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

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 06/24/2022

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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E 000	Initial Comments A recertification and complaint investigation survey was conducted from 6/20/22 through 6/24/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #A0J411	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/20/22 through 6/24/22. Event ID #A0J411 2 of the 10 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC00189429, NC00188296 and NC00189793 Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F607 at a scope and severity (J) The tags F600 and F607 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/11/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews and Physician interview the facility failed to protect a resident's right to be free from physical and emotional injuries for 1 of 2 sampled residents (Resident #222). Resident # 222 sustained a bruising on bilateral upper extremities with open skin tears on anterior right arm, posterior wrist to left arm, bruising on the left upper lip and the resident's emotional response & behaviors were "crying, fretful, and agitated." The findings included: Resident #222 was admitted to the facility on 12/28/18 with diagnoses that included major depressive disorder, dementia with behavioral disturbance, cognitive communication deficit, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. A quarterly Minimum Data Set (MDS) dated 10/19/2021 specified the resident had clear speech and was usually able to make herself understood and usually able to understand others. The MDS also specified the resident had severely impaired cognition. The MDS did not indicate Resident # 222 as resistive to care. A care plan updated 10/22/21indicated Resident #222 had an Activities of Daily Living (ADL)self-care performance deficit related to	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2 immobility, incontinence, and dementia. The resident's care plan also indicated the resident was combative with care at times. Interventions included: - she requires extensive to total assist with bed mobility - she refuses for her nails to be cut and nail care to be done - skin checks to be done on Nurse Aide (NA) rounds and as needed. Review of the Medication Administration Record (MAR) for the month of December 2021 revealed the resident was prescribed the medication Aspirin 81 milligram 1 tablet every day. The resident was not on any anticoagulant (blood thinner) medication. A 24-Hour Initial Report for an Allegation of abuse was faxed to the Health Care Personnel Registry on 01/04/22 from the facility. A review of 5-Working Day Report submitted by the facility for all allegation of abuse was faxed to the Health Care Personnel Registry on 01/10/22. The report documented the facility's Director of Nursing (DON) and Administrator became aware of the allegation of abuse on 12/27/2021. Resident #222 was documented as having been severely impaired. The alleged incident occurred on 12/25/21 at approximately 12:00 PM. The allegation description was "an allegation of physical abuse 7am-3pm shift, resident reporting "she got bruises on her arms and lip from the "morning nurse." Resident stating the "nurse from the morning" (referring to Nurse Aide (NA)#3) "beat me up." NA#3 was placed on suspension pending investigation of allegation. The resident's emotional response & behaviors were "crying, fretful, and agitated." The document also	F 600		

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F 600	Continued From page 3 indicated the following timeline for allegation of abuse: " 12/25/21 around 2:30PM, NA#2 reported to staff nurse that resident had bruising on left upper lip, and left forearm/ elbow. " The nurse stated she and house supervisor went to room and assessed the resident and saw bruising on resident. Resident was asked what happened and resident told nurse she was beat up. " Director of Nursing (DON) was notified on 12/27/21 at 12:20PM and her and unit manager with wound nurse went in room to asses resident. Bruising was noted to lip outside and inside. Red bruising was also noted on left arm. " DON notified the police at 6:30 PM of allegation. Police came out at 7:36 PM and interviewed resident. " 2 aides gave written statements to DON " Aide that was the person in question was an agency aide. DON and Administrator notified nursing agency of allegation and requested personal information and told the agency the nurse aide would no longer be used while investigating allegation " DON sent 24-hour report 12/27/21 at 2:00PM to Department of Social services (DSS). " 12/29/21 allegation was substantiated. Agency was told of findings. Review of the facility's Investigation Guide indicated the following details: "On 12/27/2021, Interim DON was notified of an abuse allegation that was alleged to have occurred on 12/25/2021. On 12/25/21 NA #1 reported to Nurse #1 that Resident #222 had bruising on left upper left and on left forearm/ elbow. Resident # 222 was assessed by Nurse#1 and Nurse #1 noted the bruising. Nurse #1 asked Resident # 222 what	F 600		

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F 600	Continued From page 4	F 600		

happened, and the resident stated that she was beat up by the morning nurse. Resident # 222 was fully assessed again with bruising and skin tears noted on the assessment.

Review of the skin assessments from October 21, 2021 - December 20,2021 revealed no injury or bruises on Resident # 222's left or right arms. The skin assessments revealed Resident # 222 had no history of bruises.

Review of the form dated 12/25/2021 titled, "Skin Monitoring: Comprehensive NA Shower Revealed." the resident had scattered bruises on bilateral upper extremities. Open skin tears on right arm and left wrist.

Review of Nurse #1's nurse's note written on 12/25/2021, documented "Noted bruising on bilateral upper extremities with open skin tears on anterior right arm, posterior wrist to left arm. Resident stated that she got the bruises from the morning nurse. Resident stated, "The nurse from the morning beat me up. She snatched my arms and squeezed them. Therefore, all my arms are bruised. The resident indicated she had to grab the nurse breast to stop her from hurting her and that was all she could do."

A telephone interview was conducted with Nurse #1 on 06/22/2022 at 9:00AM, Nurse #1 stated on 12/25/2021, NA #2 reported to her that she observed bruises on Resident # 222 bilateral upper extremities with open skin tears and observed the resident bleeding on her lips. Nurse #1 stated she completed the skin assessment and observed the bruises on the resident upper extremities and the resident's lips was injured. Nurse #1 stated she asked the resident what had

