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 _____	C 09/03/2020

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
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 09/02/2020 to 09/03/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 9OQ211	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control and Complaint Investigation Survey was conducted on 09/02/2020 to 09/03/2020. The facility was found not in compliance with 42 CFR §483.80 infection control regulations. Please see event# POQ211. 1 of the 1 complaint allegation was not substantiated.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		9/25/20

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

Electronically Signed | 09/24/2020

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F 880	Continued From page 1 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 2 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) COVID screening guidelines, and the facility's educational screening information the facility failed to implement their screening policy when staff entered the facility without being screened and were not wearing a mask for 2 of 2 staff members (Employee #1 and Employee #2) observed entering the facility. These failures occurred during the COVID-19 pandemic. Findings included: The CMS and CDC guidelines screening form, to be completed before entry, dated 06/01/2020 read: All individuals entering the building MUST be asked the following questions: 1. Has the individual washed their hands or used alcohol-based hand rub on entry? 2. Ask the individual if they have any of the following symptoms? fever, cough, sore throat, new shortness of breath, loss of smell/taste and diarrhea ... Allow entry to building and remind the individual to: Wash their hands or use ABHR throughout their time in the building and not shake hands with, touch or hug individual during their visits ... ...When there are cases in this	F 880	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1.Corrective actions Employees #1 and #2 were re-directed immediately back to screening table and screened. Employees #1 and #2 immediately placed their masks on. The Administrator also disciplined employees #1 and #2 for failing to follow the facility screening process on 9/2/2020. 2.Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: A printout of staff "punch times" from the time clock was generated for 9/2/20220	

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F 880	Continued From page 3 facility or sustained transmission in the community: Implement universal use of facemask for all health care personnel (HCP) while in the facility ..... The education form dated 05/09/2020 read: Attention Staff: We must all do the screening and temp check upon entering the building. Please do the screening accurately ....All employees must wear a facemask while in the building. The attendance record for receiving the information in the in-service dated 05/09/2020 was signed by Employee #1 and Employee #2. On 09/02/2020 at 11:45 AM, a surveyor was in the facility's front lobby being screened by the facility's Screener for the COVID-19 virus. Two people were observed to enter the facility's front entrance and walked past the front lobby's COVID screening station. These individuals walked through the lobby and walked down the hall carrying food. They did not stop to be screened and they were not wearing masks. This Surveyor asked the Screener who the two people were and was told they were employees. The Receptionist got their attention and the employees came back to the screening area to be screened. During an interview with Employee#1 on 09/02/2020 at 11:50 PM, Employee #1 stated they were picking up lunch for the facility and wasn't thinking. There was no excuse for not stopping and getting screened or for not wearing her mask. Employee #1 also stated she was aware of the policy and procedures to be screened before entering the facility and wearing masks in the facility.	F 880	and compared to the screening forms completed to ensure all other employees had been appropriately screened before entering the facility. This was completed by the Nurse Consultant on 9/18/2020. 3.Measures taken and systems changed to prevent repeat of alleged deficient practice. A root cause analysis was completed and based upon those findings the Administrator, Director of Nursing, Infection Preventionist and Consultant made the following changes to the screening process: • Screening station was moved from inside the entrance door to a designated area outside the entrance door when weather permits. During inclement weather, the screening station will be placed just inside the front entry. • The person responsible for completing the screening will now be responsible for entering the code on the door to allow entry only after appropriate screening and appropriate PPE has been donned. • All staff will be re-in serviced by SDC/IP and nursing consultant on the facility screening policy and changes made to the process. • Policy updated to reflect the above changes. • Completion date: 9/25/2020 4.Facility plans to monitor its performance to ensure compliance is maintained. A printout of staff “punch times” from the time clock will be generated for a 24-hour period at least once a week and	

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F 880	Continued From page 4 During an interview with Employee#2 on 09/02/2020 at 11:50 PM, Empoyee#2 stated she was rushing to get the food into the facility because the iced tea had spilled in her car and she wanted to come back and clean it up. Employee#2 also stated she usually stopped to get screened and wear a mask but failed to do so at that time. Employee #2 further stated she was aware of the policy and procedure for stopping and being screened at the door and wearing a mask while in the facility and she should have done so. During an interview with the Screener on 09/02/2020 at 12:57 PM, the Screener stated he has been screening at the facility since May 2020. He was screening this Surveyor and looked up and the two employees were coming in the facility and walked by without being screened. The Receptionist put the code in to let the employees in the front door. The two employees were screened earlier today but not screened at that time. He explained that all visitors and staff stop and wait to be screened but these two employees did not do that on this day and time. During an interview with the Receptionist on 09/02/2020 at 1:15PM, the Receptionist stated the screening policy is for anyone entering the facility. All of the employees know this and usually follow this procedure. The Receptionist stated she put the code in when the two employees came to the door and they were supposed to be screened but walked by screening area and down the hall, came back and then were screened. During an interview with the Administrator on 09/02/2020 at 1:34 PM, the Administrator stated she was made aware that two staff members did	F 880	compared to the screening forms/log by the Nurse Consultant or other designee. This will be completed for 3 weeks. The results will then be recorded on the “punch time” print out. The results will be reviewed and discussed in the monthly QAPI meetings. The QAPI committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 880	Continued From page 5 not stop to be screened and were not wearing their masks. The Administrator specified, all of the staff were educated for mask wear and proper entry screening procedures and they are supposed to wear their masks and stop to be screened at the door before entering the facility.	F 880		