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 _____	R 09/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE 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 000}	INITIAL COMMENTS On 09/03/2014, the Division of Health Services Regulation, Nursing Home Licensure and Certification Section conducted a revisit. The facility was found to be in compliance effective 09/03/2014.	{F 000}		
F 431 SS=B	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. 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	F 431		9/8/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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F 431	Continued From page 1 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to discard expired Advair Diskus inhalers in 2 (A hall medication cart #3, A hall medication cart #4) of 8 medication carts observed. The findings included: Manufacturer specifications for Advair Diskus include, "Safely discard Advair Diskus one month after you remove it from the pouch, or after the dose indicator reads '0', whichever comes first." An observation of the A hall medication cart #3 on 9/3/14 at 3:20 pm with Nurse #1 in attendance revealed one used Advair Diskus for Resident # 136 with an open date of 7/29/14. Nurse #1 stated the Advair Diskus inhaler should be discarded 30 days after opening. An observation of the A hall medication cart #4 on 9/3/14 at3:25 pm with Nurse #2 in attendance revealed a used Advair Diskus inhaler with an open date of 7/29/14 for Resident # 68. . During an interview on 9/3/14 at 3:35 pm, Nurse #2 stated it was the responsibility of all of the nurses to remove expired medications from the medication cart. She further stated she was not sure when the Advair Diskus inhaler expired after opening.	F 431	F000 Disclaimer Highland House Rehabilitation & 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	

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F 431	Continued From page 2 In an interview on 9/3/14 at 3:38 pm, the Director of Nursing stated it was her expectation for the nurses to remove expired medications from the medication carts.	F 431	basis. F431 It is the policy and normal practice of this facility to label drugs and biologicals in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable. 1. Corrective Action Identified Resident(s): A) The Advair discus for Resident #136 and Resident #68 was removed from the medication cart immediately by the unit nurse. Date completed: September 3, 2014 2. Corrective Action Potential Other(s): A) For all residents having the potential to be affected by the same practice the corrective action was accomplished by re-checking each medication cart for medication expiration and potential discard dates. This task was completed by Southern Pharmacy□s- Nurse Consultant and Quality Assurance Specialist on September 5, 2014. 3. Systematic Changes:	

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F 431	Continued From page 3	F 431	A) The Pharmacy will now include a label on all medications that have a manufacturer recommended once opened discard date that maybe different from the manufacturer□s labeled expiration date to alert the nurse to include: 1) The date the medication was opened and 2) The applicable discard date utilizing the Pharmacy Expiration Medication listing provided by Southern Pharmacy that is located in each medication cart. Date process was initiated: 9/4/2014. B) A step by step procedure was developed by the Nurse Consultant(s), Pharmacy Nurse Consultant and DON on how to properly label these once opened medications with the date opened and discard date utilizing the Pharmacy Expiration Medication listing provided by Southern Pharmacy. Date process was developed: 9/4/2014. C) Licensed nurses were in-serviced on the procedure noted above in item 3.B. by the Pharmacy□s- Nurse Consultant, DON, Staff Development Coordinator, Administrator and ADON beginning on 09/04/24. 4. Quality Assurance: A) Night shift licensed nurses will continue to check the carts and storage areas for expiration dates on a daily basis. Date completed: September 3, 2014 B) The DON, ADON and/or Nurse	

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F 431	Continued From page 4	F 431	Consultant will check the medication carts weekly for 4 weeks to assure all medications that require a label as noted in Item 3. A. for 1) The pharmacy label, 2) The date the medication was opened (if applicable) and 3) The date the medication is to be discarded (if applicable). A tool was developed to record these results. Medication cart inspections initiated on September 4, 2014 and will be ongoing for 4 weeks. C) The Pharmacy consultant will continue to check the medication carts and storage areas on a monthly basis to assure compliance with the process in Item 3. A. as well as any expired medications that should be discarded. These findings will be reported to the DON at the end of each visit. The DON/or designee will report findings monthly to the Quality Assurance Committee (QAA) for four months to monitor effectiveness of the plan. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken. D) The medication carts and storage areas will also be inspected by the Nurse Consultant during routine visits for 2 months. These findings will be reported to the DON and Administrator at the end of each visit. These findings will be reported to the Quality Assurance Committee (QAA) for four months to monitor effectiveness of the plan. Any	

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F 431	Continued From page 5	F 431	instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken. Complete Date: 09/08/14	