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	08/25/2017

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 a Recertification and State Licensure Survey. Survey dates: August 21, 22, 23, 24, and 25, 2017. Facility number: 000367 Provider number: 155458 AIM number: 100289280 Census bed type: SNF/NF: 26 Total: 26 Census payor type: Medicare: 3 Medicaid: 19 Other: 4 Total: 26 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/28/17.	F 0000	Preparation and or execution of this plan of correction does not constitute admission or agreement on the part of the provider to the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	
F 0156 SS=D Bldg. 00	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each			

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

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	resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact			

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	agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]			

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	(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced			

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	directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be			

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	charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or			

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	discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to ensure residents and/or their Health Care Representatives (HCR) were properly notified of Medicare Non-coverage for 3 of 3 residents reviewed for liability notices. (Residents 5, 11, and 18) Finding includes: On 8/24/17 at 10:57 a.m., the Medicare Non-coverage letter for Resident 5 was reviewed and indicated the resident's HCR was notified by phone. The letter lacked a signature from the resident's HCR. On 8/24/17 at 11:00 a.m., The Medicare Non-coverage letter for Resident 11 was reviewed and indicated the resident's HCR was notified by phone. The letter lacked a signature from the resident's HCR. On 8/24/17 at 11:05 a.m., The Medicare	F 0156	1.Residents 5, 11, and 18 still reside in the facility. Social Services will attempt to have resident or healthcare representative sign non-coverage notice letters. 2.Social Services has audited current Medicare Part A and Part B residents and will ensure non-coverage notice letter is given in a timely manner and signed. 3.Administrator in-serviced Social Services, Therapy Director, and MDS that notice letter needs to be signed. Medicare meeting is held weekly and will review potential discharge dates to ensure timely non-coverage letters are distributed and signed. 4.To ensure compliance, Medicare meeting minutes will be addressed in QAPI for a period of 6 months. If 95% compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review.	09/24/2017

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	Non-coverage letter for Residents 18 was reviewed and indicated the resident's HCR was notified verbally. The letter lacked a signature from the resident's HCR. Interview with the Social Service Director (SSD), on 8/24/17 at 11:12 a.m., indicated she called the families and gave them a copy of the letter when they came in to the building. She should have followed the guidelines per the instructions for the Notice of Medicare Non-Coverage (NOMNC). The current policy for Notice of Medicare Non-Coverage, provided by the SSD on 8/24/17 at 11:12 a.m., indicated "Form Instructions for Medicare Non-Coverage (NOMNC) CMS-10123 ... Provider Delivery of the NOMNC...The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate the beneficiary or representative received the notice and understands that the termination decision...." 3.1-4(a)			
F 0241	483.10(a)(1)			

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SS=D Bldg. 00	DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on observation and interview, the facility failed to ensure each resident was treated with dignity and respect related to staff standing while assisting residents with eating for 3 of 5 residents who required assistance with eating. (Residents 6, 7 and 11) Finding includes: On 8/21/17 at 11:44 a.m., the lunch meal was observed in the main dining room. The trays for Residents 6, 7, and 11 were delivered to their tables. The residents did not begin to feed themselves. At 11:59 a.m., CNA 3 was observed standing next to Resident 6. She stood at the resident's side and began to feed her. She did not sit or kneel down at the resident's side while she fed her. At 12:02 p.m., CNA 1 was observed standing and feeding resident 7 and CNA 2 was observed standing attempting to feed resident 11. The CNAs did not sit or kneel down at the resident's side while	F 0241	1.Table seating for residents 6, 7, and 11 were modified to have resident's at one table and staff was provided with chairs to be able to sit down to assist and cue during meal times. 2.Dining room will be arranged to accommodate all residents that need to be assisted and/or cued to eat. Two tables will be designated to seat 3 residents each that require assistance to sit at during meal times leaving the fourth side open for staff to sit and assist. 3.Nursing staff will supervise resident placement is appropriate at every meal time by going to the dining room at meal times and verifying. 4.The DON or designee will observe staff and residents in the dining room at meals times daily for 4 weeks, followed by weekly observations for 6 months. The DON or designee will be required to maintain an audit log of meal time monitoring. The results of the meal time audit will be discussed at the monthly QAPI meeting for review or revision should compliance not be achieved.	09/24/2017