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F 600	Continued From page 5 happened to her and the resident reported that the morning nurse had beat her up. Nurse #1 reported the allegation of the alleged abuse of Resident # 222 to Nurse #2 who was the weekend supervisor. Review of NA#2 statement note dated 12/25/2021 documented she was told by NA#1 that Resident #222 stated NA #3 beat her up. She (NA#2) went to Resident # 222 to check on her and she noticed her lips appeared to be busted. She noticed a medium size skin tear which was flapped over exposing arm tissue. It was bruised on her left wrist. When she asked the resident, what happened she stated the "Nurse" was mean to her and rough with her when she told her to stop, she started grabbing her by her arms. NA#2 pulled Nurse #1 to the side to let her know her findings and asked if she could go in room with her to assess the resident. Nurse #1 asked the resident what had happened. The resident told Nurse#1 about the same information that she had told her before. A telephone interview was conducted with NA#2 on 06/22/2022 at 9:25 AM, NA#2 stated she was not assigned to Resident # 222 on 12/25/2021. NA# 2 indicated she was asked to go see Resident # 222 by NA#1 who indicated she had observed bruises on Resident # 222 and the resident reported to her that she had been beaten up by NA#3. NA#2 reported she observed the resident with bruises on her left upper extremities and noticed her lips was bleeding. She asked the resident what happened, and the resident indicated her morning NA had beaten her up. NA#2 stated she reported her observation and the abuse allegation to Nurse #1.	F 600		

F 600 Continued From page 6 F 600

Review of NA#1 statement note dated 12/25/2021 documented she overheard Resident#222 yelling and screaming while she was in the process of changing another resident. She didn't think anything of it because Resident #222 always yells when she wants some attention. Later after lunch trays came out her tray was already in her room. She went to check on the resident because she always doesn't like to eat breakfast or lunch and she always needs encouragement. When she went to the resident's room to check if she was eating lunch, she noticed her lip was busted and she looked at the resident's arms and they were bleeding and bruised. The resident was saying that NA #3 beat her up and threw her around. She told NA#2 and told Nurse#1.

A telephone interview was conducted with NA#1on 06/22/2022 at 9:30AM, NA#1 stated she was in the process of changing another resident when she had Resident # 222 yelling and screaming. She did not think of anything but after she finished changing the other resident, she went to check on Resident #222. She noticed NA #3 coming from Resident # 222's room. Upon entering Resident # 222's room, she observed the resident with bruises on her left arm upper extremities and her lips was bleeding. She asked NA#2 to go in the resident's room with her to confirm what she observed. NA #1 also indicated she had spoken and observed Resident # 222 in the morning during breakfast and she did not have any bruises on her upper left or right arms. The resident told both NA#1 and NA#2 that NA#3 beat her up. They reported their findings to Nurse # 1.

Review of the skin/ wound progress notes written

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F 600	Continued From page 7	F 600		

by treatment Nurse #3 dated 12/27/2021 documented "Resident provided with full head to toe skin assessment. Generalized skin observed clean dry fragile and warm to touch. Resident is awake and verbally responsive. Reports discomfort to upper extremities and feet. Observed with dark purple bruising to left upper lip. Bottom lip is slightly excoriated. Right forearm observed with a large purplish/ red discolored area that measures 6 inches x 4 inches. Noted with scattered purplish/red discolored areas around large, bruised area. Has a 1 inch linear 100% dermal scab to right lower distal anterior forearm. Left arm observed with multiple purplish/red discoloration extending from the upper arm to hand. Has multiple scattered purplish/ red areas to left upper arm. Noted with 4 distinct purplish/ red oval discoloration consecutive to each other on the lateral left elbow, each measuring 2 cm in size. Has scattered purplish/ red discoloration to left forearm. Noted with a 1 inch linear 100 % dermal scabbed area. Left hand dorsal observed with 1 linear 100% dermal scabbed area with purplish/ red discoloration locally."

An interview was conducted with the Nurse #3 on 06/22/2022 at 11:20 AM, Nurse #3 stated she completed Resident #222 skin assessment on 12/27/2021. She reported she observed bruises on the resident as purple color discolorations on the left arms. Nurse #3 indicated it was consistent with fingerprints on the resident's left upper extremities. She stated she observed Resident #222 bottom lip was excoriated. She further stated the resident reported to her that NA#3 beat her up and that was the reason she had bruises on her left arm and her lips.

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F 600	Continued From page 8	F 600		

An interview was conducted with the weekend supervisor Nurse#2 on 06/22/2022 at 3:10PM, Nurse #2 stated Nurse #1 reported to her that Resident # 222 had bruises on her left arm upper extremities and the resident was reporting that NA#3 had beaten her up. Nurse #2 reported she went to Resident #222 to complete the skin assessment. She reported she observed bruises on the resident's left arm.

NA#3 was no longer employed at the facility. Review of the abuse investigation revealed no statement written by NA#3.

The Director of Nursing who completed the investigation was no longer employed at the facility.

The Administrator who completed the abuse investigation was no longer employed at the facility.

Resident # 222 was no longer at the facility. She expired on 05/21/2022.

On 06/23/2022 at 10:10 AM the Medical Director (MD) was interviewed and stated she was made aware of the abuse allegation. She stated the resident had history of being combative and resistive of care. MD reported she did not recall Resident # 222 as having history of bruises before 12/25/2021. MD indicated the abuse allegation happened on the weekend and she did not examine the resident.

An interview was conducted with the current Administrator on 06/23/2022 at 11:30 AM. The Administrator stated she was an interim

F 600 Continued From page 9 F 600

Administrator at the time of Resident # 222 abuse allegation. The Administrator reported she was not part of the staff that investigated the abuse allegation of Resident # 222 in December 2021. The Administrator stated the staff at the facility should treat the residents with dignity and respect. She reported the staff should not abuse the residents at the facility. She also indicated the staff at the facility will continue to be in serviced on prevention of abuse and especially with residents who had behavioral symptoms and dementia.

A telephone interview was conducted with the current DON on 06/23/2022 at 11:41 AM. DON stated she was not employed at the facility when Resident # 222 had an allegation of abuse. She stated the staff at the facility will continue to be educated on how to prevent abuse and neglect. She stated no residents should be abused at any time at the facility.

