STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155810	A. BUILDING _____ B. WING _____	**03/13/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review, the facility failed to ensure a resident was free of a physical restraint for 1 of 3 residents reviewed for restraints (Resident E). Findings include: During an observation on 3/13/20 at 8:03 a.m., Resident E was asleep in an enclosed bed in a tucked prone position. The full mesh side was zipped completely closed. The clinical record for Resident E was reviewed on 3/12/20 at 2:45 p.m. Diagnoses included, but were not limited to, Lennox-Gastaut syndrome (recurrent [MEDICAL CONDITION]), mitochondrial metabolism disorder, [MEDICAL CONDITION] and autistic disorder. The admission Minimum Data Set (MDS), dated [DATE], indicated the resident rarely or never understood. The resident had a physical restraint in place in bed that was used daily. A physician's orders [REDACTED]. No [DIAGNOSES REDACTED]. The bed was used to prevent the resident from rolling out of bed. The determination indicated the resident could not intentionally remove the device in the same manner as it was applied by staff. The device was deemed to not be a restraint for this resident and no release schedule was required. The device was to be checked every shift. A progress note, dated 2/25/20 at 9:54 a.m., indicated other options were discussed with resident's responsible party as in the standard equipment of a high-low bed use. The responsible party declined the option and only wished the enclosed bed be utilized. A progress note, dated 2/25/20 at 6:31 p.m., indicated the resident's responsible party called to check on the resident. The responsible party asked that the resident only be up in her wheelchair for meals and therapy. The remaining time was to be spent in bed where the resident could move freely. During an interview on 3/12/20 at 3:33 p.m., the Director of Nursing (DON) indicated the resident came from another facility that used this type of bed. The resident does have [MEDICAL CONDITION] disorder. Staff were checking and changing the resident every 2 hours. The only time she was in the bed is when she was asleep Review of a current facility policy, dated 3/13/18, titled Device and Restraint Use Policy, which was provided by the DON on 3/13/20 at 12:30 p.m., indicated the 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 .inhibit a resident's freedom of movement or activity; and Limits physical restraint use .Policy: 1. Use of physical restraints .symptoms that warrant the use of restraints. 2. The Physician/Practitioner's order alone is not sufficient 3. The resident or resident representative may request .the facility is responsible for evaluating the appropriateness or the request, and must determine .has a medical symptom .The resident and/or resident representative do not have the right to demand a restraint be be used when it is not necessary to treat a medical symptom. .7. Intervention, including less restrictive alternatives are to be attempted 3.1-3(w)
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transfer a resident in accordance with the plan of care for 1 of 3 residents reviewed for accidents. This deficient practice resulted in a fracture, hospitalization and surgery. (Resident B) Findings include: Review of an Indiana State Department of Health (ISDH) reportable, dated 3/8/20 at 11:01 p.m., provided by the Administrator on 3/12/20 at 9:26 a.m., indicated Resident B was noted to have swelling to his right hip. The hip was warm to touch with evidence of pain. An X-ray was obtained on 3/8/20, which indicated a fractured right femur. The resident was sent to the emergency room (ER) for evaluation and treatment. Review of the facilities internal investigation, provided by the Administrator, indicated the following time line of events related to 3/8/20: a. Qualified Medication Aide (QMA) 1 indicated he worked on 3/7/20 night shift. As he walked past Resident B's room, he noted the resident to be on the floor beside his bed on his mat. He went to find the nurse, but found CNA 2. CNA 2 indicated the resident was care-planned to crawl on the floor and that they could just place him back in bed. CNA 2 grabbed the resident's upper body and QMA 1 grabbed his legs and they lifted him back into bed. Licensed Practical Nurse 3 was made aware the resident had fallen/crawled out of his bed. b. A follow-up statement by CNA 2, dated 3/11/20, indicated she knew they did not have to use the mechanical lift for a resident who was under 50 lbs. She indicated to her he was a child and QMA 1, who was the charge (nurse)on the hall, assisted the resident back into bed. c. The first interview statement, provided by CNA 4, dated 3/9/20, indicated on 3/7/20 while doing a bed check around 4:00 a.m., the resident had urinated. She indicated that was when she noticed something wrong with his leg. She did not observe the resident in pain. d. A second interview, dated 3/9/20, indicated CNA 4 changed Resident B's brief at 4:18 a.m. on 3/8/20. She noticed the change and reported it to LPN 3. CNA 4 then left following the completion of her shift. She returned on 3/8/20 around 5:00 p.m. and did her rounds between 6:00 p.m. and 6:30 p.m. and noticed the resident's right leg/hip still looked the same from earlier that morning. The resident was fussy and crying. She stopped and notified the nurse. There were two additional aide in the room. CNA 5 went to get the nurse and they stayed with the resident. LPN 3 came to the room and noted swelling and redness. LPN 6 then came into the room and stated the leg was warm to the touch. e. A third interview by CNA 4, indicated she reported Resident B's leg looked wrong and he was being fussy. Both LPN 3 and CNA 4 thought he was fussy because of the enema he had received earlier. When she saw him again at 6:30 p.m. his leg was the same so we got the nurse. f. A statement by LPN 3 indicated on 3/8/20 at approximately 4:15 a.m., she went to