STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345078	A. BUILDING _____ B. WING _____	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND FARMS	200 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711

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E 000	Initial Comments An unannounced recertification survey was conducted on 7/26/21 through 7/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 3BLZ11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 07/26/21 through 07/28/21. Event ID# 3BLZ11.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to identify a resident with significant changes in status and failed to complete a significant change in status Minimum Data Set (MDS) assessment for 1 of 12 residents reviewed for decline (Resident #8). Findings included: Resident #8's active diagnosis included:	F 637	What actions were taken to resolve the deficient practice identified for this specific resident? The MDS Coordinator returned from vacation and failed to push the button to indicate that a significant change had occurred. As soon as she became aware of it, the significant change assessment	8/25/21

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

Electronically Signed | 08/13/2021

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F 637	Continued From page 1 dementia, Alzheimer's disease, delusional disorder, and failure to thrive. Review of the admission MDS dated 2/12/2021 revealed Resident #8 required supervision of 1 staff for bed mobility and transfers. He required limited assistance of 1 staff for toileting. A review of the quarterly MDS dated 5/12/2021 revealed Resident #8 required extensive assistance of 1 staff for bed mobility, transfers, and toileting. An interview was conducted with Nursing Assistant #1 on 7/27/2021 at 2:42 pm. She stated Resident #8 required minimal assistance with activities of daily living (ADL) upon his admission in February 2021. Around May 2021, she noticed he was less mobile and fell more often requiring more care assistance with all ADL including bed mobility, transfers, and toileting. An interview conducted with the Rehab Director on 7/27/21 at 2:18 pm revealed Resident #8 was receiving occupational and speech therapy services in May 2021 due to weight loss and swallowing difficulty. However, Resident #8 did not begin receiving physical therapy services for ADL decline until 6/28/21. The Rehab Director stated he was not aware of Resident #8's ADL decline from February to May of 2021. The MDS Coordinator was interviewed on 7/27/21 at 2:42 pm. She stated if a resident had 2 or more areas of ADL decrease by 1 level then a significant change in status assessment should be completed. The MDS nurse stated Resident #8's ADL decline from February to May would have indicated a significant change assessment.	F 637	was opened on 7/27/2021 and completed on 7/29/2021. The MDS Coordinator was educated on 7/27 by the Resident Care Coordinator about the importance of ensuring that this is reviewed before any assessment is locked to ensure that she is not missing an opportunity to complete the significant change assessment. What actions were taken to identify any other residents at risk of the deficient practice, and how are the measures implemented to ensure no other residents are affected? The MDS assessment program allows for a button to identify if there has been a significant decline in the assessment being closed. This should have been completed for any resident who had a pending assessment. Therefore, the facility completed a 100% audit of all residents in the house for any assessments that were closed in the last quarter. We had no other missed assessments, but the audit identified one other resident who was starting to show a change. An assessment was opened for a significant change for that resident, and no other changes were identified as necessary. What is your means of monitoring to ensure that no further occurrences of the deficient practices occur? The MDS Coordinator prints a copy of each assessment for backup, and the MDS Coordinator will now print a	

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F 637	Continued From page 2 During an interview with the Director of Nursing (DON) on 7/27/21 at 3:32 pm, she stated Resident #8's ADL decline from February to May of 2021 would have warranted a significant change assessment. The DON stated it was her expectation that when there was a change in a resident's level of care that a significant change in status assessment be completed. An interview conducted on 7/27/21 at 3:53 pm with the Administrator revealed it was her expectation that a significant change assessment should have been performed after Resident #8's ADL decline was observed.	F 637	screenshot of the button that identified the need for a significant change assessment, and it will be attached to the physical copy to ensure ongoing monitoring of this process. If the MDS Coordinator disagrees with the findings, a note will be added to the screenshot justifying the deviation. The Director of Nursing or designee will audit 5 random assessments per week x 4 weeks to ensure ongoing compliance and the results of the weekly audits will be reported at the monthly QAPI meeting until completed. What is your ongoing means of oversight and monitoring to ensure that this deficient practice is not allowed to re-occur? The Director of Nursing or designee will read daily nurses notes and when a change of condition is noticed, the MDS coordinator will be triggered to ensure that the assessment is opened. If the data does not validate the significant change when the assessment is completed, the printed sheet will be updated with a note to explain the discrepancy in the data. If the significant change is validated, the assessment will be completed. How will this incident be incorporated into QAPI to ensure ongoing oversight and monitoring? The Director of Nursing or designee will report the results of the weekly audits at the next QAPI meeting. After completion	

