

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

JUL 08 2013

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/14/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for</p>	F 000	<p>Disclaimer</p> <p>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.</p>	

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

Karen Connor

TITLE
Administrator

(X6) DATE
07/02/13

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 203	<p>Continued From page 1</p> <p>nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record reviews, interviews with staff and resident interview, the facility failed to give a notice of discharge in writing to the resident or legal representative prior to discharge from the facility for 1 of 1 sampled resident who was discharged to a Motel (Resident # 70). The findings include:</p> <p>Resident was admitted to the facility on 3/18/2013 with diagnoses of Anemia, Cerebrovascular Accident (CVA), Systemic Inflammatory Response Syndrome (SIRS), Acute Renal Failure, Dehydration, Nausea, Muscle Weakness and Difficulty Walking. Minimum Data Set (MDS) dated 5/14/2013 indicated the resident's cognition was intact. The resident was independent with bed mobility, transfers, locomotion, personal care, eating and bathing. The MDS also indicated the resident needed limited assistance with toileting use, not steady but able to stabilize without assist. MDS further indicated the resident used walker and wheelchair and MDS further indicated</p>	F 203	<p>It is the facility's normal practice to begin discharge planning at the time of admission, using as a guideline the prior level of function, rehab potential and, most importantly, the desires and goals of the resident and/or their family/responsible party. Resident #70 was alert and oriented with excellent therapy potential. Resident #70's stated discharge goal upon admission through discharge was to receive short-term therapy and then return to the community. Resident stated he was not interested in making arrangements to stay at the facility long-term. The facility was under the impression a 30-day notice of discharge was not required since the resident was indicating a desire to return to the community upon completion of therapy.</p> <p>Identified Resident- Resident #70 was discharged to the location of his choosing on 5/23/13. Also refer to Measures.</p> <p>Potential Residents- Any facility imitated discharge has the potential to affect, therefore the facility Administrator will review any facility initiated discharges for appropriate planning and documentation prior to the discharge. Also refer to Measures.</p> <p>Measures- Since this discharge was a thought to be a voluntary discharge, additional steps were implemented to ensure documentation is completed prior to discharge on all voluntary discharges outlining resident and/or responsible party participation, orientation and planning. Administrator will monitor process.</p>	07/15/13	

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F 203	Continued From page 2 the resident was continent of bladder and always incontinent of bowel. Nurse's note dated 5/23/2013 documented "Resident left facility in wheelchair to private vehicle with staff member." Social services note dated 5/28/2013 documented "Resident was discharged from facility to the Motel on 5/23/2013. Resident is able to make his needs and wants known verbally." During the interview with Administrator on 6/11/2013 at 2:00PM, She reported the resident was told he owe the facility money but was welcomed to stay at the facility. She further added that the resident decided to leave the facility because he did not want to give up his check and comply with the facility to give up his retirement check. The Administrator also added the resident was not given a 30 days discharge notice because the facility did not see the reason to give one. She further added the resident was discharged to the Motel because no family member was willing to take the resident in their home. Review of Resident # 70's medical record revealed the resident did not leave the facility Against Medical Advice (AMA).	F 203	Continued from Page 2 Clinical Consultant re-addressed with Administrator, Director of Nursing, Social Worker, Admissions/Discharge staff and other Clinical Care Team members the notice requirements found at 483.12 during the 07/02/13 Clinical Care Team meeting and then one-on-one with the Social Worker the same day. The Admissions/Discharge staff will track each discharge to determine whether proper notice was given to a resident and/or their family/responsible party. Any notice issues will be brought to the attention of the Administrator. Monitor- Discharge forms/documentation will be audited by the Administrator or her designee once per week for three months. Any notice issues will be discussed in the next Quality Assessment and Assurance (QAA) Committee meeting.		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	F 204	It is the facility's normal practice to begin discharge planning at the time of admission, using as a guideline the prior level of function, rehab potential and, most importantly, the desires and goals of the resident and/or their family/responsible party. Resident #70 was alert and oriented with excellent therapy potential. Resident #70's	07/15/13	

