STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			X2) MULTIPLE CONSTRUCTION X3) DAY A. BUILDING 00 COM			URVEY ETED	
		155458	B. WI	ING		04/25/2	2017
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER		9630 FI	ADDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN 46322		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	This visit was for Complaint IN00	or the Investigation of 0228094.	F 00	000			
	Complaint IN00	0228094 - Substantiated.					
	•	eficiencies related to the					
		eited at F225 and F226.					
	Survey date: April 25, 2017						
	Facility number	·· 000367					
	Provider number						
	AIM number: 1						
	Time name of . 1	00209200					
	Census bed type						
	SNF/NF: 27						
	Total: 27						
	10001. 27						
	Census payor ty	pe:					
	Medicare: 3	•					
	Medicaid: 16						
	Other: 8						
	Total: 27						
	10001. 27						
	These deficienc	ies reflect State findings					
		nce with 410 IAC					
	16.2-3.1.						
	Quality review	completed on 4.26.17					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUILDING B. WING	COMPLETED 04/25/2017		
	PROVIDER OR SUPPLIER ND NURSING AND RE	EHABILITATION CENTER	9630 FI	ADDRESS, CITY, STATE, ZIP CODE IFTH ST AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0225 SS=D Bldg. 00	exploitation, misappr mistreatment by a complete continuous aide registry or neglect, exploitation, residents or misappr property; or (iii) Have a disciplinat against his or her prostate licensure body of abuse, neglect, exploitation, residents or misappr property. (4) Report to the Stallicensing authorities actions by a court of employee, which wo	DRT VIDUALS nerwise engage guilty of abuse, neglect, opriation of property, or ourt of law; g entered into the State oncerning abuse, mistreatment of opriation of their ry action in effect of property as a result of a finding ploitation, mistreatment of opriation of resident te nurse aide registry or any knowledge it has of law against an uld indicate unfitness for de or other facility staff.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED			
		155458	B. WING		04/25/2017			
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE				
	ID AILIDOING AND	DELIABILITATION CENTED	9630 FIFTH ST					
HIGHLAN	ND NURSING AND	REHABILITATION CENTER	HIGHL	AND, IN 46322				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	` ·		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
		alleged violations						
		neglect, exploitation or uding injuries of unknown						
		propriation of resident						
		orted immediately, but not						
		after the allegation is						
		ts that cause the allegation						
		result in serious bodily than 24 hours if the events						
		egation do not involve						
abuse and do not result in serious bodily								
injury, to the administrator of the facility and								
to other officials (including to the State								
Survey Agency and adult protective services where state law provides for jurisdiction in								
		cilities) in accordance with						
	_	established procedures.						
	3							
		e that all alleged violations						
	are thoroughly inv	restigated.						
	(3) Prevent further	r potential abuse, neglect,						
	•	streatment while the						
	investigation is in	progress.						
	(4) Report the res	ults of all investigations to						
	the administrator	or his or her designated						
		d to other officials in						
		State law, including to the						
		ncy, within 5 working days d if the alleged violation is						
		te corrective action must						
	be taken.							
	Based on observ	ration, record review, and	F 0225	At the time of survey, the facility	05/05/2017			
	interview the fac	cility failed to ensure an		had in place policies and procedure	es [
		wanted resident to		to ensure allegations of abuse,				
	_	g was timely and		neglect, exploitation, or	_			
		stigated related to a male		mistreatment are investigated; and further potential abuse, neglect,	u			
		g a female and the failure		exploitation, or mistreatment are				
	``	idents were not left		prevented while the investigation is	s			
	to choure the res	TWO THOU HOU TOTAL		in progress.				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155458	B. W	ING		04/25/	2017
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			IFTH ST		
HIGHLA	ND NURSING AND	REHABILITATION CENTER			AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CO			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
		e present together in the					
	Dining Room fo	r 1 of 3 allegations of			Regarding the alleged deficient		
	Abuse reviewed. (Residents C and E)				practice for residents E and C as cited in the deficiency, on		
					4/21/2017, resident E was examine	d	
	On 4/25/17 at 10:49 a.m., Resident C was propelling his wheel chair into the Main				immediately and there was no	u	
					injury; the administrator was		
					notified immediately; and the local		
					police department was called and a	ı	
					police investigation report was filed		
	Dining Room and stopped just inside the				The physician for residents C and E		
	Dining Room. Resident E was seated at				as well as their families were		
	table near the back of the Dining Room.				notified. Resident C was placed on		
	No Staff members were present. The				1:1 observation and continued		
	Activity Directo	r entered at 10:50 a.m.			under the review of the		
	and began assist	ing other residents			interdisciplinary team during the		
	outside through	the front door to plant			investigation. Social Services		
	1	inutes later, Resident C			interviewed Resident E to assess he	er .	
