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 05/28/2021

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 Recertification survey was conducted on 05/25/21 through 05/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #G5L211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/25/21 through 05/28/21. Event ID#G5L211. 2 of the 2 complaint allegations were not substantiated.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/25/21

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

Electronically Signed | 06/19/2021

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to place the call bell within reach of 1 of 1 resident sampled for dignity. (Resident #50) Findings included: Resident #50 was admitted 01/13/2012 with diagnoses which included Parkinson's Disease, Seizure disorder or Epilepsy, Bipolar Disorder and Congestive Heart Failure. The quarterly Minimum Data Set (MDS) dated 03/31/2021 had Resident #50 coded as moderately cognitively impaired needed total dependence of staff for personal hygiene and toileting. She needed extensive assistance with dressing and bed mobility. She was also coded as having the ability to express ideas and wants, consider both verbal and non-verbal expression.	F 550	1. The call bell was placed within reach of Resident #50 immediately upon notification by the surveyor by Unit Manager. 5/25/2021 2. An audit was completed to ensure all current residents had their call bell within reach by department managers and unit nurse.5/25/2021 3. All nursing staff were in-serviced by the nurse manager on the proper placement of call bells within the reach of resident□s (in bed or in chair).6/17/2021 All new hires are in-serviced during orientation. Staff unable to attend the in-services will be in-serviced prior to their next scheduled shift by SDC/Unit managers. 4. The Director of Nursing and Unit Managers or his/her designee will observe 5 residents daily for 1 week, then weekly	

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F 550	Continued From page 2 The care plan dated 03/31/2021 had focus' of limited physical mobility r/t weakness. She requires 1/4 rails to HOB for increased independence with bed mobility, has an ADL self-care performance deficit r/t limited mobility, Parkinson's Disease/ Osteoporosis, and Dementia, receives antidepressant medication to stimulate appetite, and she has a history of mental illness and experiences hallucinations at times. During an observation on 05/25/21 at 10:10 AM of Resident #50, she was in bed clean, neat, no s/s of distress noted, observed call bell on floor and wrapped around wheel of the folded wheelchair at the head of the bed. The Unit manager came and unwrapped her call bell and clipped it on her sheet. During an interview with Resident on 05/25/2021 at 10:10 AM, she stated she has not had her call bell in a while and does not remember the last time it was attached to her bed or hooked to her sheets. She also stated she uses her call bell to call for help but she didn't need any assistance at the time. During an interview with Nursing Assistant (NA) #5 on 05/25/2021 at 10:14 AM, NA #5 stated she assisted Resident #50 with breakfast and usually made sure the call bell is within reach, but she forgot to check it. During an interview with the A Hall unit manager on 05/25/21 at 10:17 AM, she stated staff are always supposed to have the call bell at the bed side and within reach of the resident before leaving the resident's rooms.	F 550	for 2 weeks to assure the call bell is properly placed and within reach of the resident. Any deficiencies noted will be addressed immediately and corrective action taken as necessary, which may include disciplinary action. Results will be recorded on an audit tool titled Call Bell Compliance and presented by the A Hall Unit Manager to the Quality Assurance Performance Improvement Committee meetings monthly. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 550	Continued From page 3 During an interview with the Administrator on 05/26/2021 at 4:17 PM, the Administrator stated she expects all call bells to be within reach.	F 550		
F 564 SS=D	Inform Visitation Rghts/Equal Visitation Prvl CFR(s): 483.10(f)(4)(vi)(A)-(D) §483.10(f)(4)(vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, the facility failed to honor scheduled virtual visits to 1 of 1 resident sampled for	F 564	1.Resident #43 refused to participate in a virtual visit with her daughter on 6/1/2021 . The Activities Director made the family	6/21/21

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F 564	Continued From page 4 visitation. (Resident #43) Findings included: Resident #43 was admitted 05/15/2019 with diagnoses including Non-Alzheimer's Dementia, Seizure disorder or epilepsy, Anxiety disorder, and unspecified behavioral syndrom. The annual Minimum Data Set (MDS) dated 03/28/2021 had Resident #43 coded as moderately cognitively impaired needed extensive assistance with activities of daily living (ADL). Resident #43 had a antipsychotic and antidepressant 7 days during the look back period. The care plan dated 04/18/2021 had focus' of having a behavior problem, randomly making loud screaming noises daily and when approached is unable to give a cause, received antidepressant medication daily and is at risk for side effects, used antipsychotic medication and is at risk for side effects, and showed no interest in participating in daily task or activities. The May 2021 Medication Administration Record (MAR) had resident #43 medications that included Quetiapine (SEROQUEL) tab 50 mg one tab every morning via g-tube. Mirtazapine (REMERON) 7.5 mg. During an interview with Family member #1 on 05/26/2021 at 10:42 AM, Family member #1 stated she had not had any virtual visits in several weeks and she was available, waited, and had not heard from the facility concerning the visits. The visits were supposed to be twice a week on Tuesdays and Thursdays. During an interview with the Activity Director (AD)	F 564	aware via phone on 6/1/2021. The next scheduled visit for resident #43 was re-scheduled for 6/2/2021. Resident participated 2. The Activities Director and Receptionist audited the visitation schedules for the last 30 days to identify any residents that may have not attended their scheduled visitation or virtual call. Documentation for any resident that declined their scheduled visitation or virtual call is included in the resident's chart by the Activity Director. 6/14/2021 3. The Activities Director will document any resident refusals to participate in scheduled visitation and will notify the resident's responsible party and document in resident's chart. The Activities Director and visitor assistants were re-educated by the Administrator regarding the need to document if a resident declines a scheduled visitation or virtual call and to notify the resident's responsible party. Staff unable to attend the in-service will be re-educated prior to their next scheduled shift. 6/1-6/21/2021 4. The Activity Director and receptionist will audit the visitation schedules weekly for 4 weeks to determine if there is documentation and responsible party notification for any resident that declined their scheduled visitation or virtual call. Audit results will be documented on the audit tool titled Visitation Audit. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The	

