| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155458 |   | IDENTIFICATION NUMBER   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED 06/05/2019  |                 |
|--|---|---|--|--|-----------------|
|  | PROVIDER OR SUPPLIE   | REHABILITATION CENTER   | 9630 FI                                    | ADDRESS, CITY, STATE, ZIP COD<br>FTH ST<br>AND, IN 46322   |                 |
| (X4) ID<br>PREFIX  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL   | ID<br>PREFIX                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI,<br>DEFICIENCY) | (X5) COMPLETION |
| TAG<br>F 0000  | REGULATORY OF   | R LSC IDENTIFYING INFORMATION   | TAG  | DEFICIENCIT  | DATE            |
| Bldg. 00   | IN00294149 and IN  Complaint IN00294  Federal/State deficit   | ne Investigation of Complaints<br>N00297085.<br>4149 - Substantiated.<br>encies related to the<br>d at F698 and F778. | F 0000                                     |  |                 |
|  | Federal/State defici-<br>allegations are cited  | 7085 - Substantiated. encies related to the d at F660 and F846.   |  |  |                 |
|  | Survey dates: June Facility number: 00 Provider number: 1002 AIM number: 1002 Census Bed Type: SNF/NF: 27 Total: 27   | 00367<br>155458   |  |  |                 |
|  | Census Payor Type<br>Medicare: 3<br>Medicaid: 20<br>Other: 4<br>Total: 27<br>These deficiencies<br>accordance with 41 | reflect State Findings cited in   |  |  |                 |
| F 0660<br>SS=D<br>Bldg. 00   | The facility must of  | )   |  |  |                 |

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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PRINTED: 07/08/2019 FORM APPROVED

| ENTERS FOI | R MEDICARE & MEDIC  | CAID SERVICES                 |                  |  | OM               | IB NO. 0938-039 |  |
|------------|---------------------|-------------------------------|------------------|--|------------------|-----------------|--|
|            | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CO | NSTRUCTION   | (X3) DATE SURVEY |                 |  |
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER         | A. BUILDING      | 00   | COMPI            | LETED           |  |
|            |                     | 155458                        | B. WING          |  | 06/05            | /2019           |  |
| NAME OF A  | OD OLUBER OR GURRUM | D.                            | STREET A         | ADDRESS, CITY, STATE, ZIP COD  | <u> </u>         |                 |  |
| NAME OF I  | PROVIDER OR SUPPLIE | R                             | 9630 FI          | FTH ST   |                  |                 |  |
| HIGHLAI    | ND NURSING AND      | REHABILITATION CENTER         | HIGHLA           | AND, IN 46322  |                  |                 |  |
| (X4) ID    | SUMMARY             | STATEMENT OF DEFICIENCIE      | ID               | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)            |  |
| PREFIX     |                     | NCY MUST BE PRECEDED BY FULL  | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATE              | COMPLETION      |  |
| TAG        | 1                   | R LSC IDENTIFYING INFORMATION | TAG              | DEFICIENCY)  |                  | DATE            |  |
|            |                     | esident's discharge goals,    |                  |  |                  |                 |  |
|            | 1                   | f residents to be active      |                  |  |                  |                 |  |
|            | 1 3                 | ctively transition them to    |                  |  |                  |                 |  |
|            | 1 '                 | are, and the reduction of     |                  |  |                  |                 |  |
|            | _                   | preventable readmissions.     |                  |  |                  |                 |  |
|            | _                   | harge planning process        |                  |  |                  |                 |  |
|            |                     | nt with the discharge rights  |                  |  |                  |                 |  |
|            |                     | 5(b) as applicable and-       |                  |  |                  |                 |  |
|            | 1 2 2               | e discharge needs of each     |                  |  |                  |                 |  |
|            |                     | tified and result in the      |                  |  |                  |                 |  |
|            | · ·                 | discharge plan for each       |                  |  |                  |                 |  |
|            | resident.           |                               |                  |  |                  |                 |  |
|            |                     | r re-evaluation of residents  |                  |  |                  |                 |  |
|            |                     | es that require modification  |                  |  |                  |                 |  |
|            |                     | plan. The discharge plan      |                  |  |                  |                 |  |
|            | -                   | , as needed, to reflect these |                  |  |                  |                 |  |
|            | changes.            |                               |                  |  |                  |                 |  |
|            | 1 ' '               | terdisciplinary team, as      |                  |  |                  |                 |  |
|            |                     | 21(b)(2)(ii), in the ongoing  |                  |  |                  |                 |  |
|            | 1 3                 | oping the discharge plan.     |                  |  |                  |                 |  |
|            |                     | egiver/support person         |                  |  |                  |                 |  |
|            | availability and th |                               |                  |  |                  |                 |  |
|            |                     | ort person(s) capacity and    |                  |  |                  |                 |  |
|            |                     | orm required care, as part of |                  |  |                  |                 |  |
|            |                     | of discharge needs.           |                  |  |                  |                 |  |
|            | , <i>'</i>          | sident and resident           |                  |  |                  |                 |  |
|            | 1 .                 | the development of the        |                  |  |                  |                 |  |
|            |                     | nd inform the resident and    |                  |  |                  |                 |  |
|            | 1                   | ntative of the final plan.    |                  |  |                  |                 |  |
|            |                     | resident's goals of care and  |                  |  |                  |                 |  |
|            | treatment prefere   |                               |                  |  |                  |                 |  |
|            |                     | at a resident has been        |                  |  |                  |                 |  |
|            |                     | r interest in receiving       |                  |  |                  |                 |  |
|            |                     | ding returning to the         |                  |  |                  |                 |  |
|            | community.          |                               |                  |  |                  |                 |  |
|            | ` '                 | t indicates an interest in    |                  |  |                  |                 |  |
|            | _                   | ommunity, the facility must   |                  |  |                  |                 |  |
|            | document any ref    | ferrals to local contact      |                  |  |                  |                 |  |

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for this purpose.

agencies or other appropriate entities made

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|                   | MENT OF DEFICIENCIES<br>AN OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155458  | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 06/05/2019 |
|-------------------|--|--|-----------------------------------|---|---------------------------------------|
|                   | OF PROVIDER OR SUPPLIE   | REHABILITATION CENTER  | 9630                              | ET ADDRESS, CITY, STATE, ZIP COD<br>FIFTH ST<br>HLAND, IN 46322   |                                       |
| (X4) ID<br>PREFIX | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL  | ID<br>PREFIX                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)             | IATE COM EETION                       |
| TAG               | (B) Facilities must comprehensive comprehens | data on quality measures, arce use to the extent the The facility must ensure to e care standardized patient, data on quality measures, arce use is relevant and resident's goals of care and nees. In the evaluation of the geneeds and discharge of the evaluation must be the resident or resident's li relevant resident to the facilitate its implementation ecessary delays in the | F 0660                            |   | DATE                                  |
|                   | failed to ensure the included goals, nee and/or Responsible  | discharge planning process ds, and input from the resident Party, related to the lack of a residents the facility had the  | F 0660                            | What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice: |                                       |

