STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155458	A. BUILDING 00 B. WING	05/22/2017

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00229579. Complaint IN00229579- Substantiated. Federal/State deficiencies related to the allegations are cited at F246. Survey date: May 22, 2017 Facility number: 000367 Provider number: 155458 AIM number: 100289280 Census bed type: SNF/NF: 29 Total: 29 Census payor type: Medicare: 3 Medicaid: 18 Other: 8 Total: 29 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/24/17.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 0246 SS=E Bldg. 00	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure call lights were in reach for 4 of 8 residents observed for call light placement in a sample of 8. (Residents B, F, H, and J) Findings include: 1. On 5/22/17 at 8:03 a.m., Resident B was observed in bed. The call light cord was plugged into the wall. The end of the cord with the push button was in the	F 0246	F246 At the time of survey, the facility had policies and procedure in place to ensure residents are afforded reasonable accommodation of needs and preferences. Residents B, F, J, and H, affected by the alleged deficient practice as cited on 5-22-17, were assessed immediately and call lights were placed within reach of the residents in bed or, in the case of resident H, placed within reach while up in chair	06/21/2017

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	drawer of the bedside dresser and not in reach. No staff members were in the room at this time. The record for Resident B was reviewed on 5/22/17 at 9:09 a.m. The diagnoses included, but were not limited to, Parkinson's disease, anxiety disorder, insomnia, and a history of falling. The admission MDS (Minimum Data Set) assessment, completed on 3/8/17, assessed Resident B as requiring extensive assistance of two staff members for transfers, bed mobility, and locomotion on and off the unit. There was limitation in range of motion of one of the lower extremities. Balance was not steady with surface to surface transfers. A Fall Risk Assessment, completed on 2/23/17, assessed Resident B as having a history of falls in the past with a Fall Risk score of (11). A score of (10) or above represented a high risk for falls. A Care Plan, completed on 3/1/17, assessed Resident as having the potential for injuries from falls related to gait/balance problems, unaware of safety needs, and a history of falls resulting in fractures. Care Plan interventions included, but were not limited to, anticipate and meet the resident's needs,		in resident's room. All residents in bed or otherwise in their rooms have the potential to be affected by the same deficient practice. Director of Nursing made rounds on 5-22-17 to ensure call lights were within reach and corrective action taken immediately when needed. To ensure the deficient practice does not occur, all staff were inserviced on the necessity for call lights to be within a resident's reach while in bed or up in chair in their room and completed on 6-8-2017. To ensure compliance, the Director of Nursing and her designee(s) will monitor the effectiveness of staff education on necessity of call lights within reach, and document their findings and corrective action, daily on each shift for four (4) weeks; weekly on each shift for four (4) weeks; and monthly each shift for four (4) months thereafter. The Administrator is responsible for training oversite and practical application of policies and procedures governing reasonable accommodation of residents' needs. The administrator will review the call light audits and the findings will be taken to the Quality Assurance Performance Improvement Committee monthly. If 95% compliance is not achieved, an	

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	floor mat next to bed, and be sure the resident's call light was within reach. 2. On 5/22/17 at 8:10 a.m., 9:48 a.m., and 10:54 a.m., Resident F was observed in bed. The call light was on the floor between the head of the bed and the bedside dresser. The call light was not in reach. No staff members were in the room at the above times. On 5/22/17 at 1:23 p.m., Resident F was sitting next to the bed in a wheel chair. The call light was on the floor behind the wheel chair. No staff members were in the room. The record for Resident F was reviewed on 5/22/17 at 12:16 p.m. Diagnoses included, but were not limited to, heart disease and anemia. The annual MDS (Minimum Data Set) assessment, completed on 5/3/17, assessed Resident F as requiring extensive assistance of staff for bed mobility, transfers, and walking in her room and the corridor. Balance while walking, moving from a seated to standing position, and transfers between bed and chair were not steady. A Fall Risk Assessment, completed on 5/30/17, assessed Resident F as having a		action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. 6-21-17	

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	history of a fall and was ambulatory with two assists. A Care Plan, completed on 12/24/14, assessed Resident F as having the potential for falls related gait/balance problems. Interventions included, but were not limited to, ensure the call light was in reach and encourage the resident to use it. 3. On 5/22/17 at 8:32 a.m., Resident J was observed in bed. The call light cord was draped over the table with the call button hanging towards the floor and not in reach. No staff members were in the room. The record for Resident J was reviewed on 5/22/17 at 2:50 p.m. Diagnoses included, but were not limited to, cardiac pacemaker, osteoarthritis, and anxiety disorder. The quarterly MDS (Minimum Data Set) assessment, completed on 5/2/17, assessed Resident J as requiring staff assist of two for bed mobility and transfers, no impairment in range of motion, and a wheel chair to be used for mobility. A Fall Risk assessment, completed on 5/2/17, assessed Resident J as being at			

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	high risk for falls. A Care Plan, completed on 8/10/15 and last revised with a target date of 7/23/17, assessed Resident J as having the potential for falls related to the use of psychoactive medications. Interventions included, but were not limited to, keep the bed in the lowest position and ensure the call light was within reach. 4. On 5/22/17 at 8:31 a.m. and 9:50 a.m., Resident H was observed in a Broda chair in her room at the foot of the bed. The call light was on top of the dresser nightstand next to the head of the bed. The call light was not in view or in reach. No staff members were in the room. The record for Resident H was reviewed on 5/22/17 at 12:54 p.m. Diagnoses included, but were not limited to depressive disorder, seizures, abnormal posture, and a history of traumatic brain injury. The quarterly MDS (Minimum Data Assessment), completed on 3/9/17, assessed Resident H as requiring extensive assistance of staff for bed mobility, transfers, and locomotion on the unit, and not steady with surface to surface transfers.			

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	A Fall Risk assessment, last completed on 12/30/16, assessed Resident H as being at risk for falls. A Care Plan, completed on 3/25/17, assessed Resident H as having the potential for falls related to gait balance problems. Interventions included, but were not limited to, assure the resident's call light was within reach and encourage the resident to use it. On 5/22/17 at 3:00 p.m., the Nurse Consultant, Director of Nursing, and the Administrator were interviewed. The Nurse Consultant, the Director of Nursing and the Administrator indicated the call buttons should have been in reach for the above residents. This Federal tag relates to Complaint IN00229579. 3.1-3(v)(1)			

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