JUN 12 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

(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 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, review of facility policy, the facility failed to ensure insulin was dated when opened and discarded after 28 days. Findings include: On 5/23/12 at 1:30pm the mediation cart for C hall was reviewed. One Novolog Flexpen prefilled Insulin Syringe was found opened and not dated. The Novolog Flexpen was filled by the facility ' s contract pharmacy on 3/21/12. In an interview	F 425	Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with the provisions of Health and Safety Code Section 1280 and C.F.R. 405 1907. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen J Conner | TITLE: NHA | (X6) DATE: 06/06/12

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

(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 425	Continued From page 1 with nurse #3, it was stated that opened insulin should be discarded in 30 days. A review of the facility policy titled Southern Pharmacy Services Medication Suggested Drug Storage and Expiration stated the Novolog Pens should be discarded after 28 days once the pen is opened and stored at room temperature. In an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/23/12 at 3:20pm the DON stated that it was the expectation of the facility to date any insulin when opened and be discarded per facility policy. In an interview on 5/23/2012 at 4:45pm with the Staff Development Coordinator (SDC) the SDC stated that newly hired nursing staff is oriented in the expectation of the facility to date any vial of insulin when opened and discard per facility policy.	F 425	granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process. **F425** The facility utilizes a clinical pharmacy to provide the system and services of licensed pharmacists that are in accordance with state and federal guidelines related to drugs and biologicals, their records, labeling and storage. There are multiple checks and balances established to monitor the various drug and biological systems.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	I. Per procedure the referenced Novolog Flexpen was discarded on 5/23/12. In conducting a QA investigation, not dating the flexpen upon initial use was a result of an isolated human error. II. Quality Review Nurses assigned to each unit re-checked the medication carts to ensure flexpens and other opened vials were dated and within the manufacturer's use by date. No additional undated items were found. III. Licensed staff were reminded of policies and procedures regarding dating of items when opening and the subsequent monitoring procedures.	

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F 431	Continued From page 2 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, review of policy and procedures, the facility failed to ensure that mult-dose vials of medication were dated when opened in 3 of 3 medication refrigerators. Findings include: 1. On 5/23/12 at 12:45pm the medication room on A hall was reviewed. One vial of multi-dose Tuberculin Serum (PPD) used for resident and staff testing was found to be opened and not dated. In an interview with nurse #1, it was stated that any multi-dose vial should be dated when opened. In an interview with the Director of Nursing (DON), the Assistant Director to Nursing (ADON)	F 431	A revised QA tool was implemented for checking medication carts. The third shift nurse on each unit or designee is responsible for auditing the medication carts to ensure items are dated and/or monitor expiration dates. Facility Quality Review Nurses will be responsible to audit each medication cart once weekly to ensure compliance. Licensed Pharmacist will continue to audit medication rooms quarterly as an additional check. IV. DON or Designee will provide a report to the facility Quality Assurance Committee monthly for the next 2 quarters and/or until satisfied that the desired outcomes are achieved. Completion Date: 06/06/12 **F431** The facility utilizes a clinical pharmacy to provide the system and services of licensed pharmacists that are in accordance with state and federal guidelines related to drugs and biologicals, their records, labeling and storage. There are multiple checks and balances to monitor the various drug and biological systems.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

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F 431	Continued From page 3 on 5/23/12 at 3:20pm the DON stated that it was the expectation of the facility to date any multi-dose vial of Tuberculin Serum (PPD) when it is opened and discarded in 30 days. In an interview on 5/23/12 at 4:45pm with the Staff Development Coordinator (SDC) the SDC stated that newly hired nursing staff is oriented in the expectation of the facility to date any multi-dose vial of Tuberculin Serum (PPD) when it is opened and discarded in 30 days. 2. On 5/23/12 at 1:20pm the medication room on D hall was reviewed. One vial of multi-dose Tuberculin Serum (PPD) used for resident and staff testing was found to be opened and not dated. In an interview with nurse #2, it was stated that any multi-dose vial should be dated when opened. In an interview with the Director of Nursing (DON), the Assistant Director to Nursing (ADON) on 5/23/12 at 3:20pm the DON stated that it was the expectation of the facility to date any multi-dose vial of Tuberculin Serum (PPD) when it is opened and discarded in 30 days. In an interview on 5/23/12 at 4:45pm with the Staff Development Coordinator (SDC) the SDC stated that newly hired nursing staff is oriented in the expectation of the facility to date any multi-dose vial of Tuberculin Serum (PPD) when it is opened and discarded in 30 days. 3. On 5/23/12 at 2:00pm the medication room on C hall was reviewed. One vial of multi-dose Tuberculin Serum (PPD) used for resident and staff testing was found to be opened and not dated. In an interview with nurse #3, it was stated that nay multi-dose vial should be dated when	F 431	I. Per procedure the referenced vials of multi-dose Tuberculin serum (PPD) were discarded on 5/23/12. In conducting a QA investigation, only one nurse was involved with the referenced vials. The nurse's omission was accidental. The omission was addressed and Just Culture counseling conducted. II. Quality Review Nurses assigned to each unit re-checked the medication rooms to ensure opened vials were dated and within the manufacturer's use by date. No additional undated items were found. III. Licensed staff were reminded of policies and procedures regarding dating of vials when opening and the subsequent monitoring procedures. The third shift nurse on each unit or designee is responsible for auditing the medication rooms to ensure items are dated and/or monitor expiration dates. Facility Staff Development Coordinator or Designee will be responsible to audit each medication room once weekly to ensure compliance. Licensed Pharmacist will continue to audit medication rooms quarterly as an additional check.	

