

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2926 N CAPITOL AVE INDIANAPOLIS, IN 46208
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F000000	<p>This visit was for the Investigation of Complaints IN00129365, IN00129554, and IN00129785.</p> <p>Complaint IN00129365 substantiated no deficiencies related to the allegations are cited</p> <p>Complaint IN00129554 substantiated, federal/state deficiencies related to the allegations are cited at F225 and F226</p> <p>Complaint IN00129785 substantiated no deficiencies related to the allegations are cited</p> <p>Survey dates: May 31, 2013, June 3, 2013</p> <p>Facility number: 000567 Provider number: 155711 AIM number: 100289560</p> <p>Survey team: Connie Landman RN TC</p> <p>Census bed type: NF: 12 SNF/NF: 26 Total: 38</p> <p>Census payor type: Medicare: 2 Medicaid: 35</p>	F000000	<p>Please accept this plan of correction as our credible allegation of compliance. Preparation and execution of correction in general, or this corrective action in particular does not constitute an admission or agreement by Highland Manor Healthcare of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and / or executed in compliance with Federal and State law.</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.

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	<p>Other: 1 Total: 38</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 06/05/2013 by Brenda Nunan, RN.</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225		07/02/2013

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	<p>interview, the facility failed to investigate an allegation of abuse for a resident who alleged he had been burned by someone for 1 of 3 residents reviewed for allegations of abuse and injuries of unknown origin in a sample of 4 (Resident C).</p> <p>Findings include:</p> <p>The record for Resident C was reviewed on 6/3/13 at 9:05 A.M.</p> <p>Current diagnoses included, but were not limited to, dementia, joint pain, and angina.</p> <p>The resident's score on his Admission MDS (Minimum Data Set) Assessment, dated 3 /27/13, indicated he had severely impaired cognition.</p> <p>A Nursing Note, dated 5/21/13 at 8:50 (A.M. or P.M. not indicated), "Res (Resident) found w/ (with) blister on R (right) thumb and across bottom of hand, marks going up inner arm."</p> <p>Resident C had been identified by the DON (Director of Nursing) on 5/31/13 at 10:00 A.M. as having a treatment for a thumb blister.</p> <p>On 5/31/13 at 2:00 P.M., during</p>				<p>All residents have the potential to be affected.</p> <p>In light of the patient's wound healing, nothing further can be done for the individual. The Administrator did follow up interview with patient, who relayed a similar story of the event however including further information that people were pulling his thumb vigorously.</p> <p>A record review of the past three months of reported allegations of abuse revealed three reports of resident on resident abuse investigated and reported. Plus two reports of employee on resident abuse investigated and reported.</p> <p>A record review of the past three months of wounds of unknown source revealed two and they were investigated and reported.</p> <p>All Department Heads in-serviced on Reportable Unusual Occurrences. All nurses in-serviced on Reportable Unusual Occurrences with particular</p>		

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	<p>interview, the resident indicated a "guy" burned his thumb with a cigar and laughed". During another interview on 5/31/13 at 2:30 P.M., the resident indicated his arm was below the arm of his w/c (wheel chair) and he indicated he felt something burn between his thumb and finger.</p> <p>During an interview with the ED (Executive Director) on 5/31/13 at 2:50 P.M., he indicated the facility did not consider the injury to be a result of abuse and indicated the facility had not completed an investigation in regard to the allegation of abuse.</p> <p>A current facility policy, dated 1/14/2008, provided by the DON on 5/31/13 at 9:20 A.M., titled "Abuse Investigation (Including: Neglect, Injuries of Unknown Source, Misappropriation) indicated,"...It is the policy of this facility that all reports of resident abuse, neglect and injuries of an unknown source shall be promptly reported and thoroughly investigated by facility management as required by the federal guidelines.</p> <p>Procedure:...2. An internal investigation will be conducted using the following as part of the investigation:...e. Interview any witnesses to the incident. f. Interview</p>		<p>attention to unusual wounds and reporting procedures. Administrator, DON, and Executive Director convened a discussion with the Medical Director about unusual occurrences and in particular, unusual wounds that are reportable and require investigation.</p> <p>Although the in-service on Reportable Unusual Occurrences includes all abuse sub-topics and the policy of reacting and reporting such occurrences, all staff has been in-serviced on what constitutes abuse and the facility policy requirements for reacting to and reporting allegations of abuse from any source.</p> <p>Facility has postings of <i>Procedure for Abuse Known and/or Alleged</i> which includes definitions of the different types of abuse, reaction and reporting requirements throughout the building and grounds.</p> <p>Daily stand-up meetings include staff reports of any possible allegations of abuse from any source.</p>				