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F 204	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record reviews, interviews with staff and resident interview, the facility failed to provide sufficient preparation to the resident prior to discharge for 1 of 1 sampled resident who was discharged to a motel (Resident # 70). The findings include:</p> <p>Resident # 70 was admitted to the facility on 3/18/2013 with diagnoses of Anemia, Cerebrovascular Accident (CVA), Systemic Inflammatory Response Syndrome (SIRS), Acute Renal Failure, Dehydration, Nausea, Muscle Weakness and Difficulty Walking. The most current Minimum Data Set (MDS) dated 5/14/2013 indicated the resident's cognition was intact. The resident was independent with bed mobility, transfers, locomotion, personal care, eating and bathing. The MDS also indicated the resident needed limited assistance with toileting use, not steady but able to stabilize without assist. MDS further indicated the resident used walker and wheelchair and MDS further indicated the resident was continent of bladder and always incontinent of bowel.</p> <p>Review of the Social Work's note dated 5/3/2013 revealed the Social Worker (SW) spoke with the resident's family members on the phone asking if any of them were willing to take the resident in their home and none was willing to take the resident in their home.</p> <p>Nurse's note dated 5/23/2013 documented "Resident left facility in wheelchair to private vehicle with staff member."</p>	F 204	<p>Continued from Page 3</p> <p>stated discharge goal upon admission through discharge was to receive short-term therapy and then return to the community. Resident stated he was not interested in making arrangements to stay at the facility long-term.</p> <p>Identified Resident- Resident #70 was discharged to a location of his choosing (an extended stay facility) on 5/23/13. Facility Social Worker and Admissions/Discharge Worker attempted to ensure a safe and orderly transition by assisting Resident #70 with obtaining personal income checks from former landlord, providing transportation to the bank to ensure available cash for self-care, provided transportation to the extended stay facility, arranged for meals, and assisted with contacting brother to pick up medications at a nearby pharmacy. On 05/28/13 Social Worker made a follow-up visit at the resident's location where she found him well groomed with no stated needs. On 06/12/13 Admission/Discharge Worker again followed up with family and they stated resident had medications, moved closer to them, had new cell #, and was doing fine. Family had relocated resident to a place closer to their home so that they could assist better with transportation needs. DSS Case Worker was inadvertently not notified of resident's decision until 05/28/13. Also refer to Measures.</p> <p>Potential Residents- All residents and, if they choose, their families will be invited to a planning meeting which typically takes place within 3 days following an admission. The meeting is designed to further develop an</p>		

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F 204	<p>Continued From page 4</p> <p>Social services note dated 5/28/2013 documented "Resident was discharged from facility to the Motel on 5/23/2013. Resident is able to make his needs and wants known verbally."</p> <p>Review of the fax dated 5/29/2013 revealed Adult Protection Agency (APS) was notified about the resident being at the Motel on 5/28/2013.</p> <p>Social worker (SW)'s note dated 5/29/2013 documented "SW spoke with resident on 5/23/2013 in regards to discharged plans. Resident states he refuses to go to a homeless shelter. Resident does not have the income to get an apartment started."</p> <p>SW's note dated 5/29/2013 documented "APS referral was done for resident on 5/28/2013."</p> <p>During the interview with Administrator on 6/11/2013 at 2:00PM, She reported the resident was told he owe the facility money but was welcomed to stay at the facility. She further added that the resident decided to leave the facility because he did not want to give up his check and comply with the facility to give up his retirement check. The Administrator also added the resident was not given a 30 days discharge notice and there was no documentation indicating the resident left the facility Against Medical Advice (AMA). She further added the resident was discharged to the Motel because no family member was willing to take the resident in their home.</p> <p>During the interview with SW on 6/11/2013 at 2:30 PM, she reported the resident was discharged to the motel because his brother</p>	F 204	<p>Continued from Page 4</p> <p>ongoing plan for the resident's stay. The meeting will include discharge planning. Notes on this meeting will be documented by the Admissions/Discharge staff or Social Worker. Discharge planning will attempt to identify any needs or barriers involving a discharge and will be used to communicate with any outside agencies needed to provide a safe and orderly transition (i.e. home health, DME, etc.).</p> <p>Administrator will review discharges for appropriate coordination prior to the discharge. Also refer to Measures.</p> <p>Measures- Since this was believed to be a voluntary discharge, additional steps were implemented to ensure documentation is completed prior to discharge on all voluntary discharges outlining resident and/or responsible party participation, orientation and planning for safe and orderly transition. Administrator will monitor process.</p> <p>Each discharge will be discussed at least one day prior to the discharge to validate if all services are set-up and to identify if there are any additional services for the resident that might need to be addressed.</p> <p>Clinical Consultant re-addressed with Administrator, Director of Nursing, Social Worker, Admissions/Discharge staff and other Clinical Care Team members the sufficient preparation guidelines outlined for 483.12 during the 07/02/13 Clinical Care Team meeting and then one-on-one with the Social Worker.</p>		

