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	09/10/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 32663 Based on interview and record review, the facility failed to ensure residents received medications per physician orders for 5 of 6 residents reviewed for medication administration. (Residents E, F, H, J, and K) Findings include: 1. The clinical record for Resident E was reviewed on 9/10/24 at 11:50 a.m. Diagnoses included spastic quadriplegic cerebral palsy, profound intellectual disabilities, dysphagia, anemia, idiopathic epilepsy and epileptic syndromes with status epilepticus, neuromuscular dysfunction of bladder, aphasia, rheumatoid arthritis with rheumatoid factor of multiple sites, respiratory disorder, pain, and gastro-esophageal reflux disease. The clinical record indicated the following orders: baclofen (muscle relaxant) 10 mg three times daily (dated 6/3/24) and ferrous sulfate (iron supplement) 325 mg three times daily (dated 6/3/24). A care plan, dated 8/8/24, indicated Resident E was at risk for excessive tiredness, shortness of breath, and cold intolerance due to anemia. An intervention dated 8/8/24, indicated Supplement as ordered. A care plan, dated 2/3/17, indicated the resident had an order for baclofen for spasticity related to their Cerebral Palsy diagnosis. An intervention, dated 2/3/17, indicated to give mediations as ordered. A progress note, dated 9/7/24 at 3:58 a.m., indicated the resident's noon medications were found in the top drawer of the medication cart. Review of the August 2024 Medication Administration Record (MAR) indicated the medication was documented as given. 2. The clinical record for Resident F was reviewed on 9/10/24 at 12:46 p.m. Diagnoses included spastic quadriplegic cerebral palsy, severe intellectual disabilities, idiopathic epilepsy and epileptic syndromes, dysphagia, iodine-deficiency related thyroid disorders and allied conditions, chronic kidney disease, aphasia, Autistic disorder, and hypomagnesemia. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record indicated the following orders: magnesium oxide (magnesium supplement)500 mg three times daily (dated 7/22/24), midodrine (anti-hypotensive)10 mg three times daily per gastric tube (dated 2/4/24), and valporate (anti-convulsant) 250 mg/5 milliliters (ml) give 10 ml three times daily per gastric tube (dated 10/24/23). A care plan, dated 5/7/24, indicated the resident had diagnosis of hypomagnesemia, and was at risk for muscle spasms, nausea, vomiting, fatigue, and seizures. An intervention, dated 5/7/24, indicated supplements as ordered. A care plan, dated 5/28/21, indicated Resident F was at risk for complications associated with hypernatremia, recent acute kidney failure and metabolic encephalopathy. An intervention, dated 6/7/21, indicated for medication or treatment as ordered. A care plan, dated 5/28/21, indicated the resident had altered respiratory status as evidenced by recent bilateral pulmonary embolis, acute respiratory failure, and aspiration pneumonia. An intervention, dated 6/7/21, indicated to medicate as ordered. A care plan, dated 11/1/15, indicated the resident had epilepsy. An intervention, dated 6/21/18, indicated to give medications as ordered for seizures and notify physician. A progress note, dated 9/7/24 at 3:55 a.m., indicated the noon medications were found in the top drawer of the medication cart. Review of the August 2024 MAR indicated the medication was documented as given. 3. The clinical record for Resident H was reviewed on 9/10/24 at 1:06 p.m. Diagnoses included tuberous sclerosis, profound intellectual disabilities, contracture, generalized idiopathic epilepsy and epileptic syndromes with status epilepticus, gastro-esophageal reflux disease, dysphagia, hypothyroidism, aphasia, benign neoplasm of kidney, hypomagnesemia, hypo-osmolality and hyponatremia, pain, and dyspnea. The clinical record indicated the following orders: carbamazepine (anticonvulsant) 300 mg three times daily (dated 7/20/20) and magnesium (magnesium supplement) oxide 400 mg three times daily (dated 3/26/24). A care plan, dated 3/26/24, indicated Resident H had a diagnosis of hypomagnesemia and was at risk for muscle spasm, muscle cramps, fatigue and weakness. An intervention, dated 3/26/24, indicated to medicate as ordered. A care plan, dated 1/8/13, indicated the resident had a diagnosis of epilepsy with the potential for adverse effects related to acute episodes. An intervention, dated 6/20/13, indicated to administer medications as ordered and assess for signs and symptoms of toxicity. A progress note, dated 9/7/24 at 4:01 a.m., indicated the noon medications were found in the top drawer of the medication cart. Review of the August 2024 MAR indicated the medication was documented as given. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The clinical record for Resident J was reviewed on 9/10/24 at 1:10 p.m Diagnoses included spastic quadriplegic cerebral palsy, profound intellectual disabilities, dysphagia, gastro-esophageal reflux disease, gastrostomy status, adult failure to thrive, idiopathic epilepsy and epileptic syndromes with status epilepticus, aphasia, contracture, right knee and autistic disorder. The clinical record indicated the following orders: baclofen 10 mg three times daily (dated 5/26/22) and valporic acid 250 mg/5 ml give 5 ml three times daily per gastric tube (dated 5/26/22). A care plan, dated 4/20/22, indicated Resident J had seizure and was at risk for complications and injury related to seizure disorder. An intervention, dated 4/25/24, indicated to medicate as ordered. A care plan, dated 11/9/18, indicated the resident had the potential for discomfort related to the diagnosis of spastic quadriplegic cerebral palsy. An intervention, dated 11/9/18, indicated to give medications as ordered. A care plan, dated 3/14/16, indicated the resident had spastic quadriplegic cerebral palsy and contractures of arms and legs. The resident took baclofen to reduce spasticity. An intervention, dated 3/15/16, indicated to administer medications as ordered. A progress note, dated 9/7/24 at 3:46 a.m., indicated the noon medications were found in the top drawer of the medication cart. Review of the August 2024 MAR indicated the medication was documented as given. 