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	07/18/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on observation, interview and record review, the facility failed ensure a resident's controlled substances were accounted for and were being reconciled during shift change for 1 of 3 residents reviewed for medication storage and availability. (Resident B) Findings include: Resident B's clinical record was reviewed on 7/17/24 at 1:41 p.m. Diagnoses include anoxic brain damage, cognitive communication deficit, history of disorder of muscle, unspecified-hypertonia, other muscle spasm, other seizures, and familial dysautonomia ([NAME]-Day). His medication orders included lorazepam (treat anxiety) 0.4 ml (milliliter) as needed with neurostorming episodes (4/12/24) and diazepam (treat muscle spasms) 1 ml as needed 30 minutes after Tylenol (pain reliever), if not effective (7/12/24). A quarterly Minimum Data Set (MDS) assessment, dated 6/5/24, indicated he was rarely/never understood. A pharmacy packing slip, with RN 6's signature and dated 3/21/24, indicated 60 mls of diazepam was delivered to the facility for Resident B. During a controlled substance reconciliation on the Kalor hall medication cart with LPN 21, on 7/17/24 at 12:03 p.m., a narcotic sheet log/tracking form for oncoming and off going nurses for the month of July was reviewed. The log/tracking form indicated the date and time, total number of controlled substance cards, liquid and bottles, and how many count sheets were added or removed. Of the 35 shift changes, 19 cards had a total documented. There were no counts of liquids or bottles documented for the 35 shift changes. LPN 21 indicated the shift change form was made up by the previous DON and they had never completed the total liquid or the total bottles on the sheet when counting, but probably should. A narcotic count form indicated there were 60 mls of diazepam confirmed with RN 6's signature, dated 3/21/24. Handwritten on the form indicated the bottle was sent to an appointment on 4/23/24 and on 7/12/24 there were 45 mls remaining in the bottle. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A narcotic count form indicated there were 28.4 mls of lorazepam. Handwritten on the form indicated there should be 28.4 mls and on 7/12/24 there were 22 mls remaining in the bottle. There were three of four times 0.4 mls were signed out but the remaining amount of mls left in the bottle were not recorded on the form. An ambulatory visit summary note from the neurologist, dated 3/21/24, indicated for neurostorming, they recommended to first assess for any noxious stimuli, administer Tylenol 140 mg and wait 30 minutes, and if not resolved, give diazepam 1 mg (which would be sent to pharmacy). A nurses note, dated 3/21/24 at 5:01 p.m., indicated Resident B had a new order to increase his Keppra (treat seizures) and a new order for diazepam and gabapentin (treat neuropathy) to be clarified during business hours. A nurses note, dated 3/26/24 at 7:20 p.m., new order for Keppra dose to be increased to 150 mg (1.5 mls) and diazepam 1 mg (milligram) for neurostorming, if Tylenol not effective after 30 minutes. A nurses note, dated 4/23/24 at 6:12 a.m., indicated Resident B was out for an appointment, accompanied by RN 6. A review of the facility investigation, on 7/17/24 at 10:55 a.m., contained a handwritten statement by RN 6, dated 7/12/24 at 12:00 p.m., that indicated RN 6 and LPN 7 completed the narcotic count. The narcotic count for the pills in punch cards were correct, however, Resident B's liquid diazepam count was incorrect. RN 6 told LPN 7 to put the bottle aside and that she would talk to the nurse on call when she returned that evening for her shift, then RN 6 left the facility. RN 6 indicated the last time she counted the diazepam with any other nurse was unknown. During an interview with the Administrator, on 7/17/24 at 2:37 p.m., she indicated when RN 6 and LPN 7 completed a narcotic count, the diazepam had a discrepancy. LPN 7 wanted to figure it out and felt RN 6 was being rude. RN 6 was upset and left. RN 6 told her that she she couldn't tell her the last time she counted the narcotic liquids. RN 6 had accepted the delivery of the diazepam and put it in the narcotic box, but did not put the order in the electronic health record. The bottle of diazepam should have been unsealed, and shouldn't have been given, because there was not an order for it. The facility wasn't sure when the diazepam actually disappeared, whether it was that night or over an undetermined amount of time. During an interview with LPN 7, on 7/17/24 at 2:50 p.m., she indicated she attempted to get report and count the narcotics with RN 6. There was supposed to be 60 mls of Resident B's diazepam, but there were only 45 mls in the bottle. She asked RN 6 if she gave it and just forgot to sign it out. She asked RN 6 to contact her supervisor, because she didn't want to be responsible for the narcotic count not being correct. RN 6 indicated to her that she wasn't going to address or deal with it at that time and left the keys in the keyhole of the cart. LPN 7 reported RN 6's behavior and the incorrect count of the diazepam to LPN 14, who contacted the on-call nurse. There was a bottle of lorazepam in the refrigerator and LPN 7 counted that with LPN 14. The lorazepam amount was also incorrect. LPN 14 again called the on-call nurse. The amount given was not subtracted on the narcotic count sheet for the lorazepam. There was supposed to be 28 mls and there were only 22 mls in the bottle. During an interview with the Administrator, on 7/17/24 at 3:09 p.m., she indicated the facility was still looking into the missing amount of lorazepam for Resident B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the MDS Coordinator, on 7/17/24 at 3:12 p.m., she indicated at shift change the nurses should be filling out the total liquid and the total bottles to keep track of the controlled substances. A current facility policy, titled Controlled Medication Storage, provided by the Administrator, on 7/17/24 at 3:09 p.m., indicated the following: .Purpose: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state, and other applicable laws and regulations .4. At the change of custody, a physical inventory of all controlled medications is conducted by 2 licensed/certified personnel and is documented This citation relates to Complaint IN00438619. 