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	05/14/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 49411 Based on record review and interview, the facility failed to ensure the resident's representative was notified in writing of the transfer/discharge appeal rights for 1 of 3 hospitalization s. (Resident D) Findings include: Resident D's clinical record was reviewed on 5/12/25 at 3:24 p.m. Diagnoses included cerebral palsy, fracture of left lower leg, adult failure to thrive, Cauda Equina syndrome, severe intellectual disabilities, osteoarthritis, congenital deformities of feet, and diabetes. Review of a progress note, dated 3/18/25 at 10:24 a.m., indicated the resident yelled out upon being rolled onto his left side during care. The resident's left hip had non-pitting edema, was warm to the touch, and slight green discoloration was noted. An order was received for a left hip x-ray. The resident's representative was notified. A progress note, dated 3/19/25 at 12:45 a.m., indicated x-ray results showed resident had a left hip fracture. The resident's representative was notified. A progress note, dated 3/19/25 at 2:04 a.m., indicated an order was received to send the resident to the ER for treatment and possible surgery. The clinical record lacked indication that the resident's representative was notified of the transfer/discharge appeal rights in writing for the resident's transfer to the hospital. A progress note, dated 5/4/25 at 7:30 a.m., indicated the resident had bruising and swelling was noted to his left hand, wrist and shoulder. An x-ray order was received. A message was left for the resident's representative to return the call for a status update. On 5/4/25 at 2:52 p.m., indicated the Nurse Practitioner (NP) was notified of the resident's x-ray results. An order was received to send the resident to the hospital for evaluation and treatment. The resident's representative was notified. The clinical record lacked indication that the resident's representative was notified of the transfer/discharge appeal rights in writing for the resident's transfer to the hospital. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 5/6/25 at 12:00 p.m., indicated Resident D was experiencing shortness of breath with the use of his accessory muscles noted. Breathing treatments were ineffective. An order was received to send the resident to the emergency room (ER) for evaluation. A call was placed for emergency transportation. A progress note, dated 5/6/25 at 12:20 p.m., indicated the Emergency Medical Technicians (EMTs) arrived to transport the resident to the ER for evaluation. The clinical record lacked indication that the resident's representative was notified of the transfer/discharge appeal rights in writing for the resident's transfer to the hospital. During an interview, on 5/13/25 at 2:37 p.m., the Social Services Director indicated the nurses were responsible for the transfer form for hospital discharges. During an interview, on 5/13/25 at 2:59 p.m., LPN 6 and LPN 8 each indicated they discussed the facility bed hold policy during resident transfers or discharges with the resident's representative. They did not discuss appeal rights information with the residents or their representatives. During an interview, on 5/14/25 at 9:08 a.m., the DON indicated she did not inform the resident or their representative of their appeal rights during transfers or discharges. She only discussed the bed hold policy. During an interview, on 5/14/25 at 10:05 a.m., the Regional Nurse Consultant indicated she was unable to locate any information where Resident D's representative was notified of their appeal rights. A current facility policy, dated 11/15, titled Discharge, provided by the Regional Nurse Consultant on 5/14/25 at 10:35 a.m., indicated the following: .Hospital Transfer: 5. Prepare a transfer form, send with the resident. 7. Document in the nursing notes the condition of the patient, disposition of residents belongings and medications, notification to all parties of the discharge This citation relates to Complaint IN00458788. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49411 Based on interview and record review, the facility failed to follow physician orders regarding continuation of care for residents transported to day programs with medications for 2 of 3 residents reviewed for day services (Resident B and C). Findings include: During an interview, on 5/12/25 at 9:14 a.m., LPN 6 indicated the Social Services Director informed her of Resident B and Resident C's school schedules. LPN 6 was unsure if the school had received their medications, but sent Resident C to school anyway without checking on 5/6/25. The school immediately called the facility to have Resident C picked up, as he was not approved to attend at that time. During an interview, on 5/12/25 at 10:36 a.m., the DON indicated all documents were sent to the school before the residents could attend. She ordered the school their own medication supply, but it wasn't delivered at this time. Staff sent Resident C to school one day before his care plan was approved or medications were delivered. During an interview, on 5/12/25 at 11:05 a.m., the Administrator indicated Resident B was sent to school and the school called requesting the resident be picked up. The facility did not realize Resident B was not approved to start school at that time. During an interview, on 5/12/25 at 11:10 a.m., CNA 4 indicated Resident B was sent to school on 5/7/25. The school called shortly after and needed him picked up. She transported him from the school back to the facility. During an interview, on 5/12/25 at 11:44 a.m., the Social Services Director indicated Resident C was sent to school without the school having his medication on hand. To her knowledge, Resident B was never sent to school. Once the school received their medication, both residents could attend school. Review of electronic mail (e-mail) correspondence dated 5/5/25 at 2:26 p.m. and provided by the Administrator on 5/12/25 at 1:13 p.m., indicated the school nurse informed the facility both residents could not attend until the school received their rescue medications and their care plans have been approved. 1. Resident B's clinical record was reviewed on 5/12/25 at 11:30 a.m. Diagnoses included epilepsy (seizures), convulsions (violent, involuntary muscle movement and spasm), lack of coordination, and contracture of right ankle. Current orders included attending day services outside the facility with medications, Trileptal (anti-seizure) nine milliliters (mL) twice a day, diazepam (anti-convulsant) 10 milligram (mg) as needed for seizure activity, and Topamax (anti-convulsant) 75 mg twice a day. A current care plan, initiated 4/24/25, indicated the resident was at risk for seizure and injury related to epilepsy. Interventions included medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 5/1/25 at 12:39 p.m., indicated Social Services was in the process of enrolling Resident B into school. 2. Resident C's clinical record was reviewed on 5/13/25 at 10:57 a.m. Diagnoses included autism, epilepsy, and anxiety. Current orders included attending day services outside the facility with medications, clobazam (anti-seizure) 20 mg daily, Valtoco (anti-seizure) 10 mg nasal liquid as needed for seizure, Rufinamide (anti-seizure) 600 mg twice a day, and Felbamate (anti-seizure) 400 mg three times a day. A 4/22/25, quarterly, Minimum Data Set (MDS) assessment, indicated Resident C had an active diagnosis of epilepsy. A current care plan, initiated 3/18/25, indicated the resident was at risk for seizures and injury related to epilepsy. Interventions included medications as ordered. On 5/14/25 at 9:11 a.m., RN 7 indicated she sent Resident B to school. There was miscommunication between herself and the DON on which resident was approved to attend school. The school immediately called to have Resident B picked up as the school did not have his care plan approved or his medications. On 5/14/25 at 10:05 a.m., the Regional Nurse Consultant indicated the facility did not have a policy regarding residents attending school outside the facility. A current facility policy, dated 6/202, titled Physician Orders, provided by the Regional Nurse Consultant, on 5/14/25 at 10:35 a.m., indicated the following: .It is the policy of this facility to provide resident centered care that meets psychosocial, physical, and emotional needs and concerns of the resident This citation relates to Complaint IN00459066. 3.1-37(a)