

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  09/06/2012
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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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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on July 23, 2012.</p> <p>Survey dates: September 4, 5, &amp; 6, 2012</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Survey team: Lara Richards, RN, TC Heather Tuttle, RN</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 10 Medicaid: 13 Other: 4 Total: 27</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 9/10/12 by Suzanne Williams, RN</p>	F0000		

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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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F0282	Neither signing nor submission of this 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 by the facility because it is the law. F 282 Services by Qualified Persons per Care Plan (a) What corrective action(s) will be accomplished for those residents found to have been affected: Physician for Resident # 36 was contacted and informed of the resident's continued non-compliance regarding his current fluid restriction order. New order obtained to discontinue current fluid restriction. Care plan updated, as well as the C N A care guide to reflect these changes. C NA #1 was given teachable moment related to lack of following fluid restriction as ordered for Resident # 36. (b) How will you identify other residents having potential to be affected and what corrective action will be taken: Facility review was conducted to identify any other	09/24/2012	

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			<p><b>residents on fluid restrictions – however there are no other residents currently on fluid restrictions at this time. (c) What measures will be put into place or what systemic changes will be made to ensure this will not recur: RN Consultant will educate Nurses and Certified Nursing Assistants on the standard and guideline for fluid restrictions specific to: following physician orders for fluid restriction, the monitoring of compliance, reporting noncompliance of fluid restriction the proper documentation and tracking of fluid intake and output.. RN Consultant will re-educate nurses on physician notification standard and guideline for condition changes and compliance of physician orders for fluid restrictions. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: DNS or Designee will audit the documentation of residents with fluid restriction orders to ensure that physician orders are being followed and noncompliance related issues are reported to the physician. This will be completed weekly x 4 then bi-monthly for 6 months. DNS or Designee will audit/observe meal times to</b></p>		

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	<p>Based on observation, record review and interview, the facility failed to ensure physician orders were followed related to a fluid restriction for 1 of 3 residents reviewed for nutrition and supplements. (Resident #36)</p> <p>Findings include:</p> <p>On 9/5/12 at 9:00 a.m., Resident #36 was observed sitting in his wheelchair in his room. The resident had just finished eating his breakfast. The resident was served two cups of coffee and a glass of milk. The cups of coffee were six ounces each, the glass of milk was eight ounces for a total of 600 cubic centimeters (cc).</p>		<p><b>ensure ordered fluid restrictions are followed. This will be completed 3 meals per day x 30 days then 3 meals per week x 30 days then 1 meal a week xs 6 months. The findings will be reported to the Administrator and presented at the monthly Risk Management/QA committee until the committee therefore recommends quarterly monitoring by the RDCO when completing their system review which includes physician orders for fluid restriction. Date Certain: 9/24/12</b></p>		

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	<p>On 9/5/12 at 12:15 p.m., the resident was observed in the main dining room waiting on his lunch tray. CNA #1 served the resident a six ounce cup of coffee, a four ounce cup of water and a four ounce cup of cranberry juice. The resident drank all of his water and juice at that time. The resident was then served his lunch tray. At that time, he received another beverage from the kitchen which was an eight ounce glass of milk. The resident received a total of 660 cc's of fluid for lunch.</p> <p>Interview with Dietary Food Manager and the Registered Dietitian (RD) on 9/5/12 at 12:45 p.m., indicated the resident was being served too much fluid and was going over his dietary fluid restriction per meal. They both indicated the nurse was supposed to oversee the resident's meal tray and they were to take away fluids at the next meal if he had gone over his limit from the previous meal.</p> <p>The record for Resident #36 was reviewed on 9/5/12 at 10:03 a.m. The resident's diagnoses included, but were not limited to, cellulitis, high blood pressure, and diabetes.</p> <p>Review of Physician Orders dated 4/2/12, indicated the resident had a</p>						