3.1-25(e)(2) 3.1-25(e)(3)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 40241 Based on observation, interview, and record review, the facility failed to ensure residents were receiving dental services for 3 of 3 residents reviewed for mouth care. (Residents C, Resident E and Resident F) Findings include: 1. Resident C's clinical record was reviewed on 7/17/24 at 4:15 p.m. Diagnoses include spastic quadriplegic cerebral palsy, profound intellectual disabilities, dysphagia, oropharyngeal phase, aphasia, and posteruptive color changes of dental hard tissues. His orders included he may be seen by podiatrist, dentist, optometrist, psychiatrist, psychologist and an audiologist as needed (PRN). A significant change Minimum Data Set (MDS) assessment, dated 7/3/24, indicated he was severely cognitively impaired. He was dependent on staff for oral hygiene. He had obvious or likely cavity or broken teeth. His dental care plan indicated he was at risk for chewing complications related to posteruptive color changes of dental hard tissues, encounter for dental examination and cleaning without abnormal findings (2/2/22). His interventions included assist with oral care as needed (2/2/22) and dental referral as needed (2/2/22). His last dental note from, dated 5/6/22, indicated adult prophylaxis was performed, which included his teeth were hand scaled and polished. A toothette swab was used. A fluoride varnish was applied. His next visit would include mouth swab and prophylaxis. There was no indication in the clinical record that Resident C had seen a dentist since 5/6/22. 2. Resident E's clinical record was reviewed on 7/18/24 at 12:22 p.m. Diagnoses included spastic quadriplegic cerebral palsy, profound intellectual disabilities, dysphagia, oropharyngeal phase, aphasia, and posteruptive color changes of dental hard tissues. Her orders included she may be seen by podiatrist, dentist, optometrist, psychiatrist, psychologist, and an audiologist as needed. A quarterly MDS assessment, dated 4/30/24, indicated BIMS 99. She was dependent on staff for oral hygiene. Her dental care plan indicated she needed assistance to complete dental care and she had a diagnosis of posteruptive color changes of dental hard tissues (2/1/17). Her interventions included assist as needed to brush teeth and gums (2/17/17) and assist to attend dental appointments (2/17/17). (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Her last dental note, dated 3/23/22, indicated she had plaque calculus stains and inflammation recession bleeding gingivitis. She needed sedation for Full Mouth Debridement (FMD) please. The next dental visit would include FMD. There was no indication in the clinical record that Resident E had seen a dentist since 3/23/22. 3. Resident F's clinical record was reviewed on 7/18/24 at 2:10 p.m. Diagnoses included spastic quadriplegic cerebral palsy, profound intellectual disabilities, dysphagia, oropharyngeal phase, aphasia, and posteruptive color changes of dental hard tissues. His orders include he may be seen by podiatrist, dentist, optometrist, psychiatrist, psychologist, and an audiologist PRN. A quarterly MDS assessment, dated 6/5/24, indicated he was rarely/never understood. He was dependent on staff for oral hygiene. His dental care plan indicated he needed assistance to complete dental care. He had a diagnosis of post eruptive color changes of dental tissue (2/1/17). His interventions included assist as needed to complete dental care every shift (2/17/17) and assist to attend dental appointments (2/17/17). His last dental note, dated 5/6/22, indicated adult prophylaxis was performed which included a Cavitron (an ultraxonic scaling system used to clean teeth) used to scale, polished and toothette swab. His next visit would include mouth swab and to schedule annual periodic oral evaluation with the dentist. There was no indication in the clinical record that Resident F had seen a dentist since 5/6/22. During an interview with the Social Service Director (SSD) on 7/18/24 at 10:50 a.m., she indicated the new dental services for the facility, which took over the beginning of 2023, was responsible for reaching out to the residents and resident representatives to get them enrolled for dental services. It was brought to her attention by a family member that dental services had not been offered, so the SSD completed an audit and found half of the residents were not enrolled. She contacted the new dental services, and was currently assisting with the enrollment process. The previous dental services had taken care of everything. She trusted the new dental was taking care of everything and she had not completed audits to make sure the residents were receiving dental services. A current facility policy, titled Dental Services (including dentures), provided by the Administrator on 7/18/24 at 11:58 a.m., indicated the following: .Purpose: Ensure a resident obtains needed dental services .1. The facility will assist residents in obtaining routine and emergency dental care This citation relates to Complaints IN00437378 and IN00437511. 3.1-24(a)