The facility provided the following corrective action plan with a completion date of 01/05/2022

1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
"   The alleged staff was identified as an agency Certified Nurse Aide (CNA) # 3. The Administrator notified the Staffing Agency of the allegation on 12/27/2021. The Director of Nursing reported the allegation to the Nurse Aide Registry on 12/27/2021. The NA #3 no longer

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F 600	Continued From page 10 could work at the facility. " On 12/27/21 the Administrator requested validation of Abuse and Neglect Training for CNA # 3. The Staffing Agency provided the facility with the "Abuse and Neglect Training Post Test" that CNA #3 had taken on 7/20/21. The test showed a passing score of 100. The Staffing Agency also provided Nurse Aide Skills Competency and Assessment which includes: Patient Rights, Abuse Detection/reporting, Residents refusing care, Dementia Care. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " The Director of Nursing and Social Worker interviewed alert and oriented residents on 12/28/21 to ensure no other allegations of abuse had occurred. There were no other allegations of abuse identified or reported. " The Licensed Nursing Staff began a physical assessment of all non-alert/oriented residents to ensure there were no other injuries or evidence of abuse. No other allegations or injuries were identified. The assessments were completed by 12/30/21. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; " 12/30/21 - The Administrator, Director of Nursing conducted an in-depth analysis of the mechanisms, policies, training of staff relative to Abuse prevention and determined the following would continue and or be implemented: " Education and training on Abuse will continue to be provided to all newly hired staff during	F 600		

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F 600	Continued From page 11 Facility Orientation. " The facility will continue to require any Staffing Agency provide validation that Abuse Screening, Training, and professional licenses if applicable and/or qualifications required by law has been obtained on all their employees prior to them working at the facility. " Posting of abuse policy and procedures throughout the facility visible to employees, families and residents. " 12/31/21 - The Staff Development Coordinator began in-servicing all staff (including agency staff) on Abuse Prevention that included how to appropriately care for demented, combative, agitated residents. In-services to be completed by January 5, 2022. Nursing staff who did not receive the education will not be allowed to work until education is provided. " There were at least nine agency staff included in the Abuse Prevention in-services provided by the facility from 12/31/21 to 1/5/22. " Continued monitoring of care is completed daily through routine clinical rounds conducted by the Unit Managers and Director of Nursing as well as rounds completed by Clinical Consultants. The monitoring includes observation of providing activities of daily living, and day-to day interaction with residents including those resident's with behavioral issues. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. " On 12/31/21 the facility decided that a) Monitoring for signs/symptoms of abuse will be conducted through weekly skin assessments completed by the Licensed Nursing Staff and review of Incident Accident Reports in routine clinical meetings. B) Continued monitoring of care	F 600		

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F 600 Continued From page 12 F 600

is completed daily through routine clinical rounds conducted by the Unit Managers and Director of Nursing as well as rounds completed by Clinical Consultants. The monitoring includes observation of providing activities of daily living, and day-to day interaction with residents including those resident's with behavioral issues.

Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. The Committee was notified of this responsibility on 1/3/22.
Completion date: January 5, 2022

Onsite validation was completed on 06/24/2022 through staff interviews and record review. Staff were interviewed to validate in- service completion and prevention of abuse. Observations were made of residents throughout the facility and no bruises or skin tears were observed. Review of the weekly skin assessment was completed, and the Quality Assurance (QA) Committee met to discuss the weekly skin assessments findings. The facility's correction action plan was validated to be 01/05/2022.

F 607 SS=J Develop/Implement Abuse/Neglect Policies F 607
CFR(s): 483.12(b)(1)-(3)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

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F 607	Continued From page 13 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to follow their abuse policies and procedures in the areas of immediately reporting to administration, and protection of residents by allowing the alleged perpetrator to continue to work and be assigned to take care of residents, and notification of law enforcement for two days for 1 of 2 sampled residents (Resident # 222). The findings included: The policy and procedure for Resident Abuse undated stated the following procedure: " If abuse or suspicion of abuse is identified, the employee must immediately report the findings to the supervisor. " If the supervisor (like stated above) is not the administrator, director of nursing, or the social work, that supervisor must immediately contact either the administrator, director of nursing, or social work of the allegation. " Once allegation is known, any employees accused of the allegation, they must be sent home immediately and will be suspended, pending investigation. If any visitors are accused of the allegation, they must be asked to leave the facility to allow for an investigation. " Facility is to thoroughly investigate the allegation, contact appropriate departments (i.e., police department, department of social services) and determine whether the allegation will be	F 607	Past noncompliance: no plan of correction required.	

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 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 14	F 607		

substantiated or unsubstantiated.

" Reasonable suspicion of crime against any resident shall be reported to the law enforcement entities - no later than 2 hours following the allegation.

A 24-Hour Initial Report for an Allegation of abuse was faxed to the Health Care Personnel Registry on 01/04/22 from the facility. A review of 5-Working Day Report submitted by the facility for all allegation of abuse was faxed to the Health Care Personnel Registry on 01/10/22. The report documented the facility's Director of Nursing (DON) and Administrator became aware of the allegation of abuse on 12/27/2021. Resident #222 was documented as having been severely impaired. The alleged incident occurred on 12/25/21 at approximately 12:00 PM. The allegation description was "an allegation of physical abuse 7am-3pm shift, resident reporting "she got bruises on her arms and lip from the "morning nurse." Resident stating the "nurse from the morning" (referring to Nurse Aide (NA)#3) "beat me up." NA#3 was placed on suspension pending investigation of allegation. The resident's emotional response & behaviors were "crying, fretful, and agitated." The document also indicated the following timeline for allegation of abuse:
" 12/25/21 around 2:30PM, NA#2 reported to staff nurse that resident had bruising on left upper lip, and left forearm/ elbow.
" The nurse stated she and house supervisor went to room and assessed the resident and saw bruising on resident. Resident was asked what happened and resident told nurse she was beat up.

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

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F 607	Continued From page 15	F 607		

" Director of Nursing (DON) was notified on 12/27/21 at 12:20PM and her and unit manager with wound nurse went in room to assess resident. Bruising was noted to lip outside and inside. Red bruising was also noted on left arm.
" DON notified the police at 6:30 PM of allegation. Police came out at 7:36 PM and interviewed resident.
" 2 aides gave written statements to DON
" Aide that was the person in question was an agency aide. DON and Administrator notified nursing agency of allegation and requested personal information and told the agency the nurse aide would no longer be used while investigating allegation
" DON sent 24-hour report 12/27/21 at 2:00PM to Department of Social services (DSS).
" 12/29/21 allegation was substantiated. Agency was told of findings.

