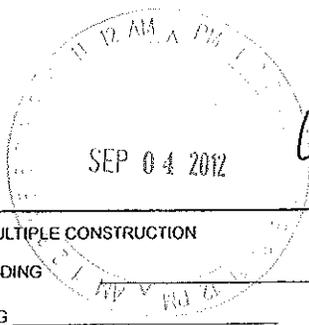


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345315	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/15/2012
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NAME OF PROVIDER OR SUPPLIER  HIGHLAND ACRES NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358
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(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
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F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, and staff interviews, the facility failed to ensure residents were free from excessive dosage of medication for 1 of 2 sampled residents receiving a sedative/hypnotic (resident #1). Findings include:  Resident #1 was admitted to the facility on</p>	F 329	<p>Highland Acres acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Highland Acres response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an-admission that any deficiency is accurate. Further, Highland Acres reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and /or any other administrative or legal proceeding.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>LAICE JHS</i>	TITLE <i>ADMINISTRATOR</i>	(X6) DATE <i>8/29/12</i>
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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.

*R.C. FW LX*

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NAME OF PROVIDER OR SUPPLIER  HIGHLAND ACRES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	
(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 329	Continued From page 1 10/22/11 with multiple diagnoses including Alzheimer's dementia, chronic kidney disease, diabetes, and failure to thrive. Review of the resident's clinical record revealed physician orders dated 12/11/11 for Halcion (triazolam) 0.25mg (milligram) every night at bedtime and Halcion 0.25mg 2 tablets (0.5mg) every night at bedtime as needed for insomnia. Halcion is a sedative/hypnotic indicated for the short term treatment of insomnia, generally 7-10 days.  Review of the MDS (minimum data set) dated 7/10/12 revealed the resident had severely impaired cognition and required extensive to total assistance with her activities of daily living.  The manufacturer's product information read: Precautions - in elderly and/or debilitated patients it is recommended that treatment with Halcion tablets be initiated at 0.125mg to decrease the possibility of development of over-sedation, dizziness, or impaired coordination. Dosage - in geriatric and/or debilitated patients the recommended dosage range is 0.125mg to 0.25mg. Therapy should be initiated at 0.125mg in these groups and the 0.25mg dose should be used only for exceptional patients who do not respond to a trial of the lower dose. A dose of 0.25mg should not be exceeded in these patients.  Review of the resident's March 2012 medication administration record (MAR) revealed she received scheduled Halcion 0.25mg on 3/31/12 at 8PM and an additional 0.5mg dose on 4/1/12 at 1:30AM.  Review of the resident's April 2012 MAR revealed she received scheduled Halcion 0.25mg every	F 329	F329 Resident #1 is no longer in the facility.  On 8/23/12, audits were completed by DON and Medical Director for all MAR's for residents with orders for hypnotics, antianxolytics, antipsychotics and benzodiazepines with no additional issues identified.  ADON or DON will review using an audit tool for unnecessary hypnotics, antianxolytics, antipsychotics and benzodiazepines to ensure proper dosing upon admission or readmission to facility on every resident. The DON or ADON will follow up as appropriate on any potential issue upon identification.  Medical Director and/or attending will review every resident MAR that is ordered hypnotics, antianxolytics, antipsychotics and benzodiazepines for continued need and dosage on each visit q 30 days x 3 months then q60 days thereafter. This will be documented in physician progress notes with action taken as deemed necessary by the Medical Director and/or attending physician.	8/23/2012  8/23/2012  8/16/2012