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F 204	<p>Continued From page 5</p> <p>refused to live with him. She added that she and the Admission Coordinator drove the resident from the facility to the motel. She further added that she did not check with the brother to find out whether he will pick up the prescription for the resident from the pharmacist since the resident had no transportation. SW also reported that Home health agency paper work was faxed from the facility on 5/28/2013. SW was asked the reason why the home health notification and APS notification were faxed after the resident's discharge on 5/23/2013. The SW answered that she could not answer why there was a delay in faxing the paperwork to home health and Adult Protection Agency (APS). She added she was out of the facility on 5/23/2013 and came back on 5/24/2013.</p> <p>During the interview with the Business Manager on 6/12/2013 at 2:00PM, she reported that she had a discussion with the resident about the payment at the facility. She stated that she was waiting to hear from the Department of Social services in reference to the resident ' s liability money before the resident ' s was discharged to the Motel. Business Manager also reported the resident did not want to give up his money. She further reported that anytime she asked the resident about the liability money, the resident would become upset.</p> <p>During the interview with the Admission Coordinator on 6/12/2013 at 2:15 PM, she reported that she and the SW drove the resident to the Motel on 5/23/2013. She added on their way to the Motel, they stopped at the resident ' s old address to get his check and helped him cash the check.</p>	F 204	<p>Continued from Page 5</p> <p>All residents and, if they choose, their families will be invited to a planning meeting which typically takes place within 3 days following an admission. The meeting is designed to further develop an ongoing plan for the resident's stay. The meeting will include discharge planning. Notes on this meeting will be documented by the Admissions/ Discharge staff or Social Worker. Discharge planning will attempt to identify any needs or barriers involving a discharge and will be used to communicate with any outside agencies needed to ensure a safe and orderly transition (i.e. home health, DME, etc.).</p> <p>If there is a questionable discharge environment, when possible, the facility will utilize agencies that are willing and able to complete home visits.</p> <p>Each discharge will be discussed at least one day prior to the discharge to validate if all services are set-up and to identify if there are any additional services for the resident that might need to be addressed.</p> <p>Monitor- Corrective actions will be monitored through the Administrator's weekly meetings with the Admission/Discharge staff.</p> <p>Discharges will be discussed during the morning Administrative meetings to identify any additional needs.</p> <p>Within one to two days following a resident's discharge home, the interdisciplinary team will call the resident and/or family/responsible</p>		

