessed by the Director of Nursing or designee and both remain stable at this time and do not exhibit signs or symptoms of constipation. Resident C and Resident D had bowel assessment completed and bowel management report reviewed by the Clinical Interdisciplinary Team and no new interventions needed at this time. Both residents Care Plans were reviewed and updated as appropriate. **Step 2** Current facility residents had bowel assessment completed and bowel management report reviewed by the Clinical Interdisciplinary Team with Care Plans reviewed and updated as appropriate. **Step 3** Licensed Nurses were re-educated to review residents bowel	08/13/2019

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	b. Rectal tube twice daily as needed. c. Sodium phosphate enema every 2 days as needed for constipation. d. Bisacodyl (stimulant laxative drug) suppository every 3 days for constipation. Review of bowel monitoring documents for March 2019 indicated the resident had a documented bowel movement on the following days: March 3, 4, 7, 8, 11, 13, 15-17, 21, 22, 25-27, and 30 There was no bowel movement documented March 18-20 and or treatment for constipation Review of bowel monitoring documents for April 2019 indicated the resident had a documented bowel movement on the following days: April 8, 11, 14, 23 and 24 There was no documentation of a bowel movement from April 1-7, 15-22, 25-30 or treatment for constipation. Review of bowel monitoring documents for May 2019 indicated the resident had a documented bowel movement on the following days: May 1, 6, 8, 13-20, 28 and 29. There was no documentation of a bowel movement from May 2-5, 9-12, 21-27 or treatment for constipation. A discharge and transfer form was completed on 5/30/19 to another facility. During an interview with an employee of the receiving facility, on 7/26/2019 at 9:16 a.m., they		movements daily to ensure the resident has had a bowel movement within the past three days or per the physician's orders and to implement interventions as appropriate. Licensed nurses were educated on the daily bowel management report and validations needed as it relates to interventions and assessments. Licensed Nurses and Certified Nursing Assistants were re-educated on the importance of documentation of the resident's bowel movements. This education included Point of Care documentation related to incontinence, ADLs, and Vital Sign documentation related to bowel movements recording for each shift. The Clinical Interdisciplinary Team will review the daily bowel management program at the Morning Clinical Meeting for additional oversight and monitoring. **Step 4** The Director of Nursing or designee will perform Quality Assurance Performance Review to ensure residents are treated for constipation as appropriate and that resident bowel movements are documented 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed	

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident was sent to them because he was not having bowel movements. 2. The clinical record for Resident C was reviewed on 7/25/19 at 11:46 a.m. Diagnoses included, but were not limited to, traumatic cerebral edema, dysphagia, post traumatic seizures and pain. The most recent quarterly MDS assessment, dated 5/24/19, indicated the resident was severely cognitively impaired and always incontinent of bowel. A health care plan, dated 9/10/13, indicated the resident had the potential for constipation related to decrease mobility and dependence on others for hydration. Interventions included, but were not limited to, document stools for frequency and amount and give medications as ordered by the physician. Resident C had the following prescribed medications for constipation to have been given as needed: a. Tap water enema, rectally every week for constipation. b. Soap suds enema every other day as needed for constipation. Review of bowel monitoring documents for May 2019 indicated the resident had a documented bowel movement on the following days: May 1, 3-6, 9, 11, 13, 15, 17, 22, 23, 24, 27, 29-31. There was no documentation of a bowel movement from 18-21 or treatment for constipation. Review of bowel monitoring documents for June 2019 indicated the resident had a documented		immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bowel movement on the following days: June 1, 3-6, 9, 11, 13, 15, 17, 22-24, 27, 29 and 30. There was no documentation of a bowel movement from 18-21 or treatment for constipation. An event report, dated 6/28/19 at 12:05 a.m, indicated the resident had abnormal vital signs and loose stools. A progress note, dated 6/28/19 at 12:20 a.m., indicated the facility attempted to call the physician to notify him of the residents status and vital signs. At 12:45 a.m, the Executive Director (ED) was called related to the residents status and suggested they contact the Interim Director of Nursing (DON). At 12:56 a.m, the DON was notified of the residents status. On 6/28/19 at 6:03 a.m., the facility had not yet received a reply from the physician. At 10:38 a.m, the physician was notified of the residents condition and a new order was received to repeat a KUB, x-ray, Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP). A progress note, dated 6/28/19 at 12:29 p.m., indicated the resident appeared lethargic, but responded to verbal commands. At 4:14 p.m., a new order was received to obtain a Urinalysis (UA) with culture and sensitivity test.			