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F 564	Continued From page 5 on 05/27/2021 at 10:13 AM, the AD stated she was aware of the missed virtual visits for Resident #43 because it was becoming difficult to have them due to her refusals and the transition to onsite visits. Her virtual visits were Tuesdays and Thursdays. The AD also stated she did not call the family to let her know her visits would not happen on the scheduled days or document the reason she did not have them. During an interview with the Administrator on 05/26/2021 at 4:17 PM, the Administrator stated she expects all scheduled visits to be honored for residents.	F 564	Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		6/25/21

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F 623	Continued From page 6	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 7 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the resident and/or resident representative a written notification for the reason for transfer to the hospital for 3 of 3 residents reviewed for hospitalization. (Resident	F 623	1. A copy of the notice of hospital transfer was mailed to the resident representative of Residents # #67, #76, and #96 by D/C Planner on 6/15/2021. 2. Residents transferred to the hospital	

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HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

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F 623	Continued From page 8 #67, Resident #76, and Resident #96). Findings included: 1. Resident #67 was admitted to the facility on 4/09/21 with the following diagnoses: stroke, atrial fibrillation, coronary artery disease, history of falling, muscle weakness, chronic obstructive pulmonary disease, and nontraumatic intercranial hemorrhage. A review of the most recent Admission MDS (Minimum Data Set) dated 4/20/21 revealed Resident #67 was severely cognitively impaired. Review of Resident #67's chart revealed a physician's order dated 4/26/21 to send to hospital for evaluation for Altered Mental Status(AMS). No written notice of transfer was documented to have been provided to the resident or resident representative. An interview was conducted with the Social Services Director on 5/28/21 at 9:10 AM, she stated that she was not aware that a notice needed to be given to the resident or resident representative when transferring to the hospital. The Social Services Director reported she was not sure of the person who was responsible to send the letter. The Social Services Director stated she sends a report to the Ombudsman regarding transfers and discharge. During an interview with Business Office Manager on 5/28/21 at 9:20 AM, she stated she did not provide a written notification for the reason for transfer to the resident or the resident ' s representative. She stated maybe the Admission Coordinator was responsible.	F 623	within the last 60 days are being reviewed to determine if the hospital transfer notice was provided to the resident/representative by D/C Planner. 6/25/2021 3. The staff nurse completing the hospital transfer will notify the D/C Planner who will then assure the Transfer Notice is given to the resident/representative either in person or via mail. The date and delivery method will be notated on the facility copy of the transfer notice which will be retained in the D/C Planner's office. Discharge Planner and Social Worker were educated on this process by Administrator and/or designee. Staff unable to attend the in-service will be educated prior to their next scheduled shift. 6/7/2021 4. The Discharge Planner will review all hospital transfers to assure a copy of transfer notice was provided to the resident/representative at the time of the transfer or as soon as practicable. This will be completed for 30 days. The results of the review will be recorded on a tool titled "Hospital Transfer Notices". Results will be presented at the Quality Assurance Performance Improvement Committee meetings monthly. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

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F 623	Continued From page 9	F 623		

During an interview with the Admission Coordinator on 5/28/21 at 10:40 AM, she stated she did not send a letter with the resident and she had not sent a letter to the resident's family member. She explained she had never been assigned that task.

An interview with the Director of Nursing on 5/28/21 at 1:23 PM, she stated the nursing staff makes a note in the chart and calls the resident's representative about the transfer, but they do not provide any written notification to the resident or the resident's representative.

During an interview with the Administrator on 5/28/21 at 11:43 AM, she stated the facility had not sent notices to the resident or resident representative when the resident transferred to the hospital, but this would be corrected immediately. She expressed since COVID happened, the facility dropped the ball.