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F 204	<p>Continued From page 6</p> <p>During the interview with Nurse #1 on 6/12/2013 at 3:00 PM, she reported that she called in the resident ' s medications to the pharmacy on the day he was discharged on 5/23/2013. She added she did not confirm with the resident or the family member to find out as to whether they will be able to pick his medication from the pharmacist.</p> <p>During the phone interview with Pharmacist on 6/13/2013 at 11:00 AM, she stated the medication was called in on 5/23/2013 by the facility ' s staff. The Pharmacist also added the resident ' s prescription was not filled due to lack of financial information from the resident or family member.</p> <p>During the phone interview with APS worker on 6/13/2013 at 11:16 AM, she reported that facility ' s SW notified her about the resident being at the motel on 5/28/2013. She added that she visited the resident on 5/29/2013 and found the resident without medication and had feces in his bed. The APS worker added that the day he visited the resident he had a bad case of diarrhea at the Motel and the staff at the Motel were asking the resident to leave. APS worker further reported that Home Health Agency had not visited the resident as of 5/28/2013. She also stated that her concern was that she did not understand why she was not notified about the resident being discharged to Motel prior to the resident ' s date of discharge of 5/23/2013. APS worker stated that the facility ' s SW was aware that she was the resident ' s case worker as they had communicated regularly before the resident ' s discharge. APS worker also reported currently the resident is residing at a different Motel and she is in the process of finding the resident a permanent</p>	F 204	<p>Continued from Page 6</p> <p>party to inquire if the resident needs assistance with making arrangements for any additional services.</p> <p>Any transition issues identified will be discussed in the next Quality Assessment and Assurance (QAA) Committee meeting.</p>	
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F 204	<p>Continued From page 7 residency.</p> <p>During a phone interview with the resident on 6/13/2013 at 11:39 AM, he reported that he did not want to leave the facility on 5/23/2013. He added that he was forced to leave by the Administrator. The resident also reported that the day he was discharged from the facility he mentioned to the SW that he had no where to go and he did not want to end up in a homeless shelter. He added that he told the SW that he would rather die in the street than go to a homeless shelter. The resident further reported he would have still liked to be at the facility because at the motel, he did not have his medicine or place to move to for a permanent residency. He also reported that the day he was discharged he had no money in his pocket. Currently he reported that he is still looking for a permanent residency as he is still leaving in a Motel. He also reported that the Home Health Agency never came to see him at the Motel because they told him over the phone that they could not see him because he did not have a permanent address. The resident also added he had to go to the hospital to get his medication because he still did not know how to go about paying for his medication at the pharmacy.</p> <p>During a phone interview with Home Health Agency staff on 6/13/2013 at 2: 00PM. She reported that they received the referral from the facility to follow up with the resident at the Motel on 5/28/2013. She further reported that they did not provide home health services to the resident because he did not have a permanent address or plans to move to a permanent address.</p>	F 204		

Division of Health Service Regulation

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D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and staff and resident interview, the facility failed to ensure that there were no medication errors for one of four residents sampled (Res. #1). Findings included:</p> <p>Resident #1 was admitted to the facility in 2006 with diagnoses of vascular dementia, history of Stroke, anxiety, diabetes, depression with psychotic features, and agitation. The admission Minimum Data Set (MDS) noted that Resident #1 was cognitively intact, and independent for activities of daily living (ADLs).</p> <p>On 6/13/2013 at 2:00 PM, in an interview, Resident #1 stated that on May 4, 2013 a nurse came in her room and told the resident that she had her medicine and asked if she were Resident #2, Resident #1 replied that she was not, and gave the nurse her name. The nurse gave her the cup with the medicine. Resident #1 stated that she did not think it was her medicine, but the nurse said it was for her and she took it. Resident #1 stated that later the nurse came in and said I have your medicine, and called Resident #1 by name. Resident #1 told the nurse that she had already given the resident her medicine, and that</p>	D 000	<p><u>Response Preface</u></p> <p>The Provider submits this Plan of Action (PoA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Corrective Action Report (CAR) nor does it constitute an admission that the stated citation is accurate.</p> <p>The Provider submits this PoA 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 if at any time the Provider determines that the 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 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's 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.</p>	
		D 358	<p><u>Action Plan</u></p> <p>It is always the goal this facility to maintain error free medication administration. The facility had in place developed policies, procedures and audits. The facility's Administrator, Resident Care Director, pharmacy consultant, and others provide routine reviews, documentation monitoring, staff training and refresher in-services. Consultant reviews, quality assurance monitoring and record audits are some examples of various components utilized to comply with rules concerning medication administration.</p> <p>Identified Residents- Resident #1 and #2's physician was notified on 05/04/13 of the errors. Physician instructed staff to observe and follow-up if necessary. An error investigation was completed on 06/26/13. There were no negative outcomes as a result of these errors. Nurse #1 is a newly licensed nurse and this was her first nursing job. Nurse #1 was re-trained on 06/14/13 regarding medication administration, preventing medication errors and</p>	07/15/13