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At 5:59 p.m., the physician was notified of the abnormal laboratory values and ordered potassium chloride 20 milliequivalents per litre (mEq/L) daily for 7 days and then repeat the blood work in 1 week. A progress note, dated 6/28/19 at 7:15 p.m., indicated the resident was observed with slow respiration, 8-10 shallow breaths per minute. He had hypoactive bowel sounds. His blood pressure was elevated to 184/100 mmHg and 166/100 mmHg and was lethargic. The physician was contacted and indicated to send the resident to the hospital. An abdominal x-ray was completed 6/29/19 and indicated a persistent pattern of air distention of bowel throughout the abdomen, but not significantly changed. The resident was discharged from the hospital on 7/2/19 and returned to the facility on the following medications: a. Augmentin (antibiotic) 875-125 mg, 1 tablet twice daily for 6 days. b. Keflex (antibiotic) 500 mg, 1 tablet twice daily for 6 days. c. Procardia (to treat high blood pressure) 60 mg daily. Review of bowel monitoring documents for July 2019 indicated the resident had a documented bowel movement on the following days: July 4, 5, 10. The resident was in the hospital from 7/13-7/17. There was no documentation of a bowel movement from July 6-9 and 17-24 and no treatment for constipation.			

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A progress note, dated 7/12/19, indicated the resident's abdomen appeared to be "taut." The nurse held the water bolus for 2 hours. His gastrostomy feeding tube button was opened to help depress the abdomen with slight improvement. A progress note, dated 7/13/19 at 1:09 a.m., indicated the residents water bolus had been turned off related to the residents abdomen being distended. The resident had no active bowel sounds. The resident was given a soap suds enema on 7/12/19 at 9:50 p.m. The resident had a large amount of liquid stool following the enema. The resident continued to have hypoactive bowel sounds and the nurse continued to monitor. An Situation, Background, Assessment, Recommendation (SBAR) event, dated 7/13/19 at 10:08 a.m., indicated the resident's abdomen was distended, hypoactive bowel sounds, low blood pressure and decreased respirations. He was less responsive. On 7/13/19 at 10:27 a.m., a CNA notified the nurse the resident was not very responsive. His blood pressure was 84/57 mmHg and his respirations were 12 breaths per minute. Bowel sounds were hypoactive and his skin was clammy. The physician gave an order to send the resident to the hospital. Review of the hospital records, indicated the resident was hospitalized with a diagnosis of disease of the rectum. The history of present illness indicated the resident was admitted with altered mental status. The physical assessment indicated the resident had a distended abdomen and minimal auscultated			

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

bowel sounds.

On 7/13/19, a CT scan indicated the resident had persistent gaseous distention of the colon suggesting an ileus. A large amount of stool was in the rectum and rectal wall thickening.

A progress note, dated 7/17/19 at 4:44 p.m., indicated the resident would be returning to the facility soon with a new order for a suppository to be given daily if he did not have a bowel movement. The hospital also indicated the surgeon asked if the facility physician would review the amount of laxatives the resident was receiving and possibly decrease a little.

The resident was discharged from the hospital on 7/17/19 and returned to the facility.

3. The clinical record for Resident D was reviewed on 7/25/19 at 12:49 p.m. Diagnoses included, but were not limited to, profound intellectual disabilities, aphasia, dysphagia, and cerebral palsy.

The most recent annual MDS assessment, dated 3/20/19, indicated the resident was severely cognitively impaired and always incontinent of bowel.

