

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 12/11/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00158748.</p> <p>This visit was done in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 10/20/14.</p> <p>Complaint IN00158748-Substantiated. Federal/State deficiencies related to the allegations are cited at F166, F309, and F514.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: December 10 & 11, 2014</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Survey team: Heather Tuttle, RN-TC Lara Richards, RN</p> <p>Census bed type: SNF/NF: 31 Total: 31</p> <p>Census payor type: Medicare: 9 Medicaid: 18</p>	F000000	<p>Neither the signing or submission of the plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies" This plan of correction is being submitted in good faith because it is the law</p> <p>Compliance date 12/31/14</p>	
---------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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 12/11/2014	
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			
F000166 SS=D	<p>Other: 4 Total: 31</p> <p>Sample: 15</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 16, 2014, by Janelyn Kulik, RN.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on record review and interview, the facility failed to ensure complaint and grievances by family members were acted upon with resolution according to the facility policy for 1 of 15 sampled residents. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 12/10/14 at 9:30 a.m. The resident's diagnoses included but were not limited to, cellulitis, high blood pressure, venous</p>	F000166	<p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? SSD filled out agrievance form and called Resident #B daughter on 12/23/14 and let her knowthat all concerns were addressed. SSD spoke with Resident #B on 12/23/14 andresident stated that she is satisfied with the care she receives in facility. 1.How will you identify other residents that maybe affected by the alleged deficient practice? All residents have the potential</p>	12/31/2014			

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 12/11/2014
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>insufficiency, dermatitis, leg pain, lymphodema, stroke, peripheral vascular disease, anemia, renal insufficiency, and chronic kidney disease stage 4, and bacterial skin infection of leg.</p> <p>The complaint and grievances were reviewed for the resident from 2012 until current 2014.</p> <p>Interview with the Social Service Designee (SSD) on 12/11/14 at 9:15 a.m., indicated the resident's daughter had also written two letters as well, regarding care issues.</p> <p>The letters were reviewed. The letter dated 11/3/14 indicated the daughter had concerns with a rash on the resident's legs, receiving wrong medications, lack of central air in the facility, an infected right hand, and constant opening and closing of the back door where staff go out and smoke bringing in cold air and causing her mom to be sick.</p> <p>Interview with the SSD on 12/11/14 at 9:25 a.m., indicated she had done nothing with the daughter's concerns in the letter. The SSD indicated she had called the resident's Power of Attorney (who was not the resident's daughter making the complaints) and informed her of the daughter's concerns. She indicated she</p>		<p>risk to be affected by the alleged deficient practice.</p> <p>1. What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not occur? Department heads were re in serviced on grievances policy by DCO on 12/29/14. All staff was re in serviced on grievance policy by DCO on 12/29/14. SSD will ensure grievance forms are available at nurse's station for completion. SSD will review grievance 5x/week at department head standup meeting, appropriate department head will be given a copy of grievance for follow through. SSD will ensure follow thru within 7 days of c/o.</p> <p>1. How will the corrective actions be monitored to ensure the deficient practice will not occur? Administrator will review grievance log weekly to ensure appropriate follow thru and completion of grievance x 1 month, then bi monthly x 1 month, then monthly x 1 month. SSD will report grievances to QA. Administrator will report findings of audit to QA. All information will be discussed monthly in QA x 3 months (a quarter), if QA findings show error rate of greater than 20% by end of quarter, audits will continue until error rate <20% Completion date: 12/31/14</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 12/11/2014	
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>informed the Administrator of the letters, however, she indicated she did not complete a complaint and grievance form.</p> <p>Interview with the Director of Nursing on 12/11/14 at 10:18 a.m., indicated she did look into the concern regarding the medications and not being given for two months. She indicated she tried to call the daughter and when she talked to her, she said the conversation was going fine and then all of sudden the daughter started yelling at her and was going to notify the police. The Director of Nursing indicated she did not look into anything about the rash, infection, lack of central air, or the back door being opened all the time. She further indicated she had not completed a complaint and grievance form for the daughter's concerns.</p> <p>Interview with the Administrator on 12/11/14 at 10:10 a.m., indicated he was aware of both letters received by the daughter. He indicated he did not complete a concern or grievance form for any of the concerns or provide any resolution to the daughter regarding her concerns.</p> <p>The current and undated Complaint and Grievance policy provided by the Social</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 12/11/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F000309 SS=D	<p>Service Designee indicated "Any resident, his or her representative, interested family member or advocate may file a concern complaint or formal grievance concerning his or her treatment, medical care, behavior of the residents, staff members.... You are requested to follow the procedures outlined below when filing a formal grievance: obtain a yellow grievance complaint report form the nurses's station. answer all the questions on the report as applicable. give the completed report form to the socials service department or to the administrator. Within 10 working days of the date you filed the report, you will be informed orally of the results of the investigation."</p> <p>This Federal Tag relates to Complaint IN00158748.</p> <p>3.1-7(a)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</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 12/11/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure bruises were monitored and assessed for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 3 residents who met the criteria for skin conditions (non-pressure related). (Residents #C)</p> <p>Findings include:</p> <p>On 12/10/14 at 9:30 a.m., and 11:44 a.m., Resident #C was observed sitting in a wheelchair outside of her room. At those times, there were two bruises noted to the back of her right and left hands. Both bruises were purple/blue in color.</p> <p>On 12/10/14 at 2:14 p.m., CNA #1 was asked to remove the bed linens from the resident's hands to observe her skin. At that time, there were two bruises noted to the back of her right and left hands. Both bruises were purple/blue in color.</p> <p>On 12/10/14 at 2:35 p.m., the resident remained in bed, LPN #1 was asked to do a skin assessment of the resident's hands. At that time, the LPN indicated the bruises to the back of her hands were</p>	F000309	<p>F 309</p> <p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? Resident # C has expired.</p> <p>2.How will you identify other residents that maybe affected by the alleged deficient practice? All residents receiving lab draws have thepotential to be affected by this alleged deficient practice. All residents will have skin check audit toidentify bruising.</p> <p>3.What measures have been put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur?</p> <p>1.All nursing staff will receive directedin-service training on the facility's policy and procedure for assessing andmonitoring bruises by the Director of Clinical Operations on 12/29/14.</p> <p>2.CNAs will be in serviced on shower sheets and toidentify any new areas and report them to the nurse.</p> <p>3.Nurses will be in-serviced on completion ofnon-pressure sheets with identified areas.</p> <p>1.How will the corrective actions be monitored toensure the deficient practice will not recur?</p> <p>1.The phlebotomist will leave a copy of the formused to indicate</p>	12/31/2014