2. Resident #76 was admitted to the facility on 12/10/20 with the following diagnoses: pericarditis, pneumonia, hyperlipidemia, Alzheimer's Disease, depression, Bipolar Disease, psychotic disorder, asthma, adult failure to thrive, benign prostatic hyperplasia and cranial hemorrhage.

A review of the most recent quarterly MDS (Minimum Data Set) dated 5/14/21 revealed Resident #67 was severely cognitively impaired.

Review of Resident #76's chart revealed Resident #76 was sent to the hospital on 4/25/21 was to evaluate and treat. On 4/30/21 Resident #76 was sent to hospital via emergency services due to a fall. There were no written notices of transfer

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F 623	Continued From page 10	F 623		

documented to have been provided to the resident or resident representative.

An interview was conducted with the Social Services Director on 5/28/21 at 9:10 AM, she stated that she was not aware that a notice needed to be given to the resident or resident representative when transferring to the hospital. The Social Services Director reported she was not sure of the person who was responsible to send the letter. The Social Services Director stated she sends a report to the Ombudsman regarding transfers and discharge.

During an interview with Business Office Manager on 5/28/21 at 9:20 AM, she stated she did not provide a written notification for the reason for transfer to the resident or the resident's representative. She stated maybe the admission coordinator was responsible.

During an interview with the Admission Coordinator on 5/28/21 at 10:40 AM, she stated she did not send a letter with the resident and she had not sent a letter to the resident's family member. She explained she had never been assigned that task.

An interview with the Director of Nursing on 5/28/21 at 1:23 PM, she stated the nursing staff makes a note in the chart and calls the resident's representative about the transfer, but they do not provide any written notification to the resident or the resident's representative.

During an interview with the Administrator on 5/28/21 at 11:43 AM, she stated the facility had not sent notices to the resident or resident representative when the resident transferred to

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F 623	Continued From page 11 the hospital, but this would be corrected immediately. She expressed since COVID happened, the facility dropped the ball. 3. Resident #96 was admitted to the facility on 11/1/15. The resident diagnoses included idiopathic peripheral autonomic neuropathy, schizoaffective disorders, and chronic pain. The quarterly Minimum Data Set (MDS) dated 1/13/21 indicated Resident #96 was cognitively intact. A physician order dated 3/31/21 indicated send to the Emergency Department (ED) for evaluation and treatment due to complaint of abdominal pain. Progress note dated 3/31/21 revealed Resident # 96 was transported to the ED by emergency services on 3/31/21 at 8:13 PM. There was no documentation of written notice of transfer provided to the resident or resident representative (RR). During an interview on 5/26/21 at 5:12 PM, the Social Service Director indicated she was had not send a written notice of transfer to RR since she was not aware that a written notice was to be provided for discharge to the hospital. During an interview on 5/27/21 at 10:34 PM with Administrator, she indicated a written notice should have been send to RR and she was going to look into it.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		6/25/21

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	345353	A. BUILDING _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 12 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide information about the Bed Hold Policy upon transfer to the hospital for 2 (Resident #67 and Resident #76) of 2 residents reviewed for hospitalization. Findings included: 1. Resident #67 was admitted to the facility on 4/09/21 with diagnoses including stroke, atrial fibrillation, and coronary artery disease.	F 625	1. A copy of the facility bed hold notice was mailed to the resident representative of Residents #67 and #76 by the business office on 6/15/2021. 2. Residents transferred to the hospital or on therapeutic leave within the last 90 days were reviewed to determine if the bed hold notice was provided at the time of the transfer/therapeutic leave by the business office. 6/25/2021 3. The facility will continue to issue the	

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F 625	Continued From page 13 Review of the most recent Admission Minimum Data Set (MDS) 4/20/21 revealed Resident #67 was severely cognitively impaired and required extensive assistance in most areas of activities of daily living. Review of physician's order dated 4/26/21 revealed Resident #67 was sent to the hospital for evaluation for Altered Mental Status. Interview on 5/28/21 at 9:10 AM, the Social Services Director stated she did not notify the resident or Responsible Party (RP) of the Bed Hold Policy when Resident #67 was transferred to the hospital. The Social Services Director reported she was not sure of the person who was responsible for notification of the bed hold. The Social Services Director stated she sends a report to the Ombudsman regarding transfers and discharges. Interview with Business Office Manager on 5/28/21 at 9:20 AM, she stated she did not provide a bed hold notification to the resident or the resident's representative. She stated maybe the Admission Coordinator was responsible. Interview with the Admission Coordinator on 5/28/21 at 10:40 AM, she stated she did not provide a bed hold notice to the resident or the resident's Responsible Party. She explained she provides bed hold information on admission, but she does not provide additional information when the resident is sent to the hospital. Interview with the Director of Nursing on 5/28/21 at 1:23 PM, she stated the nursing staff makes a note in the chart and calls the resident's representative about the transfer, but they do not	F 625	bed hold notice/policy upon admission. The second notice will be provided to the resident and if applicable the resident representative at the time of transfer, or in cases of emergency transfer, within 24 hours by the business office. The date and delivery method will be notated on the facility copy of the notice which will be retained in the resident's financial file. The business office and admissions coordinator were educated by the administrator on the process for providing the bed hold policy on admission and at the time of transfer. 6/15/2021 4. The business office will review all hospital transfers and therapeutic leaves to assure a copy of the written bed hold notice was provided to the resident and/or resident representative at the time of the transfer or in cases of emergency transfers within 24 hours. This will be completed for 30 days. The results of the review will be recorded on a tool titled "Notice of Bed Hold". Results will be presented at the Quality Assurance Performance Improvement Committee meetings monthly. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 625	Continued From page 14	F 625		