A health care plan, dated 6/19/17, indicated the resident had the potential for constipation related to immobility and being dependent on others for all fluids. Interventions included, but were not limited to, document my stools for frequency and amount and notify the physician if the interventions were not effective.

Resident D had the following prescribed medications for constipation to have been given

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	as needed: a. Sodium phosphate enema every 3 days for constipation. Review of the bowel monitoring documents for June 2019 indicated the resident did not have a documented bowel movement on the following days: June 1, 2, 5, 7, 8, 9, 10, 11, 12, 13, 28, 29, 30, A progress note, dated 6/4/19 at 9:33 a.m., indicated the resident was at workshop and had a bloody stool and they would be returning him to the facility. At 10:07 a.m. the resident returned to the facility and was noted to have hypoactive bowel sounds in all four quadrants. The resident was noted to have loose stool with no blood present. The physician was notified. On 6/13/19 at 1:18 p.m., the resident returned from workshop related to low body temperature. Staff were unable to obtain a body temperature, breath sounds were coarse and bowel sounds were active. Warm blankets were applied to the resident and the physician was notified. A new order was received for a CBC, UA and chest x-ray. On 6/13/19 at 2:24 p.m., the physician ordered furosemide (treat fluid retention) 40 mg daily for 5 days. On 6/14/19 at 7:38 a.m., the CNA indicated the resident was not swallowing his drink. The nurse assessed the resident and found a blood pressure of 93/60 mmHg, heart rate 89, respirations 32 and a body temperature of 92.1. The residents oxygen saturation was 85% on room air. Respiratory therapy applied 3 liters of oxygen. The chest x-ray			

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	showed slight cardiomegaly. A progress note, dated 6/14/19 at 3:20 p.m., indicated the resident had slow bowel sounds in the right and left upper quadrants. The last large bowel movement was 6/4/19. The nurse administered an enema with results. On 6/14/19 at 5:06 p.m., the nurse indicated the resident had some mucous and blood present in his stools. The physician was notified. The vital sign task lacked documentation of a bowel movement. On 6/14/19 at 8:15 p.m., the resident had a oxygen saturation on 77% on 5 liters of oxygen. He was placed on a Venturi masks (delivers controlled percentages of oxygen) with 6 liters of oxygen at 50%. The facility attempted to contact the physician on 6/14/19 at 8:15 p.m. and 9:00 p.m. On 6/14/19 at 10:20 p.m., the resident was transported to the hospital. On 6/15/19 at 12:40 a.m., the hospital indicated the resident had been intubated, had a central line and was placed on a ventilator. He was going to be transferred to another hospital. On 6/15/19 at 5:45 a.m., the hospital indicated the resident was diagnoses with pancreatitis and pneumonia. A CT scan completed 6/15/19, indicated the findings were compatible with acute pancreatitis and possibly choledocholithiasis (gallstone or gallstones become lodged within any duct of the			

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

bile system).

On 6/19/19 at 10:03 a.m., the hospital indicated the resident was no longer intubated and would be seen by a gastroenterologist for a Endoscopic Retrograde Cholangiopancreatography (ERCP) test.

A progress note, dated 6/27/19 at 5:20 p.m., indicated the hospital notified the facility the resident was admitted to septic shock and aspiration.

On 7/25/19 at 10:05 a.m., RN 1 provided a bowel monitoring report. There was a total of 9 residents were not listed on the bowel report.

During an interview of 7/25/19 at 10:20 a.m., RN 1 indicated the night nurses printed a bowel report then gave it to the day shift nurse to let them know who was on a bowel monitoring program.

On 7/25/19 at 10:23 a.m., the DON provided another bowel monitoring report. The report indicated the last bowel movement documented for each resident. The dates included, but were not limited to, 7/16/19, 7/17/19, 7/18/19, 7/20/19 and 7/21/19.

On 7/25/19 at 10:32 a.m., LPN 2 indicated the aides were pretty good about letting them know who had not had a bowel movement or the staff can run a report.