		If to the window side of			mood and psychosocial status.		
		n across the room from			During the days following, Social Services followed up with Resident	_	
	_				who voiced no concerns and	_	
		ivity staff continued to			expressed contentment with the		
		e Dining room. At 11:00			arrangements made to summon		
		y Director took Resident			help and the use of a stop sign on		
	C outside for the	e activity.			her door. The care plans for		
					residents C and E were reviewed		
	An Incident/Acc	eident Report, completed			and updated.		
	on 3/3/17, indica	ated Resident E was					
	seated at a back	table in the Dining Room			To identify other residents who ma	У	
	with her arms ar	nd head resting on the			have been affected by the same		
		C approached her and she			deficient practice, residents were interviewed using the Resident		
		ween her legs, including			Abuse Protocol. Additionally, staff		
		and went to the Therapy			members were interviewed to		
	•	1.0			ensure residents who were not		
	Koom to report	what had occurred.			interviewable were not affected.		
					There were no concerns or issues		
		eident Report, completed			identified as a result of the		
	on 3/3/17, indica	ated Resident C			interviews.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	A. BUILDING <u>00</u> COMPLETED		
		155458	B. W	ING		04/25/2017
				STREET /	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹				
	AD MITIBOING AND	REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN 46322			
ПІВПЕАІ	ND NORSING AND	REHABILITATION CENTER		HIGHLA	AND, IN 40322	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	approached Resi	dent E in the Dining				
	Room and grabb	ed her in her private			To ensure the deficient practice	
	peri-area. Reside	ent C was sent to the			does not recur, policies and	
		ychiatric evaluation and			procedures governing all aspects of	
	admission.	y chiadric o variation and			Abuse Prevention, Pre-employment	
	adiiiissioii.				Screening, Employee Orientation	
					and Training, Identification	
	The record for Resident E was reviewed				(including clinical assessment, care	
	on 4/25/17 at 8:40 a.m. The diagnoses				planning, and monitoring residents	
	included, but were not limited to,				with behaviors that could lead to	
	hemiplegia (limitation in use of an				abuse), Investigation, Protection of	
	extremity) following cerebral vascular				Residents, and Reporting were	
					reviewed (The Abuse Protocols); and	u
	disease, high blood pressure, and				all staff were inserviced, including	
	osteoarthritis.				facility management, on the above	
					policies and procedures prior to working subsequent to 4/21/2017.	
	The admission N	MDS (Minimum Data			See Attachment: Highland Abuse	
	Set) assessment,	completed on 1/11/17,			Protocols and Staff Training	
	assessed Resider	nt C's cognition as intact.			Trotocois and Stajj Training	
		transferring, dressing,			The Administrator is responsible for	
		giene was required.			the training and practical application	
					of the Abuse Protocols and	
	_	ange of motion on one			monitoring their effectiveness. Any	
	upper and one lo	ower extremity was			events, occurrences, patterns and	
	present.				trends that may constitute abuse	
					will be reviewed by the Quality	
	A Quarterly Nur	rsing Assessment,			Assurance Performance	
	completed on 4/	11/17, assessed Resident			Improvement Committee on a	
	_	earing as adequate, able			monthly basis as a permanent	
					agenda item. Monthly QAPI reports	5,
		in a wheel chair, alert			including findings and action plans,	
	•	son, place, and time and			are submitted to regional operation	S
	was friendly and	l cooperative.			staff and the corporate risk	
					management team for review.	
