

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  09/09/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 0000  Bldg. 00	<p>This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on July 15, 2016.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00208976 and IN00209286.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00202538 completed on June 15, 2016.</p> <p>Survey dates: September 8, &amp; 9, 2016</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 2 Medicaid: 20 Other: 8 Total: 30</p> <p>These deficiencies reflect State findings</p>	F 0000		
------------------------	--	--------	--	--

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.

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  09/09/2016	
NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 0312 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 9/12/16.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure every resident who was dependent on staff for Activities of Daily Living (ADLs) were shaved and had their hair shampooed at least one time a week for 1 of 3 residents reviewed for ADLs. (Resident #C)</p> <p>Finding includes:</p> <p>Interview with Resident #C on 9/08/16 at 11:25 a.m., indicated staff would not shave him on his bath days when he had asked. The resident further indicated he received a complete bed bath two times a week.</p> <p>On 9/9/16 at 10:50 a.m., the resident was</p>	F 0312	<p><b>F312</b></p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident C has received a shave and a shampoo since the survey.</p> <p><b>2.How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?</b> All residents who are dependent on staff for ADLs will be reviewed for any need to be shaved and if hair is in need of shampoo. Any identified as needing shave will be shaved and hair will be shampooed if resident requests or if in need if resident cannot request.</p> <p><b>3.What measures will be put</b></p>	09/14/2016			

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  09/09/2016
NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>observed in bed. The resident had a moderate amount of facial hair on his face and chin areas.</p> <p>Interview with Resident #C at that time, indicated the nurses gave him a complete bed bath this morning and neither one of them asked him if he wanted to be shaved. He indicated his hair had not been washed in about 3 months and it was starting to itch as well.</p> <p>The record for Resident #C was reviewed on 9/08/16 at 11:36 a.m. The resident's diagnoses included, but were not limited to, quadriplegic, diabetes, anemia, neuromuscular dysfunction of the bladder, and anxiety.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 7/29/16 indicated the resident had a Brief Interview for Mental Status score of 15 indicating he was alert and oriented. The resident was totally dependent on staff for personal hygiene and bathing.</p> <p>The updated plan of care dated 7/2016 indicated the resident had an ADL deficit. The Nursing approaches were Bathing: Resident was totally dependent of staff to provide a bath. Personal Hygiene: Resident requires total assistance with personal hygiene care.</p>		<p><b>into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Nursing staff will be educated to offer shampoos and shave every time residents are offered a bath/shower and Care Plans will be updated with refusals and individual preferences as requested by resident. Shower sheets will be updated to provide place to document shaves and shampoos.</p> <p><b>4.How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</b> Charge Nurse will sign off Shower sheets to verify that shave and shampoo has been offered and if refused or if provided. DON will audit shower sheets weekly to assure shaves and showers have been offered and provided. These audits will be completed weekly and summarized monthly when provided to QA Committee for 6 months for further recommendations and/or until Committee determines audits are no longer necessary.</p> <p><b>5.When will the systemic changes be completed?</b> By 9-14-2016</p>		

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  09/09/2016	
NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The ADL flow sheets completed by the CNAs indicated there was no documentation the resident was shaved on daily basis or on bath days. There was no documentation to indicate when the resident's hair was last washed.</p> <p>The resident's shower days were on Tuesdays and Fridays during the day shift. The resident's preference was a complete bed bath.</p> <p>Interview, with the Director of Nursing (DON) on 9/08/16 at 1:30 p.m., indicated she was unaware where the CNAs documented personal hygiene for the residents. The DON indicated she had asked the CNAs regarding where they document personal hygiene and there was no place on the current shower sheets or the ADL flow sheets to document if and when the resident gets a shave and shampoo.</p> <p>Interview with CNA #1 on 9/9/16 at 11:10 a.m., indicated a shower includes shampooing the hair and shaving the resident both male and female. The CNA indicated there was no place to document a shave or a hair wash on the new ADL sheets. She indicated the old flow sheets had a place to document when a resident received a shave and had their hair</p>						

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  09/09/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0323 SS=D Bldg. 00	<p>washed. CNA #1 indicated she had not washed Resident #C's hair in about 3 weeks. She indicated she would shave the resident on his bath days, if he wanted to be shaved otherwise on Sunday, it was our "shave and nail day".</p> <p>Interview with LPN #1 on 9/9/16 at 11:15 a.m., indicated she had helped the other nurse give the resident a complete bed bath today, however neither one of them had washed his hair or shaved him.</p> <p>This deficiency was cited on July 15, 2016. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(D)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure each resident was free from accidents related to a</p>	F 0323	<p><b>F323</b> <b>1.What corrective action(s) will be accomplished for those residents found to have been</b></p>	09/14/2016

