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	04/25/2017

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00228094. Complaint IN00228094 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226. Survey date: April 25, 2017 Facility number: 000367 Provider number: 155458 AIM number: 100289280 Census bed type: SNF/NF: 27 Total: 27 Census payor type: Medicare: 3 Medicaid: 16 Other: 8 Total: 27 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4.26.17	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.

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	04/25/2017

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
F 0225 SS=D Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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	04/25/2017

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
	(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation 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 long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, record review, and interview the facility failed to ensure an allegation of unwanted resident to resident touching was timely and thoroughly investigated related to a male resident touching a female and the failure to ensure the residents were not left	F 0225	At the time of survey, the facility had in place policies and procedures to ensure allegations of abuse, neglect, exploitation, or mistreatment are investigated ; and further potential abuse, neglect, exploitation, or mistreatment are prevented while the investigation is in progress.	05/05/2017

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	04/25/2017

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
	unattended while present together in the Dining Room for 1 of 3 allegations of Abuse reviewed. (Residents C and E) Finding includes: On 4/25/17 at 10:49 a.m., Resident C was propelling his wheel chair into the Main Dining Room and stopped just inside the Dining Room. Resident E was seated at table near the back of the Dining Room. No Staff members were present. The Activity Director entered at 10:50 a.m. and began assisting other residents outside through the front door to plant flowers. Two minutes later, Resident C propelled himself to the window side of the Dining Room across the room from Resident E. Activity staff continued to enter and exit the Dining room. At 11:00 a.m., the Activity Director took Resident C outside for the activity. An Incident/Accident Report, completed on 3/3/17, indicated Resident E was seated at a back table in the Dining Room with her arms and head resting on the table. Resident C approached her and she felt his hand between her legs, including her private area, and went to the Therapy Room to report what had occurred. An Incident/Accident Report, completed on 3/3/17, indicated Resident C		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. During the days following, Social Services followed up with Resident E who voiced no concerns and expressed contentment with the arrangements made to summon help and the use of a stop sign on her door. The care plans for residents C and E were reviewed and updated. To identify other residents who may have been affected by the same deficient practice, residents were interviewed using the Resident Abuse Protocol. Additionally, staff members were interviewed to ensure residents who were not interviewable were not affected. There were no concerns or issues identified as a result of the interviews.	

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	04/25/2017

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
	approached Resident E in the Dining Room and grabbed her in her private peri-area. Resident C was sent to the hospital for a psychiatric evaluation and admission. The record for Resident E was reviewed on 4/25/17 at 8:40 a.m. The diagnoses included, but were not limited to, hemiplegia (limitation in use of an extremity) following cerebral vascular disease, high blood pressure, and osteoarthritis. The admission MDS (Minimum Data Set) assessment, completed on 1/11/17, assessed Resident C's cognition as intact. Assistance with transferring, dressing, and personal hygiene was required. Impairment in range of motion on one upper and one lower extremity was present. A Quarterly Nursing Assessment, completed on 4/11/17, assessed Resident E's vision and hearing as adequate, able to propel herself in a wheel chair, alert orientated to person, place, and time and was friendly and cooperative. Nursing Progress Notes, completed on 4/19/17 and 4/20/17, indicated there were no assessments of the resident to resident altercation or any body/skin assessment.		To ensure the deficient practice does not recur, policies and procedures governing all aspects of Abuse Prevention, Pre-employment Screening, Employee Orientation and Training, Identification (including clinical assessment, care planning, and monitoring residents with behaviors that could lead to abuse), Investigation, Protection of Residents, and Reporting were reviewed (The Abuse Protocols); and all staff were inserviced, including facility management, on the above policies and procedures prior to working subsequent to 4/21/2017. *See Attachment: Highland Abuse Protocols and Staff Training* 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 operations staff and the corporate risk management team for review.	

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	04/25/2017

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
	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.			

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	04/25/2017

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
	A Care Plan, initiated on 5/13/16, assessed Resident C as having exhibited sexually inappropriately behaviors as evidenced by Schizophrenia. Interventions included, encourage resident to express feelings and explain to the resident that behavior is not appropriate. A one page copy of an email related to an occurrence on 4/19/17 was provided by the Director of Nursing (DON). The DON indicated the email had been completed 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. A 4/21/17 Police Report, completed by the local Police Department, indicated the Police Officer spoke with Resident E,			

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	04/25/2017

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
	who reported she was inappropriately touched by Resident C. Staff advised the Officer Resident C was not to be left alone with Resident E at any time. 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 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. The SSD indicated Resident E's Sister and Niece came to the facility on 4/21/17. The family members were informed of the 4/19/17 occurrence with Resident E's permission, as Resident E was her own Responsible Party. A few minutes later, the Niece informed staff Resident E reported Resident C had touched her vaginal area. The Police were called and arrived at the facility. 4/21/17 was the first time Resident E told anyone she was touched in the vaginal area.			