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	assisting the residents. Interview with the Administrator, on 8/24/17 at 2:00 p.m., indicated staff should remain at the Resident's eye level while feeding or attempting to feed residents. 3.1-3(t)			
F 0329 SS=D Bldg. 00	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a			

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	resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to insulin administration and the lack of documentation of blood sugar and blood pressure monitoring per Physician's orders for 1 of 5 residents reviewed for unnecessary medications. (Resident 23) Finding includes: The record for Resident 41 was reviewed on 8/22/17 at 2:12 p.m. Diagnoses included, but were not limited to, stroke, hyperglycemia (high blood sugar), and depression. A Physician's order, dated 9/26/16, indicated blood sugar checks two times daily at 6 a.m. and 4 p.m. The resident was to receive Humalog (insulin) 100u/ml per sliding scale as follows:	F 0329	1.Physician's orders for Resident 23 for blood pressure monitoring, glucose monitoring, and insulin administration was reviewed and verified. Resident care plan was updated to reflect orders. 2.Every resident's physician orders in the facility receiving insulin was reviewed and verified. Treatment books updated to reflect orders. Blood pressures that require weekly monitoring will coincide to Mondays for all residents with an order for weekly BP checks beginning 9/11/2017. 3.In-service on 9/8/17 will be held for all licensed staff about the policy, following physician orders, and documenting properly in regards to blood pressure checks and accu-checks . 4.The DON or designee will monitoring the treatment books daily for 4 weeks followed by weekly for 6 months to ensure all treatments are being completed and documented per physicians	09/24/2017

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	0 - 149 = 0 units 150 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units If blood sugar is less than 70 or greater that 400, call the Physician. The July 2017 Medication Administration Record (MAR) indicated a lack of documentation related to blood sugar results and insulin administration on the following dates: 7/26 at 4:00 p.m. 7/28 at 6:00 a.m. 7/28 at 4:00 p.m. 7/29 at 4:00 p.m. A Physician's order, dated 7/27/17, indicated a one time order for 12 units of Humalog for a blood sugar reading greater than 400 and to recheck the resident's blood sugar at 7:00 p.m. There was no documentation related to a follow up blood sugar result at 7:00 p.m. A Physician's order, dated 12/8/15, indicated the resident's blood pressure was to be obtained weekly on Mondays on the 2-10 shift.		orders beginning 9/11/17. The results of the audit will be discussed at the monthly QAPI meeting for review or revision should compliance not be achieved.	

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	The July 2017 MAR indicated a lack of documentation related to the resident's blood pressure readings on the following dates: 7/17/17 7/24/17 7/31/17 Interview with the Director of Nursing on 8/24/17 at 11:44 a.m., indicated the Physician's orders should have been followed as ordered. 3.1-48 (a)(6)			
F 0371 SS=F Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.			

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	(iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, record review, and interview, the facility failed to ensure desserts were covered while being transported down the hallway. The facility also failed to ensure the dishwasher was functioning properly in the main kitchen. This had the potential to affect the 26 residents residing in the facility. Findings include: 1. On 8/21/17, at 11:46 a.m., room trays were observed being served on the back hall. Five trays were on the cart. The bowls of apple sauce were uncovered and the tray cart was not covered. 2. On 8/24/17, at 12:04 p.m., room trays were observed being served on the back hall. Three trays were on the cart. The strawberry shortcake desserts were not covered at this time. Four residents had	F 0371	1.In regards to food being covered, food items were immediately covered by dietary manager and staff as soon it was brought to attention by surveyor. 2.Dietary manager in-serviced dietary staff on making sure food items are covered when being brought out to dining room. Covers for food carts have been ordered and will be implemented immediately. 3.All staff members have been in-serviced on 9-8-17 in regards to making sure food items are covered as they are being passed in hallways. 4.To ensure compliance, The Dietary Manager or designee will audit food items to ensure they are covered while transporting in hallways daily, for one meal, for 4 weeks, and then weekly, for one meal, for 6 months thereafter. These audits will be addressed in monthly QAPI meeting. If 95% compliance isn't achieved, then an action plan will be developed	09/24/2017