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F 637	Continued From page 3	F 637	of the weekly audits, any significant change assessments will be reported by the MDS Coordinator during the monthly QAPI meeting routinely from this point forward to ensure that anyone who is identified as a change is not missed. All components of this plan of correction will be completed on or before August 25, 2021.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff	F 757	What actions were taken to resolve the	8/25/21

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F 757	Continued From page 4 interview, the facility failed to follow the parameter set by the physician to hold diuretic as ordered for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #31). Findings included: Resident #31 was admitted to the facility on 08/01/19 with multiple diagnoses including congested heart failure and edema. The quarterly Minimum Data Set (MDS) assessment dated 06/29/21 assessed Resident #31with intact cognition. She had adequate hearing and vision with clear speech. Further review of the MDS revealed Resident #31 was receiving diuretic daily in the 7-day look back period. Review of physician's order dated 01/15/21 revealed Resident #31 was ordered to receive furosemide 20 milligrams (mgs), 1 tablet by mouth one time a day for congestive heart failure/edema. The order specified to hold the medication if systolic blood pressure (SBP) was less than 110. Review of Medication Administration Records (MARs) for June and July 2021 revealed Resident #31 had received 1 tablet of furosemide 20 mg daily despite the SBPs were below 110 on the following dates: 06/08/21 - SBP - 105 06/13/21 - SBP - 107 06/19/21 - SBP - 105 06/25/21 - SBP - 94 06/30/21 - SBP - 97 07/04/21 - SBP - 107	F 757	deficient practice identified for this specific resident? Resident #31 was assessed for any negative outcomes, and none were identified. The Medical Director was consulted on 8/4 about removing parameters on the furosemide for resident #31, as it can be held based on nursing judgment, and this request was approved. Medication use was reviewed and is considered necessary for resident based on her history of congestive heart failure with edema. New order was written on 8/4. The Director of Nursing and/or designee began education for all licensed nursing staff and medication aides on 7/28/21 on the importance of utilizing parameters if indicated in a doctor□s order. What actions were taken to identify any other residents at risk of the deficient practice, and how are the measures implemented to ensure no other residents are affected? A 100% audit of all current in-house resident orders was completed between 8/4 and 8/5 to identify any medication orders that have existing parameters, and any medications given outside those parameters. On 8/6, the Medical Director approved removal of all parameters for medications that can be held based on nursing judgment. On 8/6, July□s pharmacy report was used to reconcile discrepancies due to not following	