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07/08/2019 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/05/2019 155458 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 9630 FIFTH ST HIGHLAND NURSING AND REHABILITATION CENTER HIGHLAND, IN 46322 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE intent to transfer/discharge, for 2 of 4 residents Residents B and C will not be reviewed for transfer/discharge. (Residents B & C) affected by this alleged deficient practice. Resident B Findings Include: and C were not transferred/discharged from the The facility provided a Closure Plan to the Indiana facility on 6/3/19 due to family State Department of Health (ISDH) on 5/24/19. input had not been obtained The Closure plan indicated the facility would yet, even though both residents cease operation by 8/1/19. Ongoing interviews were their own responsible with residents and their legal or other responsible parties and were willing to parties would be held to determine each resident's transfer to sister facility. Family goals, preferences, and needs in planning for the for Residents B and C have services upon discharge/transfer. selected facilities, Resident B and C no longer reside at the During an interview on 6/3/19 at 11:45 a.m., the facility. Administrator indicated Resident B could make How other residents having the his own decisions and would be transferred and potential to be affected by the discharged to one of other Corporate Sister same deficient practice will be Facilities. Resident B had no Power of Attorney identified and what corrective and the family had not been notified. Resident C's action(s) will be taken: family had come in today for a meeting to discuss All residents have the potential to options be affected by this alleged deficient practice. No other A Confidential Interview during the survey residents were affected by this indicated Resident B and Resident C were both alleged deficient practice. All scheduled to be transferred/discharged to another residents and/or family member corporate owned facility on 6/3/19 and the have been provided with alternative transportation had just been canceled. facilities for placement. Each resident and/or family member has During 3 additional Confidential Interviews, selected which facility/facilities persons indicated Resident B was scheduled to be they would like referrals sent to for transferred/discharged to (Corporate Facility approval of placement. name) on 6/3/19 and the transfer/discharge was What measures will be put into canceled after the ISDH surveyor entered the place and what systemic building. The transportation for the changes will be made to transfer/discharge had already been scheduled. ensure that the deficient practice does not recur: During an interview on 6/3/19 at 2:21 p.m., the All residents and/or family

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Social Service Director indicated the

Administrator was handling all the transfers and

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member have been provided with

alternative facilities for placement.

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) M                           | (X2) MULTIPLE CONSTRUCTION |          | (X3) DATE SURVEY   |          |            |
|--|--|----------------------------------|----------------------------|----------|--|----------|------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER            | A. BU                      | JILDING  | 00   | COMPL    | ETED       |
|  |  | 155458                           | B. WI                      | ING      | <u> </u>   | 06/05/   | 2019       |
|  |  | <u> </u>                         |                            | STREET A | ADDRESS, CITY, STATE, ZIP COD  | <u> </u> |            |
| NAME OF I  | PROVIDER OR SUPPLIE  | R                                |                            |          | IFTH ST  |          |            |
| HIGHLAI  | ND NURSING AND   | REHABILITATION CENTER            |                            |          | AND, IN 46322  |          |            |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE         |                            | ID       | PROVIDER'S PLAN OF CORRECTION  |          | (X5)       |
| PREFIX   | (EACH DEFICIEN   | NCY MUST BE PRECEDED BY FULL     |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATF.     | COMPLETION |
| TAG  | REGULATORY O   | R LSC IDENTIFYING INFORMATION    |                            | TAG      | DEFICIENCY)  |          | DATE       |
|  | notifying the famil  | ies. No discharge planning had   |                            |          | Each resident and/or family  |          |            |
|  | been completed ye  | t.                               |                            |          | member has selected which  |          |            |
|  |  |                                  |                            |          | facility/facilities they would like                                    | е        |            |
|  | During an interv   | view on 6/3/19 at 1:05 p.m., the |                            |          | referrals sent to for approval of                                      | of       |            |
|  |  | for Resident B indicated she     |                            |          | placement. The resident and/   | or       |            |
|  |  | cility was closing until 6/2/19  |                            |          | family member is notified as e   | each     |            |
|  |  | a confidential phone call and    |                            |          | resident is accepted for place   | ment     |            |
|  | was informed the r   |                                  |                            |          | at another facility. Family and  | /or      |            |
|  | 1  | ged on 6/3/19 to another         |                            |          | resident then determines the   |          |            |
|  |  | She indicated she did not want   |                            |          | date for discharge to occur. O   |          |            |
|  | the resident that far away and had not approved  |                                  |                            |          | discharge is confirmed, the fa   | -        |            |
|  | the transfer/dischar   | rge.                             |                            |          | will obtain a signature from th  |          |            |
|  |  |                                  |                            |          | resident (if applicable) or fami                                       | -        |            |
|  |  | l was reviewed on 6/3/19 at 1:10 |                            |          | member on the "Notice of Tra   |          |            |
|  |  | s included, but were not limited |                            |          | or Discharge Form". There are  |          |            |
|  |  | pehavioral disturbance and       |                            |          | currently 3 residents residing   | at       |            |
|  | schizophrenia.   |                                  |                            |          | the facility.  |          |            |
|  | 1.0  | D . C                            |                            |          | How the corrective action(s)   |          |            |
|  |  | num Data Set assessment, dated   |                            |          | will be monitored to ensure  |          |            |
|  |  | a moderately impaired cognitive  |                            |          | that the deficient practice wi   | III      |            |
|  | status.  |                                  |                            |          | not recur:   |          |            |
|  | A same mlan datad  | 12/11/17 indicated an immaired   |                            |          | Administrator and/or Designer  |          |            |
|  | cognition status.  | 12/11/17 indicated an impaired   |                            |          | fax the signed "Notice of Tran or Discharge Form" to the location      |          |            |
|  | cognition status.  |                                  |                            |          | Ombudsman within 48 hours  |          |            |
|  | A Psychiatric Prog   | ress Note, dated 5/31/19,        |                            |          | resident discharging. In additi  |          |            |
|  |  | n, severely impaired cognition,  |                            |          | these same forms will be ema   |          |            |
|  |  | and moderately impaired          |                            |          | to the State Ombudsman with  |          |            |
|  | comprehension and  |                                  |                            |          | 48 hours of a resident dischar   |          |            |
|  | The state of the s | . J ···· Q                       |                            |          | The facility will cease operation                                      |          |            |
|  | There were no Disc   | charge Planning meetings,        |                            |          | once placement has been  | •        |            |
|  |  | care planning in regards to the  |                            |          | obtained for all residents and   | all      |            |
|  | resident's transfer/o  |                                  |                            |          | residents have been discharg   |          |            |
|  |  |                                  |                            |          | from the facility. There are   | -        |            |
|  | 2. During an interv  | iew on 6/3/19 at 2:26 p.m.,      |                            |          | currently 3 residents residing   | at       |            |
|  | _  | onsible Party indicated she was  |                            |          | the facility.  |          |            |
|  | _  | y was closing until she had      |                            |          | <b>1</b>   |          |            |
|  |  | ntial phone call during the      |                            |          |  |          |            |
|  |  | r the resident was being         |                            |          |  |          |            |
|  |  | ner Corporate Facility on        |                            |          |  |          |            |