On 7/25/19 at 11:11 a.m., the DON indicated the staff were not measuring Resident B's abdomen and his abdomen size varied with what he ate. He was dependent on staff for all meals and snacks. The resident had not yet been seen by a gastroenterologist, but were letting his family

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	know of things they had done such as a KUB and changing medications The night shift nurse should run the bowel report and give any medications prescribed by the physician and then put it on the 24 hour report. On 7/25/19 at 11:27 a.m., LPN 3 indicated, as far as she knew, the night shift nurses' ran the reports, but it had been a long time since she last was told a resident had a PRN medication for a bowel movement. On 7/25/19 at 12:03 p.m., RN 4 indicated he did not run the report when he worked nights unless the resident was having an issue, but has not worked night shift for some time. On 7/25/19 at 1:07 p.m., RN 5, DON and RN 1, indicated they had checked with the aides and were told they were charting "incontinent" and it meant the resident had a bowel movement. On 7/25/19 at 1:18 p.m., the DON provided a daily report form the workshops provided each day when the resident participated in the program. The form included information related to bowel movements, fluid intake, food intake and medications given. She indicated all of the forms were in her box that day. The forms were dated, 7/18/19, 7/19/19, 7/22/19 and 7/24/19. She indicated the resident returned to the facility and the nurse would take the information and document it on the residents clinical record. On 7/25/19 at 3:04 p.m., the DON indicated she had calls out to staff and said she thought they are charting "incontinent," but was not sure why they would then chart "none" under the bowel movement report under the vital sign task.			

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 7/25/19 at 3:20 p.m., CNA 6 indicated she was not sure why the Point of Care (POC) charting indicated "incontinent," but the vital sign task indicated no bowel movement for a date and time she had charted. If a resident had a bowel movement, it should reflect it under the vital sign task. She indicated she was not able to see what other aides charted to know if a resident had a bowel movement or not. On 7/25/19 at 3:49 p.m., CNA 7 indicated if a resident did not have a bowel movement on her shift and they were known to be incontinent, she would mark "incontinent." She was not sure how she would know if a resident had not had a bowel movement for 3 days. On 7/25/19 at 4:00 p.m., CNA 8 indicated if a resident did not have a bowel movement, she would put "no bowel movement" on the POC charting. If they had a bowel movement, she would document it under the vital sign task. On 7/25 at 4:22 p.m., CNA 9 indicated if a resident had a bowel movement, she would document if they were incontinent or continent and then put it under the vital sign task. On 7/26/19 at 10:16 a.m., CNA 10 with the DON present, indicated she received an in-service that day and was unsure when she received a prior in-service related to toileting documentation. Prior to the in-service, if a resident did or did not have a bowel movement, she would document what their bowel history was. She could not see what other CNAs documented and they used to have a clip board to monitor bowel movements, but no longer used it. CNA 10 returned at 10:32 a.m. and indicated the			

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	07/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	aides completed rounds with other aides and they also completed a morning huddle. On 7/26/19 at 10:39 a.m., DON and Administrator indicated they updated their system to run a facility wide report for a 7 to 14 days look back. They started an in-service last evening and staff were made aware prior to working. On 7/26/19 at 10:51 a.m., LPN 3 indicated if a resident such as Resident C, did not have a bowel movement, she would document "incontinent" and then she would put "none" under the vital sign task. She felt staff were documenting the resident was incontinent even though they were not having a bowel movement. On 7/256/19 at 10:53 a.m., the DON indicated they did not have a bowel management program and they would follow the physician orders. If they had an order for a PRN medication they would give, if not, they would call for an order. On 7/26/19 at 10:54 a.m., the DON provided the new resident Bowel Management Report which included a total of 69 residents being monitored for bowel. On 7/26 at 1:00 p.m., the DON indicated they did not have a formal policy for bowels. The nurses' would follow the physician orders and the CNAs would follow their orientation. This Federal tag relates to complaint IN00300036. 3.1-37(a)			