STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155810	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on observation, record review and interview, the facility failed to ensure changes in a resident's condition was reported immediately to the charge nurse for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: Resident B's clinical record was reviewed on 5/1/24 at 10:15 a.m. Diagnoses included, but were not limited to, anoxic brain damage, cognitive communication deficit, and tracheostomy status. The current physician's orders included, but were not limited to, baclofen (muscle relaxer) 12.5 mg (milligram) three times daily, clobazam (treat seizures) 5 mg twice daily, gabapentin (treat nerve pain) 1 ml (milliliter) twice daily, and levetiracetam (treat seizures) 1.5 ml twice daily. A quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident B was rarely, never understood. Resident B had an impairment to his bilateral upper and lower extremities, and was dependent on staff for showering, toilet hygiene, personal hygiene, upper and lower body dressing, putting on and taking off footwear. The resident was dependent on staff to transfer from chair/bed-to-chair transfer, tub/shower transfer, and rolling left and right, and did not use a wheelchair/scooter. A nurses note, dated 4/29/24 at 4:44 p.m., indicated Resident B was crying out. The resident's left leg appeared shorter than normal and pointed more towards the left. Range of motion was unable to be assessed due to his condition. The nurse practitioner was updated, and the resident was sent to the emergency room for an evaluation and treatment. A nurses note, dated 4/29/24 at 9:11 p.m., indicated Resident B was being transferred to the emergency department to a children's hospital due to a dislocated left hip and a left femur fracture. The hospital x-ray report, dated 4/30/24 indicated Resident B had an unchanged alignment of the mildly angulated and impacted distal left femoral metaphyseal fracture, osteopenia, and a dysplastic and dislocated left hip. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A handwritten statement by Activity Assistant 5, dated 4/30/24 and included in the facility investigation documents, indicated the Activity Assistant (who was also a CNA) provided Resident B a shower between 9:00 a.m. and 9:30 a.m. on 4/29/24. Resident B's left foot was observed to be more midline than it usually was, looked different in the knee, and was more bent than usual. The Activity Assistant dressed Resident B, placed him in his car seat, and placed the car seat in the bed. At 11:00 a.m., the Activity Assistant returned to the room to re-position the resident, and Resident B cried out when his left leg was moved to place a blanket between his legs. Activity Assistant 5 asked LPN 21 to check on Resident B. The LPN told the Activity Assistant that Resident B acted like that when his medication was due to be given. Activity Assistant 5 also voiced her concerns to another CNA, who agreed there was something wrong and knew which leg was bothering the resident. During an interview with Activity Assistant 5, on 5/1/24 at 12:48 p.m., she indicated on 4/29/24, between 9:00 a.m. and 9:30 a.m., she carried Resident B into the shower, laid him on the shower bed, and took his shirt and diaper off. Resident B cried when the Activity Assistant moved his leg and started the shower, but then was fine. The resident's left leg looked funny, and it didn't look like it usually did. The resident's legs were normally straight, his heels were normally pointed inward, and his feet were pointed outward. The resident was showered and dressed, and assisted into a car seat, which was placed inside the crib. The resident fell asleep. At 11:00 a.m., an agency aide was taking over care of Resident B. Activity Assistant 5 took Resident B out of the car seat and placed him in bed. When a thin blanket was placed between his legs, Resident B cried out. His left leg was bent at the knee and his legs were normally straight. The resident's left leg was warm to touch. The Activity Assistant called for the nurse, and LPN 21 indicated Resident B got this way before it was time for his medications, but would keep a close eye on him. Activity Assistant 5 didn't report his left leg looking abnormal at 9:00 a.m., because the resident didn't cry when she carried him to the shower or during the shower. The Activity Assistant indicated she should have reported the resident's leg appearing abnormal to the nurse at 9:00 a.m., but she didn't work with him often. She knew something was definitely wrong when Resident B cried out when the blanket was placed in between his legs. During an interview with LPN 21, on 5/1/24 at 1:11 p.m., she indicated nothing was brought to her attention in the morning when Activity Assistant 5 gave Resident B a shower. LPN 21 was in the dining room assisting residents with eating lunch and she saw Activity Assistant 5 in Resident B's room rocking him, which was a normal activity. Resident B was not crying. Activity Assistant 5 came and got LPN 21 during that time or right after lunch, around 1:00 p.m. Activity Assistant 5 indicated to her that Resident B's legs felt warm. At that time, the resident was due for his medication, and he got warm and flushed when his medications were due. About 15 to 20 minutes after Resident B received his medications, the warmth and the skin flushing subsided. Resident B was normally passively fussy. LPN 21 looked at Resident B's legs and they didn't look anything out of the ordinary. She gave the resident his medication and then asked LPN 45 to look at the resident for a second pair of eyes. LPN 45 startled Resident B, who cried for a second and then went back to sleep. A few hours later, LPN 21 was going to administer Resident B's tube feeding, when an agency CNA was standing in Resident B's room holding him. When the agency aide went to lay the resident in bed, he screamed bloody murder. LPN 21 had never heard him cry that intensely. LPN 33 assessed Resident B, called the nurse practitioner, and sent the resident to the emergency room . It would be the facility's expectation that staff report any change in the condition of a resident immediately to the nurse. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON, on 5/1/24 at 2:14 p.m., she indicated she was informed that Resident B's left leg was slightly shorter than normal and turned outward. The nurse practitioner was contacted, and they were to send him to the emergency room . When Activity Assistant 5 mentioned Resident B's leg, it was close to the time of the resident's next medication administration. Resident B's skin got flushed, and he was fussy, almost like he was neuro-storming, when his medication was due. Once the medications were given, Resident B calmed down. The aide was rocking him and once she laid him down, he cried differently than normal. LPN 45 also assessed Resident B. According to the medication administration record, his morning medications were charted late at 11:26 a.m. and lunch time medications were charted late at 1:14 p.m. Lunch medications can be given from 11:00 a.m. to 1:00 p.m. She felt LPN 21 was using her nursing judgement; there was an hour difference in the CNA reporting Resident B's leg to the nurse, but she should have reported it at 9:00 a.m. A current facility policy, titled Notification of Changes Policy, dated 8/14/19 and provided by the DON on 5/1/24 at 2:07 p.m., indicated the following: .Notification occurs when .A significant change in the resident's physical, mental or psychosocial status (i.e., deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications) This citation relates to Complaint IN00433587. 3.1-5(a)(2)