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F 757	Continued From page 5 07/05/21 - SBP - 107 07/06/21 - SBP - 107 07/08/21 - SBP - 108 07/11/21 - SBP - 103 07/13/21 - SBP - 101 07/14/21 - SBP - 100 07/19/21 - SBP - 106 Review of labs dated 06/15/21 revealed Resident #31 had blood urea nitrogen (BUN) of 18.0 and creatinine of 0.97 which indicated she was free of dehydration. Further review of the labs revealed potassium level of 4.7 millimoles per liter (mmol/L), calcium level of 9.0 milligram/deciliter (mg/dl), and sodium level of 141 milliequivalents per liter (mEq/L). All the electrolytes were within normal limits. Review of medical records for June and July 2021 revealed Resident #31's blood pressures (BP) were within normal limits with SBP being slightly lower at the 90s twice on June. During an interview with Resident #31 on 07/27/21 at 3:08 PM she recalled nursing staff measured her BP each time before administering furosemide. Sometimes the diuretic was held by the nurse due to her low BP. She denied having any signs and symptoms of dehydration or episodes of hypotension in the past 6 months. Per observation, Resident #31 did not show any signs and symptoms of dehydration or hypotension. During an interview with Nurse #2 on 07/28/21 at 9:30 AM she stated that she was assigned to Resident #31 on 6/13/21, 6/25/21, 6/30/21, 07/14/21, and 07/19/21. She indicated she was aware that Resident #31 had a parameter to hold	F 757	parameters. All errors identified during audit were reviewed and written up as a medication variance. Between 8/6 and 8/25, the DON or designee will have provided education with the responsible staff who made to error. The results will be reported at the next QAPI meeting and reviewed in the next Medication Management meeting. The Director of Nursing and/or designee began education for all licensed nursing staff and medication aides on 7/28/21 on the importance of utilizing parameters if indicated in a doctor□s order. Any staff who have not completed education by or before August 25, 2021, will not be allowed to work until education has been completed. What is your means of monitoring to ensure that no further occurrences of the deficient practices occur? The Director of Nursing will review physician order slips twice weekly x 12 weeks to identify orders with parameters. If parameters are identified, they will be added to a list to be tracked and reviewed weekly in Standards of Care meeting. The Director of Nursing and/or designee will ensure that the pharmacy report from the prior month did not identify any errors due to following parameters. All errors will be reported as medication variances and reviewed in monthly QAPI and Medication Management meeting x3 months for the plan of correction, and as an ongoing line item for the Medication Management meeting quarterly.	

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F 757	Continued From page 6 the furosemide and acknowledged that it should be held when Resident #31's SBP was less than 110 for the dates mentioned above. She stated she normally would measure BP to determine if Resident #31 would receive furosemide. If the SBP was 110 or more, she would administer the furosemide and then chart it in the MAR. She explained sometimes due to distractions, she had to administer furosemide a few minutes after she had measured the BP and forgot to follow the parameter. During an interview with Medication Aide #1 (MA#1) on 07/28/21 at 10:19 AM she stated that she was assigned to Resident #31 on 07/05/21. Normally she would check the parameter of each medication before administration. She did not know why she did not follow the parameter on 07/05/21. She acknowledged that based on Resident #31's SBP of 107/58, furosemide should be held on 07/05/21. She could not recall what had happened that morning that resulted her failure to follow the parameter set by the physician. During an interview with the Director of Nursing on 07/28/21 at 11:09 AM she stated that all the nursing staff had been trained to interpret the parameters set forth by the physician. It was her expectation for all the nursing staff to review and follow physician's parameters each time before administering medication. During an interview with the Administrator on 07/28/21 at 11:58 AM she stated it was her expectation for all the nursing staff to follow the parameter set by the physician before administering medication.	F 757	What is your ongoing means of oversight and monitoring to ensure that this deficient practice is not allowed to re-occur? The Director of Nursing or designee will review all pharmacy recommendations, and their outcomes monthly and as needed. The Director of Nursing or designee will routinely review documentation for completeness and accuracy. During monthly Medication Management Meeting, the pharmacy consultant will identify any failure to follow a physician□s orders as a medication error in the monthly medication error report. How will this incident be incorporated into QAPI to ensure ongoing oversight and monitoring? The Director of Nursing or designee will address any deficient practice identified in the Medication Regimen Review at the monthly QAPI and Medication Management meetings to continue to monitor for compliance. Audits for deficiencies will be completed as needed to determine system compliance. All components of this plan of correction will be completed on or before August 25, 2021.	

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F 757	Continued From page 7 During a phone interview with the Medical Director (MD) on 07/28/21 at 12:07 PM he stated he did not usually set parameter for furosemide. However, when he set parameter for certain medications, he expected nursing staff to follow. He added failure to follow the parameter for Resident #31's diuretic therapy could trigger dehydration or orthostatic hypotension.	F 757		