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	04/25/2017

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
	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			

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	04/25/2017

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
	IN00228094. 3.1-27(a)(1)			
F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their			

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	04/25/2017

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
	staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on observation, record review, and interview, the facility to ensure the Abuse and Neglect Policy and protocols were followed related to investigating an allegation of a male resident touching a female resident for 1 of 3 allegations of Abuse reviewed. (Residents C and E) Finding includes: On 4/25/17 at 10:49 a.m., Resident C was propelling his wheel chair into the Main Dining Room and stopped just inside the Dining Room. Resident E was seated at table near the back of the Dining Room. No Staff members were present. The Activity Director entered at 10:50 a.m. and began assisting other resident outside through the front door to plant flowers. Two minutes later Resident C propelled himself to the window side of the Dining Room across the room from Resident E. Activity staff continued to enter and exit the Dining room. At 11:00 a.m. the	F 0226	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

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	04/25/2017

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
	Activity Director took Resident C outside for the activity. The record for Resident E was reviewed on 4/25/17 at 8:40 a.m. The diagnoses included, but were not limited to, hemiplegia (limitation in use of an extremity) following cerebral vascular disease, high blood pressure, and osteoarthritis. The admission MDS (Minimum Data Set) assessment, completed on 1/11/17, assessed Resident C's cognition as intact. Assistance with transferring, dressing, and personal hygiene was required. Impairment in range of motion on one upper and one lower extremity was present. A Quarterly Nursing Assessment, completed on 4/11/17, assessed Resident E's vision and hearing as adequate, able to propel herself in a wheel chair, alert orientated to person, place, and time and was friendly and cooperative. Nursing Progress Notes, completed on 4/19/17 and 4/20/17, indicated there were no assessments of the resident to resident altercation or any body/skin assessment. The record for Resident C was reviewed on 4/25/17 at 12:32 p.m. The diagnoses		During the days following, Social Services followed up with Resident E who voiced no concerns and expressed contentment with the arrangements made to summon help and the use of a stop sign on her door. The care plans for residents C and E were reviewed and updated. To identify other residents who may have been affected by the same deficient practice, residents were interviewed using the Resident Abuse Protocol. Additionally, staff members were interviewed to ensure residents who were not interviewable were not affected. There were no concerns or issues identified as a result of the interviews. To ensure the deficient practice does not recur, policies and procedures governing all aspects of Abuse Prevention, Pre-employment Screening, Employee Orientation and Training, Identification (including clinical assessment, care planning, and monitoring residents with behaviors that could lead to abuse), Investigation, Protection of Residents, and Reporting were reviewed (The Abuse Protocols); and all staff were inserviced, including facility management, on the above policies and procedures prior to working subsequent to 4/21/2017. *See Attachment: Highland Abuse Protocols and Staff Training*	

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	04/25/2017

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
	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 cognitive impaired. requiring assistance with transfers, dressing, eating, and personal hygiene. Mobility devices used included a wheel chair. A Care Plan, initiated on 5/13/16, assessed Resident C as having exhibited sexually inappropriately behaviors as evidenced by Schizophrenia. Interventions included, encourage resident to express feelings and explain to the resident that behavior is not appropriate. A one page copy of an email related to an occurrence on 4/19/17 was provided by the Director of Nursing. The DON indicated the email had been completed		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 operations staff and the corporate risk management team for review.	

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	04/25/2017

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
	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.			

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	04/25/2017

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

The SSD indicated Resident E's Sister and Niece came to the facility on 4/21/17. The family members were informed of the 4/19/17 occurrence with Resident E's permission as Resident E was her own Responsible Party. A few minutes later the Niece informed staff Resident E reported Resident C had touched her vaginal area. The Police were called and arrived at the facility. 4/21/17 was the first time Resident E told anyone she was touched in the vaginal area.

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 9:45 a.m., the DON provided the the Abuse & Neglect Policy dated 8/5/16, and indicated this was the current policy. Each resident had the right to be free from abuse and neglect. The facility staff were to identify occurrences, events, patterns and trends

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	04/25/2017

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
	that may constitute abuse and determination of the investigation. Clinical staff were to assess, care plan, and monitor residents with behaviors that could lead to neglect or conflicts. Such behaviors could include residents with a history of aggressive behaviors and behaviors of entering other resident rooms. The Investigator was to review documentation and interview witnesses. This Federal tag relates to Complaint IN00228094. 3.1-28(c) 3.1-28(d)			