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	<p>1500 cc fluid restriction as follows: 300 cc at breakfast, 360 cc lunch and dinner, nursing 120 cc and activities 120 cc daily.</p> <p>Review of Nursing Progress Notes for the month of 9/12, indicated there was no documentation the resident was asking for more fluids during the day. There was no documentation indicating the resident was non-compliant with his fluid restriction.</p> <p>Interview with LPN #1 on 9/6/12 at 8:10 a.m., indicated nursing staff were not keeping any written documentation of the resident's intake and output for the fluid restriction. She further indicated he was only supposed to get fluids from dietary and the nurses. No other staff were to give him fluids. LPN #1 also indicated at the time, the CNAs were supposed to inform the nurse if the resident wanted more fluids during the meal.</p> <p>This deficiency was cited on July 23, 2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was served under sanitary conditions related to serving toast in a sanitary manner, lack of hair restraint, and food debris and grease. This had the potential to affect 25 who received their meals from the kitchen of 27 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 9/6/12 at 7:09 a.m., Dietary Cook #1 was observed preparing the breakfast meal. At that time, the cook was observed standing by the stove with no hair restraint on her head. She was observed directly standing over the fruit danish which was noted on top of the stove as well as a pan of hot cereal that was uncovered. The Dietary Food Manager was in the kitchen as well helping the cook with breakfast.</p> <p>Interview with Dietary Cook #1 at the time, indicated she had forgot to put a</p>	F0371	<p>The Food Service Manager and Cook #1 were educated on the proper use of hair restraints and the proper use of gloves – in regards to food handling by the Regional Nurse Consultant on 9/6/12.</p> <p>The grey metal box and its adjoining pipes located near the three compartment sink and stove was cleaned and sanitized on 9/6/12.</p> <p>The Consulting Dietitian was asked to be replaced effective immediately by the Corporate Director of Nutritional Services.</p> <p><b>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</b></p> <p>25 of 27 residents receiving the breakfast meal on 9/6/12 were potentially affected; however, no specific resident was identified.</p> <p><b>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</b></p> <p>The Food Service Manager and staff will be educated on ensuring Sanitary Condition and safe food handling – to include all items as</p>	09/24/2012			

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	<p>hair net on her head before serving the breakfast.</p> <p>During further observation, the cook began preparing the breakfast trays. She had on a pair of clean gloves to both of her hands at that time. She then opened the oven and pulled the plates and bowls out and placed them on the counter. She then removed the lids from both warmers where the eggs and toast were located. The cook did all of the above with the same gloves on both of her hands. Dietary Cook #1 then begin placing the food on the plates. She placed one egg omelette using tongs and then picked up the toast with her gloved hands. She did not use any kitchen utensils to pick up the toast. The Dietary Food Manager and the Registered Dietitian were observed in the kitchen at that time watching the cook prepare the meal. The cook continued to serve the toast using the same gloves to both of her hands. The cook did not change her gloves while serving the toast. She was observed picking up plates, bowls, plate covers, and other utensils using the same gloves on her hands. The cook prepared a total of 15 breakfast trays touching the resident's toast with the same gloved hands.</p>		<p>noted in Section A by a Regional Consultant – who holds certifications in Dietary Management and nationally accredited Serv-Safe Food Safety on 9/20/12.</p> <p><b>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</b></p> <p>The HFA and/or designee will conduct a random weekly audit to include all 3 meals for the next 30 days then bi-monthly X 2 months to ensure that hair restraints are worn properly – as well proper food handling is being followed.</p> <p>The HFA, and/or designee will conduct a random weekly audit the grey box and adjoining pipes located near the three compartment sink and stove is clean and free of debris, food crumbs and dust over the next 30 days then bi-monthly X 6 months to ensure sanitary conditions.</p> <p>The findings will be reported to the Administrator and monthly to the Risk Management/QA committee.</p> <p><b>(E) Date Certain: 09/24/2012</b></p>		

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	<p>Interview with the Dietary Food Manager on 9/6/12 at 7:50 a.m., indicated Dietary Cook #1 had just started working at the facility and was hired on 8/28/12.</p> <p>Interview with Dietary Cook #1 at that same time, indicated when she was observing other cooks during meal times, they had used their gloved hands for the toast as well and had not used tongs. She indicated she had not been taught to use tongs to pick up the toast.</p> <p>During the kitchen sanitation tour on 9/6/12 at 7:50 a.m., indicated the gray metal box located next to the stove and the three compartment sink had a moderate amount of dust, grease and food crumbs observed around the pipes.</p> <p>Interview with the Dietary Food Manager at the time, indicated the above was in need of cleaning.</p> <p>This deficiency was cited on July 23, 2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-21(i)(3)</p>						