provide any written notification to the resident or the resident's representative about the bed hold policy.

During an interview with the Administrator on 5/28/21 at 11:43 AM, she stated the facility had not provided the bed hold policy notification to the resident or resident representative when the resident transferred to the hospital, but this would be corrected immediately.

2. Resident #76 was admitted to the facility on 12/10/20 with diagnoses including pericarditis and pneumonia.

A review of the most recent quarterly Minimum Data Set (MDS) dated 5/14/21 revealed Resident #76 was severely cognitively impaired and was totally dependent for most of his activities of daily living.

Review of Resident #76's chart revealed Resident #76 was sent to the hospital on 4/25/21 was to evaluate and treat. On 4/30/21 Resident #76 was sent to the hospital via emergency services due to a fall.

Interview on 5/28/21 at 9:10 AM, the Social Services Director stated she did not notify the resident or Responsible Party (RP) of the Bed Hold Policy when Resident #76 was transferred to the hospital. The Social Services Director reported she was not sure of the person who was responsible for notification of the bed hold. The Social Services Director stated she sends a report to the Ombudsman regarding transfers and discharges.

Interview with Business Office Manager on

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F 625	Continued From page 15 5/28/21 at 9:20 AM, she stated she did not provide a bed hold notification to the resident or the resident's representative. She stated maybe the Admission Coordinator was responsible. Interview with the Admission Coordinator on 5/28/21 at 10:40 AM, she stated she did not provide a bed hold notice to the resident or the resident's Responsible Party. She explained she provides bed hold information on admission, but she does not provide additional information when the resident is sent to the hospital. Interview with the Director of Nursing on 5/28/21 at 1:23 PM, she stated the nursing staff makes a note in the chart and calls the resident's representative about the transfer, but they do not provide any written notification to the resident or the resident's representative about the bed hold policy. During an interview with the Administrator on 5/28/21 at 11:43 AM, she stated the facility had not provided the bed hold policy notification to the resident or resident representative when the resident transferred to the hospital, but this would be corrected immediately.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS, a tool used for resident	F 641	1. Resident # 91 – The admission MDS Assessment with an ARD of 5/5/2021 was modified on 6/16/2021 by the MDS Nurse	6/25/21

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F 641	Continued From page 16 assessment) for 2 of 32 resident assessments reviewed (Resident #91 and Resident # 33) Findings included: 1.Resident # 91 was admitted to the facility on 4/28/2021 with multiple diagnoses that included anemia, hypertension, diabetes, dementia and psychotic. The Admission Minimum Data Set (MDS) assessment dated 05/05/2021 indicated that Resident # 91 had severe cognitive impairment. Further review of the MDS revealed Resident # 91 was coded for Antipsychotic, antianxiety, antidepressant. Resident # 91 was not coded for the diagnoses of anxiety and depression. Review of Resident # 91 Medication Administration Record (MAR) for the month of May 2021 revealed that the resident had diagnoses of anxiety and depression. It further revealed the resident was taking the following medication: Quetiapine 25 mg tab one-tab po 3x daily, Risperidone 0.5 mg tab one-tab po (by mouth) twice a day (BID) and Sertraline (depression medication) 50 mg tab one-tab po daily, Lorazepam (anxiety medication) 1 mg tab po BID. On 5/27/ 2021 at 12:10 PM, the MDS Nurse was interviewed. She verified that Resident # 91 had the diagnoses of anxiety and depression upon admission and the MDS assessment should have been coded with the diagnoses. MDS Nurse also stated that moving forward she will review all the MDS carefully for the accuracy in the residents' diagnoses. On 5/27/ 2021at 12:35 PM, the Administrator was	F 641	to include the diagnosis of depression and anxiety. Resident #33 – The annual MDS Assessment with an ARD of 3/16/2021 was modified on 5/28/2021 by the MDS RN to include the diagnosis of anxiety, depressive disorder, and psychosis. 2. All current residents with Psychotropic medication orders were audited by the MDS Nurses to assure the active diagnosis are listed in Section I (Active Diagnosis) of the most current MDS assessment for each resident. An audit tool was utilized by MDS Nurses to document the results. Any required corrections or modifications to the MDS assessments were completed by the MDS Nurses. 6/25/2021 3. An active diagnosis for the use of psychotropic medications will be coded in Section I (Active Diagnosis) of the MDS assessment for each resident receiving Psychotropic medications. The MDS Nurses were re-educated regarding coding of active diagnosis for psychotropic medications in section I0100-I8000 of the MDS Assessments by the Administrator and Nurse Consultant. 6/1/2021, 6/11/2021 4. The MDS Nurses will review at least 3 MDS assessments weekly for 4 weeks to determine if diagnosis for psychotropic medications are coded correctly on Section I0100 – I8000 Active Diagnoses of the MDS Assessment. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meeting. The	