	Nursing Progres	s Notes, completed on				
		0/17, indicated there were				
		of the resident to resident				
	attercation or an	y body/skin assessment.			1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUILDING B. WING	00	COMPLE 04/25/2	TED	
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322				
	ND NURSING AND REHABILITATION CENTER		AND, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	A Care Plan, initiated on 3/6/17, assessed Resident E as having a psychosocial well-being problem r/t (related to) another resident grabbed her inappropriately. The intervention listed was to allow the resident time to answer questions and verbalize feelings, perceptions, and fears. The record for Resident C was reviewed on 4/25/17 at 12:32 p.m. The diagnoses included, but were not limited to, hemiplegia related to cerebral infarction, dementia, and schizophrenia. Physician orders were obtained on 3/3/17 to send the resident to the hospital for a psychiatric evaluation. No entries were completed in the Nursing Progress Notes on 4/19/17. A Nursing Progress Note, completed on 4/21/17 at 12:00 p.m., noted a female resident reported Resident C had touched her private area while they were in the Dining Room. He was placed on 1:1 visits at this time. The quarterly MDS assessment, completed on 2/24/17, assessed Resident C as being cognitively impaired, requiring assistance with transfers, dressing, eating, and personal hygiene. Mobility devices used included a wheel chair.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED B. WING 04/25/2017				
		155458	D. WI	_		04/25/	2017
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>			ADDRESS, CITY, STATE, ZIP CODE		
	ID NI IDRING AND	REHABILITATION CENTER		9630 FII	FTH ST AND, IN 46322		
					(ND, IN 40322		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
IAG		tiated on 5/13/16,		IAG	,		DATE
	· · · · · · · · · · · · · · · · · · ·	nt C as having exhibited					
		priately behaviors as					
	evidenced by Sc	-					
	_	cluded, encourage					
		ss feelings and explain					
	•	at behavior is not					
	appropriate.	at ochavior is not					
	appropriate.						
	A one hage cons	of an email related to an					
	A one page copy of an email related to an occurrence on 4/19/17 was provided by						
	the Director of Nursing (DON). The						
		he email had been					
		e previous Administrator.					
		d Resident E yelling and					
		office. Resident E was					
		ble in the Dining Room					
		was seated next to her					
		rned towards resident E.					
		ediately removed					
		from Resident E.					
	Resident E was t						
		office. Resident E was					
		d Resident C had touched					
		ist below her knee.					
		offered reassurance that					
		not hurt her nor has he					
		horn was provided to the					
	_	t" for help if ever					
	approached by R	-					
	approaction by N	Coldoni C ugani.					
	A 4/21/17 Polic	e Report, completed by					
		Department, indicated the					
		ooke with Resident E,					
	1 01100 0111001 01	The man region L,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155458	B. W	ING		04/25/	/2017
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HIGHI AN	ND NI IRSING AND	REHABILITATION CENTER		9630 FII	FTH ST AND, IN 46322		
(X4) ID				ID	110022		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	e was inappropriately					
	-	dent C. Staff advised the					
		C was not to be left ent E at any time.					
	alone with Kesiu	ent E at any time.					
	On 4/25/17 at 8::	59 a.m., the Director of					
		and the Social Service					
	Designee (SSD)	were interviewed. The					
	DON indicated t						
	altercation involving Residents C & E on						
4/19/17. Resident C touched Resident							
	•	" On 4/19/17, COTA					
	,	pational Therapy Resident E yelling "get					
	·	Resident C was seated					
		E at the time. The					
		ely wheeled Resident E					
		Administrator's office.					
	No Incident Rep	ort was provided for the					
	4/19/17 resident	to resident touching					
	occurrence.						
