

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 09/24/2015
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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 a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on August 7, 2015.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00183022.</p> <p>Survey dates: September 23 & 24, 2015</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 6 Medicaid: 18 Other: 9 Total: 33</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on September 28, 2015.</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 0202 SS=D Bldg. 00	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>Based on record review and interview, the facility failed to ensure complete and accurate documentation was completed in the clinical record prior to discharge for 2 of 3 residents reviewed for admission, transfer, and discharge. (Residents #B and #H)</p> <p>Findings include:</p> <p>1. The Closed record for Resident #B was reviewed on 9/23/15 at 11:10 a.m. The resident's diagnoses included, but were not limited to, diabetes and end stage renal disease with dialysis.</p> <p>An SBAR (a form completed when the resident has a change in condition) completed on 9/2/15 at 1:00 p.m., indicated the resident had low blood pressure and complaints of dizziness. The Physician was notified and the</p>	F 0202	<p>F 202</p> <p>1.What corrective action(s) will be accomplished forthose residents found to have been affected by the practice: Both residents B and H were directlyaffected. However, both d/c from thefacility and did not return to the facility</p> <p>1.How you will identify other residents having potentialto be affected by the same practice and what corrective action will be taken: All residents having the desireto discharge from the facility have the potential to be affected and will beidentified by care planning upon admission. (C) What measures will be put into place or whatsystematic changes you will make to ensure that the practice does not reoccur: A form for proper discharge willbe used to ensure all departments have reviewed the resident wishing todischarge from the facility. The</p>	10/11/2015
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	<p>residents vital signs were to be monitored. Documentation on the back of the form at 5:00 p.m., indicated the resident was discharged. There was no documentation indicating where the resident went.</p> <p>A Social Service progress note dated 9/2/15 (no time), indicated the resident stated to the Social Service Designee that he wanted to go home because he needed to pay his mortgage and did not want to pay the facility. The resident indicated that he wanted to go home at 5:00 p.m. and to arrange for transport. The Social Service Designee set up Home health and faxed the resident's medications to the Physician.</p> <p>There was no Physician's order for discharge as well as no discharge instructions in the record.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 9/24/15 at 11:10 a.m., indicated an Interdisciplinary Discharge summary was completed. She indicated she was told that this was what was used for discharge instructions. She indicated there was no documentation of a Physician's order as well as an assessment in the Nursing progress notes. She indicated there was also no paperwork where home health was faxed</p>		<p>Director of Nursing or designee will obtain an order from the medical doctor on all residents wishing to discharge from the facility. The director of nursing or designee will obtain orders for home health services on all residents wishing to discharge from the facility and requiring such services. The DON or designee will notify the home health company will be made aware of orders for home health. All nursing staff, the DON and the SSD will be in-serviced by the HFA or designee on proper discharge planning, obtaining proper orders, and faxing of orders to home health companies by 10-11-15. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Social Services Director or Designee will audit each new admission upon admission for their desire to discharge weekly x30 days after 30 days the Social Services Director or Designee will follow the plan below of scheduling a care plan for all new admissions within 5 days of admission to determine discharge plan. A Care plan meeting will be held within 5 days of admission to include documentation of the care plan meeting, individuals in attendance, and discharge plan. Once discharge from the facility is determined the facility the</p>	

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	<p>information about the resident's discharge.</p> <p>2. The Closed record for Resident #H was reviewed on 9/23/15 at 1:16 p.m. The resident's diagnoses included, but were not limited to, diabetes, lung nodule, anxiety and depression.</p> <p>The Social Service progress note dated 9/17/15 (no time) indicated the resident was discharged with Home Health and her medications were faxed to the pharmacy.</p> <p>The Physician orders for the month of September 2015 were reviewed. There was no Physician order related to the resident being discharged. There was no documentation in the Nursing progress notes related to when and where the resident was discharged. There were also no discharge instructions in the resident's record.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 9/24/15 at 11:10 a.m., indicated there was no order for discharge and an assessment and discharge instructions weren't available.</p> <p>3.1-12(a)(5)</p>		<p>Administrator or Social Services Director will ensure the proper forms are used, the MD has written an order, home health is ordered if applicable, and that home health is made aware. The Social Services Director or Designee will audit all discharges prior to the discharge occurring for each discharge from the facility as they arise. All discharge audits will be reviewed during QA meetings until substantial compliance is met.</p> <p>Tag F 202: Please indicate what residents were reviewed to determine if the deficient practice occurred if is the deficient practice occurred what the facility did to correct the deficient practice. Please indicate if monitoring will be for 6 months or less the criteria to be used to determine monitoring may stop to ensure the deficient practice does not recur.</p> <p><i>Both residents identified in the 2567 were already d/c from the facility at the time of survey. Both resident charts were reviewed by ISDH surveyors and facility staff determining that the findings were appropriate. No additional measures were taken in regards to residents B and H as they were no longer in the facility. Going forward the facility has the following plan in place to avoid similar occurrences. A form for proper discharge will be used to ensure all departments</i></p>		