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F 641	Continued From page 17	F 641	Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

interviewed. She stated that she expected the MDS assessments to be accurate. The Administrator further stated she also expected the MDS nurse to check for the accuracy of the MDS.

2. Resident #33 was admitted 12/14/2018 with diagnoses that included Alzheimer's Disease and Non-Alzheimer's Dementia. The annual Minimum Data Set (MDS) dated 03/16/2021 had Resident #33 coded as and as having had a antipsychotic, antidepressant and antianxiety medication 7 days out of the 7 day look back period.

The care plan dated had focus' of the resident has a behavior problem periodically due to Dementia, Alzheimer's, had impaired cognitive function and impaired thought processes related to Alzheimer's and confabulation, used antidepressant medication (Lexapro) due to diagnosis of depression, used antipsychotic medications due to diagnosis Psychosis, usesd anti-anxiety medications related to (r/t) adjustment issues, had a mood problem, and had depression.

The Medication Administration Records (MAR) for May 2021 included Escitalopram (Lexapro) tab 10 mg daily, Mirtazapine (Remeron) tab 7.5 mg at bedtime, Risperidone (Risperdal) tab 0.5 mg for psychosis.
Reviewed consultant pharmacist note dated 05/25/2021 read: Risk meds: Remeron 7.5 mg for appetite evening (HS), and Lexapro 10 mg Risperdal 0.5 mg HS for psychosis.

During an interview with the Pharmacist Consultant (PC) on 05/26/2021 at 2:36 PM, the PC stated Resident #33 had weight loss and was

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F 641	Continued From page 18 prescribed Remeron for an appetite stimulant, Lexapro 10 mg for anxiety since 04/2020 and Risperdal 0.5 mg for psychosis since 11/2020. She was also on Buspar which was discharged (D/C) in March and she put a recommendation in today for a GDR for Risperdal. During an interview with The MDS nurse #1 on 05/26/2021 at 3:39 PM, MDS #1 stated she does have a diagnosis of Anxiety and Psychosis and should have been coded in with her diagnosis on the MDS. MDS #1 also stated they usually get order clarification for the correct codes for the diagnosis but these diagnoses were overlooked. During an interview with the Administrator on 05/26/2021 at 4:17 PM, the Administrator stated she expects the MDS to be coded correctly.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a	F 644		6/25/21

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F 644	Continued From page 19 related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASARR) for a resident with an active diagnosis of a serious mental illness for 1 of 5 sampled resident reviewed for PASRR (Resident #58). The findings included: Resident #58 was admitted to the facility on 07/10/2019 with diagnoses including End Stage Renal Disease, Psychotic disorder (other than schizophrenia), Coronary artery disease (CAD), and Depression. The quarterly Minimum Data Set (MDS) dated 04/09/2021 had resident #58 coded as independent with activities of daily living (ADL) and extensive assistance with transferring. The annual MDS dated 10/23/2020 revealed the resident was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS coded the resident with diagnoses of depression and psychotic disorder. The care plan dated 04/12/2021 had focus' of Resident # 58 presents a display of behaviors related to unspecified psychosis not due to a substance abuse or known physiological condition. Resident # 58 has jokingly expressed self-harm and denied suicidal ideations. Resident # 58 has a potential of physically harming himself Resident # 58 has jokingly made comments about harming himself, he denies any attempts of suicidal ideations. He holds medications in mouth and doesn't swallow medications at times. Resident # 58 uses antidepressant	F 644	1. The Social Worker submitted the updated PASARR level II referral for Resident #58 on 6/4/2021. 2. All current residents will be reviewed by the Social Worker to ensure all residents with a newly evident or possible serious mental disorder, intellectual disability, or a related condition had been evaluated for a level II PASARR. If a resident was identified needing a level II PASAAR evaluation Social Worker submitted it immediately.6/25/2021 3. All residents with a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred for a level II PASARR evaluation upon a significant change in status assessment by the Social Worker. The Social Worker was re-educated by the Administrator on how to submit all residents with a newly evident or possible serious mental disorder, intellectual disability, or a related condition for a level II PASARR evaluation upon a significant change in status assessment. 6/14/2021 4. The Social Worker will audit 5 residents a week for 4 weeks to ensure the level II PASARR referral was submitted timely for all residents with a newly evident or possible serious mental disorder, intellectual disability, or a related condition. Results of the audits will be reviewed and discussed in the monthly Quality Assurance Performance	