5. The clinical record for Resident K was reviewed on 9/10/24 at 1:15 p.m. Diagnoses included spastic quadriplegic cerebral palsy, severe intellectual disabilities, impulse disorder, epilepsy, unspecified without status epilepticus, dysphagia, aphasia, pain, and respiratory disorder. The clinical record indicated the following order: baclofen 10 mg per gastric tube 3 times daily (dated 7/20/20). A care plan, dated 11/29/12, indicated the resident had epilepsy and the potential for adverse effects related to acute episodes, and medication usage. An intervention, dated 11/12/15, indicated to administer medications as ordered by physician for seizure activity and assess for symptoms of toxicity. A progress note, dated 9/7/24 at 3:49 a.m., indicated the noon medications were found in the top drawer of the medication cart. Review of the August 2024 MAR indicated the medication was documented as given. During an interview on 9/9/24 at 3:09 p.m. the DON indicated, on 9/6/24 between 11:00 a.m. and 1:00 p.m., Residents E, F, H, J, and K were not administered medications. The DON indicated the nurse on duty was an agency nurse. The medications were found by the night shift nurse in the top drawer of the medication cart. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/24 at 1:22 p.m., the Administrator and the DON indicated, according to the Medication Administration policy, refusal of a medication would also be applied to not being administered. Any missed or refused medication should be documented as such in the electronic MAR. A current policy, dated 6/17/21, titled Medication Administration was provided by the Administrator on 9/10/24 at 12:00 p.m. The policy indicated the following: Procedure: 12. If resident refuses medication, document refusal and based on plan of care notify physician. This citation relates to Complaint IN00441262. 3.1-13(m)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32663 Based on interview and record review, the facility failed ensure a resident's medication was available for administration for 1 of 6 residents reviewed for medication availability. (Resident G) Findings include: During an interview on 9/9/24 at 3:09 p.m., the DON indicated the facility had experienced two incidents of medication errors within the past 30 days. The DON provided a list of 6 residents who had medication errors within the past 30 days. Resident G (whose name was on the list) had not been administered a dose of diazepam 15 mg on 9/7/24 between 5:30 a.m. and 9:30 a.m. The facility had failed to secure a refill prescription, and the pharmacy could not refill the medication without a prescription from the provider. The DON indicated staff had attempted to call the Nurse Practitioner (NP) to get a renewed prescription for the medication with no response. The staff then called the alternate NP, with no response. After staff were unable to reach the NP, they called the DON. The DON instructed them to call the NP again and if no response inform her (DON). The staff were able to reach the NP and the prescription for the medication was sent to pharmacy. The clinical record for Resident G was reviewed on 9/10/24 at 12:12 p.m. Diagnoses included spastic quadriplegic cerebral palsy, cardiomegaly, apraxia, heart failure, dysphagia, gastrostomy status, asthma, severe intellectual disabilities, Cauda Equina Syndrome, aphasia, abnormal posture, gastro-esophageal reflux disease, and anxiety disorder. A current, 5/5/22 physician order indicated diazepam (anti-anxiety) 15 mg was to be administered per gastric tube twice daily (once in am and once in pm). A care plan, dated 3/20/20, indicated the resident had anxiety as evidenced by shortness of breath. The resident had a diagnosis of dysphasia and would sometimes not be able to swallow, causing anxiety. The resident received an antianxiety medication. An intervention, dated 6/8/21, indicated Medication as ordered. A care plan, dated 2/28/12, indicated the resident had cerebral palsy with the upper and lower extremity impairments and spasticity. The medication regimen included an anti-anxiety medication. An intervention, dated 7/1/16, indicated to give medications as ordered. During an interview on 9/10/24 at 1:22 p.m., the DON indicated it was the responsibility of all nurses to reorder medications as needed. All nurses were to be mindful of when medications needed to be reordered from pharmacy and alert management if there were an issue. A current policy, dated 6/17/21, titled Medication Administration was provided by the Administrator on 9/10/24 at 12:00 p.m. The policy indicated the following: Purpose: Medications are administered as prescribed in accordance with manufacture's specifications, good nursing principles and practices and only by persons legally authorized to d so. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: 2. Medications are administered in accordance with written orders of the physician/prescriber. This citation relates to Complaint IN00441262. 3.1-25(g)(3)