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(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
	already been served in their rooms. Interview with the Administrator, on 8/25/17 at 3:00 p.m., indicated the desserts should have been covered when being transported down the hall. The current "Food Production Guidelines-Sanitation and Safety" policy, provided by the Administrator, on 8/25/17 at 1:15 p.m., indicated the following: "Food items transported to halls will be covered." 3. During the initial tour of the Main Kitchen on 8/21/17 at 9:35 a.m., an observation of the dish washing machine was made with the Dietary Manger (DM). She placed silverware into the washer and started the machine. The wash cycle temperature reading reached 115 degrees Fahrenheit and the rinse cycle temperature reading reached 115 degrees Fahrenheit. Interview at the time with DM indicated the dishwasher was a low temp chemical dishwasher and the wash and rinse cycle temperatures should be at least 120 degrees. On 8/23/17 at 11:30 a.m., the DM activated the dishwasher and indicated they were re-setting the heat booster, located on the floor under the dish		and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. 1.In regards to the dishwasher temperature, during the day of initial survey, Ecolab was scheduled for a routine visit for inspection. During this visit, Ecolab verified parts were not working properly, but was reaching temperature after the booster had been reset. Parts needed were ordered by Ecolab. Paper plates and plastic silverware were being used when low temp dishwasher was not reaching 120 degrees. 2.Because all residents have the potential to be affected by this, an in-service was conducted immediately for dietary staff to make sure that temperature is reaching at least 120 degrees before use. The In-service also instructed staff to contact dietary manager for further instructions if temperature did not reach 120 degrees. 3.Ecolab came out to install parts on 8-29-17. Low temp Dishwasher has effectively been reaching temperatures above 120 degrees without resetting. Temperatures of low temperature dishwasher are recorded daily, before use of each meal, by dietary staff. 4.To ensure compliance,	

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	machine, manually. After running the dishwasher the first time, the DM reset the heat booster, the temperature read 115 degrees. The DM ran the dishwasher a total of 9 times, resetting the heat booster each time. The wash and rinse cycle temperatures did not read above 116 degrees. The August 2017 Dish Machine Log indicated the wash and rinse temperatures on the dishwasher were 100 degrees on 8/2, 8/4, 8/5, 8/6, 8/8, 8/9, 8/10, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22 and 8/23. The 2009 policy titled, "Cleaning Dishes and Utensils - Dish Machine Operation" provided by the Administrator on 8/24/17 at 9 a.m., indicated "Policy: Dish machines will be properly used to ensure sanitation of dishes and utensils...Procedure: ...G. Check that temperatures are appropriate: 2. Low Temp using Sanitizer - Temperatures should be between 120 - 150 degrees F...." 3.1-21(i)(3)		Dietary Manager or designee will audit temperatures daily, before each meal, for four weeks and weekly, before each meal for 6 months thereafter. The results of these audits will be discussed at monthly QAPI meeting. If 95% compliance isn't achieved, then an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review.	
F 0431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS			

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Bldg. 00	& BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and			