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F 644	Continued From page 20 Review of the PASRR Level I Determination Notification letter was completed on 06-07-2019. Resident # 58 was diagnosed with major depressive disorder on 07-23-2020 and Psychosis on 11-06-2019. In an interview on 05/27/21 at 10:31 AM with the Social Worker (SW), she stated when a resident was newly diagnosed with a mental illness the resident needed to be evaluated for a Level II PASRR. The SW stated she was not in the current position when the evaluation should have been completed, she did not know what had happened or why the evaluation was not done. She stated she would make the corrections and she shared the monitoring sheet the facility was currently using for PASRR tracking. An interview was conducted with the facility's Administrator on 05/27/2021 at 03:28 PM, she expressed the PASARR information is expected to be updated immediately and follow up documentation sent for evaluation as appropriate to the interdisciplinary team. She expressed all residents should be reviewed and screened for any needed Level II PASRR assessments when changes occur.	F 644	improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		6/18/21

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F 684	Continued From page 21 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to follow the Physician's order for Physical Therapy/Occupational Therapy evaluation for 1 of 1 resident reviewed (Resident #10). Findings included: Resident #10 was admitted on 2/08/2021with diagnoses including debility, diabetes, and renal insufficiency. The Minimum Data Set dated 2/15/21 had Resident #10 coded as cognitively intact and totally dependent for bed mobility, transfer, locomotion off unit, dressing, toilet use and personal hygiene. Resident #10 was assessed as independent for eating. The comprehensive care plan dated 6/19/20 included a focus of Resident #10 has an Activities of Daily Living (ADL) self-care deficit related to Spina Bifida. The goals included Resident #10 will maintain current level of function in all ADL ' s through the review dates. Interventions included Physical Therapy/Occupational Therapy/Speech Therapy evaluation and treatment as per medical doctor's order. Record review of physician's orders dated 3/25/21 revealed an order for physical therapy/occupational therapy evaluation due to weakness. Interview with Resident #10 on 5/25/21 at 12:36	F 684	1. Resident #10 was evaluated for therapy on 6/2/2021 by the Physical Therapist. 2. The Therapy Director audited one month of orders to identify any residents with new orders for therapy. Any residents with new orders for therapy evaluations were reviewed with the Therapy department to ensure all new orders were addressed timely. This audit will be completed on 6/18/2021. 3. The Interdisciplinary team, including the Therapy Director, reviews all new orders during the morning clinical meetings Monday-Friday. The Therapy Director then schedules the evaluation with the appropriate discipline. Therapy staff was re-educated by the Therapy Director regarding the process for reviewing new orders for therapy and ensuring the residents are evaluated/screened by the therapy department timely. Staff unable to attend the in-service will be re-educated prior to their next scheduled shift. 6/1/2021-6/9/2021 4. The Therapy Director will audit all new orders for therapy evaluations weekly for 4 weeks to determine if all new orders for therapy evaluations were communicated to the therapy department and if the resident was scheduled for an evaluation timely. Results will be reviewed and discussed in the monthly Quality	

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F 684	Continued From page 22 PM, he stated he had not been evaluated by therapy since his admission. He stated therapy had been discussed, but no evaluation had been completed. An interview with the Therapy Director on 5/27/21 at 9:10 AM, the Therapy Director stated she did not receive a referral for Resident #10 written by physician on 03/25/21. Interview with Nurse #3 on 5/27/21 at 10:00 AM, she explained physician's orders are usually noted by the nurses and they are discussed during morning rounds with all disciplines which includes rehab therapists. During a follow-up interview with the Therapy Director on 5/27/21 at 11:30 AM, the Therapy Director explained the therapy department did not receive Resident # 10's order for physical therapy until 4/20/21. The Therapy Director stated Resident #10 went to the hospital on 4/17/21 and was not sure what happened with the order. The Therapy Director confirmed the evaluation for physical therapy did not occur. Interview on 5/27/21 at 12:30 PM with the Administrator, the Administrator stated she expected residents care be completed according to the physician's orders.	F 684	Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		6/10/21

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	345353	A. BUILDING _____ B. WING _____	C 05/28/2021

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

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F 732	Continued From page 23 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post the daily staffing information for one of three days of the recertification survey. The findings included:	F 732	1. No residents were affected by this practice. The SDC immediately posted the nursing staff on 5/27/2021 for the 1st shift. 2. No potential for residents to be affected by the practice. The scheduler will post	