Review of the facility's Investigation Guide indicated the following details: "On 12/27/2021, Interim DON was notified of an abuse allegation that was alleged to have occurred on 12/25/2021. On 12/25/21 NA #1 reported to Nurse #1 that Resident #222 had bruising on left upper left and on left forearm/ elbow. Resident # 222 was assessed by Nurse#1 and Nurse #1 noted the bruising. Nurse #1 asked Resident # 222 what happened, and the resident stated that she was beat up by the morning nurse. Resident # 222 was fully assessed again with bruising and skin tears noted on the assessment.

Review of the form dated 12/25/2021 titled, "Skin Monitoring: Comprehensive NA Shower Revealed." the resident had scattered bruises on bilateral upper extremities. Open skin tears on right arm and left wrist.

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 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 16	F 607		

Review of Nurse #1's nurse's note written on 12/25/2021, documented "Noted bruising on bilateral upper extremities with open skin tears on anterior right arm, posterior wrist to left arm. Resident stated that she got the bruises from the morning nurse. Resident stated, "The nurse from the morning beat me up. She snatched my arms and squeezed them. Therefore, all my arms are bruised. The resident indicated she had to grab the nurse breast to stop her from hurting her and that was all she could do."

A telephone interview was conducted with Nurse #1 on 06/22/2022 at 9:00AM, Nurse #1 stated on 12/25/2021, NA #2 reported to her that she observed bruises on Resident # 222 bilateral upper extremities with open skin tears and observed the resident bleeding on her lips. Nurse #1 stated she completed the skin assessment and observed the bruises on the resident upper extremities and the resident's lips was injured. Nurse #1 stated she asked the resident what had happened to her and the resident reported that the morning nurse had beat her up. Nurse #1 reported the allegation of the alleged abuse of Resident # 222 to Nurse #2 who was the weekend supervisor.

A telephone interview was conducted with NA#2 on 06/22/2022 at 9:25 AM, NA#2 stated she was not assigned to Resident # 222 on 12/25/2021. NA# 2 indicated she was asked to go see Resident # 222 by NA#1 who indicated she had observed bruises on Resident # 222 and the resident reported to her that she had been beaten up by NA#3. NA#2 reported she observed the resident with bruises on her left upper extremities

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

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 607	Continued From page 17	F 607		

and noticed her lips was bleeding. She asked the resident what happened, and the resident indicated her morning NA had beaten her up. NA#2 stated she reported her observation and the abuse allegation to Nurse #1.

A telephone interview was conducted with NA#1on 06/22/2022 at 9:30AM, NA#1 stated she was in the process of changing another resident when she had Resident # 222 yelling and screaming. She did not think of anything but after she finished changing the other resident, she went to check on Resident #222. She noticed NA #3 coming from Resident # 222's room. Upon entering Resident # 222's room, she observed the resident with bruises on her left arm upper extremities and her lips was bleeding. She asked NA#2 to go in the resident's room with her to confirm what she observed. NA #1 also indicated she had spoken and observed Resident # 222 in the morning during breakfast and she did not have any bruises on her upper left or right arms. The resident told both NA#1 and NA#2 that NA#3 beat her up. They reported their findings to Nurse # 1.

An interview was conducted with the Nurse #3 on 06/22/2022 at 11:20 AM, Nurse #3 stated she completed Resident #222 skin assessment on 12/27/2021. She reported she observed bruises on the resident as purple color discolorations on the left arms. Nurse #3 indicated it was consistent with fingerprints on the resident's left upper extremities. She stated she observed Resident #222 bottom lip was excoriated. She further stated the resident reported to her that NA#3 beat her up and that was the reason she had bruises

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

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F 607	Continued From page 18	F 607		

on her left arm and her lips.

An interview was conducted with the weekend supervisor Nurse#2 on 06/22/2022 at 3:10PM, Nurse #2 stated Nurse #1 reported to her that Resident # 222 had bruises on her left arm upper extremities and the resident was reporting that NA#3 had beaten her up. Nurse #2 reported she went to Resident #222 to complete the skin assessment. She reported she observed bruises on the resident's left arm.

NA#3 was no longer employed at the facility.

The Director of Nursing who completed the investigation was no longer employed at the facility.

The Administrator who completed the abuse investigation was no longer employed at the facility.

Resident # 222 was no longer at the facility. She expired on 05/21/2022.

An interview was conducted with the current Administrator on 06/23/2022 at 11:30 AM. The Administrator stated she was an interim Administrator at the time of Resident # 222 abuse allegation. The Administrator reported she was not part of the staff that investigated the abuse allegation of Resident # 222 in December 2021. The Administrator stated the weekend supervisor Nurse #3 on 12/25/2021 was required to report immediately to the DON and Administrator per facility abuse policy. The Administrator reported CNA#3 should have been suspended immediately and the police should have been notified immediately. She also indicated the staff

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 06/24/2022

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F 607	Continued From page 19	F 607		

at the facility will continue to be in serviced on reporting the allegation immediately to their supervisor.

A telephone interview was conducted with the current DON on 06/23/2022 at 11:41 AM. DON stated she was not employed at the facility when Resident # 222 had an allegation of abuse. She stated the staff at the facility will continue to be educated reporting an allegation of abuse immediately to their supervisors. She stated no residents should be abused at any time at the facility.

The facility provided the following corrective action plan with a completion date of 01/05/2022.

1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

" The Director of Nursing submitted the allegation of abuse report to the Division of Health Service Regulation (DHSR) agency on 12/27/21. Investigation was initiated. Administrator contacted the local police department 12/27/21 at 5:10 pm. Police interviewed the resident 12/27/21 at 7:30 p.m.
" The alleged staff was identified as an agency CNA#3. The Administrator notified the Staffing Agency of the allegation on 12/27/2021. The Director of Nursing reported the allegation to the Nurse Aide Registry on 12/27/2021. The CNA#3 no longer could work at the facility.
" The Director of Nursing and Nurse Consultant counseled the Nurse Supervisor on 12/28/21 for failing to report the allegation to Administration immediately.