| CENTERS FOR                | R MEDICARE & MEDIC   |   |  |   | ON   | MB NO. 0938-039             |
|----------------------------|--|---|--|---|------|-----------------------------|
|                            | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155458   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION 00  | COMP | E SURVEY<br>LETED<br>5/2019 |
|                            | PROVIDER OR SUPPLIER   | REHABILITATION CENTER   | 9630 FI                                    | ADDRESS, CITY, STATE, ZIP COD<br>FTH ST<br>AND, IN 46322  |      |                             |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE  |
|                            | her about finding an Administrator was transfer/discharge to not approved and oby the Responsible Resident C's record p.m. The diagnoses to, stroke, dementian A Quarterly Minim 5/13/19, indicated a status.  There were no Disciniterviews, and/or content in the resident's transfer/discharge of Party/resident decided transferred/discharge of Party/resident decided tr | notified this morning, the of the Corporate Facility was ther placement was requested Party.  was reviewed on 6/3/19 at 2:05 included, but were not limited at an advisory and schizophrenia.  um Data Set assessment, dated a severely impaired cognition  charge Planning meetings, care planning in regards to the ischarge.  won 6/4/19 at 10:37 a.m., the ctor indicated the discharge recompleted when the actual occurred after the Responsible ded where they would like to |  |   |      |                             |
| F 0698<br>SS=D<br>Bldg. 00 | require dialysis re<br>consistent with pro<br>practice, the comp   | s. ensure that residents who ceive such services, ofessional standards of orehensive person-centered e residents' goals and   |  |   |      |                             |

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Event ID:

PRL911

F 0698

Facility ID: 000367

If continuation sheet

What corrective action(s) will

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07/05/2019

| STATEMEN  | NT OF DEFICIENCIES                                | X1) PROVIDER/SUPPLIER/CLIA       | (X2) M | ULTIPLE CO | ONSTRUCTION   | (X3) DATE SURVEY | _ |
|-----------|---|----------------------------------|--------|------------|---|------------------|---|
| AND PLAN  | OF CORRECTION                                     | IDENTIFICATION NUMBER            | A. BU  | JILDING    | 00  | COMPLETED        |   |
|           |   | 155458                           | B. W   | ING        |   | 06/05/2019       |   |
|           |   |                                  |        | STREET     | ADDRESS, CITY, STATE, ZIP COD                                       |                  | _ |
| NAME OF I | PROVIDER OR SUPPLIE                               | R                                |        |            | IFTH ST   |                  |   |
| нісні лі  | ND NI IDSING AND                                  | REHABILITATION CENTER            |        |            | AND, IN 46322   |                  |   |
| HIGHLA    | ND NORSING AND                                    | TREHABIEITATION CENTER           |        | THOTIL     |   |                  |   |
| (X4) ID   | SUMMARY   | STATEMENT OF DEFICIENCIE         |        | 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 APPROPRIA | COMPLETION       |   |
| TAG       |   | R LSC IDENTIFYING INFORMATION    |        | TAG        | DEFICIENCY)   | DATE             | _ |
|           |   | view and interview, the facility |        |            | be accomplished for those   |                  |   |
|           |   | e and treatment was provided     |        |            | residents found to have bee   | n                |   |
|           | in accordance with professional standards related |                                  |        |            | affected by the deficient   |                  |   |
|           | _   | ot available to transfer a       |        |            | practice:   |                  |   |
|           | 1   | s appointments for 1 of 1        |        |            | Resident E will not be affected                                     | -                |   |
|           | residents reviewed                                | for dialysis. (Resident E)       |        |            | this alleged deficient practice.                                    |                  |   |
|           |   |                                  |        |            | Resident E no longer resides  | at               |   |
|           | Finding includes:                                 |                                  |        |            | the facility.   |                  |   |
|           |   |                                  |        |            | How other residents having  |                  |   |
|           | _   | w on 6/4/19 at 8:52 a.m.,        |        |            | potential to be affected by the                                     |                  |   |
|           |   | ed some of her dialysis          |        |            | same deficient practice will  |                  |   |
|           |   | been canceled due to             |        |            | identified and what corrective                                      | /e               |   |
|           | transportation not c                              | coming to pick her up.           |        |            | action(s) will be taken:  |                  |   |
|           |   |                                  |        |            | All residents have the potentia                                     | al to            |   |
|           |   | d was reviewed on 6/4/19 at      |        |            | be affected by this alleged   |                  |   |
|           |   | noses included, but were not     |        |            | deficient practice. No other  |                  |   |
|           | limited to, stroke a                              | nd kidney failure.               |        |            | residents will be affected by the                                   |                  |   |
|           |   | D . G                            |        |            | alleged deficient practice. No                                      |                  |   |
|           |   | num Data Set assessment, dated   |        |            | residents residing in the facilit                                   | -                |   |
|           | 5/2//19, indicated a                              | an intact cognition status.      |        |            | receive dialysis. Transportation                                    |                  |   |
|           | A   | 2/20/10 :- 1:                    |        |            | be provided to residents who  | have             |   |
|           | _   | 3/29/19 indicated dialysis was   |        |            | dialysis.   | -4-              |   |
|           |   | ventions included to encourage   |        |            | What measures will be put in  | 110              |   |
|           | Wednesday, and Fr                                 | is as scheduled on Monday,       |        |            | place and what systemic   |                  |   |
|           | wednesday, and Fi                                 | iday.                            |        |            | changes will be made to ensure that the deficient                   |                  |   |
|           | A Physician's Orde                                | er, dated 3/27/19, indicated     |        |            |   |                  |   |
|           | · ·   | onday, Wednesday, and            |        |            | practice does not recur:  DON and/or Designee will not              | tify             |   |
|           | Friday.   | onday, wednesday, and            |        |            | Administrator immediately of  | ui y             |   |
|           | Triday.   |                                  |        |            | transportation cancellations.                                       |                  |   |
|           | The Nurses' Progre                                | ess Notes indicated:             |        |            | Administrator will obtain altern                                    | native           |   |
|           |   | .m., the resident was to be      |        |            | transportation. The facility will                                   |                  |   |
|           | _   | ospital for a Permacath          |        |            | cease operations once placer  |                  |   |
|           | (dialysis catheter)                               | •                                |        |            | has been obtained for all resid                                     |                  |   |
|           |   | p.m., the Transportation         |        |            | and all residents have been   |                  |   |
|           |   | d canceled the transportation    |        |            | discharged from the facility. T                                     | here             |   |
|           |   | he morning of 4/3/19.            |        |            | are currently 3 residents resid                                     |                  |   |
|           | _   | 5 a.m., the Dialysis Center was  |        |            | at the facility.  | 9                |   |
|           |   | no transportation available for  |        |            | How the corrective action(s)  |                  |   |
|           |   | rmacath placement and they       |        |            | will be monitored to ensure   |                  |   |