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			<p><i>have reviewed the resident wishing to discharge from the facility. The Director of Nursing or designee will obtain an order from the medical doctor on all residents wishing to discharge from the facility. The director of nursing or designee will obtain orders for home health services on all residents wishing to discharge from the facility and requiring such services. The DON or designee will notify the home health company to make them aware of orders for home health. If the physician does not write the discharge order, the facility staff will request the resident and/or legal representative to sign an AMA form. The nurse on duty will discuss the risks of discharging against medical advice with the resident.</i></p> <p><i>All nursing staff, the DON and the SSD will be in-serviced by the HFA or designee on proper discharge planning, obtaining proper orders, obtaining a signature on an AMA form, proper documentation and faxing of orders to home health companies by 10-11-15</i></p> <p><i>The Social Services Director or Designee will audit each new admission upon admission for their desire to discharge weekly x 180 days. After 180 days the Social Services Director or Designee will follow the plan below of scheduling a care plan meeting for all new</i></p>	

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			<p><i>admissions within 5 days of admission to determine discharge plan and needed services for each resident wanting to discharge from the facility.</i></p> <p><i>A Care plan meeting will be held within 5 days of admission to include documentation of the care plan meeting, individuals in attendance, and discharge plan. The Social Services Director will ensure that all residents desiring to discharge are referred to the attending physician to determine what orders need to be obtained to properly secure a discharge. Once discharge from the facility is determined the facility Administrator or Social Services Director will ensure the proper forms are used, the residents' physician will document in the clinical records when required, the MD will write an order or the resident will be requested to sign an AMA consent form, home health will be ordered if applicable, and the DON or designee will ensure that home health is made aware of the need for services. The Social Services Director or Designee will audit all requested discharges prior to the discharge occurring for each discharge from the facility as they arise. All discharge audits will be reviewed during QA meetings for 180 days until substantial compliance is met as evidenced by residents not being sent home without proper documentation</i></p>	

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F 0225 SS=D Bldg. 00	<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>			
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	<p>Based on record review and interview, the facility failed to ensure an allegation of resident to resident abuse was reported to the State Agency for 1 of 1 resident to resident abuse allegations reviewed. (Residents #D and #E)</p> <p>Finding includes:</p> <p>The record for Resident #D was reviewed on 9/23/15 at 2:36 p.m. The resident's diagnosis included, but was not limited to, Alzheimer's.</p> <p>An entry in the Nursing progress notes dated 9/11/15 at 6:00 p.m. indicated, following incident between resident and other resident at facility, assessment revealed no new injuries or bruises at this time. Resident unable to explain what caused incident, but states she too was combative. Resident neither aggressive nor agitated at this time and denied pain.</p> <p>The facility Incident/Accident Investigation form dated 9/11/15 at 6:00 p.m., indicated the resident was wandering into Resident #E's room. He told her to get out of his room. She continued forward and the resident hit her and she hit him back, she proceeded to the QMA who was standing in the hallway and told her that man hit me. Both residents have a diagnosis of</p>	F 0225	<p>F225</p> <p>1.What corrective action(s) will be accomplished forthose residents found to have been affected by the practice: Resident #D and Resident #E were both assessed forinjuries by a licensed nurse. The familyand physician were notified of the altercation; a review of the resident's medicationregimen was completed by a licensed nurse and a medical doctor Any further incidents will be immediately reportedto ISDH according to ISDH guidelines for usual occurrences. (b)How you will identify other residents havingpotential to be affected by the same practice and what corrective action willbe taken: All residents in the facility have the potential tobe affected</p> <p>1.What measures will be put into place or what systematicchanges you will make to ensure that the practice does not reoccur: All staff will be in-serviced by theadministrator by 10-11-15 using the ISDH unusual occurrence reportableguidelines to better understand what is a reportable in the state of Indiana.</p> <p>1.How the corrective action(s) will be monitored toensure the practice will not recur, i.e., what quality assurance program willbe put into place: The SSD will meet with interviewable residentsdaily on</p>	10/11/2015			