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  09/09/2016	
NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dependent resident who had fallen out of bed due to unattached bed bolsters for 1 of 3 residents reviewed for accidents. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 9/09/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, history of multiple gun shot wounds, pressure ulcer, tracheostomy, brain injury, seizures, dysphasia, flexion contractures, and quadriplegia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 8/12/16, indicated the resident was severely impaired for decision making, had long and short term memory problems, and was rarely understood or understands. The resident was totally dependent on staff with a one person physical assist for bed mobility, transfers, dressing, personal hygiene and bathing. The resident had one fall since the last assessment.</p> <p>Nurse's notes dated 7/31/16 at 9:15 a.m., indicated "Observed resident laying on left side near low bed. Alert no injury noted. Notified MD (Medical Doctor) and orders to send to (name of hospital) ER (Emergency Room). Called</p>		<p><b>affected by the deficient practice?</b> Resident #B no longer resides in this facility.</p> <p><b>2.How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?</b> Beds requiring any air mattress bolster overlays have been audited to assure properly attached. There are currently no bolster overlays in use. Any such overlays required will be placed only on beds that the device can be properly attached to.</p> <p><b>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> The DME provider has been contacted and aware of facility request to have overlays only placed on beds that device can be properly attached to. Only the DON or her designee will order air mattress overlays from any DME company and will personally verify that device is securely in place. C.N.A. will check daily to assure that overlay is properly attached.</p> <p><b>4.How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</b> DON or her designee will verify all new orders for overly device are in place upon arrival.Overlays will be</p>				

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  09/09/2016
NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ambulance service. Called resident's mom and received no answer times 2."</p> <p>Nurse's notes dated 8/1/16 at 10:00 a.m., indicated "IDT (Interdisciplinary Team) met to discuss resident event on 7/31/16. Resident had previously been seen and cared for by staff 12 minutes prior and was in bed on back with knees bent facing the wall. Resident was then seen by staff on left side of bed laying on his left side, sheet had pulled off bed. Resident probably slid in between bolsters on head and foot of the bed. Upon investigation, noted bed was in lowest position, bed was placed against wall and overlay on bed was not fastened to frame. Upon return will order a bariatric bed and mattress to increase surface area."</p> <p>The Incident form dated 7/31/16 indicated the resident was found on the floor by the bed. Resident was assessed for injury, had a hematoma on his head, so the resident was sent to the Emergency Room due to the hematoma.</p> <p>Preventative Measures: Resident has been admitted to the hospital for further assessment. Prior to his return, appropriate modification will be made to bed once a cause has been determined that resulted in the resident ending up on</p>		<p>audited weekly by the DON/designee for 6 months and results will be presented to the QA Committee for further recommendations and/or the committee determines that such audits are no longer necessary.</p> <p><b>5. When will the systemic changes be completed? By</b> 9-14-2016</p>		

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  09/09/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the floor.</p> <p>The conclusion of the investigation: "The Administrator, Director of Nursing (DON), and nurse who found resident on floor attempted to recreate the incident in order to determine how resident came to be on the floor by his bed. The nurse laid out the draw sheet as it was found under the resident with part still on the bed. She described how the resident was last seen positioned in bed approximately 12 minutes prior to finding him on the floor. Resident was on his right back side with his legs drawn up. (This does not mean he was in the same position when he came out of the bed). Administrator laid in that position and was not able to slide out of the bed. When drew up legs and pushed out right arm, as resident has been (previously) observed to do, was able to push self out of bed. The bolsters were flat. We discovered the right side of the bolster overlay was not fastened to the bed frame, consequently allowing the overlay to slide toward the left and also allowing the bolsters to be flat and ineffective. Our conclusion as to PROBABLE cause of the resident being on the floor, was due to the overlay not being properly fastened to the bed frame. The (name of bed company) representative puts the bed together including fastening the bolsters upon</p>			

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  09/09/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>delivery. As a preventative measure the facility has implemented a policy to check bed upon arrival to verify ties are in place and every time bed is cleaned on shower days." (sic)</p> <p>An interview with the delivery tech from the bed company indicated there was no way for the bolsters to be attached at the top if the bed they had to work with was one of the "flat ones." The administrator looked at the bed and discovered there was no hole or other way to attach a strap on each side. If the strap would be attached to the frame as it was on the bottom, the head would not be able to be raised. Therefore, it never was attached to the bed at the top and any of our beds that have bolsters on a bed that had a flat base will not be effective. The facility had some other beds that had open mesh and the base of the bolster could be attached to, so if anyone needed bolsters, those beds would be used. If those beds were not available, the facility would rent a bed that would work with the bolsters.</p> <p>Interview with the DON on 9/09/16 at 1:56 p.m., indicated the resident was moved from room 7 to room 5, however he kept the same the bed. The resident's right side of the bed in room 5 was against the wall, which was different from room 7. She indicated at times the</p>			

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  09/09/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 9999  Bldg. 00	<p>resident would move his right arm, which meant he could have used the wall to push himself to the left side. She indicated the bolsters on the left side were flat and were not attached to the bed frame. The DON indicated the bed had a plastic overlay on the bed frame so there was no place to attach the bolster to the frame. The DON indicated she was unaware the bolster was not attached to the bed frame thus making it flat and ineffective.</p> <p>This deficiency was cited on July 15, 2016. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>	F 9999	F9999 not on 2567	09/14/2016