PRL911

| STATEMEN  | IT OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA        | (X2) M | ULTIPLE CO | NSTRUCTION   | (X3) DATE | SURVEY     |
|-----------|-----------------------|-----------------------------------|--------|------------|--|-----------|------------|
| AND PLAN  | OF CORRECTION         | IDENTIFICATION NUMBER             | A. BU  | ЛLDING     | 00   | COMPL     | ETED       |
|           |                       | 155458                            | B. W   | ING        |  | 06/05/    | 2019       |
|           |                       |                                   |        | CTDFFT A   | DDDFGG CITY GTATE ZID COD  |           |            |
| NAME OF P | PROVIDER OR SUPPLIEF  | 8                                 |        |            | ADDRESS, CITY, STATE, ZIP COD  |           |            |
|           | ID NUIDOINIO AND      | DELIABILITATION CENTED            |        |            | FTH ST   |           |            |
| HIGHLAN   | ND NURSING AND        | REHABILITATION CENTER             |        | HIGHLA     | AND, IN 46322  |           |            |
| (X4) ID   | SUMMARY               | STATEMENT OF DEFICIENCIE          |        | ID         | PROVIDER'S PLAN OF CORRECTION  |           | (X5)       |
| PREFIX    | (EACH DEFICIEN        | CY MUST BE PRECEDED BY FULL       |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE        | COMPLETION |
| TAG       | REGULATORY OF         | R LSC IDENTIFYING INFORMATION     |        | TAG        | DEFICIENCY)  |           | DATE       |
|           | recommended to se     | nd the resident to the            |        |            | that the deficient practice wil  | I         |            |
|           | Emergency Room.       | The Physician agreed.             |        |            | not recur:   |           |            |
|           | - On 4/3/19 at 11:35  | 5 a.m. ,, the resident was        |        |            | Administrator and/or Designee  | will      |            |
|           |                       | ılance to the Emergency room      |        |            | notify the Regional Director ea  |           |            |
|           | -                     | lacement and dialysis.            |        |            | time alternative transportation  |           |            |
|           |                       | m., the Transportation            |        |            | provided for dialysis. The facili  |           |            |
|           | _                     | ied to confirm transportation     |        |            | will cease operations once   |           |            |
|           | to dialysis on 4/4/19 | -                                 |        |            | placement has been obtained  | for       |            |
|           | -                     | p.m., multiple calls were made to |        |            | all residents and all residents h  |           |            |
|           |                       | Company and no rides were         |        |            | been discharged from the facil   |           |            |
|           | -                     | the resident to dialysis. The     |        |            | There are currently 3 residents  | •         |            |
|           |                       | s notified that she would miss    |        |            | residing at the facility.  |           |            |
|           | -                     | 9 due to no transportation. The   |        |            | reciaing at the lability.  |           |            |
|           |                       | upset she was not picked up.      |        |            |  |           |            |
|           | No further arrangen   |                                   |        |            |  |           |            |
|           | -                     | m., the Transportation            |        |            |  |           |            |
|           | _                     | he facility and could not         |        |            |  |           |            |
|           |                       | nt to Dialysis. The Physician     |        |            |  |           |            |
|           | -                     | order to send the resident to     |        |            |  |           |            |
|           |                       | om was received. The resident     |        |            |  |           |            |
|           |                       | he Emergency Room for             |        |            |  |           |            |
|           | dialysis at 12:10 p.r |                                   |        |            |  |           |            |
|           |                       | 0 p.m., the resident was not      |        |            |  |           |            |
|           |                       | sis. The Dialysis center was      |        |            |  |           |            |
|           |                       | order to send the resident to     |        |            |  |           |            |
|           | the hospital for dial |                                   |        |            |  |           |            |
|           | *                     | , the resident was sent by        |        |            |  |           |            |
|           |                       |                                   |        |            |  |           |            |
|           | ambulance to hospi    | tai for diarysis.                 |        |            |  |           |            |
|           | During on intervious  | on 6/4/19 at 3:11 p.m., the       |        |            |  |           |            |
|           | _                     | ; indicated they can only go      |        |            |  |           |            |
|           | _                     |                                   |        |            |  |           |            |
|           | -                     | insportation Company for          |        |            |  |           |            |
|           |                       | than on 4/5/19, the other times   |        |            |  |           |            |
|           |                       | Physician was notified and        |        |            |  |           |            |
|           |                       | nt by ambulance to the            |        |            |  |           |            |
|           | Hospital for dialysis | S.                                |        |            |  |           |            |
|           |                       | (/5/10 + 0.401                    |        |            |  |           |            |
|           | -                     | on 6/5/19 at 8:49 a.m., the       |        |            |  |           |            |
|           | -                     | indicated she has tried to        |        |            |  |           |            |
|           | contact several other | er Transport Companies with       |        |            |  |           |            |

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PRINTED: 07/08/2019

| DEPARTMENT<br>CENTERS FOI  |   | FORM APPROVED<br>OMB NO. 0938-039   |                                    |  |  |   |                            |
|----------------------------|---|---|------------------------------------|--|--|---|----------------------------|
| STATEMEN                   | T OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155458   | (X2) MULTI<br>A. BUILDI<br>B. WING | PLE CONSTRUCTION NG 00   | N  | (X3) DATE SURVEY<br>COMPLETED<br>06/05/2019 |                            |
|                            | PROVIDER OR SUPPLIER  | REHABILITATION CENTER   | 96                                 | REET ADDRESS, CIT<br>330 FIFTH ST<br>GHLAND, IN 46   | TY, STATE, ZIP COD   |   |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  no results.   |   | PRE                                | ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRIDENCE)  TAG DEFICIENCY)                            |  | ATE   | (X5)<br>COMPLETION<br>DATE |
| F 0778<br>SS=D<br>Bldg. 00 | 3.1-37(a)  483.50(b)(2)(iii) Assist w/ Transport Radiology §483.50(b)(2)(iii) making transportat from the source of needs assistance Based on record revisited to ensure care in accordance with obtain diagnostic set transportation not at to multiple stress to residents reviewed (Resident E)  Finding includes: During an interview Resident E indicate test today if the Tra | view and interview, the facility e and treatment was provided professional standards to ervices related to vailable to transfer a resident st appointments for 1 of 1 for diagnostic testing.  v on 6/4/19 at 8:52 a.m., d she was going for her stress insport Company showed up. the time this had been the Transport Company had | F 0778                             | be accorresidents affected practice: Resident this alleg Resident the facility How other potential same defidentified action(s) All resident | E will not be affecte<br>led deficient practice<br>E no longer resides   | ed by a at the he be ve                     | 07/05/2019                 |
|                            | p.m. The diagnoses<br>to, stroke and kidne<br>A Quarterly Minim   | was reviewed on 6/4/19 at 1:20 included, but were not limited by failure.  um Data Set assessment, dated in intact cognition status.  |                                    | residents alleged d Transpor residents testing ou What me  | practice. No other swill be affected by the deficient practice. Intation will be provided who have diagnosticutside the facility. Passures will be put indicated by the distribution of th | ed to<br>ic                                 |                            |

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The Nurses' Progress Notes indicated:

On 4/19/19 at 12:10 p.m., the Cardiologist had

scheduled a stress test at the Hospital on 4/23/19

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changes will be made to

ensure that the deficient

practice does not recur:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155458 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | ONSTRUCTION 00 | (X3) DATE SURVEY  COMPLETED  06/05/2019   |  |
|--|--|---|----------------|---|--|
|  | PROVIDER OR SUPPLIER   | REHABILITATION CENTER   | 9630 F         | ADDRESS, CITY, STATE, ZIP COD<br>IFTH ST<br>AND, IN 46322   |  |
| (X4) ID<br>PREFIX  |  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL   | ID<br>PREFIX   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI  | (X5) COMPLETION  |
| F 0846<br>SS=D<br>Bldg. 00   | at 9 a.m. and transp On 4/23/19 at 8:15 at the door for the tran Company was notificanceled due to their vehicle available. On 5/7/19, no time test rescheduled for no transportation was During an interview Director of Nursing through the one Tratransfers.  During an interview Director of Nursing contact several other no results.  This Federal Tag re 3.1-49(j)(3) 483.70(m) Facility Closure §483.70(m) Facility The facility must he | ortation had been obtained.  a.m., the resident was waiting at sfer. The Transportation ied and the transfer was re was no transportation  was documented, the stress 5/7/19 was canceled related to as available.  on 6/4/19 at 3:11 p.m., the indicated they can only go insportation Company for  on 6/5/19 at 8:49 a.m., the indicated she has tried to ransport Companies with  lates to Complaint IN00294149. | TAG            | DON and/or Designee will no Administrator immediately of transportation cancellations. Administrator will obtain alter transportation. The facility will cease operations once placed has been obtained for all resi and all residents have been discharged from the facility. The are currently 3 residents resident the facility. How the corrective action(si will be monitored to ensure that the deficient practice who trecur:  Administrator and/or Designer notify the Regional Director etime alternative transportation provided for dialysis. The faci will cease operations once placement has been obtained all residents and all residents been discharged from the facility. | tify  native I ment dents There ding  ill  e will ach n is lity d for have sility. |
|  | duties and respon<br>the appropriate no<br>facility closure, as<br>this section.<br>Based on observation<br>interview, the facility<br>transfer/discharge re   | sibilities involve providing stices in the event of a required at paragraph (I) of on, record review and ty had an intent to esidents without prior roval from the Responsible  | F 0846         | What corrective action(s) wi<br>be accomplished for those<br>residents found to have bee<br>affected by the deficient<br>practice:  |  |

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| STATEMEN  | NT OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA        | (X2) M | ULTIPLE CO | ONSTRUCTION  | (X3) DATE | SURVEY     |
|-----------|-----------------------|-----------------------------------|--------|------------|--|-----------|------------|
| AND PLAN  | OF CORRECTION         | IDENTIFICATION NUMBER             | A. BU  | JILDING    | 00   | COMPL     | ETED       |
|           |                       | 155458                            | B. W   | ING        |  | 06/05/    | /2019      |
|           |                       | <u> </u>                          |        | CTDEET A   | ADDRESS, CITY, STATE, ZIP COD  |           |            |
| NAME OF I | PROVIDER OR SUPPLIEF  | ₹                                 |        |            | FTH ST   |           |            |
| нісні лі  | ND NI IDSING AND      | REHABILITATION CENTER             |        |            | AND, IN 46322  |           |            |
| HIGHLA    | ND NORSING AND        | REHABILITATION CENTER             |        | TIIGHE     | 4ND, IN 40322  |           |            |
| (X4) ID   | SUMMARY               | STATEMENT OF DEFICIENCIE          |        | ID         | PROVIDER'S PLAN OF CORRECTION  |           | (X5)       |
| PREFIX    | (EACH DEFICIEN        | ICY MUST BE PRECEDED BY FULL      |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE        | COMPLETION |
| TAG       |                       | R LSC IDENTIFYING INFORMATION     |        | TAG        | DEFICIENCY)  |           | DATE       |
|           | _                     | other facility. The facility      |        |            | Residents B and C will not be  |           |            |
|           |                       | discharge goals and needs and     |        |            | affected by this alleged deficie                                       |           |            |
|           |                       | options, including information    |        |            | practice. Resident B and C we  |           |            |
|           |                       | ality of the providers and        |        |            | not transferred/discharged from  |           |            |
|           |                       | n the area. The facility also     |        |            | the facility on 6/3/19 due to far                                      | -         |            |
|           | -                     | Responsible Parties in a timely   |        |            | input had not been obtained y  |           |            |
|           |                       | are of the facility, for 2 of 4   |        |            | even though both residents we  |           |            |
|           |                       | for transfer/discharges.          |        |            | their own responsible parties a  |           |            |
|           | (Residents B & C)     |                                   |        |            | were willing to transfer to siste                                      |           |            |
|           |                       |                                   |        |            | facility. Family for Residents B                                       |           |            |
|           | Findings includes:    |                                   |        |            | and C have selected facilities,  |           |            |
|           |                       |                                   |        |            | Resident B and C no longer re  |           |            |
|           |                       | ed a Closure Plan to the Indiana  |        |            | at the facility. Closure letters v                                     | vere      |            |
|           | -                     | f Health (ISDH) on 5/24/19.       |        |            | sent to families and/or hand   |           |            |
|           |                       | ndicated the facility would       |        |            | delivered to residents who we  |           |            |
|           |                       | 8/1/19. Written notification of   |        |            | their own responsible parties of                                       |           |            |
|           |                       | ure along with the copy of the    |        |            | 5/31/19. All residents who are   |           |            |
|           | _                     | plan would be submitted to        |        |            | their own responsible party we   |           |            |
|           |                       | Representatives or other          |        |            | notified on 5/30 and/or 5/31 in  |           |            |
|           | -                     | s of said residents by June 1,    |        |            | person. Responsible parties/L  | -         |            |
|           |                       | s will be transferred to the most |        |            | Representatives/Guardians we   |           |            |
|           |                       | or other setting, taking into     |        |            | notified via phone or in person  | ı if      |            |
|           |                       | eeds, choice, and best            |        |            | present at the facility on 5/30  |           |            |
|           | interests of each res | sident.                           |        |            | and/or 5/31. No resident was   |           |            |
|           |                       |                                   |        |            | transferred/discharged from th   |           |            |
|           |                       | Family Members on 6/1/19,         |        |            | facility without input from a far                                      | -         |            |
|           |                       | Administrator on 6/4/19 at 9:43   |        |            | member even if the resident w  | as        |            |
|           | _                     | We can ensure immediate           |        |            | their own responsible party.   |           |            |
|           |                       | r family member at another        |        |            | How other residents having t   |           |            |
|           |                       | care family that fits their       |        |            | potential to be affected by th   |           |            |
|           |                       | ver the costs and logistics of    |        |            | same deficient practice will b   |           |            |
|           | moving to (Corpora    | ate Facility)"                    |        |            | identified and what correctiv  | е         |            |
|           | <b>D</b>              | (2/10 + 11 45 3                   |        |            | action(s) will be taken:   |           |            |
|           |                       | v on 6/3/19 at 11:45 a.m., the    |        |            | All residents have the potentia  | II to     |            |
|           |                       | eated Resident B was able to      |        |            | be affected by this alleged  |           |            |
|           |                       | sions and would be transferred    |        |            | deficient practice. No other   |           |            |
|           | _                     | nother Corporate Facility not     |        |            | residents were affected by this  | 3         |            |
|           |                       | nt B had no Power of Attorney     |        |            | alleged deficient practice. All  |           |            |
|           |                       | not been notified. Resident C's   |        |            | residents and/or family member   |           |            |
|           | I tamily had come in  | today for a meeting to discuss    | 1      |            | have been provided with altern   | native    | I          |