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F 607	Continued From page 20	F 607		

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
" The Licensed Nursing Staff began a physical assessment of all non-alert/oriented residents to ensure there were no other injuries or evidence of abuse. No other allegations or injuries were identified. The assessments were completed by 12/30/21.
" The Director of Nursing interviewed all alert/oriented residents on 12/28/21 to determine if other allegations of abuse had occurred. There were no other allegations reported or abuse identified.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
" After completing a root cause analysis of why the allegation was not reported to Administration immediately, it was determined the Licensed Practical Nurse notified the Nurse Supervisor and thought the supervisor was contacting Administration. The Nurse Supervisor failed to report the allegation timely to Administration.
" 12/31/21 Staff Development Coordinator and or Director of Nursing will in-service all staff to ensure each person knows the policy and procedure revision for abuse reporting. The in-service material included identification and reporting of suspected abuse, protecting the resident involved as outlined in the facility policy:
" 7. B (2) - All alleged violations are to be reported immediately to the Administrator, Director of Nursing, Nursing Supervisor, On-Call

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

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F 607	Continued From page 21 Nurse and/or other Administrative Designee. " 6. A - Protecting the Resident During the Investigation of the Alleged Abuse: The Administrator in consultation with the appropriate supervisor will decide on an employee working status. The employee may be terminated or suspended from their duties pending the results of the investigation. It will be the direct responsibility of the Nursing Supervisor to ensure that the resident involved continues to receive appropriate care. " In-services will be completed by January 5, 2022. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. 12/31/21 - The Director of Nursing will monitor all allegations of abuse for one month to determine if facility policy was followed for reporting the allegation to Administration immediately, steps to protect the resident were taken (alleged staff suspended, removed from work duties). Audit results will be documented on the audit tool titled "Allegations of Abuse Reporting". Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. The Committee was notified of this responsibility on 01/3/22. As part of the validation process on 06/24/2022, the plan of correction was reviewed. The licensed staff, nursing assistants, supervisors who interact with residents and alert and oriented residents that were interviewed were aware of to	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 22 whom and how to report allegations, incidents, and or complaints. Five direct care staff representing all three shifts were interviewed to determine whether each staff member was trained in and knowledgeable about, how to appropriately intervene in situations involving residents who have aggressive or catastrophic reactions and knowledgeable regarding what, when, and to who to report according to the facility policies. The facility alleges full compliance with this plan of correction effective 01/05/2022.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		7/22/22

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 06/24/2022

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F 656	Continued From page 23 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a careplan related to indwelling urinary catheter care for 1 of 19 residents sampled for care plans (Resident #71). Findings included: Resident #71 was initially admitted to the facility on 11/23/21 with the last readmission on 4/27/22. His diagnoses included overactive bladder and retention of urine. Physician order dated 4/27/22 indicated provide catheter care every shift 7 am- 3 pm, 3 pm-11 pm, and 11 pm- 7 am. The most recent quarterly Minimum Data Set (MDS) assessment dated 5/4/2022 indicated Resident #71 had an indwelling urinary catheter.	F 656	PLAN OF CORRECTION F656 CARE PLANS Disclaimer Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial	

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 06/24/2022

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 656 Continued From page 24

Physician order dated 6/9/22 indicated continue with aggressive hygiene, change promptly after bathroom to prevent breakdown and further urinary tract infection (UTI).

Resident #71's care plan revised 6/9/2022 did not include information or interventions related to indwelling urinary catheter care.

An interview was conducted on 6/22/22 at 2:49 pm with the MDS Nurse. She stated Resident #71 should have had a careplan for indwelling urinary catheter since he had a catheter. The MDS Nurse stated she was responsible for updating the careplan and it was an oversight.

During an interview on 6/22/22 at 3:30 pm with the Director of Nursing (DON), she stated Resident #71's careplan should have been updated to include urinary catheter care.

During an interview with Facility Administrator on 06/23/22 at 11:32 am, she stated her expectation was Resident #71's careplan should have been updated to reflect the care of Resident #71.

F 656

measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.

1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
On June 22,2002 the Minimum Data Set (MDS) nurse updated Resident #71's care plan to include the following interventions: monitor for signs and symptoms of urinary tract infection and provide catheter every shift and after incontinent episodes.

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
Care plans were reviewed on June 22,2022 by the Minimum Data Set (MDS) nurse for all residents who had indwelling catheters to determine if the care plan included the indwelling catheter and catheter care interventions. If the care plan was not evident or accurate, one was implemented or revised accordingly by the Minimum Data Set (MDS) nurse to include the indwelling catheter and catheter care interventions.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
On July 11, 2022 the Interdisciplinary care plan team members were in-serviced by the Nurse Consultant on care plan

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 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 25	F 656	development and updating care plans to reflect the resident's current condition/problems and care regimen. Staff not present for these in-services will be in-serviced prior to working their next scheduled shift. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Interdisciplinary Care Plan team will monitor at least 3 care plans each week for 3 weeks to determine accuracy and the plan includes the current care regimen and condition of the resident. The Clinical Consultant will also assist with monitoring at least 5 care plans during routine visits. Audit results will be recorded on an audit tool titled "Care Plan Updates". Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee (Administrator, Director of Nursing, Medical Director, Quality Assurance nurse, Infection Preventionist nurse, Minimum Data Set nurse, Social Worker, Maintenance, Therapy, Pharmacy) will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 07/22/22	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care.	F 687		7/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 26 To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide toenail care for 1 of 1 resident sampled for podiatry services (Resident #71). Findings included: Resident #71 was initially admitted to the facility on 11/23/21 with the last readmission on 4/27/22. His diagnoses included diabetes and generalized muscle weakness. The most recent quarterly Minimum Data Set (MDS) assessment dated 5/4/2022 indicated Resident #71 was moderately impaired and was totally dependent on staff for personal hygiene. Resident #71's care plan initiated 3/3/21 indicated he had selfcare deficit and required assistance with activities of daily living. Resident #71's toenails were observed on 6/22/22 at 11:40 am when Nursing Assistant #3 (NA#3) took off his socks. Toenails to both feet were noted to be long and thick. NA #3 stated Resident #71's toenails had been like that since	F 687	PLAN OF CORRECTION F687 FOOT CARE Disclaimer Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. # 1 - Address how corrective action will be	

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 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 687

Continued From page 27

Resident #71 was transferred to C-Hall over a week ago. NA #3 explained she had informed Nurse #4 about the overgrown toenails, and she did not know when the toenails would be clipped.