Division of Health Service Regulation

Karen J. Connor
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator
TITLE

07/03/14
(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: nh0117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/14/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHC		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
D 358	<p>Continued From page 1</p> <p>the resident thought it was the wrong medicine. The nurse left the room and Resident #1 stated that she had not seen her since then.</p> <p>On 6/13/2013 the Medication Administration Record (MAR) was reviewed and noted that Resident #1 had an order for Clonazepam 0.5 milligram (mg) tablet, take one tablet by mouth twice daily, and scheduled at 9:00 AM, and 9:00 PM. Resident #2 had an order for Clonazepam 0.5mg, take ½ tab=0.25mg by mouth twice daily, scheduled at 9:00 AM and 4:00 PM.</p> <p>A review of the chart for Resident #1 revealed no documentation of any medication error in the nurse notes. A review of the facility medication error report did not have any report for this date or this resident.</p> <p>In an interview on 6/14/2013 at 10:15 AM, Nurse #1 stated that she was the weekend charge nurse on 5/4/13, and the med tech called out, so she took the med cart and started to pass medications. Nurse #1 stated that the MAR did not have pictures of all of the residents, so she had to ask the other nurse who some of the residents were. Nurse #1 stated that Resident #1 came to the cart and asked for her medicine, and Nurse #1 asked her name and Resident #1 stated that she was Resident #2. Nurse#1 gave Resident #1 Resident #2 's medicine and Resident #1 told her that she had given her the wrong medicine. Nurse #1 stated that she told Nurse #2 what had happened, and Nurse #2 called the physician.</p>	D 358	<p>Continued from Page 1</p> <p>medication error documentation policies and procedures. Resident #1 and #2's MAR were reviewed to ensure identifying photos were available. Also see Measures.</p> <p>Potential Residents- RCD completed a photo review and chart review for all remaining residents on the Adult Care Home unit (ALF). Any other errors identified were investigated and documented. Also see Measures.</p> <p>Measures- ALF Medication Techs were in-serviced by senior administrative nursing staff on "Preventing Medication Errors" on 06/28/13. This in-service was the first in a series of educational sessions scheduled for the ALF Medication Techs and/or ALF licensed nurses on medication administration and critical thinking.</p> <p>The SDC or designee will complete a medication pass audit and review the med error policy and procedure with all newly hired medication techs or licensed nurses during their orientation period.</p> <p>All Medication Techs or licensed nurses who make a medication error(s) will receive additional training from the SDC or her designee on "Preventing Medication Errors".</p> <p>Monitor- The SDC, RCD, DoN or pharmacy consultant will conduct at least ten medication administration observation/audits per month with ALF medication staff for the next 3 months. Any identified errors will be addressed and reported to the Quality Assessment and Assurance (QAA) Committee.</p>	

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: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	AUG 01 2013 COMPLETED	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II protected construction and is equipped with a complete automatic sprinkler system. CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD	K000	Preface Highland House Rehabilitation and Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. 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.	
K 025 SS=D	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K025	The provider strives to ensure penetrations in any smoke barrier are sealed with fire rated material to ensure smoke resistance. 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. Smoke barriers are inspected at least quarterly for non-sealed penetrations as part of the Quality Assessment & Assurance (QAA) Program and safety inspections. Corrective Action- Maintenance used fire rated caulk to seal the hole at the sprinkler pipe at the cross corridor doors near room 115 on 07/10/13. Identification of Others- Maintenance re-checked on 07/10/13 the remaining smoke barrier walls for other potential non-sealed penetrations. No additional non-sealed areas were found. The hole around the sprinkler pipe was an isolated oversight. Measures- Maintenance will assess all areas after any outside service/repairs to ensure penetrations are sealed. Monitor- Smoke barrier penetrations are monitored at least quarterly as part of the facility safety inspections conducted by the Maintenance Director or designee.	07/10/13
K 078 SS=E	This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/9/2013 the following item was observed as noncompliant, specific findings include: There were unsealed penetrations in the rated wall above the cross corridor doors near room 115 at the sprinkler piping. CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD		The QAA Committee reviews facility safety inspections monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Karen J. Connor, RHA* TITLE: Administrator (X6) DATE: 07/31/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K076	<p>Continued From page 1</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 10.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/9/2013 the following item was observed as noncompliant, specific findings include: The "A" hall oxygen storage room empty cylinder section leaves the cylinders unsecured condition.</p> <p>CFR#: 42 CFR 483.70 (a)</p>	K076	<p>It has always been the goal and practice of the facility to store full and empty oxygen cylinders per NFPA guidelines. The facility has policies and procedures designed to maintain this practice. The facility has an established Quality Assessment & Assurance (QAA) Program which includes the monitoring of environmental and physical plant areas. Oxygen cylinder storage is evaluated at least monthly as part of the QAA/ Safety inspections.</p> <p>Corrective Action- Maintenance secured the empty E type cylinders (observed in the A-Hall Oxygen Storage Room) on 07/10/13.</p> <p>Identification of Others- Maintenance evaluated remaining oxygen cylinders in the other storage areas on 07/09/13 to ensure they were stored per guidelines. All cylinders were found in a secure condition.</p> <p>Measures- Cylinder storage areas are checked monthly as part of the facility safety inspections conducted by the Maintenance Director or his designee.</p> <p>Monitor- Maintenance Director or his designee will routinely monitor cylinder storage areas to ensure that cylinders are being stored securely.</p> <p>The QAA Committee reviews facility safety inspections monthly.</p>	07/10/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301	