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F 732	Continued From page 24 Observations during tour hallways on 5/25/21 at 10:00 AM and 5/26/21 at 8:30 AM revealed daily staffing information posted at the facility entrance hallway. On 5/27/21 at 8:30 AM, there was no daily staffing information posted in an area visible to residents and visitors. A tour of the hallways on 5/27/21 at 11:20 AM revealed no posting of daily staffing information. During an interview on 5/27/21 at 11:22 AM with the Staff Development Coordinator, she communicated that the daily staffing was normally posted at the facility entrance hallway by the Scheduler who was absent on that day. During an interview on 5/27/21 at 11:27 AM with Director of Nursing (DON), the DON indicated that the staff posting should be posted daily at the entrance hallway, but it was not posted that morning. An interview was conducted on 5/27/21 at 11:45 AM with the Administrator who indicated the staff posting information should be posted daily in an area visible to residents and visitors. An interview conducted on 5/28/21 at 3:35 PM with Facility Scheduler revealed he was responsible for posting the daily staffing at the beginning of each shift. He indicated he was on leave and could not speak to who was responsible for posting the daily staffing information when he was absent.	F 732	staffing for 1st and 2nd shifts Monday through Friday. SDC will be back-up to ensure staffing data is posted. 3rd shift staffing data will be posted by 11-7 nurse. Weekend supervisors will ensure staffing data is posted timely. 3. To assure nursing staff forms are posted when the Facility Scheduler is absent, the Staff Development Coordinator was assigned this duty as back up to the Facility Scheduler. The DON notified the Staff Development Coordinator and Facility Scheduler of this process change on 6/10/2021. 4. The SDC/Supervisors will review the staff posting forms daily for 2 weeks, then weekly for 2 weeks to ensure they are completed and posted daily with current staffing data. Results will be reviewed and discussed in the Quality Assurance Performance Improvement Committee monthly meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/24/21

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F 880	Continued From page 25 §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, 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,	F 880		

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F 880	Continued From page 26 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. §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 record reviews, observations and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 2 of 2 staff members (Nurse Aide #2 and Nurse Aide #3) failed to wear eye protection, gown, gloves, and N95 mask when delivering and setting up meal trays to residents on the facility's enhanced droplet-contact precautions rooms. Findings included:	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	

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F 880	Continued From page 27 A review of a document updated 11/20/20 and published by the CDC titled: "Preparing for COVID-19 in the Nursing Home" indicated in part under section headed Evaluate and Manage Residents with symptoms of COVID-19, resident known or suspected of COVID-19 should be cared for by Health Care Personnel (HCP's) using all recommended PPE which includes use of a N-95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or face shield that covered the front and sides of the face) gloves and gown. The document defines HCP to include but not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomist, pharmacist, students and trainees, contractual staff not employed by the facility, and person not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting i.e., clerical, dietary, environmental services, laundry, security, engineering, and facility management, administrative, billing, and volunteer personnel. An observation on 05/25/21 at 12:15 PM revealed a red and black facility new admission/quarantine resident door sign titled, "Enhanced Droplet-Contact Precautions" indicated in part: Surgical mask when entering room, eye protection when entering room, gown when entering room, and gloves when entering was observed on Resident #54 and #345's outer door. An observation an interview on 05/25/21 at 12:15 PM revealed Nurse Aide (NA) #3 entered Resident #54's room, who was on Enhanced Droplet-Contact Precautions without eye protection, gloves, or gown. NA #3 was observed	F 880	deficiencies cited have been or will be completed by the dates indicated. 1. The DON immediately educated NA #3 to apply all required PPE (gown, gloves, eye protection, N95 or face mask) when entering a room on enhanced droplet precautions on 5/25/2021 . The DON immediately notified NA #2 to place the mask over their nose immediately on 5/25/2021. The Aide was also immediately re-educated to apply all required PPE (gown, gloves, eye protection, N95 or face mask) when entering a room on enhanced droplet precautions on 5/25/2021. 2.Residents on enhanced droplet precautions have been assessed to determine if enhanced precaution is needed per direction of Medical Director. Staff assigned to residents on enhanced droplet precautions have been in-serviced again on proper PPE requirements by the DON and IP Nurse. 3. All staff were re-educated on appropriate use of Personal Protective Equipment (PPE) for residents on Enhanced Droplet Contact Precautions via the CDC YouTube videos titled Demonstration of Donning (Putting on) Personal Protective Equipment and Demonstration of Doffing (Taking off) Personal Protective Equipment, the CDC Poster titled Use Personal Protective Equipment (PPE) when caring for patients with Confirmed or Suspected COVID-19, the CDC poster titled Facemask's Do's	

