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	12/19/2025

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 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. Based on record review and interview, the facility failed to consistently notify the nurse practitioner or physician of a resident's weight gain per order for 1 of 5 residents reviewed for unnecessary medications. (Resident 3) Finding includes: Resident 3's clinical record was reviewed on 12/17/25 at 10:48 a.m. Diagnoses included atherosclerotic heart disease of the native coronary artery with angina pectoris (buildup of plaque in the heart's arteries), chronic atrial fibrillation (irregular heartbeat), acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, cardiomegaly (enlarged heart), ischemic cardiomyopathy (weakened and enlarged heart caused by lack of blood flow), edema, and stage 3 chronic kidney disease. Current orders included bumetanide (diuretic) 2 mg twice a day (8/28/25), metolazone (diuretic) 2.5 mg every Monday (11/10/25), and daily weight in the morning - notify the Nurse Practitioner (NP) for 3-pound weight gain in 24-hour period or 5 pounds in 48 hours (7/22/25). A current care plan, initiated on 5/13/25, indicated the resident had altered cardiovascular status related to cardiomegaly, atherosclerotic heart disease of native coronary artery without angina pectoris, combined heart failure, and shortness of breath. Interventions included daily weight and notify MD/NP of 3-pound weight gain over one day or 5-pound weight gain over 3 days (5/13/25). The resident's medication administration records for November 2025 and December 2025 indicated the following: The resident had a weight gain of 5.6 pounds on 11/6/25, a 4.2-pound weight gain on 11/13/25, a 4-pound weight gain on 11/15/25, a 10-pound weight gain on 11/17/25, a 7.8-pound weight gain on 12/6/25, and a 3-pound weight gain on 12/8/25. The resident's clinical record lacked physician/NP notification of the weight gains on those days. During an interview, on 12/19/25 at 10:27 a.m., LPN 12 indicated when the resident's orders had parameters which included calling the NP or physician, then the notification of the NP or physician should be completed and documented in the progress notes if the parameters were met. During an interview, on 12/19/25 at 2:53 p.m., LPN 7 indicated if a resident had a weight gain and the physician or NP notification was ordered, then the NP/physician would be notified and the notification would be placed in the resident's progress notes. During an interview, on 12/19/25 at 3:00 p.m., RN 11 indicated if a resident had a weight gain and the physician or NP should be notified, typically the notification would be placed in the progress notes. For some orders with parameters the software would require documentation if the parameters were/were not met depending on the order. During an interview, on 12/19/25 at 4:11 p.m., the DON and the Corporate Nurse Consultant indicated they were unable to find physician/NP notification as ordered of the resident's weight gain on several days during November and December 2025. A current facility policy, last reviewed 7/1/21 and provided by the Administrator on 12/19/25 at 4:30 p.m., titled Notification of Changes, indicated the following: The facility shall promptly notify the resident and/or the resident's representative and his or her physician or delegate of changes in the resident's condition or status in order to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences.Document the notification and record any new orders in the resident's medical record. 3.1-5(a)(3)

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, related to medications not being administered via ordered route for 2 observed medication administration opportunities of 34, resulting in a medication error rate of 5.88%.Findings include:During a medication administration observation, on 12/19/25 at 8:08 a.m., the following was observed:LPN 7 prepared aspirin 81 milligrams (mg) and ferrous sulfate (iron) 325 mg for Resident 17. Both medications were removed from medication cards and placed into a plastic sleeve to be crushed. Both medications were crushed by a pill crusher then mixed with vanilla pudding before administering the mixture orally to Resident 17.Resident 17's current physician orders included aspirin 81 mg daily via gastrostomy tube ([g- tube], a tube placed directly into the stomach for feedings, medications, nutrients, etc) and ferrous sulfate 325 mg daily via g-tube.During an interview, on 12/19/25 at 8:13 a.m., LPN 7 indicated Resident 17 did not have an order to give medications orally. Both medications should have been administered via her g-tube.On 12/19/25 at 9:49 a.m., the DON indicated Resident 17 had always been given crushed medications orally. Resident 17 previously had an order to crush medications and give orally but that order had been discontinued. The two medications should have been administered via Resident 17's g-tube per physician orders.A current facility policy, dated 6/22/22, titled Medication Administration, provided by the Corporate Consultant, on 12/19/25 at 9:08 a.m., indicated the following: .Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician. 10. Ensure that the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, right documentation 3.1-48(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to remove discontinued medications from the Kalor Court medication cart for 2 of 15 residents' medications contained in the medication cart. (Resident 10 and Resident 26) Findings include: During an observation, on 12/16/25 at 10:51 a.m., of the Kalor Court medication cart with LPN 13, an undated and opened bottle of GenTeal Tears (eye drops) with a pharmacy sent date of 6/20/25 and instructions to instill two drops a day to both eyes four times a day for Resident 10 was in the top right-hand drawer of the medication cart. An undated opened bottle of Blink Tears (eye drops) with a pharmacy sent date of 10/22/25 and instructions to instill two drops into right eye every six hours for two days was in the top right-hand drawer of the medication cart for Resident 26. The bottle did not have a change of directions sticker or writing on it. At the same time as the observation, LPN 13 indicated when the last dose of the eye drops was given, they should have been discarded. 1. Resident 10's clinical record was reviewed on 12/17/25 at 11:21 a.m. Current orders did not include GenTeal Tears. The resident had two previous orders for GenTeal Tears which included GenTeal Tears - Instill two drops in both eyes four times a day for dry eyes, started 5/9/25 and discontinued 6/20/25 and GenTeal Tears - Instill two drops in both eyes four times a day for dry eyes, started 6/21/25 and discontinued 7/10/25.2. Resident 26's clinical record was reviewed on 12/17/25 at 10:56 a.m. Current orders included Artificial Tears - Instill one drop in both eyes two times a day, started 10/23/25. An order for Blink Tears - Instill 2 drops in right eye every six hours for two days was started 10/22/25 and discontinued on 10/24/25. During an interview, on 12/17/25 at 2:50 p.m., the Corporate Consultant Nurse indicated she was unable to locate a current order for Resident 10's GenTeal eye drops. Resident 26's Blink Tears could have been used for his Artificial Tears order as they were the same drops. The pharmacy removed discontinued and expired medications from the cart and should have removed them when the pharmacy had observed the cart a few weeks ago. During an interview, on 12/19/25 at 2:27 p.m., LPN 12 indicated when an order for medication including eye drops changed, a sticker could be placed on the medication label to indicate the change in orders, and the medication could continue to be used. With a big change, such as the eye drops where it went from one eye to both eyes and the times changed, she would have waited for the new medication from the pharmacy. The order on the medication administration record should match the order on the medication. During an interview, on 12/19/25 at 2:47 p.m., LPN 7 indicated if an eye drop was ordered for a few days, then completed, she would discard medication in the drug buster. If the order was changed, she would put it on the alert charting and put a sticker on the label that said the order changed. During an interview, on 12/19/25 at 2:54 p.m., RN 11 indicated once an eye drop order was discontinued, the eye drops should be removed from the medication cart. Typically, the nurse that administered the last ordered drop removed the eye drops from the cart. If the order was changed, that should be caught during the triple checks with medication administration, and the eye drop should not be given unless the order matched the order on the medication administration record. A current, undated facility policy, provided by the Administrator on 12/19/25 at 4:30 p.m., titled Destruction of Unused Drugs, indicated the following: .Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed. 3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food was served under safe sanitary conditions during meal service regarding food handling for 1 of 35 residents who received meals orally. (Resident 37) Findings include:During a lunch service observation, on 12/15/25 at 12:31 p.m., the following was observed. CNA 14 touched a piece of bread inside a storage bag. With her bare hands, she reached into the storage bag and pulled the bread out with her bare hands before placing it on Resident 37's plate. She then proceeded to butter the bread before she picked the bread up with her bare hands, folded it in half, and handed it to Resident 37. Resident 37 took a bite out of the bread before placing it down on his plate.During an interview, on 12/15/25 at 12:48 p.m., CNA 14 indicated she did not recall pulling the bread from the plastic bag with her bare hands. She probably touched the bread with her bare hands when she folded it in half and handed it to the resident.On 12/19/25 at 9:05 a.m., the Corporate Consultant indicated the facility had already started in-servicing staff members regarding proper food handling. Written education with CNA 14 was completed.On 12/19/25 at 9:08 a.m., the DON indicated staff members should not be touching food with their bare hands. Staff should wear gloves before touching food.A current facility policy, dated 2/27/25, titled Serving a Meal, provided by the Administrator, on 12/17/25 at 9:30 a.m., indicated the following: .6. Avoid handling actual unwrapped food items with bare hands. Be careful to handle wrapping/packaging instead of the food/condiment when opening. In the rare instance that this is necessary, gloves must be worn 3.1-21(i)(3)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer eligible residents and/or the residents' representatives the current pneumococcal immunization according to the Centers for Disease Control and Prevention (CDC) guidelines for 2 of 5 residents reviewed for immunizations. (Resident 2 and Resident 7). Findings include: 1. Resident 2's clinical record was reviewed on 12/17/25 at 9:12 a.m. Diagnoses included tracheostomy status, heart failure, obstructive sleep apnea, chronic pulmonary edema, and emphysema. Current orders included Vaccines - May receive vaccines as scheduled as recommended per CDC, per responsible part consent unless contraindicated (4/30/25); Change Trach Shiley 8 cuffless and as needed once a day on the first day of the month (5/1/25); Albuterol nebulizer 0.083% inhale orally twice a day (5/11/25); and Ipratropium solution 0.02% inhale orally via nebulizer twice a day (5/11/25). Resident 2's immunization record was reviewed. A pneumococcal vaccination, Prevnar 13 (PCV13), was given on 12/11/23. The record lacked consent or declination for a Prevar 20 (PCV20) or PCV21 as recommended by the CDC. 2. Resident 7's clinical record was reviewed on 12/17/25 at 3:10 p.m. Diagnoses included shortness of breath, chronic kidney disease, stage 4 (severe), and type 2 diabetes mellitus. Resident 7's immunization record was reviewed. The resident received, prior to facility admission, a PCV13 on 9/4/18 and a Pneumovax 23 (PPSV23) on 11/28/18. A pneumonia vaccination consent which indicated two types of vaccines were used to prevent pneumococcal disease, the PCV13 and the PPSV23, was signed on 11/19/25 by the resident's representative and indicated the resident had already received the pneumococcal vaccine on 11/28/18. The record lacked consent or declination for a PCV20 or PCV21 as recommended by the CDC. During an interview, on 12/19/25 at 4:03 p.m., the ADON/Infection Preventionist indicated Resident 2 and Resident 7 had not been offered that PCV20 or PCV21 as far as she knew. She indicated she would check the previous electronic medical record software to see if it had been offered at some time. During an interview, on 12/19/25 at 4:11 p.m., the DON and the Corporate Consultant Nurse indicated they were unable to find consents or declinations of the PCV20 or PCV21. According to the CDC website, the Morbidity and Mortality Weekly Report for 1/9/25 article Expanded Recommendations for the Use of Pneumococcal Conjugate Vaccines Among Adults Aged > 50 Years: Recommendations of the Advisory Committee on Immunizations Practices - United States, 2024, accessed on 12/19/25, adults aged greater than or equal to [AGE] years of age and have received the PCV 13 at any age and the PPSV23 at age less than 65 years then a single does of PCV21 or PCV20 greater than or equal to 5 years after the last pneumococcal vaccine dose is recommended. The guidance for adults aged 19 to [AGE] years of age with chronic medical conditions which include alcoholism, chronic heart disease, including congestive heart failure and cardiomyopathies, chronic liver disease, chronic lung disease (chronic obstructive pulmonary disease, emphysema, and asthma), cigarette smoking, or diabetes mellitus, is to receive the PCV 21 or PCV 20 one year or greater after receiving the PCV 13 dose. A current facility policy, dated 4/1/21, provided by the Administrator on 12/15/25 with entrance conference paperwork, with no title, indicated the following POLICY: All residents will be offered pneumococcal vaccines to aid in prevention pneumonia/pneumococcal infections.Administration of pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 3.1-13(a)