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K 000	INITIAL COMMENTS	K000	Preface Highland House Rehabilitation and Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. 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 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.	
K 052 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 8.8.1.4 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/9/2013 the following item was observed as noncompliant, specific findings include: 1. The pull station for the fire alarm system on the "B" hall is above 48 inches above the finished floor. 2. The "D" Hall mechanical room duct detector	K052	The provider strives to ensure proper functioning of the fire alarm system. The facility has policies and procedures designed to maintain those goals. Routine maintenance checks, safety committee audits and meetings, fire marshal inspections and various quality assurance measures are examples of the many components utilized. The fire alarm system is checked monthly by the maintenance staff and quarterly by an outside contract vendor as part of the Quality Assessment & Assurance (QAA) Program and safety inspections. The oversight on the pull station height has been missed since the construction of B-Hall and the installation of the fire alarm equipment in the 1980s. Corrective Action- Fire system contract vendor is scheduled to relocate the referenced B-Hall pull station to 48 inches above the finished floor by 08/05/13. Maintenance removed the dust and lint from the sampling tube on the D-Hall mechanical room duct detector on 07/09/13. Identification of Others- Maintenance checked remaining pull stations on 07/10/13 to ensure a height within the outlined NFPA height range. All were within placement height. Measures- The remaining duct detectors were inspected for dust or lint by Maintenance on 07/10/13. No other sampling tubes were found dusty.	08/05/13

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

Loree J. Connor, NHA

TITLE
Administrator

(X6) DATE
07/31/13

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

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NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301
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K 052	Continued From page 1 has dust in and lint on the sampling tube holes. CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD	K052	Continued from Page 1 Monitor- Monthly facility safety and quarterly vendor inspections are reviewed monthly by the QAA Committee.	
K 058 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/9/2013 the following item was observed as noncompliant, specific findings include: The "D" hall Lift Room across from the "D" hall nurses station has an sprinkler obstructed by a light fixture. CFR#: 42 CFR 483.70 (a)	K056	The provider strives to ensure proper functioning and testing of the sprinkler system. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety committee audits and meetings, fire marshal inspections, contract vendor inspections and various quality assurance measures are examples of the many components utilized. The sprinkler system is checked monthly by the maintenance staff and quarterly by an outside contract vendor as part of routine safety inspections and the Quality Assessment & Assurance (QAA) Program. Corrective Action- Although the facility had been informed by the sprinkler system installer, Fire Marshal and DHSR inspector that the system was in compliance upon completion in 06/2012, the light fixture on D-Hall was relocated on 07/31/13 by Maintenance to avoid a potential obstruction. Identification of Others- The sprinklers were re-reviewed by Maintenance on 7/31/13 for placement to ensure the standard is being met. No other areas required relocation. Measures- The maintenance staff will continue to check the sprinkler system monthly. A licensed inspector with the outside contractor will inspect the sprinkler system at least quarterly. Monitor- Inspection reports will be reviewed by the Administrator. Areas requiring correction will be reviewed at the next QAA Committee.	07/31/13