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	biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure the emergency drug kit (EDK) was secured in 1 of 1 medication rooms. (The Main Medication Room) Finding includes: On 8/25/17 at 11:00 a.m., the EDK was observed in the Medication Room. The EDK box was not locked at this time. There was one tray of medications that was not secure and the top shelf of the EDK box was not secured. The top shelf of the box contained oral and intravenous medications. There was also a slip of paper on the top shelf indicating the EDK box was opened on 8/12/17. Interview with the Director of Nursing, on 8/25/17 at 1:15 p.m., indicated the EDK box should have been secured	F 0431	1.EDK lid and unsecured drawer were immediately sealed with tabs provided by pharmacy on 8/25/17. 2.Licensed staff will have an in-service regarding resealing the EDK after every use on 9/8/17. 3.Pharmacy was notified on 8/25/17 that the EDK lid latch was broken and could not be properly locked. EDK has been repaired. 4.The DON or designee will ensure the lid and drawers on the EDK remain sealed and daily for 4 weeks followed by weekly for 6 months beginning 9/11/17. The DON or designee will be required to maintain an audit log and review results at the monthly QAPI meeting or review of compliance or revision should compliance not be met.	09/24/2017

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	based on the Pharmacy policy. The "Emergency Medication Supplies" policy provided by the Director of Nursing, on 8/25/17 at 1:05 p.m., indicated the following: "The emergency kit is sealed and stored in a secured area to prevent unauthorized access and to assure a proper environment for the preservation of the medications, but in such a manner to allow immediate access by authorized staff." Further review of the policy also indicated the following: "Facility should ensure that each drawer is secured in a manner that allows Pharmacy to identify which Emergency Medication Supplies have been accessed." 3.1-25(m)			
F 0441 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for			

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	all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			

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	(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure handwashing was completed after glove removal for 1 of 1 observations of incontinence care as well as after picking items up from the floor and discarding glucometer test strips correctly for 1 of 1 glucometers observed. The facility also failed to ensure a water management policy & implementation plan was in place. (Residents 25 and 27) Findings include: 1. On 8/21/17 at 11:46 a.m., CNA 1 was observed passing room trays on the back hall. At 11:50 a.m., the plastic lid covering a juice container fell to the floor. CNA 1 bent over and picked the plastic lid up from the floor and placed it on a shelf on the juice cart. The CNA then proceeded to deliver a room tray.	F 0441	1.Regarding resident 25, the CNA caring for the resident immediately received an in-service on proper handwashing and glove use on 8/25/17. Regarding resident 1, the LPN self-recognized the error and informed the state representative that she should have disposed of the test strip in the sharps box. LPN received an in-service about proper disposal of test strips in the sharps box on 8/25/17. 2.All staff will receive an in-service on policy regarding glove use and handwashing on 9/8/17. Licensed staff will receive an in-service regarding policy and procedure of disposal of glucose test strips on 9/8/17. 3.The DON or designee will observe staff during resident care to monitor for proper handwashing, glove use, and test strip disposal on randomly selected residents weekly for 6 months. The DON or designee	09/24/2017

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	She did not wash her hands or use hand sanitizer after picking the plastic lid up from the floor. Interview with the Director of Nursing, on 8/25/17 at 12:20 p.m., indicated the CNA should have sanitized her hands after picking the lid up. 2. On 8/24/17 at 10:42 a.m., CNA 4 was observed putting Resident 25 in bed. The CNA put on a pair of clean gloves and proceeded to provide incontinence care at this time. After completing incontinence care, the CNA repositioned the resident's pillows underneath the resident's head and neck. The CNA was wearing the same pair of gloves she wore for incontinence care. The CNA then proceeded to touch the resident's sheets and blanket with the same gloved hands. The CNA removed the gloves prior to leaving the room, she did not wash her hands or use alcohol gel prior to leaving the resident's room. Interview with the Director of Nursing, on 8/25/17 at 12:20 p.m., indicated the CNA should have used hand sanitizer after removing her gloves and she shouldn't have touched the resident's pillow and blanket with the same gloves that she had used for incontinence care.		will be required to maintain an audit log of results. 4.The DON or designee monitor audit of handwashing, glove use, and test strip disposal and review the results monthly at the QAPI meeting for compliance or revision should compliance not be met. 1.Regarding the water management plan, no residents were identified as immediately affected. 2.All residents have the potential to be affected. A water management policy and plan will be developed and implemented immediately. 3.An audit tool has been put in place to monitor implementation and efficacy. All staff members were in-serviced on 9-8-17. 4.The administrator or designee will monitor the implementation audit weekly for four weeks and monthly thereafter. To ensure compliance, the water management policy and plan will be discussed at QAPI meeting monthly for 6 months. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review.	