	TI COD III	1D '1 (ELC')					
		ed Resident E's Sister					
		to the facility on 4/21/17. bers were informed of					
		rrence with Resident E's					
		esident E was her own					
		ry. A few minutes later,					
	•	ed staff Resident E					
	reported Resider	at C had touched her					
	_	e Police were called and					
	arrived at the fac	ility. 4/21/17 was the					
		nt E told anyone she was					
	touched in the va	nginal area.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/25/2017		
	PROVIDER OR SUPPLIER ND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	On 4/25/17 at 11:15 a.m. the Nurse Consultant was interviewed. She was informed of the allegation on 4/21/17 and the Police were called. An Incident Report should have been initiated on 4/19/17 when Resident E reported she was touched by Resident C. A physical assessment of Resident E should have been completed by Nursing staff on 4/19/17. Nursing staff should have been aware of the 4/19/17 occurrence between Residents C and E. On 4/25/17 at 11:20 a.m., the DON was interviewed. Resident C was not started on 1:1 observations until 4/21/17. 15 minute checks were then initiated on 4/24/17. No 1:1 observations or 15 minute checks were initiated on 4/19/17. On 4/25/17 at 11:30 a.m., LPN #1 was interviewed via telephone. She had not been informed of any resident to resident altercations between Residents C & E until Sunday 4/23/17. On 4/25/17 at 11:55 a.m., COTA 1 was interviewed. Resident E was crying when she reported to her that Resident C had touched her and the resident was taken to the Administrator's office at that time. This Federal tag relates to Complaint					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/25/2017			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	IN00228094. 3.1-27(a)(1)						
F 0226 SS=D Bldg. 00	ETC POLICIES 483.12	ENT ABUSE/NEGLECT,					
	written policies and	st develop and implement d procedures that: event abuse, neglect, and					
	exploitation of resi misappropriation of	dents and f resident property,					
	investigate any su	es and procedures to ch allegations, and gas required at paragraph					
	§483.95, 483.95	, as roganos at paragraph					
	addition to the free	, and exploitation. In edom from abuse, neglect, quirements in § 483.12, provide training to their					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155458	B. W	ING		04/25/	2017	
HIGHLAN		REHABILITATION CENTER		9630 FI HIGHLA	ADDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN 46322			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	(c)(1) Activities that neglect, exploitation of resident proper (c)(2) Procedures abuse, neglect, exploitation of the control	ration, record review, and cility to ensure the Abuse icy and protocols were to investigating an nale resident touching a for 1 of 3 allegations of . (Residents C and E)	F 02	226	At the time of survey, the facility had in place policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; including training on activities that constitute abuse, reporting, and resident abuse prevention. Regarding the alleged deficient practice for residents E and C as cited in the deficiency, on 4/21/2017, resident E was examined immediately and there was no injury; the administrator was notified immediately; and the local police department was called and a police investigation report was filed The physician for residents C and E as well as their families were notified. Resident C was placed on 1:1 observation and continued under the review of the interdisciplinary team during the investigation. Social Services interviewed Resident E to assess her mood and psychosocial status.		05/05/2017	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		155458	B. W	ING		04/25/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			FTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER			AND, IN 46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Activity Director took Resident C outside				During the days following, Social		
	for the activity.				Services followed up with Resident	: E	
					who voiced no concerns and		
	The record for F	Resident E was reviewed			expressed contentment with the		
		40 a.m. The diagnoses			arrangements made to summon		
		•			help and the use of a stop sign on		
	· ·	ere not limited to,			her door. The care plans for		
	1 1	itation in use of an			residents C and E were reviewed		
	extremity) follo	wing cerebral vascular			and updated.		
	disease, high blood pressure, and				To identify other residents who ma	ау	
	osteoarthritis.				have been affected by the same		
					deficient practice, residents were		
	The admission I	MDS (Minimum Data			interviewed using the Resident		
	Set) assessment	, completed on 1/11/17,			Abuse Protocol. Additionally, staff		
	assessed Reside	nt C's cognition as intact.			members were interviewed to		
		transferring, dressing,			ensure residents who were not		
		O- O-			interviewable were not affected.		
	-	giene was required.			There were no concerns or issues		
	-	ange of motion on one			identified as a result of the		
	upper and one lo	ower extremity was			interviews.		
	present.				To assessment the state of the		
					To ensure the deficient practice		
	A Quarterly Nu	rsing Assessment,			does not recur, policies and	f	
		/11/17, assessed Resident			procedures governing all aspects o Abuse Prevention, Pre-employmen		
	_	earing as adequate, able			Screening, Employee Orientation		
		f in a wheel chair, alert			and Training, Identification		
		· ·			(including clinical assessment, care		
	_	rson, place, and time and			planning, and monitoring residents		
	was friendly and	a cooperative.			with behaviors that could lead to		
					abuse), Investigation, Protection of	f	
	Nursing Progres	ss Notes, completed on			Residents, and Reporting were		
	4/19/17 and 4/2	0/17, indicated there were			reviewed (The Abuse Protocols); a	nd	
		of the resident to resident			all staff were inserviced, including		
		ny body/skin assessment.			facility management, on the above		
	uncication of all	ij oody/okiii uosoosiiioiit.			policies and procedures prior to		
	The mark of C	Desident Conservation of			working subsequent to 4/21/2017.		