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| STATEMEN  | NT OF DEFICIENCIES   | FICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2 |       | (X2) MULTIPLE CONSTRUCTION |   |        | (X3) DATE SURVEY |  |
|-----------|--|--|-------|----------------------------|---|--------|------------------|--|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER                    | A. BU | ILDING                     | 00  | COMPL  | ETED             |  |
|           |  | 155458                                   | B. WI | NG                         |   | 06/05/ | 2019             |  |
|           |  | <u> </u>                                 | -     | STREET /                   | ADDRESS, CITY, STATE, ZIP COD   |        |                  |  |
| NAME OF I | PROVIDER OR SUPPLIEF   | 3  |       |                            | IFTH ST   |        |                  |  |
| HIGHLAI   | ND NURSING AND   | REHABILITATION CENTER                    |       |                            | AND, IN 46322   |        |                  |  |
|           | T  |  |       |                            | ,<br>I  | ı      |                  |  |
| (X4) ID   |  | STATEMENT OF DEFICIENCIE                 |       | ID                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA |        | (X5)             |  |
| PREFIX    | `  | ICY MUST BE PRECEDED BY FULL             |       | PREFIX                     | CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)  | TE     | COMPLETION       |  |
| TAG       |  | R LSC IDENTIFYING INFORMATION            |       | TAG                        |   |        | DATE             |  |
|           | options.   |  |       |                            | facilities for placement. Each  |        |                  |  |
|           | A Confidential Into  | majore during the gurrent                |       |                            | resident and/or family membe  |        |                  |  |
|           |  | erview during the survey                 |       |                            | selected which facility/facilities  |        |                  |  |
|           | indicated Resident B and Resident C were scheduled to be transferred/discharged to another |  |       |                            | they would like referrals sent t  |        |                  |  |
|           |  | _  |       |                            | approval of placement. Closur   |        |                  |  |
|           | _  | cility on 6/3/19 and the                 |       |                            | letters were sent to families ar  |        |                  |  |
|           |  | ust been canceled. The                   |       |                            | hand delivered to residents wh  |        |                  |  |
|           |  | vere located at the Nurses'              |       |                            | were their own responsible pa   |        |                  |  |
|           | Station.   |  |       |                            | on 5/31/19. All residents who   |        |                  |  |
|           |  | 6/2/10 + 12 45                           |       |                            | their own responsible party we  |        |                  |  |
|           |  | 6/3/19 at 12:45 p.m., indicated          |       |                            | notified on 5/30 and/or 5/31 in   |        |                  |  |
|           | _  | mary for Residents B &C were             |       |                            | person. Responsible parties/L   | ٠ ١    |                  |  |
|           |  | on and both indicated the                |       |                            | Representatives/Guardians w   |        |                  |  |
|           |  | g discharged to a Corporate              |       |                            | notified via phone or in person   | וול    |                  |  |
|           | Facility not in the a  | irea.                                    |       |                            | present at the facility on 5/30   |        |                  |  |
|           |  |  |       |                            | and/or 5/31. No resident was  |        |                  |  |
|           | _  | view on 6/3/19 at 12:35 p.m.,            |       |                            | transferred/discharged from th  |        |                  |  |
|           |  | ing on the side of the bed and           |       |                            | facility without input from a far   | -      |                  |  |
|           |  | had came in and told him he              |       |                            | member even if the resident w   | /as    |                  |  |
|           |  | another facility. He indicated           |       |                            | their own responsible party.  |        |                  |  |
|           |  | as leaving "Monday". He                  |       |                            | What measures will be put in  | ito    |                  |  |
|           |  | mily who helped him with                 |       |                            | place and what systemic   |        |                  |  |
|           | making decisions.  |  |       |                            | changes will be made to   |        |                  |  |
|           | D : 20 %1  |  |       |                            | ensure that the deficient   |        |                  |  |
|           | _  | tial Interviews, persons                 |       |                            | practice does not recur:  |        |                  |  |
|           |  | B was scheduled to be                    |       |                            | All residents and/or family   |        |                  |  |
|           | -  | ged to (Corporate Facility               |       |                            | member have been provided v   |        |                  |  |
|           |  | nd the transfer/discharge was            |       |                            | alternative facilities for placem   | nent.  |                  |  |
|           |  | SDH surveyor entered the                 |       |                            | Each resident and/or family   |        |                  |  |
|           | building. The transp   |  |       |                            | member has selected which   |        |                  |  |
|           | transfer/discharge h   | nad already been scheduled.              |       |                            | facility/facilities they would like   |        |                  |  |
|           | <u>.</u>   | (10/10 + 1.05                            |       |                            | referrals sent to for approval o  |        |                  |  |
|           |  | v on 6/3/19 at 1:05 p.m., the            |       |                            | placement. The resident and/o   |        |                  |  |
|           |  | for Resident B indicated she             |       |                            | family member is notified as e  |        |                  |  |
|           |  | cility was closing until 6/2/19          |       |                            | resident is accepted for placer   |        |                  |  |
|           |  | a confidential phone call and            |       |                            | at another facility. Family and/  |        |                  |  |
|           | was informed the re  | •  |       |                            | resident then determines the b  |        |                  |  |
|           | · ·  | ged on 6/3/19 to another                 |       |                            | date for discharge to occur. O  |        |                  |  |
|           |  | not in the area. She indicated           |       |                            | discharge is confirmed, the fac   | -      |                  |  |
|           | I she did not want the   | e resident that far away and             |       |                            | will obtain a signature from the  | _      |                  |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) M   | (X2) MULTIPLE CONSTRUCTION (X3) DATE S |          |  | URVEY   |            |
|--|--|--|--|----------|--|---------|------------|
| AND PLAN   | OF CORRECTION                                | IDENTIFICATION NUMBER  | A. BU                                  | JILDING  | 00   | COMPLE  | ETED       |
|  |  | 155458   | B. Wl                                  | NG       |  | 06/05/2 | 2019       |
|  |  | 1  |  | STREET / | ADDRESS, CITY, STATE, ZIP COD  |         |            |
| NAME OF I  | PROVIDER OR SUPPLIE                          | R  |  |          | FTH ST   |         |            |
| нісні лі   | ND NI IDSING AND                             | REHABILITATION CENTER  |  |          | AND, IN 46322  |         |            |
| HIGHLA   |  | REHABIEITATION CENTER  |  | THOTILA  |  |         |            |
| (X4) ID  | SUMMARY                                      | STATEMENT OF DEFICIENCIE                                     |  | ID       | PROVIDER'S PLAN OF CORRECTION  |         | (X5)       |
| PREFIX   | (EACH DEFICIEN                               | NCY MUST BE PRECEDED BY FULL                                 |  | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE      | COMPLETION |
| TAG  |  | R LSC IDENTIFYING INFORMATION                                |  | TAG      | DEFICIENCY)  |         | DATE       |
|  | had not approved the                         | ne transfer/discharge.                                       |  |          | resident (if applicable) or famil                                      |         |            |
|  |  |  |  |          | member on the "Notice of Trai  |         |            |
|  |  | I was reviewed on 6/3/19 at 1:10                             |  |          | or Discharge Form". There are  |         |            |
|  |  | s included, but were not limited                             |  |          | currently 3 residents residing a                                       | at      |            |
|  | to, dementia with behavioral disturbance and |  |  |          | the facility.  |         |            |
|  | schizophrenia.                               |  |  |          | How the corrective action(s)   |         |            |
|  |  |  |  |          | will be monitored to ensure  |         |            |
|  |  | num Data Set assessment, dated                               |  |          | that the deficient practice wi   | II      |            |
|  | •  | a moderately impaired cognitive                              |  |          | not recur:   |         |            |
|  | status.                                      |  |  |          | Administrator and/or Designed  |         |            |
|  | A 1 1 . 4 . 1 .                              | 10/11/17 : 1:  |  |          | fax the signed "Notice of Trans  |         |            |
|  | _  | 12/11/17 indicated an impaired                               |  |          | or Discharge Form" to the loca   |         |            |
|  | cognition status.                            |  |  |          | Ombudsman within 48 hours  |         |            |
|  | A Davishiatria Draga                         | ross Note dated 5/21/10                                      |  |          | resident discharging. In addition                                      |         |            |
|  |  | ress Note, dated 5/31/19,<br>n, severely impaired cognition, |  |          | these same forms will be ema   |         |            |
|  |  | and moderately impaired                                      |  |          | to the State Ombudsman with  |         |            |
|  | comprehension and                            |  |  |          | 48 hours of a resident dischar   |         |            |
|  | Comprehension and                            | i judgement.   |  |          | The facility will cease operation once placement has been              | 115     |            |
|  | During an interview                          | w on 6/3/19 at 2:21 p.m., the                                |  |          | obtained for all residents and   | اادا    |            |
|  | Social Service Dire                          |  |  |          | residents have been discharge  |         |            |
|  |  | handling all the transfers and                               |  |          | from the facility. There are   |         |            |
|  | notifying the famili                         |  |  |          | currently 3 residents residing   | at      |            |
|  |  |  |  |          | the facility.  |         |            |
|  | During an interview                          | v on 6/3/19 at 3:10 p.m., the                                |  |          |  |         |            |
|  | _  | cated an attempt to call the                                 |  |          |  |         |            |
|  |  | was made today, but she was                                  |  |          |  |         |            |
|  |  | . The letter had been sent out                               |  |          |  |         |            |
|  | to the Responsible                           |  |  |          |  |         |            |
|  |  |  |  |          |  |         |            |
|  | During an interview                          | w on 6/4/19 at 9:20 a.m., the                                |  |          |  |         |            |
|  |  | cated she had spoken to the                                  |  |          |  |         |            |
|  |  | on 6/3/19 in the evening and                                 |  |          |  |         |            |
|  | she approved the tr                          | ansfer to the Corporate                                      |  |          |  |         |            |
|  |  | ther facilities was also emailed                             |  |          |  |         |            |
|  | to her and she wou                           | ld get back with the facility.                               |  |          |  |         |            |
|  |  |  |  |          |  |         |            |
|  | _  | v on 6/4/19 at 9:30 a.m., the                                |  |          |  |         |            |
|  |  | indicated there was no                                       |  |          |  |         |            |
|  | approval to transfer                         | r/discharge the resident to the                              |  |          |  |         |            |