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 12/11/2014
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>new. He further indicated he was not made aware she had any new bruises.</p> <p>The record for Resident #C was reviewed on 12/10/14 at 2:40 p.m. The resident's diagnoses included, but were not limited to, dementia, anemia, heart failure, and dementia with delusion.</p> <p>Physician Orders dated 11/12/14 indicated monitor bruising everyday.</p> <p>The laboratory data was reviewed and indicated the resident had a new lab draw on 12/8/14.</p> <p>Review of the lab information sheet provided by the lab company indicated the resident's blood was obtained from the back of the right hand.</p> <p>The non pressure wound sheet indicated new measurements of both bruises were obtained on 12/10/14. The right hand measured 3 centimeters (cm) by 2 cm and the left hand measured 3 cm by 1 cm.</p> <p>The current and undated Bruises policy provided by the Director of Nursing indicated "When a resident is noted to have a bruise, the nurse must: Assess the bruise for color, location, warmth, and/or pain. New bruises will be addressed in each morning meeting under the quality</p>		<p>who had blood draws and the area that was drawn from. Thenurse will use this form and initial off that he or she has assessed theresident. If a bruise is noted, a skinsheet will be completed and the MD notified for orders. The DON/Designee willaudit this form bi-weekly.</p> <p>2. Any newbruising will be discussed daily in morning meeting DON/Designee will conduct 3random skin checks weekly x3 months.</p> <p>3. Allinformation will be discussed monthly in QA meeting x3 months (a quarter) , ifQA findings show error rate of greater than 20% by end of quarter, audits willcontinue until error rate <20%. Completion date: 12/31/14</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 12/11/2014	
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			
F000312 SS=D	<p>improvement meeting."</p> <p>Interview with LPN #1 on 12/10/14 at 2:40 p.m., indicated new bruises were to be assessed and monitored on the non pressure sheet. He further indicated both of the bruises were new.</p> <p>This Federal Tag relates to Complaint IN00158748.</p> <p>3.1-37(a)</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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to maintain good personal hygiene related to nail care for 1 of 3 residents reviewed for Activities of Daily Living of the 3 residents who met the criteria for Activities of Daily Living. (Resident #C)</p> <p>Findings include:</p>	F000312	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #C nails were cleaned and trimmed on 12/10/14. Resident #C has expired.</p> <p>2. How will you identify other residents that may be affected by the alleged deficient practice? All dependent residents have the potential to be affected by this alleged deficient practice. An audit on all residents has been completed to identify long dirty</p>	12/31/2014			