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NAME OF PROVIDER OR SUPPLIER  HIGHLAND ACRES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28368		
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F 329	<p>Continued From page 2</p> <p>night at bedtime through 4/23/12. The MAR revealed she received additional doses of Halcion 0.5mg on 4/7/12, 4/13/12, 4/14/12, 4/15/12, 4/16/12, 4/18/12, 4/19/12, 4/20/12, 4/22/12, and 4/23/12.</p> <p>Review of the resident's June 2012 MAR revealed she received scheduled Halcion 0.25mg every night at bedtime. The MAR revealed she received additional doses of Halcion 0.5mg on 6/1/12, 6/3/12, and 6/4/12.</p> <p>Record review of the nursing progress notes revealed no documentation that the staff had questioned the Halcion dosage.</p> <p>Record review of the consultant pharmacist' progress notes revealed no request to the attending physician for an assessment of the Halcion dosage.</p> <p>Record review of the physician's progress notes revealed no assessment of the Halcion dosage.</p> <p>In an interview on 8/15/12 at 9:34AM, the resident's evening nurse (nurse #1) stated she administered the resident's bedtime medications. The resident usually did not sleep well and received scheduled Halcion 0.25mg. Nurse #1 stated the resident received an extra dose of Halcion if the first one wasn't effective. The nurse was not sure what the maximum dose of Halcion was and stated "I would have to look it up."</p> <p>In an interview on 8/15/12 at 12:36PM, the Director of Nursing (DON) stated the resident was admitted with orders for Halcion and her insomnia was ongoing. The consultant</p>	F 329	<p>The Pharmacy Regional Clinical Manager re-educated the consultant pharmacist on 8/15/12 regarding the guidance to surveyors at F329 that addresses benzodiazepine utilization.</p> <p>The Pharmacy Regional Clinical Manager visited the facility and audited all active benzodiazepine orders on 8/27/12. The pharmacist provided the facility with a written report of those findings on 8/27/12.</p> <p>The Pharmacy Director of Clinical Services will assist the consultant pharmacist with the September medication regimen review. During that review the Director will query the Consultant Pharmacist to confirm retention of information in-serviced on 8/15/12.</p> <p>The Pharmacy Regional Clinical Manager or Director of Clinical Services will visit the facility monthly in September, October, and November 2012 after completion of the regularly scheduled medication regimen review. The Regional</p>	8/15/2012  8/27/2012  8/27/2012	

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F 329	Continued From page 3 pharmacist reviewed all the residents' medications monthly and made written recommendations to the DON. The DON had not received a recommendation regarding resident #1's Halcion dosage.  In a telephone interview on 8/16/12 at 3:40PM, the attending physician stated resident #1 received Halcion at home prior to her admission in October 2011. She stated the Halcion was started at the facility in December 2011. The physician stated the resident was on the same dosage previously and she did not question it at that time. She acknowledged the dose was above the usual maximum recommended dose. The physician stated "it was an oversight on our part and by the pharmacist."	F 329	Manager or Director will randomly audit 25% of the active residents' records to confirm compliance with F329.  Nurses have been in-serviced by the Staff Facilitator on side effects of hypnotics, antianxiolytics, antipsychotics and benzodiazepines currently used in this facility and the manufactures recommended dose.  Results of all audits will be compiled by the QI Nurse and forwarded to the Executive QI Committee for review monthly x 3 then quarterly	8/29/2012	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist interview, physician interview, and staff interview, the facility failed to ensure the consultant pharmacist identified and reported excessive dosage of	F 428	F428 Resident #1 is no longer in the facility.  On 8/23/12, audits were completed by DON and Medical Director for all MAR's for residents with orders for hypnotics, antianxiolytics, antipsychotics and benzodiazepines with no additional issues identified.	8/23/2012	

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F 428	<p>Continued From page 4</p> <p>medication for 1 of 2 sampled residents receiving a sedative/hypnotic (resident #1). Findings include:</p> <p>Resident #1 was admitted to the facility on 10/22/11 with multiple diagnoses including Alzheimer's dementia, chronic kidney disease, diabetes, and failure to thrive. Review of the resident's clinical record revealed physician orders dated 12/11/11 for Halcion (triazolam) 0.25mg (milligram) every night at bedtime and Halcion 0.25mg 2 tablets (0.5mg) every night at bedtime as needed for insomnia. Halcion is a sedative/hypnotic indicated for the short term treatment of insomnia, generally 7-10 days.</p> <p>Review of the MDS (minimum data set) dated 7/10/12 revealed the resident had severely impaired cognition and required extensive to total assistance with her activities of daily living.</p> <p>The manufacturer's product information read: Precautions - in elderly and/or debilitated patients it is recommended that treatment with Halcion tablets be initiated at 0.125mg to decrease the possibility of development of over-sedation, dizziness, or impaired coordination. Dosage - in geriatric and/or debilitated patients the recommended dosage range is 0.125mg to 0.25mg. Therapy should be initiated at 0.125mg in these groups and the 0.25mg dose should be used only for exceptional patients who do not respond to a trial of the lower dose. A dose of 0.25mg should not be exceeded in these patients.</p> <p>Review of the resident's March 2012 medication administration record (MAR) revealed she received scheduled Halcion 0.25mg on 3/31/12 at</p>	F 428	<p>ADON or DON will review using an audit tool for unnecessary hypnotics, antianxylitics, antipsychotics and benzodiazepines to ensure proper dosing upon admission or readmission to facility on every resident. The DON or ADON will follow up as appropriate on any potential issue upon identification.</p> <p>Medical Director and/or attending will review every resident MAR that is ordered hypnotics, antianxylitics, antipsychotics and benzodiazepines for continued need and dosage on each visit q 30 days x 3 months then q60 days thereafter. This will be documented in physician progress notes with action taken as deemed necessary by the Medical Director and/or attending physician.</p> <p>The Pharmacy Regional Clinical Manager re-educated the consultant pharmacist on 8/15/12 regarding the guidance to surveyors at F329 that addresses benzodiazepine utilization.</p>	8/23/2012  8/16/2012  8/15/2012	