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	The current "Personal Protective Equipment - Gloves" policy was provided by the Director of Nursing, on 8/25/17 at 11:30 a.m. The policy indicated gloves should be used only once and discarded into the appropriate receptacle located in the room in which the procedure was being performed. Hands should be washed after removing gloves. 3. On 8/24/17 at 11:29 a.m., LPN 1 was observed performing a glucometer (blood sugar) test for Resident 27. The LPN washed her hands with soap and water, put on gloves and explained the procedure to the resident. After obtaining the blood sample, the LPN removed the test strip from the glucometer and removed her gloves. The LPN proceeded to throw the gloves and test strip in the garbage. Interview with the LPN at the time, indicated the test strip should have been discarded in the sharps container and not wrapped up in her gloves. Interview with the Director of Nursing, on 8/25/17 at 1:05 p.m., indicated the test strip should have been discarded in the sharps container. The current "Blood Sampling - Capillary			

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	(Finger Sticks)" policy was provided by the Director of Nursing on 8/25/17 at 1:05 p.m. The policy indicated to obtain the blood sample following the manufacturer's instructions for the device and discard the lancet and platform into the sharps container. 4. Interview with the Administrator, on 8/25/17 at 1:00 p.m., indicated there was no water management plan or policy to monitor for Legionella (bacteria) in the water at the current time. He had spoken to the Corporate Office, who was also unaware of the requirement to have a water management system put in to place to test for Legionella. Observation during the survey indicated there were no decorative fountains or hot tubs at the facility. Review of the facility's Resident Census & Condition report indicated three of the 26 residents received respiratory treatments. Facility records indicated 1 of the 26 residents smoked cigarettes and one resident in the facility was age 50 or younger. 3.1-18(b)(1) 3.1-18(l)			
F 0463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM -			

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Bldg. 00	ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a functioning call system was in place for 1 of 23 resident rooms observed. (Room 13) Finding includes: On 8/22/17 at 9:51 a.m., the call pad in Room 13 was pressed. The light did not illuminate outside of the room nor did it alarm at the nurses' station. On 8/25/17 at 9:30 a.m., the call pad in Room 13 was pressed. The light did not illuminate outside of the room nor did it alarm at the nurses' station. Interview at the time with the Maintenance Director indicated the call pad was malfunctioning and needed to be replaced. 3.1-19(u)(1)	F 0463	1.Call light in resident's room was replaced immediately by maintenance as soon as it was brought to attention by surveyor. 2.All of the residents call lights were audited to ensure they were functioning properly and there were no findings of any other call lights not functioning properly. 3.All call lights are scheduled for inspections and preventative maintenance on a monthly basis or as needed by the maintenance director. All staff members have been in-serviced on 9-8-17 in regards to checking call lights and reporting any issues immediately to the director of maintenance or administrator to be addressed. 4.To ensure compliance, the maintenance director, administrator, or designee, will audit call lights for functioning on a daily basis, once a shift, for four weeks. The results of these audits will be discussed at monthly QAPI meeting. If 95% compliance isn't achieved, then an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and	09/24/2017