During an interview on 6/22/22 at 12:00 pm with Nurse #3, she indicated Resident #71's toenails were supposed to be clipped by podiatry since he was a diabetic and his toenails were thick. Nurse #3 stated she did not know when Resident #71's toenails would be clipped.

During an interview with Nurse #4 on 6/22/22 at 1:40 pm, she stated she was not aware Resident #71's toenails required clipping. She indicated she could not recall a time she was notified by NA#3 or any other staff member that Resident #71's toenails required clipping.

An interview was conducted with C-Hall Unit Manager (UM) on 6/22/22 at 1:57 pm. The UM indicated Resident #71 missed being seen by the podiatrist that came to the building on 5/16/22 and was to be transported to podiatry office for toenail clipping.

During an interview with facility Social Worker (SW) on 6/22/22 at 2:00 pm, she stated Resident #71 was not on the list to be seen by podiatry at the facility in March, April, and May 2022. The SW stated she had not been notified by anyone to add Resident #71 to the list for podiatry services.
An interview was conducted with Director of Nursing (DON) on 6/22/22 at 3:30 pm. The DON stated Resident #71 missed being seen by the Podiatrist that came to the facility in May 2022 and he was scheduled to be seen at podiatry clinic on 6/23/22. She further stated Resident

F 687

accomplished for those residents found to have been affected by the deficient practice;
On 6/23/22 Resident #¬¬¬¬¬¬ 71 was seen by the Podiatrist at his office and toenail care was provided by the Podiatrist.

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
The Unit Managers observed all residents on June 22, 2022 to assess if any additional residents needed toenails trimmed or podiatry services. Toenail care was provided by the nurse aide staff or licensed nurses for any resident identified as needing toenail care. Any resident identified needing podiatry service not already scheduled for an appointment was scheduled.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
On June 28,2022 the Staff Development Coordinator began in-servicing all licensed nurses and nurse aide staff, including agency staff, on assessing and providing toenail care on the days the resident receives a bath/shower.
Re-training included podiatry service identification and scheduling. Staff not present for these in-services will be in-serviced prior to working their next scheduled shift.

The Administrator and Director of Nursing

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 06/24/2022

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 687	Continued From page 28 #71's toenails should have been clipped when they were noted to be overgrown. During an interview on 6/22/22 at 4:00 pm with Facility Administrator, she stated she had been informed by long-term care Ombudsman about the overgrown toenails and she thought Resident #71 was added on the list to be seen by podiatrist in May 2022, but he somehow missed being seen. The Administrator stated the facility was planning to send Resident #71 to an offsite podiatrist for nail clipping.	F 687	reviewed the process for scheduling resident's to be seen by Podiatry. The following process will be implemented: • The Unit Managers will be responsible for reviewing the list of residents to be seen by the Podiatrist prior to the scheduled visit to ensure all residents are on the list. • The Unit Managers will then give the Social Worker the list to provide to the Podiatrist on the day of the scheduled visit. • The Unit Managers will be responsible for notifying the Social Worker for residents needing to be seen by Podiatry outside of the routine scheduled visits so an appointment with the Podiatrist office can be made. The Unit Managers and Social Worker were notified of the process changes listed above on July 7, 2022 by the Administrator. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Unit Managers or his/her designee will observe at least 3 residents on each unit weekly for 3 weeks to determine if toenail care has been provided. The Unit Managers or his/her designee will review the resident roster for Podiatry visits to assure that all residents that require Podiatry visits are seen according to the schedule. This review will be done quarterly for two quarters. The results of the observations will be recorded on an	

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

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F 687	Continued From page 29	F 687	audit tool titled “Toenail Care/Podiatry Visits”. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee (Administrator, Director of Nursing, Medical Director, Quality Assurance nurse, Infection Preventionist nurse, Minimum Data Set nurse, Social Worker, Maintenance, Therapy, Pharmacy) will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 07/22/22	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		7/22/22

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 30	F 690		

is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews, the facility failed to provide indwelling urinary catheter care according to physician orders for 1 of 1 sampled resident reviewed for indwelling urinary catheter (Resident #71).

Findings included:

Resident #71 was initially admitted to the facility on 11/23/21 with the last readmission on 4/27/22. His diagnoses included overactive bladder and retention of urine.

The most recent quarterly Minimum Data Set (MDS) assessment dated 5/4/2022 indicated Resident #71 was moderately impaired and was totally dependent on staff for personal hygiene. The MDS also indicated Resident #71 had an indwelling urinary catheter.

Resident #71's care plan revised 6/9/2022 did not

F690 CATHETER CARE

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F 690

Continued From page 31

include information or interventions related to indwelling urinary catheter care.

Physician order dated 6/9/22 indicated continue with aggressive hygiene, change promptly after bathroom to prevent breakdown and further urinary tract infection (UTI).

Physician order dated 6/10/22 indicated provide catheter care every shift 7 am- 3 pm, 3 pm-11 pm, and 11 pm- 7 am.

During observation of incontinence care on 06/22/22 at 11:34 am, Resident #71 had a large bowel movement. Nursing Assistant # 4 (NA#4) assisted Resident #71 to a side lying position and cleaned Resident #71 buttocks using wipes. NA#4 did not clean the meatus or urinary catheter.

During an interview with NA#4 on 6/22/22 at 11:45 am she stated she had not provided urinary catheter care for Resident #71 since she started her shift at 7 am. She verbalized she did not provide catheter care on 6/22/22 at 11:34 am because it was normally provided on the days Resident #71 was scheduled for baths and he was not scheduled for a bath on 6/22/22. NA#4 stated she had been trained to provide catheter care after every incontinence episode and she would provide catheter care for Resident #71 when she transferred him back to bed after lunch later that afternoon.

