

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

PRINTED: 09/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/12/2017	
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00239420.</p> <p>Complaint IN00239420 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Survey date: September 12, 2017</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 2 Medicaid: 21 Other: 4 Total: 27</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 9/13/17.</p>			F 0000	<p>Preparation and or execution of this plan of correction does not constitute admission or agreement on the part of the Provider to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and or executed solely as required.</p>		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0282 SS=D Bldg. 00	<p>483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to transfer the resident as per the plan of care for 1 of 1 allegations of neglect reviewed. (Resident C)</p> <p>Finding includes:</p> <p>On 9/12/17 at 8:15 a.m., Resident C was observed in her room. The resident was awake and alert.</p> <p>A facility reported Incident Report form, dated 8/29/17, was reviewed. The facility Administrator provided the Incident Report form. The Incident Report indicated Resident C reported that a staff</p>		F 0282	<p>1. Resident C is now being transferred per care plan 2. MDS and DON audited all resident care plans to ensure anyone with a mechanical lift is documented as having two staff members present while providing care. 3. DON in-serviced all nursing staff in regards to having two staff members present while providing care with sit to stand lift and using care cards as a reference. 4. To ensure compliance, The DON or designee will audit care being provided with sit to stand lift daily, during one shift, for four weeks, then weekly, during one shift, for 6 months thereafter. These audits will be addressed in monthly QAPI meeting. If 95% compliance isn't achieved, then</p>		10/12/2017	

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	<p>member had refused to change her that morning. The staff member was identified as CNA 2 who had worked the night shift. A written statement was obtained from RN 2 on 9/3/17. RN 1 indicated CNA 2 approached her in the morning of 8/29/17 and stated she had changed Resident C's brief and buckled the resident in the Sit to Stand lift and shortly after the resident was positioned in the lift, she was incontinent of urine, soiled her brief, and the floor was wet with urine also. Verbal exchanges occurred between Resident C and CNA 2 with the resident becoming angry and crying. RN 1 then approached the resident who stated CNA 2 was rude to her and had not changed her brief.</p> <p>The clinical record for Resident C was reviewed on 9/12/17 at 10:03 a.m. The diagnoses included, but were not limited to, high blood pressure, depressive disorder, epilepsy, and stroke.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 8/16/17, indicated the resident's cognitive skills for decision making were not impaired, extensive assistance of two staff members was required for bed mobility and total assistance of two staff members was required for transfers.</p>				<p>an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review.</p>		

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	<p>A Care Plan, initiated on 1/13/17, indicated Resident C had an ADL (Activities of Daily Living) self care deficit related to limited mobility and range of motion. The Care Plan was last updated with a target goal date of 8/1/2017. Care Plan interventions included, but were not limited to, dependence of (2) staff required with sit to stand device transfers.</p> <p>The current CNA Assignment Sheet was reviewed. Resident C required assistance of two staff members for transfers.</p> <p>During an interview on 9/12/17 at 9:05 a.m., Resident C indicated CNA 2 had assisted her up using a Sit to Stand lift and she began to urinate while being lifted. The CNA told me that my bed and covers "smelled like pee" and indicated she was not going to change her. The CNA informed her that she would have to wait until the next shift came in to be changed.</p> <p>During an interview on 9/12/17 at 11:35 a.m., the facility Administrator indicated Resident C voiced concerns about incontinence care not being provided timely by CNA 2. The resident was transferred with the Sit to Stand transfer lift by CNA 2 on the night shift of 8/29/17. The Administrator indicated he</p>						

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	<p>was not aware there was a Care Plan intervention in place for Resident C to be transferred with (2) staff member.</p> <p>During an interview on 9/12/17 at 11:40 a.m., CNA 1 indicated she was currently assigned to care for Resident C. The resident was to be transferred with the use of a Sit to Stand lift. Two staff members were to be present.</p> <p>During an interview on 9/12/17 at 11:55 a.m., the Director of Nursing indicated she was aware of the 8/29/17 incident reported by Resident C. Upon investigation it was noted CNA 2 transferred the resident herself instead of (2) staff members as per the Care Plan.</p> <p>This Federal tag relates to Complaint IN00239420.</p> <p>3.1-35(g)(2)</p>						