| STATEMENT OF DEFICIENCIES                  |  | X1) PROVIDER/SUPPLIER/CLIA                                    | (X2) MULTIPLE CONSTRUCTION   |                                  | NSTRUCTION                    | (X3) DATE SURVEY |       |  |  |
|--|--|---|--|----------------------------------|-------------------------------|------------------|-------|--|--|
| AND PLAN OF CORRECTION                     |  | IDENTIFICATION NUMBER   | A. BUILDING <u>00</u>  |                                  | 00                            | COMPLETED        |       |  |  |
|  | 155458   |   | B. WING  |                                  |                               | 06/05/           | /2019 |  |  |
| NAME OF P                                  | DOMINED OF CLIRBITIES  |   | ST   | REET A                           | ADDRESS, CITY, STATE, ZIP COD | _                |       |  |  |
| NAME OF PROVIDER OR SUPPLIER               |  |   | 96   | 9630 FIFTH ST                    |                               |                  |       |  |  |
| HIGHLAND NURSING AND REHABILITATION CENTER |  |   | HIGHLAND, IN 46322   |                                  |                               |                  |       |  |  |
| (X4) ID                                    | SUMMARY STATEMENT OF DEFICIENCIE   |   | ID   | ID PROVIDER'S PLAN OF CORRECTION |                               | (X5)             |       |  |  |
| PREFIX                                     | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA |                                  |                               |                  |       |  |  |
| TAG  |  | R LSC IDENTIFYING INFORMATION                                 | TA   | TAG DEFICIENCY)                  |                               |                  | DATE  |  |  |
|  | -  | cility. The Administrator had he was to get back to her about |  |                                  |                               |                  |       |  |  |
|  |  | . The Administrator informed                                  |  |                                  |                               |                  |       |  |  |
|  |  | rate Facility was chosen, the                                 |  |                                  |                               |                  |       |  |  |
|  | -  | to pay for the transportation of                              |  |                                  |                               |                  |       |  |  |
|  | the transfer.  |   |  |                                  |                               |                  |       |  |  |
|  |  |   |  |                                  |                               |                  |       |  |  |
|  | -  | on 6/4/19 at 9:43 a.m., the                                   |  |                                  |                               |                  |       |  |  |
|  |  | ated letters about the closure                                |  |                                  |                               |                  |       |  |  |
|  |  | residents and Responsible                                     |  |                                  |                               |                  |       |  |  |
|  |  | and she had personally called 9 except Resident B's & C's     |  |                                  |                               |                  |       |  |  |
|  | -  | -   |  |                                  |                               |                  |       |  |  |
|  | Responsible Party because it had gotten late. The Responsible Party had not been notified until  |   |  |                                  |                               |                  |       |  |  |
|  | 6/3/19 after the ISDH entered the building.  |   |  |                                  |                               |                  |       |  |  |
|  | Resident B had no Power of Attorney and was  |   |  |                                  |                               |                  |       |  |  |
|  | listed on the face sheet as his own Responsible Party. She was not sure how payment for the transportation to non-Corporate facilities would |   |  |                                  |                               |                  |       |  |  |
|  |  |   |  |                                  |                               |                  |       |  |  |
|  |  |   |  |                                  |                               |                  |       |  |  |
|  | be handled.  |   |  |                                  |                               |                  |       |  |  |
|  | During an interview  | y on 6/4/19 at 11:20 a m the                                  |  |                                  |                               |                  |       |  |  |
|  | During an interview on 6/4/19 at 11:20 a.m., the Administrator indicated the Corporate Facility had  |   |  |                                  |                               |                  |       |  |  |
|  |  | B and the transfer bus was                                    |  |                                  |                               |                  |       |  |  |
|  | available to pick him up. The transfer/discharge   |   |  |                                  |                               |                  |       |  |  |
|  | was to occur after the Responsible Party was   |   |  |                                  |                               |                  |       |  |  |
|  | notified. Resident B was "his own person", but   |   |  |                                  |                               |                  |       |  |  |
|  | the family was still going to be notified.   |   |  |                                  |                               |                  |       |  |  |
|  | 2 During an intervi  | ew on 6/3/19 at 2:26 p.m.,                                    |  |                                  |                               |                  |       |  |  |
|  | -  | nsible Party indicated she was                                |  |                                  |                               |                  |       |  |  |
|  | -  | was closing until she had                                     |  |                                  |                               |                  |       |  |  |
|  |  | tial phone call during the                                    |  |                                  |                               |                  |       |  |  |
|  |  | the resident was being  |  |                                  |                               |                  |       |  |  |
|  | _  | er Corporate Facility outside                                 |  |                                  |                               |                  |       |  |  |
|  |  | v. No one from the facility had                               |  |                                  |                               |                  |       |  |  |
|  |  | finding another facility. The                                 |  |                                  |                               |                  |       |  |  |
|  | Administrator was notified this morning that the transfer/discharge to the Corporate Facility was  |   |  |                                  |                               |                  |       |  |  |
|  |  |   |  |                                  |                               |                  |       |  |  |
|  | not approved and other placement was requested   |   |  |                                  |                               |                  |       |  |  |