During an interview with Nurse #5 on 06/22/22 at 12:00 pm, she stated NA#4 should have provided urinary catheter care for Resident #71 during the incontinence care at 11:34 am. Nurse #5 stated urinary catheter care was to be provided at least

F 690

How will corrective action be accomplished for those residents found to have been affected by the deficient practice:
Catheter care was provided immediately on June 22, 2022, by the Charge Nurse and Nurse Aide for Resident # 71.
On June 22, 2022 the Unit Manager counseled the Nurse Aide # 4 on failure to provide proper catheter care during the time she provided incontinence care.

How will the corrective action be accomplished for those residents having the potential to be affected by the same deficient practice:
On June 23, 2022, the nurse aide care guides for residents who had an indwelling catheter, were updated by the Minimum Data Set (MDS) nurse to include: Catheter care every shift and as needed after every incontinent episode.

The Unit Managers observed incontinence care on June 28,2022, on the two residents who had indwelling catheters to ensure catheter care was provided. Compliance was noted.
What measures will be put into place or systemic changes made to ensure the deficient practice does not recur:
The Staff Development Coordinator began educating the nurse aide staff and licensed nursing staff (including agency staff) on June 28, 2022, on the need to provide catheter care every shift and each time incontinent care is provided. Staff not present for these in-services will be

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

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F 690	Continued From page 32 once a shift and after every incontinence episode. During an interview on 6/22/22 at 3:30 pm with the Director of Nursing (DON), she stated NA#4 should have provided urinary catheter care during the first shift (7 am- 3 pm). The DON indicated she expected all nursing staff to follow physician orders and facility policy and procedure. During an interview with Facility Administration on 06/23/22 at 11:32 am, she stated her expectation was for NA#4 to follow physician order and provide urinary catheter care during 7am-3pm shift. During an interview on 11:53 am with the facility Physician. She stated she expected nursing staff to follow physician orders as given.	F 690	in-serviced prior to working their next scheduled shift. On June 23, 2022, the nurse aide care guides for residents who had an indwelling catheter, were updated by the Minimum Data Set (MDS) nurse to include: Catheter care every shift and as needed after every incontinent episode. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality Assurance program will be put into place: The Unit Managers will observe incontinence care for residents with an indwelling catheter weekly for 3 weeks to determine if catheter care is provided. The results of the observations will be recorded on an audit tool titled “Indwelling Catheter Care”. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee (Administrator, Director of Nursing, Medical Director, Quality Assurance nurse, Infection Preventionist nurse, Minimum Data Set nurse, Social Worker, Maintenance, Therapy, Pharmacy) will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 07/22/22	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		7/22/22

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

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

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F 695 Continued From page 33

tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, staff and physician interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident (Resident #9) reviewed for respiratory care.

The findings included:

Resident #9 was initially admitted to the facility on 1/13/12 with the last readmission on 1/31/22. Her diagnoses included cerebrovascular disease, heart failure and dependence on supplemental oxygen.

Resident #9's care plan revised 2/1/22 indicated Resident #9 was on oxygen therapy related to congestive heart failure. Interventions included administer oxygen per physician orders.

The most recent comprehensive Minimum Data Set (MDS) assessment dated 3/11/22 indicated Resident #9 was cognitively impaired and received oxygen therapy. Diagnoses included heart failure and respiratory failure.
Physician order dated 6/2/22 indicated administer oxygen at 2 liters/minute via nasal cannula as needed to maintain oxygen saturations at 90%.

During observation on 06/20/22 at 10:15 AM

F 695

PLAN OF CORRECTION

F695 Respiratory Care

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1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695 Continued From page 34

Resident #9 was observed with the oxygen nasal canula. Resident #9's oxygen regulator on the concentrator was set at 4.5 liters/minute when viewed horizontally at eye level.

During observation on 06/20/22 at 2:39 PM Resident #9 was observed with the oxygen nasal canula. Resident #9's oxygen regulator on the concentrator was set at 4.5 liters/minute when viewed horizontally at eye level. Resident #9's oxygen regulator was verified with Nurse #4 to be set at 4.5 liters/minute.

During an interview on 06/20/22 at 3:02 PM with Nurse #4, she stated Resident #9 had a physician order for oxygen at 2 liters/minute via nasal cannula as needed. Nurse #4 stated she had not adjusted the oxygen levels during her shift and did not know when the oxygen settings were adjusted.

During observation on 06/22/22 at 1:39 PM Resident #9 was observed with the oxygen nasal canula. Resident #9's oxygen regulator on the concentrator was set at 3 liters/minute when viewed horizontally at eye level. Resident #9's oxygen regulator was verified with Medication Aide #1 to be set at 3 liters/minute.

During an interview on 06/22/22 at 1:42 PM with Medication Aide #1, she stated she had not adjusted Resident #9's oxygen levels during her shift and did not know when the oxygen settings were adjusted.

An interview was conducted on 06/22/22 3:15 PM with the Director of nursing (DON). She stated Nurse #4 and Medication Aide #1 should have ensured Resident #9's oxygen regulator was set

F 695

Nurse # 4 adjusted the flow of Resident # 9’s oxygen concentrator to 2 liters per the Physician order immediately on June 22, 2022. The Director of Nursing counseled Nurse # 4, and Medication Aide #1 on observing the oxygen flow rate meter to ensure it was set at the flow rate ordered.

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
On June 22, 2022, the Unit Managers compiled a list of all residents using oxygen and the prescribed liters. The Unit Managers then observed the oxygen regulator to ensure it was on the appropriate setting. A total of 10 residents were observed and compliance noted (oxygen rate was set at the rate prescribed by the Physician).

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
On June 23, 2022 the Staff Development Coordinator began in-servicing all licensed nursing staff (including agency staff) to observe the concentrator regulator horizontally at eye level to ensure an accurate reading and to ensure the level is at the prescribed rate. The technique was demonstrated by the instructor. Staff not present for these in-services will be in-serviced prior to working their next scheduled shift.