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F 880	Continued From page 28 as she passed out resident's meal tray and exited his room. When asked why she was not wearing eye protection, gloves, and gown. NA #3 responded that she did not think she needed to wear full PPE while she delivered meal trays to residents on Enhanced Droplet-Contact Precautions An observation an interview on 05/25/21 at 12:20 PM of NA #2 inside Resident #345's room, who was on Enhanced Droplet-Contact Precautions with her surgical mask pulled down under her chin, without eye protection, gloves, or gown on. NA #3 was observed talking to the resident as she cut up the resident's food on his meal tray. When asked why she was not wearing eye protection, gloves, gown, and had her surgical mask pulled down under her chin. NA #3 responded that she knew she should have donned full PPE with the surgical mask covering her nose and mouth, when she entered room #78, who was on Enhanced Droplet-Contact Precautions and did not. An interview on 05/27/21 at 11:20 AM with the facility's Administrator revealed it was her expectation that all staff fully follow all the facility's infection control policies, and for all staff to wear full PPE when they entered an Enhanced Droplet-Contact Precautions room. An interview on 05/27/21 at 11:45 AM with the Director of Nursing (DON) revealed it was her expectation that NA #2 and #3 should have followed the facility's infection control policy and donned full PPE when they entered the two residents Enhanced Droplet-Contact Precautions rooms and did not. Staff were recently in-serviced on donning and doffing PPE, hand washing.	F 880	and Don'ts, and the UNC SPICE Enhanced Droplet Precautions Sign. Timeline for education: This education was provided by the Director of Nursing and IP Nurse. Any staff member not completing the education by 6/24/2021 will not be permitted to work their next scheduled shift until it is completed. A root cause analysis was completed with the assistance of the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) Committee, and governing body to determine the root cause they may have led to the deficient practice. 4.Observe employees daily for two (2) weeks then weekly for 1 month to ensure staff are wearing face mask correctly to cover mouth and nose and that staff are donning all required PPE (isolation gown, gloves, eye protection and N95 or surgical mask) when entering rooms on Enhanced Droplet Contact precautions. Results will be recorded on a PPE Audit Tool beginning 6/1/2021 by the Director of Nursing, Infection Preventionist/ Assistant Director of Nursing, Unit Managers, Department Managers and/or designated nursing staff. Any deficiencies noted will be addressed immediately and corrective action taken as necessary, which may include disciplinary action. Results will be presented at the Quality Assurance Performance Improvement Committee meetings monthly. The Quality Assurance Committee will assess and modify the	

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F 880	Continued From page 29	F 880	action plan as needed to ensure continued compliance.	
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure handrails in facility corridors were secured to the wall and free of sharp edges for 1 of 1 facility hallways (the corridor of the "C" Hall). Findings included: Observation on 5/25/21 at 11:28 AM revealed no end caps on eight rail locations throughout the "C" hallway corridor. There was no maintenance working in the area. The ends of the handrail had sharp edges that were not covered by the endcaps. Observation also revealed this was a heavily used corridor, used by staff and residents. Residents were sitting in their doorways and/or traveling down the hallway during the observation. No foam/tape was noted on the edges or the floor in the corridor. Observation of the handrails on the "C" hallway corridor on 5/25/21 at 4:00 PM revealed two end caps were just sitting on the rail not attached. There was no maintenance working in the area. The raw edges remained exposed. No foam/tape was noted on the edges or on the floor. Observation of the handrails in the "C" hallway corridor on 5/26/21 at 9:10 AM revealed no	F 924	1. The handrails on C Hall were repaired to ensure the end caps were properly installed and no sharp edges were exposed on 5/26/2021 by the maintenance department. 2. The Maintenance Director and Administrator audited the handrails throughout the facility on 5/26/2021. Handrails needing end caps were repaired by maintenance department on 5/26/2021. 3. All Maintenance Staff were in-serviced by the Administrator on 5/26/2021 ensuring the handrails are firmly secured and fixated to the corridor walls with end caps in place and no sharp edges exposed. Handrail inspection is included on weekly preventative maintenance checklist. Handrails will be repaired/replaced immediately upon observation. Handrail Audit Tool is maintained in the maintenance department. Additional handrail supplies are ordered monthly to ensure we have plenty of material in stock. 4. The Administrator or his/her designee will audit the handrails throughout the facility corridors weekly for 4 weeks then	6/1/21

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F 924	Continued From page 30 repairs had been done. Observation also revealed this was a busy corridor with staff and residents constantly using the area to navigate between units. No foam/tape was noted on the edges or the floor. During an interview on 05/26/21 at 11:31 AM, the Maintenance Director indicated he was aware that the end caps to the handrails were missing. The Maintenance Director indicated these were being repaired; but had not finished the "C" hallway corridor. He stated it had taken a while for the parts, but he had the parts and they were not up yet. When asked about resident safety and the uncovered edges, he responded the maintenance staff had covered the end caps with foam/tape to protect the edges. He stated maybe the residents had peeled it off. During an interview on 5/26/21 at 2:12 PM, the Administrator explained the handrails were being repaired and things had been slow. She expressed the rails should be covered for safety while waiting to be repaired. She stated the repairs would be done immediately.	F 924	monthly for 3 months to ensure the handrails are firmly secured and fixated to the corridor walls with end caps in place and no sharp edges exposed. Any deficiencies noted will be addressed immediately and repaired as necessary. Results will be recorded on an audit tool titled “Handrail Audit Tool” and presented at the Quality Assurance Performance Improvement Committee monthly meeting. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	