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F 431	Continued From page 4 opened. In an interview with the Director of Nursing (DON), the Assistant Director to Nursing (ADON) on 5/23/12 at 3:20pm the DON stated that it was the expectation of the facility to date any multi-dose vial of Tuberculin Serum (PPD) when it is opened and discarded in 30 days. In an interview on 5/23/12 at 4:45pm with the Staff Development Coordinator (SDC) the SDC stated that newly hired nursing staff is oriented in the expectation of the facility to date any multi-dose vial of Tuberculin Serum (PPD) when it is opened and discarded in 30 days.	F 431	IV. DoN or Designee will provide a report to the facility Quality Assurance Committee monthly for the next 2 quarters and/or until satisfied that the desired outcomes are achieved. Completion Date: 06/06/12	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35861 FAYETTEVILLE, NC 28301

(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
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/08/2012 the large Med. storage room in the basement near the Maintinance office has two doors that do not close and latch. B. Based on observation on 06/08/2012 the Med. Supply room on A Hall did not close and latch (room is greater than 100 sq. feet). The soiled linen room and the shower room near room 21 failed to latch when closed. 42 CFR 483.70 (a)	K 029	Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with the provisions of Health and Safety Code Section 1280 and C.F.R. 405 1907. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tracy Connor | TITLE: NHA | (X6) DATE: 06/29/12

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	345353	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

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K 038	Continued From page 1 A. Based on observation on 06/08/2012 there was a barrel bolt on the Dining room doors on A Hall. 42 CFR 483.70 (a)	K 038	K029 The provider strives to ensure all doors that should latch to ensure a smoke tight seal do so. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. On 6/9/12, maintenance adjusted the A-Hall soiled linen room, shower room and medical supply doors to ensure latching sufficient to provide a tight seal. On 6/9/12, maintenance adjusted the basement medical storage room doors to ensure latching sufficient to provide a tight seal. Other facility smoke barrier doors were re-checked to ensure positive latching. Adjustments were made where needed. Door inspections for positive latching are a part of the monthly QAA Building Inspection Checklist. The Maintenance Director or designee will check doors for positive latching weekly for the next month and then monthly with the QAA Building Inspection. The Maintenance Director will report to the QAA Committee his findings. Completion Date: 6/9/2012 K038 The provider strives to ensure all exit access is arranged so that exits are accessible at all times. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 06/08/2012 the door to the utility closet near room #8 opened into the corridor less than 180 degrees and did not have a closer on it. 42 CFr 483.70 (a)	K 072		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		

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	345353	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35681 FAYETTEVILLE, NC 28301

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K 076	Continued From page 2 This STANDARD is not met as evidenced by: A. Based on observation on 06/08/2012 there were full and empty 02 cylinders mixed near room 23. 42 CFR 483.70 (a)	K 076	committee audits and meetings, and various quality assurance measures are examples of the many components utilized. The provider believes this standard was being met on 06/08/12. The door referenced was not utilized as or designated as an exit access for the kitchen. There are two other doors that are designated and serve as the exits that were readily accessible on 06/08/12. However, on 6/9/12 maintenance removed the barrel lock from the kitchen door leading into the A-Hall dining room door. Other exit doors were re-checked to ensure that fire exits are readily accessible. Door inspections to ensure ready access to fire exits are a part of the monthly QAA Building Inspection Checklist. The Maintenance Director or designee will check doors for ready access to fire exits weekly for the next month and then monthly with the QAA Building Inspection. The Maintenance Director will report to the QAA Committee his findings. Completion Date: 6/9/12 K 072 The Facility strives to maintain obstruction-free means of egress in case of fire or other emergency. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. On 6/9/12, maintenance installed a closer to the utility closet door near room 8.	

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	345353	A. BUILDING _____ B. BUILDING 02 B. WING _____	06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

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			Other facility doors were re-checked to ensure means of egress were maintained free from impediments. There were no other impediments. Inspections to ensure that doors used for means of egress are free of obstructions or impediments are a part of the monthly QAA Building Inspection Checklist. The Maintenance Director or designee will check doors weekly for the next month and then monthly with the QAA Building Inspection. The Maintenance Director will report to the QAA Committee his findings. Completion Date: 6/9/12 K076 The Facility strives to ensure that all oxygen is stored in a safe and readily accessible manner. Routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. The identified O2 cylinders were appropriately placed in full/empty slots immediately upon identification of the issue on 6/8/12. Other oxygen storage areas were also audited on 6/8/12 to ensure proper oxygen storage. Nursing staff and oxygen supply company delivery driver were provided refresher training regarding proper oxygen storage during the week of 6/25/12 to ensure that they can assist with the monitoring of oxygen storage.	

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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			Inspections to ensure that oxygen cylinders are properly stored are a part of the daily routine rounds made by the maintenance department. In addition to this daily sweep, the Maintenance Director or designee will oxygen storage weekly for the next month and then monthly with the QAA Building Inspection. The Maintenance Director will report to the QAA Committee his findings. Completion Date: 6/27/12	

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