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F 428	<p>Continued From page 5</p> <p>8PM and an additional 0.5mg dose on 4/1/12 at 1:30AM.</p> <p>Review of the resident's April 2012 MAR revealed she received scheduled Halcion 0.25mg every night at bedtime through 4/23/12. The MAR revealed she received additional doses of Halcion 0.5mg on 4/7/12, 4/13/12, 4/14/12, 4/15/12, 4/16/12, 4/18/12, 4/19/12, 4/20/12, 4/22/12, and 4/23/12.</p> <p>Review of the resident's June 2012 MAR revealed she received scheduled Halcion 0.25mg every night at bedtime. The MAR revealed she received additional doses of Halcion 0.5mg on 6/1/12, 6/3/12, and 6/4/12.</p> <p>Record review of the consultant pharmacist' progress notes revealed no recommendations to the attending physician or Director of Nursing (DON) regarding the resident's dosage of Halcion.</p> <p>In a telephone interview on 8/15/12 at 11:55AM, the consultant pharmacist stated he reviewed the resident's medications monthly. The pharmacist stated the usual maximum dose of Halcion in the elderly was 0.25mg. He stated resident #1's dose was "a little higher than the normal dose." He did not consider the dose to be "an exceptional dose or a red flag." The pharmacist did not recall making a recommendation to the attending physician regarding the Halcion dosage. He stated any recommendations would be documented in his progress notes.</p> <p>In an interview on 8/15/12 at 12:36PM, the DON stated the consultant pharmacist reviewed all the</p>	F 428	<p>The Pharmacy Regional Clinical Manager visited the facility and audited all active benzodiazepine orders on 8/27/12. The pharmacist provided the facility with a written report of those findings on 8/27/12.</p> <p>The Pharmacy Director of Clinical Services will assist the consultant pharmacist with the September medication regimen review. During that review the Director will query the Consultant Pharmacist to confirm retention of information in-serviced on 8/15/12.</p> <p>The Pharmacy Regional Clinical Manager or Director of Clinical Services will visit the facility monthly in September, October, and November 2012 after completion of the regularly scheduled medication regimen review. The Regional Manager or Director will randomly</p>	8/27/2012	

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F 428	Continued From page 6 residents' medications monthly, including psychoactive medications. The pharmacist made written recommendations to the DON and she forwarded them to the attending physicians. The DON had not received a recommendation regarding resident #1's Halcion dosage. Her expectation was for the pharmacist to have identified the excessive dose and reported it to her.  In a telephone interview on 8/16/12 at 3:40PM, the attending physician stated the pharmacist reviewed the residents' medications and made recommendations to her if excessive dosages were identified. She stated resident #1's Halcion was started at the facility in December 2011. The resident was on the same dosage previously and she did not question it at that time. She acknowledged the dose was above the usual maximum recommended dose. She had not received a request from the pharmacist to evaluate the dosage. The physician stated "it was an oversight on our part and by the pharmacist."	F 428	audit 25% of the active residents' records to confirm compliance with F329.  Nurses have been in-serviced by the Staff Facilitator on side effects of hypnotics, antianxiolytics, antipsychotics and benzodiazepines currently used in this facility and the manufactures recommended dose.  Results of all audits will be compiled by the QI Nurse and forwarded to the Executive QI Committee for review monthly x 3 then quarterly	8/29/2012	