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	<p>the resident (as medically appropriate). g. Interview the resident's attending physician to determine the resident's current mental status as needed. h. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. i. Interview the resident's roommate, family members, and visitors...."</p> <p>This federal tag relates to Complaint IN00129554.</p> <p>3.1-28(d)</p>		<p>DON will report in daily stand-up meeting any new wounds with the circumstances reported and documented by the charge nurse.</p> <p>Administrator is responsible for abuse investigation and formal reporting. All staff is responsible for abuse reporting and documentation. DON and Administrator will monitor daily, indefinitely. Monitor in QA by record review monthly for three months, then quarterly thereafter for compliance.</p> <p>Original date completed June 17th, 2013, however to ensure full compliance with correcting the citation, the last series of all staff abuse in-services was completed over July 1 st and 2 nd .</p>		

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow their policy for investigation of an allegation of abuse for a resident who alleged he had been burned by someone for 1 of 3 residents reviewed for allegations of abuse and injuries of unknown origin in a sample of 4 (Resident C).</p> <p>Findings include:</p> <p>The record for Resident C was reviewed on 6/3/13 at 9:05 A.M.</p> <p>Current diagnoses included, but were not limited to, dementia, joint pain, and angina.</p> <p>The resident's score on his Admission MDS (Minimum Data Set) Assessment, dated 3 /27/13, indicated he had severely impaired cognition.</p> <p>A Nursing Note, dated 5/21/13 at 8:50 (A.M. or P.M. not indicated), "Res (Resident) found w/ (with) blister on R</p>	F000226	<p>All residents have the potential to be affected.</p> <p>In light of the patient's wound healing, nothing further can be done for the individual. The Administrator did follow up interview with patient, who relayed a similar story of the event however including further information that people were pulling his thumb vigorously.</p> <p>A record review of the past three months of reported allegations of abuse revealed three reports of resident on resident abuse investigated and reported. Plus two reports of employee on resident abuse investigated and reported.</p> <p>A record review of the past three months of wounds of unknown source revealed two and they were</p>	07/02/2013

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	<p>(right) thumb and across bottom of hand, marks going up inner arm."</p> <p>Resident C had been identified by the DON (Director of Nursing) on 5/31/13 at 10:00 A.M. as having a treatment for a thumb blister.</p> <p>On 5/31/13 at 2:00 P.M., during interview, the resident indicated a "guy" burned his thumb with a cigar and laughed". During another interview on 5/31/13 at 2:30 P.M., the resident indicated his arm was below the arm of his w/c (wheel chair) and he indicated he felt something burn between his thumb and finger.</p> <p>During an interview with the ED (Executive Director) on 5/31/13 at 2:50 P.M., he indicated the facility did not consider the injury to be a result of abuse and indicated the facility had not completed an investigation in regard to the allegation of abuse.</p> <p>A current facility policy, dated 1/14/2008, provided by the DON on 5/31/13 at 9:20 A.M., titled "Abuse Investigation (Including: Neglect, Injuries of Unknown Source, Misappropriation) indicated,"...It is the policy of this facility that all reports of resident abuse, neglect and injuries of</p>		<p>investigated and reported.</p> <p>All Department Heads in-serviced on Reportable Unusual Occurrences. All nurses in-serviced on Reportable Unusual Occurrences with particular attention to unusual wounds and reporting procedures. Administrator, DON, and Executive Director convened a discussion with the Medical Director about unusual occurrences and in particular, unusual wounds that are reportable and require investigation.</p> <p>Although the in-service on Reportable Unusual Occurrences includes all abuse sub-topics and the policy of reacting and reporting such occurrences, all staff has been in-serviced on what constitutes abuse and the facility policy requirements for reacting to and reporting allegations of abuse from any source.</p> <p>Facility has postings of <i>Procedure for Abuse Known and/or Alleged</i> which includes definitions of the different types of abuse, reaction and reporting requirements throughout the building and</p>	

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	<p>an unknown source shall be promptly reported and thoroughly investigated by facility management as required by the federal guidelines.</p> <p>Procedure:...2. An internal investigation will be conducted using the following as part of the investigation:...e. Interview any witnesses to the incident. f. Interview the resident (as medically appropriate). g. Interview the resident's attending physician to determine the resident's current mental status as needed. h. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. i. Interview the resident's roommate, family members, and visitors...."</p> <p>This federal tag relates to Complaint IN00129554.</p> <p>3.1-28(a)</p>		<p>grounds.</p> <p>Daily stand-up meetings include staff reports of any possible allegations of abuse from any source.</p> <p>DON will report in daily stand-up meeting any new wounds with the circumstances reported and documented by the charge nurse.</p> <p>Administrator is responsible for abuse investigation and formal reporting. All staff is responsible for abuse reporting and documentation. DON and Administrator will monitor daily, indefinitely. Monitor in QA by record review monthly for three months, then quarterly thereafter for compliance.</p> <p>Original date completed June 17th, 2013, however to ensure full compliance with correcting the citation, the last series of all staff abuse in-services was completed over July 1 st and 2 nd .</p>		