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			corporate teams for review.	
F 0465 SS=E Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to torn wheelchair cushions, marred and scuffed door frames and walls, cracked, unpainted, and missing plaster, chipped and peeling paint, gouged, marred and scuffed floor tiles, displaced cove bases, holes in walls, dirty call buttons, and chipped and gouged soffits for 2 of 2 halls. (The Front and Back Halls) Finding includes: 1. The Front Hall a. The hallway floor tiles and walls were scuffed and marred. The cove bases were displaced from the walls.	F 0465	1.Front hallway – tiles have been cleaned and scuff marks have been removed. Cove bases have been placed appropriately on walls. Room 1 – door frame has been painted. Soffit behind head of the bed has been repaired and painted. Call button for bed b was immediately cleaned. Cushion for wheelchair arm has been replaced. Room 2 - door frame has been painted. Soffit behind head of bed has been repaired and painted. The bottom of closet has been painted. Room 3 – soffit behind bed B has been repaired and painted. The bathroom door frame has been painted and corner of wall has been repaired and painted. Floor tile next to bed b has been replaced. Room 4 – wheelchair cushions for Bed A have been replaced. Back hallway – floor tiles have been	09/24/2017

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	b. Room 1, the door frame was scuffed and marred. There was cracked plaster and peeling paint at the bottom corner of the closet. The call button for bed b was dirty. The wheelchair arm cushion was torn for bed B. Two residents shared this room. c. Room 2, the door frame was scuffed and marred. The soffit behind the head of the bed had chipped wood and paint. The bottom of the closet was scuffed. Two residents shared this room. d. Room 3, the soffit behind the head of bed B had chipped and peeling paint. The bathroom door frame and the corner of the wall had chipped and peeling paint. The floor tile was gouged next to bed B. Two residents shared this room. e. Room 4, the wheelchair cushions for bed A were cracked and worn. 2. Back Hall a. The hallway floor tiles and walls were scuffed and marred. The cove bases were displaced from the walls. b. Room 7, the wheelchair arm cushion was torn for bed A. c. Room 9, there was a section of the		cleaned and scuff marks removed. Cove bases have been placed appropriately on walls. Room 7 – cushion for wheelchair arm has been replaced for bed A. Room 9 – Cove base has been replaced by the door. Room 10 – holes in wall along side of window have been repaired. Room 11 – drywall along the side of window has been repainted. Holes in wall about TV have been repaired and painted. Room 13 – missing drywall along corner of closet has been repaired and painted. Room 14 – floor tile has been cleaned. Chipped paint along corner of closet has been repaired and painted. Soffit behind head of bed was repaired and painted. Wall behind head of bed was painted. 2.All rooms and wheelchairs were audited by maintenance and administrator to ensure rooms, call lights, and wheelchairs are safe, functional, sanitary, and comfortable. Any additional rooms and/or equipment audited that need fixing will have a completion date of 9-15-17. 3.All resident rooms and wheelchairs are scheduled for inspections and preventative maintenance on a monthly basis or as needed by the director of maintenance. All staff members have been in-serviced on 9-8-17 in regards to bringing the attention of environmental concerns to the director of maintenance or administrator in a timely manner.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND NURSING AND REHABILITATION CENTER	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
	cove base missing by the door. Two residents shared this room. d. Room 10, there were three holes in the wall along the side the window. Two residents shared this room. e. Room 11, there was dried unpainted plaster on the wall along the side of the window. There were holes in the wall above the TV. One resident resided in this room. f. Room 13, there was missing plaster along the corner of the closet. One resident resided in this room. g. Room 14, the floor tile was scuffed. There was chipped paint along the corner of the closet. The soffit behind the head of bed a had chipped wood and the wall was marred. Two residents shared this room. Interview at the time with the Maintenance Director indicated the above was in need of cleaning and/or repair. 3.1-19(f)		4.To ensure compliance, the maintenance director, administrator, or a designee, will audit rooms and wheelchairs weekly for four weeks, and monthly for six months. The results of these audits will be reviewed at monthly QAPI meeting. If 95% compliance is not achieved, then an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review.	