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 12/11/2014	
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>On 12/10/14 at 9:30 a.m., and 11:44 a.m., Resident #C was observed sitting in a wheelchair outside of her room. At those times, the resident's fingernails were long with a brown like substance noted underneath the nails on her right hand.</p> <p>On 12/10/14 at 2:14 p.m., CNA #1 was asked to remove the bed linens from the resident's hands to observe her skin. At that time, the resident's fingernails were long with a brown like substance noted underneath the nails on her right hand. The CNA indicated the resident will often place her hands in her food during meal times. The CNA further indicated her nails were long and dirty and in need of cleaning. She indicated the resident will jerk her hands when trying to trim her nails, so she felt it was best the nurse cut them.</p> <p>On 12/10/14 at 2:35 p.m., the resident remained in bed, LPN #1 was asked to do a skin assessment of the resident's hands. At that time, the LPN indicated the resident's nails were long and dirty. He indicated he would get someone from activities to trim and clean them.</p> <p>The record for Resident #C was reviewed on 12/10/14 at 2:40 p.m. The resident's diagnoses included, but were not limited</p>		<p>nails.</p> <p>3.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? All nursing staff will receive directed in-service training by the Director of Clinical Services on 12/29/14 on the facility's policy and procedure for providing personal hygiene to residents that are unable to so regarding trimming and cleaning of fingernails.</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur? The staff will indicate on the shower sheets whether or not the resident's nails were trimmed and/or cleaned. During room rounds the IDT team will assess residents to ensure that personal hygiene has been completed. A random audit will be completed by the DON/Designee on 3 residents weekly to ensure nails have been trimmed weekly x3 months. . All information will be discussed monthly in QA meeting x3 months (a quarter) , if QA findings show error rate of greater than 20% by end of quarter, audits will continue until error rate <20%. Completion date: 12/13/14</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 12/11/2014
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>to, dementia, anemia, heart failure, and dementia with delusion.</p> <p>The 5 day Prospective Payment Systems (PPS) Minimum Data Set (MDS) assessment dated 11/19/14 indicated the resident was not alert and oriented. She needed extensive assist with one person physical assist for personal hygiene. The resident was coded as not having any mood or behavior problems and there was no evidence of rejection of care or medications.</p> <p>The current 10/12/14 plan of care indicated the resident had self care deficit related to dementia and limited mobility. The Nursing goal was to maintain current level of function with personal hygiene.</p> <p>Further review of the current plan of care indicated there was no care plan the resident resisted care.</p> <p>Interview with the MDS Coordinator on 12/10/14 at 3:25 p.m., indicated the resident's nails were very long and dirty and in need of being cleaned and trimmed.</p> <p>3.1-38(a)(3)(E)</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 12/11/2014	
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			
F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the medical records for a resident currently residing at the facility was readily accessible for 1 of 15 sampled residents. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 12/10/14 at 9:30 a.m. The resident was admitted to the facility on 3/29/12.</p> <p>Review of the resident's past clinical records indicated information was readily available and accessible from 8/6/12 through the present year 2014.</p> <p>Continued review indicated Resident #B's clinical record was not available</p>	F000514	<p>1) Greystone has been contacted and informed of the need for accessibility of records in 2012 for all current residents with admission date prior to Aug., 2012)All records for current residents admitted prior to 2012 are at risk for this practice.3)Upon request,Greystone will grant access to records prior to August,2012, for current residents that resided at the facility with admission date prior to 8/2012.4) Administrator will report to QAPI any concerns due to availability of records prior to August, 2012.5)12/31/2015</p>	12/31/2014			

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 12/11/2014
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>from March 2012 through August 2012. These records included, Physician Orders, Nursing Progress Notes's, Medication Administration Records and other Nursing assessments.</p> <p>Interview with the Administrator on 12/10/14 at 11:44 a.m., indicated old clinical records for residents were transported out of the facility when the new corporation took over in 2012. He further indicated since then, that corporation had sold the facility again and now they were owned by a new corporation. He indicated the medical records were stored at a large medical record storage place and not at the facility. He further indicated he did not have accessibility to Resident #B's clinical record.</p> <p>This Federal Tag relates to Complaint IN00158748.</p> <p>3.1-50(a)(3)</p>				