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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 <u>00</u>      |  | 00                            | COMPLETED             |      |
| 155458                                     |  | B. WING   |                            |  | 06/05/2019                    |                       |      |
| NAME OF DROWING OR CURRILIED               |  |   | •                          | STREET A   | ADDRESS, CITY, STATE, ZIP COD |                       |      |
| NAME OF PROVIDER OR SUPPLIER               |  |   | 9630 FIFTH ST              |  |                               |                       |      |
| HIGHLAND NURSING AND REHABILITATION CENTER |  |   |                            | HIGHLA   | AND, IN 46322                 |                       |      |
| (X4) ID                                    | SUMMARY STATEMENT OF DEFICIENCIE   |   |                            | IID PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRO |                               | COMPLETION COMPLETION |      |
| PREFIX                                     | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   |                            |  |                               |                       |      |
| TAG  | REGULATORY OR LSC IDENTIFYING INFORMATION  |   |                            | TAG DEFICIENCY)  |                               |                       | DATE |
|  |  | Party. They had a meeting at                    |                            |  |                               |                       |      |
|  |  | Iministrator and wondered, if                   |                            |  |                               |                       |      |
|  | if the resident would  | ed the confidential phone call,                 |                            |  |                               |                       |      |
|  |  |   |                            |  |                               |                       |      |
|  | transferred/discharged to the Corporate Facility without her approval or knowledge.  |   |                            |  |                               |                       |      |
|  | Transaction approval of knowledge.   |   |                            |  |                               |                       |      |
|  | Resident C's record  | was reviewed on 6/3/19 at 2:05                  |                            |  |                               |                       |      |
|  | p.m. The diagnoses included, but were not limited  |   |                            |  |                               |                       |      |
|  | to, stroke, dementia   | , and schizophrenia.                            |                            |  |                               |                       |      |
|  | A O and all Minim  | D. 1. C. 1                                      |                            |  |                               |                       |      |
|  | A Quarterly Minimum Data Set assessment, dated   |   |                            |  |                               |                       |      |
|  | 5/13/19, indicated a severely impaired cognition status.   |   |                            |  |                               |                       |      |
|  | status.  |   |                            |  |                               |                       |      |
|  | A Psychiatric Progress Note, dated 5/21/19, indicated confusion, severely impaired cognition   |   |                            |  |                               |                       |      |
|  |  |   |                            |  |                               |                       |      |
|  | and judgement.   |   |                            |  |                               |                       |      |
|  |  |   |                            |  |                               |                       |      |
|  |  | 3/19 at 2:21 p.m., the Social                   |                            |  |                               |                       |      |
|  |  | dicated the resident was unable                 |                            |  |                               |                       |      |
|  | to make his own de   | to make his own decisions.                      |                            |  |                               |                       |      |
|  | During an interview  | During an interview on 6/4/19 at 9:43 a.m., the |                            |  |                               |                       |      |
|  | Administrator indicated she had not spoken to the Responsible Party on 5/31/19 because it had  |   |                            |  |                               |                       |      |
|  |  |   |                            |  |                               |                       |      |
|  | became so late and the Responsible Party came in   |   |                            |  |                               |                       |      |
|  | on their own on 6/3/19 to discuss the options.   |   |                            |  |                               |                       |      |
|  | Resident C had no Power of Attorney and was his  |   |                            |  |                               |                       |      |
|  | own Responsible Party.   |   |                            |  |                               |                       |      |
|  | During an interview  | on 6/4/19 at 11:20 a.m., the                    |                            |  |                               |                       |      |
|  | _  | rated they were going to                        |                            |  |                               |                       |      |
|  |  | to the Corporate Facility after                 |                            |  |                               |                       |      |
|  |  | the Responsible Party. The                      |                            |  |                               |                       |      |
|  |  | nad not wanted him transferred                  |                            |  |                               |                       |      |
|  | to the Corporate Facility. She (Administrator) had not written the letters sent out, they were done by the Corporation. The facility would pay for the |   |                            |  |                               |                       |      |
|  |  |   |                            |  |                               |                       |      |
|  |  |   |                            |  |                               |                       |      |
|  | transportation to any facility and the list of other   |   |                            |  |                               |                       |      |

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2019 FORM APPROVED OMB NO. 0938-039

|   | F CORRECTION IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION  A. BUILDING 00 |                                | (X3) DATE SURVEY COMPLETED |   |   |            |            |  |
|---|---|--------------------------------|----------------------------|---|---|------------|------------|--|
| THOTEMY   | or condection   | 155458                         | B. WING                    |   |   | 06/05/2019 |            |  |
| NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER |   |                                |                            | STREET ADDRESS, CITY, STATE, ZIP COD<br>9630 FIFTH ST<br>HIGHLAND, IN 46322 |   |            |            |  |
| (X4) ID   | SUMMARY   | STATEMENT OF DEFICIENCIE       |                            | ID  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |            | (X5)       |  |
| PREFIX  | (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL    | 1                          | PREFIX  |   |            | COMPLETION |  |
| TAG   | REGULATORY OR   | LSC IDENTIFYING INFORMATION    |                            | TAG   |   |            | DATE       |  |
|   | facilities in the area letter to families.                                    | was not sent with the closure  |                            |   |   |            |            |  |
|   | This Federal Tag re   | lates to Complaint IN00297085. |                            |   |   |            |            |  |

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