

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2016
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00202538.</p> <p>Complaint IN00202538 - Substantiated. Federal/State deficiencies related to the allegation are cited at F241.</p> <p>Survey date: June 15, 2016</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289560</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census payer type: Medicare: 3 Medicaid: 24 Other: 2 Total: 29</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 6/16/16.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff provided care with dignity related to taking pictures and posting them on social media for 1 of 3 reportable events reviewed. (Resident #C)</p> <p>Finding includes:</p> <p>On 6/5/16 at 8:12 a.m., Resident #C was observed in a wheel chair in the Dining Room near the front entrance doors. The resident was awake and looking out the glass doors. The resident responded correctly when asked her name. The resident then replied "Who are you?"</p> <p>The record for Resident #C was reviewed on 6/15/15 at 8:39 a.m. The residents diagnoses included, but were not limited</p>	F 0241	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The resident "C" has not had any more pictures captured and posted on snap chat or any other social media site.</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All other residents could be affected. The employee who took the picture and video of the resident has been terminated. The staff have been educated on the company cell phone and cameras in the workplace policy and instructed to leave their phones in non-work</p>	07/15/2016

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	<p>to Parkinson's, heart failure, high blood pressure, anemia, and schizophrenia.</p> <p>Review of the 5/26/16 MDS (Minimum Data Set) annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (12). A score of (12) indicated the resident's cognitive patterns were moderately impaired. The assessment indicated the resident's hearing was adequate and her speech was clear. The resident understood others and was able to make herself understood. The resident had no signs of delirium or acute changes in her mental status. The resident displayed no behaviors. The assessment indicated the resident did not have Alzheimer's Disease.</p> <p>Review of an Incident Intake report indicated an incident occurred on 6/11/16. The incident indicated Social Service reported an email was sent to her along with a photo of Resident #C and a video which was posted on Snap Chat (a social media site) by a staff member. The CNA involved was suspended and the resident was assessed for her emotional well being. No injury was noted. Staff inservicing began and other residents were interviewed. The final report related to the incident had not been completed.</p> <p>When interviewed on 6/15/16 at 9:10</p>		<p>areas.</p> <p>3.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur? The staff havebeen re-educated and provided copies of the company cell phone and cameras inthe workplace policy and instructed to leave their phones in non-work areas whilein the facility at work and they have been instructed not to take any picturesor videos of residents on their personal devices. Administrator/designee will perform an auditdaily on different shifts on different days for 30 days, then once per week for 6 months. Results will be reviewed dailyat morning meeting for first 30 days and presented to QA committee for furtherrecommendations for 6 months.</p> <p>4.Howwill the corrective action be monitored to ensure the deficient practice willnot recur, i.e. what quality assurance program will be put into place? At Resident Counselmeeting the residents will be asked if any staff members have taken theirpictures. Any affirmative answers willbe investigated immediately and the facility protocol for abuse reporting willbe initiated, including additional education regarding camera use and socialmedia.</p>				

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	a.m., Social Service indicated she was at home on 6/9/16 (Friday) evening and noted an email on her work phone. The email indicated the writer noted pictures of Resident #C at the facility. Social Service indicated no picture or video was included with the email. The Director of Nursing was called immediately as the Administrator was on vacation. CNA #1, who had cared for the resident, was not working when the email was received. Social Service indicated she tried replying to the email with a request for the video and no email was returned that evening. Social Service was in the facility on Saturday (6/11/16) as the Weekend Manager and did receive a reply email on 6/11/16 with the Snap Chat video attached. The video did reveal CNA #1 and Resident #C in the hallway. CNA #1 was heard saying "you're a nitwit" The resident was seen on the video mouthing something right before the CNA's statement. The CNA was not loud or screaming. The video showed the resident remained in the chair with no signs of distress. The Director of Nursing was notified again and they verified CNA #1 was not working and was suspended. Social Service began staff interviews and inservicing on Saturday. No other staff or residents were aware of videos or pictures of themselves taken or of staff taking pictures of any		Results of Administrator auditand Resident Counsel feed- back will be presented to QA monthly for furtherreview and any recommendations for 6 months. This will be ongoing or until the QA committee determines no longer necessary. 5.Bywhat date will the systemic changes be completed? By July 15, 2016.	

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	<p>residents.</p> <p>When interviewed on 6/15/16 at 9:30 a.m., the facility Administrator indicated CNA #1 had been interviewed. CNA#1 indicated she did take a video of the resident and did make the statement about "nit wit" but she and the resident often joked around and the resident said it first and she had replied. The CNA indicated the resident was always playful with her.</p> <p>The facility policy titled "Cell Phones & Cameras in the Workplace Policy" was reviewed on 6/15/16 at 9:45 a.m. The policy had a last revised date of 4/15/15. The Administrator provided the policy and indicated the policy was current. The policy indicated employees were not permitted to take pictures, videos, or auditory recording while on working time.</p> <p>This Federal tag relates to Complaint IN00202538.</p> <p>3.1-3(t)</p>			