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	<p>dementia or Alzheimer's. No injuries were noted to either resident, no complaint of pain or discomfort, no bruising.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 9/24/15 at 9:45 a.m., indicated the resident to resident altercation had not been reported to the State Department of Health due to both residents had a diagnosis of dementia.</p> <p>Interview with the Administrator on 9/24/15 at 11:50 a.m., indicated that he was not informed until the following Wednesday of the resident to resident altercation. He indicated that he should have been notified immediately since he was the Abuse Coordinator. He indicated the incident should have been reported to the State Department of Health.</p> <p>3.1-28(c)</p>		<p>business days x 60 days asking CMS question QP253 and documenting theresults on the form. The SSD will then complete this weekly x 4 weeks. Allresults will be reviewed in QA. Any allegations of abuse will be reported toISDH and the local police department as required by regulation and the elderjustice act.</p> <p>TagF225: Please indicate if the incidentwas reported to the State Department of Health.</p> <p>Pleaseindicate what residents were reviewed to determine if the deficient practiceoccurred if is the deficient practice occurred what the facility did to correctthe deficient practice.</p> <p>Pleaseindicate how the facility is auditing incidents to make sure they are reportedto the State Department of Health timely. Please indicated if monitoring will be for 6 months or less the criteriato be used to determine monitoring may stop to ensure the deficient practicedoes not recur.</p> <p><i>The incident was not reported to ISDH</i></p> <p><i>Resident #D andResident #E were both assessed for injuries by a licensed nurse. The family and physician were notified of thealtercation; a review of the resident's medication regimen was completed by alicensed</i></p>	

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F 0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT,		<p><i>nurse and a medical doctor</i></p> <p><i>All staff will be in-serviced by the administrator by 10-11-15 using the ISDH unusual occurrence reportable guidelines to better understand what is a reportable in the state of Indiana.</i></p> <p><i>The NHA and DON and/or designee will review all Incident/Accident Investigation reports during morning meeting to determine if the incident needs to be reported</i></p> <p><i>The SSD or designee will meet with interviewable residents weekly on business days x 180 days asking CMS question QP253 and documenting the results on the form.. All results will be reviewed in QA for 180 days or until substantial compliance is met.</i></p> <p><i>Any allegations that require reporting under Indiana regulations, including abuse, will be reported by the Administrator or designee in the time frame designated by ISDH, to ISDH and the local police department as required by regulation and the elder justice act.</i></p>	

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Bldg. 00	<p>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 ensure their abuse policy was followed as written related to reporting allegations of abuse for 1 of 1 resident to resident abuse allegations reviewed as well as ensuring reference checks were completed at the time of hire for 2 of 5 employee files reviewed. (Residents #D and #E and CNA #1 and #2)</p> <p>Findings include:</p> <p>1. The record for Resident #D was reviewed on 9/23/15 at 2:36 p.m. The resident's diagnosis included, but was not limited to, Alzheimer's.</p> <p>An entry in the Nursing progress notes dated 9/11/15 at 6:00 p.m. indicated, following incident between resident and other resident at facility, assessment revealed no new injuries or bruises at this time. Resident unable to explain what caused incident, but states she too was combative. Resident neither aggressive nor agitated at this time and denied pain.</p> <p>The facility Incident/Accident</p>	F 0226	<p>F 226</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>1. Resident #D and Resident #E were both assessed for injuries. The family and physician were notified of the altercation; a review of the resident's medication regimen was completed. Any further incidents will be immediately reported to ISDH according to ISDH guidelines for usual occurrences.</p> <p>1. All employee files have been audited for all required documents required prior to an employee starting work in the facility. CNA #1 AND CNA #2, reference checks have been completed.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>1. All residents have the potential to be affected 2. All residents have the potential to be affected</p> <p>1. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</p> <p>1. All staff will be in-serviced by the administrator or designee by</p>	10/11/2015			