		Resident C was reviewed			See Attachment: Highland Abuse		
	on 4/25/17 at 12	2:32 p.m. The diagnoses			Protocols and Staff Training		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
155458		B. W.	B. WING			04/25/2017	
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (COMPLETION)				
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	included, but we hemiplegia relat dementia, and so orders were obtat the resident to the psychiatric evaluation on 4/19/17. A N completed in the on 4/19/17. A N completed on 1/10 visits at this The quarterly M completed on 2/10 C as being cognussistance with the and personal hygused included a A Care Plan, initial assessed Resides sexually inappropriate of the resident the appropriate.	ere not limited to, ed to cerebral infarction, chizophrenia. Physician ained on 3/3/17 to send he hospital for a liation. No entries were en Nursing Progress Notes aursing Progress Notes are awaited to progress Note, 21/17 at 12:00 p.m. noted at reported Resident C had late area while they were from. He was placed on time. DS assessment, 24/17, assessed Resident litive impaired. requiring ransfers, dressing, eating, giene. Mobility devices wheel chair. tiated on 5/13/16, at C as having exhibited opriately behaviors as			The Administrator is responsible for the training and practical application of the Abuse Protocols and monitoring their effectiveness. Any events, occurrences, patterns and trends that may constitute abuse will be reviewed by the Quality Assurance Performance Improvement Committee on a monthly basis as a permanent agenda item. Monthly QAPI reports including findings and action plans, are submitted to regional operation staff and the corporate risk management team for review.	n 	
	occurrence on 4, the Director of N	Vol all email related to all values and valu					

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	OF CORRECTION OF CORRECTION 155458	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/25/2017			
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	by the previous Administrator. The COTA heard Resident E yelling and came out of the office. Resident E was pulled up to a table in the Dining Room and Resident C was seated next to her with his head turned towards resident E. The COTA immediately removed Resident C away from Resident E. Resident E was taken to the Administrators office. Resident E was crying and stated Resident C had touched her, indicating just below her knee. Resident E was offered reassurance that Resident C can not hurt her nor has he ever actually. A horn was provided to the resident to "blast" for help if ever approached by Resident C again. On 4/25/17 at 8:59 a.m., the Director of Nursing (DON) and the Social Service Designee (SSD) were interviewed. The DON indicated there had been an altercation involving Residents C & E on 4/19/17. Resident C touched Resident C touched Resident E's "private area." On 4/19/17, COTA 1(Certified Occupational Therapy Assistant) heard Resident E yelling "get away from me." Resident C was seated next to Resident E at the time. The COTA immediately wheeled Resident E to the previous Administrator's office. No Incident Report was provided for the 4/19/17 resident to resident touching occurrence.						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	l í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/25/	ETED		
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	and Niece came The family mem the 4/19/17 occu permission as Re Responsible Part the Niece inform reported Resider vaginal area. The arrived at the fac first time Reside touched in the va On 4/25/17 at 11 Consultant was i informed of the a the Police were of Report should ha 4/19/17 when Re was touched by I assessment of Re been completed 4/19/17. Nursing aware of the 4/19 Residents C and On 4/25/17 at 9: provided the the dated 8/5/16, and current policy. I right to be free fi The facility staff	:15 a.m. the Nurse interviewed. She was callegation on 4/21/17 and called. An Incident ave been initiated on esident E reported she Resident C. A physical esident E should have by Nursing staff on a staff should have been 6/17 occurrence between E. 45 a.m., the DON Abuse & Neglect Policy d indicated this was the Each resident had the from abuse and neglect.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	ľ í	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	-	COMPLETED				
		155458				5/2017			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
LUCHUAND MUDOING AND DELIABULITATION OFNITED				9630 FIFTH ST					
HIGHLAND NURSING AND REHABILITATION CENTER			HIGHLAND, IN 46322						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	`	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETION			
TAG	1	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE			
	that may consti								
		of the investigation.							
		vere to assess, care plan,							
		sidents with behaviors that							
		eglect or conflicts. Such							
		d include residents with a							
	history of aggre	essive behaviors and							
	behaviors of er	ntering other resident							
	rooms. The Investigator was to review								
	documentation	and interview witnesses.							
	This Federal ta IN00228094.	g relates to Complaint							
	3.1-28(c)								
	3.1-28(d)								

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