see if the resident had any results from his enema. The CNA came in and asked her if she could check him because he was fussy. The resident was awake, but fussy. He grimaced when she palpated his abdomen. CNA 4 asked her how his legs looked, so she went back into the room and did not observe any abnormality or discoloration. During a shift round at 4:30 a.m., the resident was resting with his eyes closed. She came back into work at 5:00 p.m. and between 6:00 p.m. and 6:30 p.m., she was called to his room. Several staff were at the bedside, then went to get his nurse. LPN 6 came in and did an assessment and found his leg to be swollen and warm. She notified the physician who ordered an X-ray. g. A second interview with LPN 3 was related to any action taken after the resident was found on his mat on 3/7/20. She indicated she was told later in the shift that the resident was found on his mat beside his bed and CNA 2 picked him up and put him back to bed. LPN 3 saw the resident several times and did not notice anything out of the ordinary. She did a gastrointestinal assessment on him towards the end of her shift. After assessing the resident, CNA 4 asked her if his legs looked right. She went back in and the resident was in him normal frog-like position and nothing appeared to be unusual. h. On 3/8/20, LPN 7 provided a statement that indicated a CNA reported to her the resident was crying. The resident was assessed for discomfort and found to have a temperature of 99.9 Fahrenheit (F). She did give the resident bolus (method of tube feeding) and he acted his normal self. During the last bolus, the resident did kick the Asepto (instrument for introducing fluid) out of her hand. i. A second interview on 3/8/20, indicated LPN 7

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) worked the day shift on 3/7/20 and 3/8/20. On 3/8/20, CNA 8 came to her and said the resident was fussy during care. Tylenol was given for discomfort. LPN 7 indicated she received report from QMA 1 that morning and he reported nothing to her regarding any abnormalities for Resident B. j. An interview with CNA 8 on 3/10/20, indicated she was the resident's aide for both 3/7/20 and 3/8/20 from 5:00 a.m. until 1:30 p.m. On 3/8/20, between 9:00 a.m. and 10:00 a.m., she gave the resident a bed bath and only dressed him on the top because he had been crying. She left him in bed and then told LPN 7 he was crying. The nurse reported to her between 11:00 a.m - 11:30 a.m., the resident had a temperature. CNA 8 went back in to check on the resident between 12:30 p.m. - 1:00 p.m. and noted he was acting as though he did not feel good, but he was not crying. She indicated it was unusual for the resident to cry. The clinical record for Resident B was reviewed on 3/11/20 at 10:20 a.m. [DIAGNOSES REDACTED]. The most recent annual Minimum Data Set (MDS) assessment, dated 1/31/20, indicated the resident rarely or never understood. The resident required two-person assistance for transfers. The resident was dependent on staff for all care. A current care plan, dated 10/21/16, indicated the resident was unable to independently change position while in bed, feed self, toilet self or transfer self due to non-weight bearing. An intervention was implemented on 10/21/16 to use a mechanical lift during transfers. Resident B weighed 74.4 lbs. A physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. A radiology report, dated 3/8/20 at 11:04 p.m., indicated the resident had an acute fracture with displacement of the proximal femoral shaft. A bone fragment and soft tissue swelling was also noted. The report was called to the facility at 8:00 p.m. An emergency room (ER) report, dated 3/9/20 at 1:50 a.m., indicated a CNA checked on the resident and noted him holding his leg in a different position than normal. An x-ray indicated an acute fracture. The resident did not appear to be in acute distress and no other bruising was noted on the resident. A second x-ray was done 3/9/20 and indicated an offset [MEDICAL CONDITION] with some angulation and butterfly fragments. The report indicated the fracture was likely related to osteopenia. The resident was evaluated and sent to a larger hospital for treatment. A progress note, dated 3/10/20 at 11:30 a.m., indicated the resident had surgical repair on 3/9/20. During a telephone interview on 3/12/20 at 2:04 p.m., CNA 4 indicate when she saw the resident's leg around 6:30 p.m., she immediately got LPN 3. QMA 1 was the nurse on that hall, but she was always told to go to the nurse. She indicated LPN 7 did not receive any information in morning report from QMA 1 or LPN 3. During a telephone interview on 3/12/20 at 2:28 p.m., LPN 7 indicated she did not receive any information from the morning report she received from QMA 1 on 3/8/20. During a telephone interview on 3/12/20 at 2:36 p.m., QMA 1 indicated he was walking down the hall with a tray and saw Resident B on the floor, on his mat. CNA 2 assisted him in picking the resident up off the floor and putting him back in bed. He grabbed the resident's trunk and CNA 2 grabbed his upper half. CNA 4 did not tell him anything about the resident having a problem with his leg. He was unaware the resident required the use of a mechanical lift. Two attempts were made to contact the following staff with no return phone call; CNA 2, LPN 3, or CNA 8. During an interview on 3/13/20 at 12:13 p.m., the Administrator indicated she had received a message from Child Protective Services (CPS) the resident's fracture was due to osteopenia and would be returning to the facility at an unknown date. Review of a current facility policy, dated 8/14/19, titled MECHANICAL LIFT, which was provided by the Administrator on 3/13/20 at 11:44 a.m., indicated the following; Purpose: Transfer a dependent resident safely. Procedure: 1. Confirm mechanical lift to be used. 2. Place sling under resident .8. Slowly lower resident into bed or chair This Federal tag relates to Complaint IN 902. 3.1-45(a)(2)