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	<p>Investigation form dated 9/11/15 at 6:00 p.m., indicated the resident was wandering into Resident #E's room. He told her to get out of his room. She continued forward and the resident hit her and she hit him back, she proceeded to the QMA who was standing in the hallway and told her that man hit me. Both residents have a diagnosis of dementia or Alzheimer's. No injuries were noted to either resident, no complaint of pain or discomfort, no bruising.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 9/24/15 at 9:45 a.m., indicated the resident to resident altercation had not been reported to the State Department of Health due to both residents had a diagnosis of dementia.</p> <p>Interview with the Administrator on 9/24/15 at 11:50 a.m., indicated that he was not informed until the following Wednesday of the resident to resident altercation. He indicated that he should have been notified immediately since he was the Abuse Coordinator. He indicated the incident should have been reported to the State Department of Health.</p> <p>The Abuse Prevention policy was provided by the Minimum Data Set (MDS) Coordinator and identified as</p>		<p>10-11-15 using the ISDH unusual occurrence reportable guidelines to better understand what is a reportable in the state of Indiana.</p> <p>2. The HR department and all department heads will be serviced by the administrator or designee by 10-11-15 on proper pre-employment processed to include obtaining reference checks on all new hires</p> <p>1. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>1. The SSD will meet with interviewable residents daily on business days x 60 days asking CMS question QP253 and documenting the results on the form. The SSD will then complete this weekly x4 weeks. All results will be reviewed in QA. Any allegations of abuse will be reported to ISDH and the local police department as required by regulation and the elder justice act.</p> <p>2. The HR manager will audit all potential employee files prior to scheduling them for orientation to ensure each potential employee has all required documents.</p> <p>Tag F 226: Please indicate if the incident was reported to the State Department of Health. Please indicate what residents were reviewed to determine if the deficient practice occurred if is the deficient practice occurred what</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2015	
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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	<p>current on 9/24/15 at 11:20 a.m. The policy indicated the following:</p> <p>"Allegations of abuse are reported to the state survey agency within 24 hours. If the abuse involved serious bodily injury it must be reported to ISDH and local law enforcement within 2 hours. The administrator or designee will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency within 5 days of the reported incident."</p> <p>2. The employee file for CNA #1 was reviewed on 9/24/15 at 11:00 a.m. The CNA was hired on 7/23/15. There were no reference checks available for review.</p> <p>The employee file for CNA #2 was reviewed on 9/24/15 at 11:10 a.m. The CNA was hired on 8/5/15. There were not reference checks available for review.</p> <p>Interview with the Business Office Manager on 9/24/15 at 11:30 a.m., indicated the reference checks had not been completed.</p> <p>Interview with the Administrator on 9/24/15 at 11:50 a.m., indicated the reference checks for the CNA's should have been completed at the time of hire.</p>		<p>the facility did to correct the deficient practice. Please indicate how the facility is auditing incidents to make sure they are reported to the State Department of Health timely. Please indicate if monitoring will be for 6 months or less the criteria to be used to determine monitoring may stop to ensure the deficient practice does not recur.</p> <p><i>The incident was not reported to ISDH</i></p> <p><i>After review it was found that the incident did occur.</i></p> <p><i>Resident #D and Resident #E were both assessed for injuries. The family and physician were notified of the altercation; a review of the resident's medication regimen was completed.</i></p> <p><i>Any further incidents will be immediately reported to ISDH according to ISDH guidelines for usual occurrences. All employee files have been audited for all required documents required prior to an employee starting work in the facility. CNA #1 AND CNA#2, reference checks have been completed.</i></p> <p><i>All staff will be in-serviced by the administrator or designee by 10-11-15 using the ISDH unusual occurrence reportable guidelines to better understand what is a reportable in the state of Indiana.</i></p>				

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	<p>The Abuse Prevention policy was provided by the Minimum Data Set (MDS) Coordinator and identified as current on 9/24/15 at 11:20 a.m. The policy indicated the following:</p> <p>"The personnel director, or other person designated by the Administrator, will conduct employment background checks, reference checks and criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment."</p> <p>3.1-28(a)</p>		<p><i>The HR department and all department heads will bein-serviced by the administrator or designee by 10-28-15 on properpre-employment processed to include obtaining reference checks on all newhires</i></p> <p><i>The SSD will meet with interviewable residents weekly onbusiness days x 180 days asking CMS question QP253 and documenting the resultson the form. All results will be reviewed in QA for 180 days or untilsubstantial compliance is met. Any allegations of abuse will be reportedimmediately to ISDH and the local police department as required by regulationand the elder justice act.</i></p> <p><i>The HR manager will audit all potential employee files priorto scheduling them for orientation to ensure each potential employee has allrequired documents. No employee will bepermitted to work until the required documentation is obtained.</i></p> <p><i>The HR files will be audited monthly x 180 days and reviewedin QA x 180 days or until substantial compliance is reached.</i></p>	
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