- 4 Indicate how the facility plans to

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 06/24/2022

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 695	Continued From page 35 at the physician ordered rate. The DON explained she expected nursing staff to follow physician orders and to request an updated order if there was a need to titrate the oxygen. During an interview on 06/23/22 at 11:32 AM with the facility Administrator, she stated she expected nursing staff to administer oxygen per physician orders. An interview was conducted on 06/23/22 at 11:53 AM with the facility Physician. She stated Resident #9 had an order for oxygen at 2 liters/minute via nasal cannula as needed. The Physician stated she expected nursing staff to follow physician orders as given and to call the physician if they needed to titrate the oxygen rate.	F 695	monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing and/or Registered Nurse Supervisors will monitor at least 2 residents using oxygen to ensure the regulator setting is as prescribed by the Physician. This will be done 3x/week for 2 weeks. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee (Administrator, Director of Nursing, Medical Director, Quality Assurance nurse, Infection Preventionist nurse, Minimum Data Set nurse, Social Worker, Maintenance, Therapy, Pharmacy) will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 07/22/22	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		7/22/22

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 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 727	Continued From page 36 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 5 of 50 days reviewed (5/9/22, 5/20/22, 5/23/22, 5/30/22 and 6/13/22). Findings included: A review of the Nursing schedule dated 5/1/22 through 6/19/22 revealed no scheduled Registered Nurse (RN) on 5/9/22, 5/20/22, 5/23/22, 5/30/22 and 6/13/22. During an interview on 6/23/22 at 1:21 pm with the facility Scheduler, she indicated she was aware there should have been a Registered Nurse scheduled daily for at least 8 hours. The Scheduler stated she may not have scheduled an RN on some of the days because there was no available RN to schedule. During an interview with the Director of Nursing (DON) on 6/24/22 at 1:25 pm, she indicated the facility did not have an RN on duty for at least 8 hours a day on 5/9/22, 5/20/22, 5/23/22, 5/30/22 and 6/13/22 due to call outs. The DON stated the facility should have had a Registered Nurse on duty for at least 8 hours a day, 7 days a week for the 5 days that an RN was not scheduled. An interview was conducted with the facility Administrator on 6/24/22 at 3:28 pm. She stated she expected the Scheduler to staff a Registered Nurse for 8 hours per day, 7 days a week.	F 727	F727 RN COVERAGE 8 hours day/7 days/week Disclaimer Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: On June 22, 2022, the Director of Nursing provided additional education to the Nursing Scheduler on the need to ensure a Registered Nurse is scheduled at least 8 hours per day/7 days a week. How will the corrective action be accomplished for those residents having	

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	345353	A. BUILDING ______ B. WING ______	C 06/24/2022

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F 727	Continued From page 37	F 727	the potential to be affected by the same deficient practice: On June 23, 2022 the Nursing Scheduler reviewed the nursing schedule for the upcoming four (4) weeks to ensure a Registered Nurse was scheduled for each day. Compliance was noted. What measures will be put into place or systemic changes made to ensure the deficient practice does not recur: The Director of Nursing will continue to review the monthly staffing schedule at least two times per week to ensure a Registered Nurse is scheduled for at least 8 hours a day. On July 07, 2022 the Administrator notified the Registered Nurses via email and/or memorandum of the procedure change for calling out. The procedure change outlines that any Registered Nurse who cannot work their assigned shift must notify the Director of Nursing directly. On July 07, 2022, The Administrator, Director of Nursing and Director of Operations reviewed the facilities current recruitment plan for Registered Nurses. As a result, the current recruitment efforts will continue: • The fiscal year staffing budget (October 2021 – September 2022), budgeted additional Registered Nurse positions to the Nursing Budget by facility Management in an attempt to include Registered Nurse positions for at least two shifts, 7 days a week. • On January 7, 2022 advertisements were updated with Indeed (staff recruiting agency) for vacant nursing staff positions	

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F 727	Continued From page 38	F 727	that included Registered Nurses. The Registered Nurse advertisements were refreshed and updated on April 12, 2022 and April 21, 2022. The advertisements were placed by the Administrator. • In the month of June, the Director of Nursing had six (6) scheduled interviews for Registered Nurse Applicants. Of the six (6) applicants, only two presented for an interview. Two Registered Nurses were hired. One (Part-time 7-3) on 5/25/2022 and one (Full-time 7-3) on June 6, 2022, with a start of employment date of 5/31/2022 and June 20, 2022. Neither new hire showed up for orientation. The Director of Nursing called the applicants on 5/31/2022 to determine why they did not report for orientation. The applicants did not take the call nor return a phone call to the Director of Nursing. • The early part of 2022 the facility entered into agreements with additional staffing agencies to provide a variety of personnel on an as needed basis that includes Registered Nurses. Nurse Select was added on 1/6/22, LRS Healthcare was added on 01/07/22 and Professional Healthcare on 3/17/22. • On 1/15/22 the facility Management approved and implemented the following incentives for staff recruitment and retention: • Wage increases were implemented for licensed staff nurses to better align with industry wage trends and other health care providers. • Registered Nurses retention bonuses are offered as follows: $1,000.00 per year each year retained.	

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F 727	Continued From page 39	F 727	• Attendance bonus is paid at the end of each pay period, the Payroll Clerk reviews the employee schedule to determine if the employee worked all of the shifts they were scheduled. Employees who work scheduled shifts, receive an additional $3.00 an hour for each hour worked in addition to their hourly rate, shift pay and/or weekend pay. • The Administrator will continue to ensure advertising and recruitment for registered nurses. Director of Nursing will continue making recruiting and interviewing registered nurse applicants a priority. The following new measures will be implemented to enhance the facility recruitment efforts of Registered Nurses: • By 07/08/2022 Administrator will contact the North Carolina Board of Nursing to obtain a list of Registered Nurses with addresses in the residing county (Cumberland County) as well as surrounding counties (Harnett County-north, Sampson County- east, Bladen County- south, Robeson County- southwest, Hoke County- west, and Moore County- west). A direct mail recruitment letter for employment will be mailed directly to all those registered nurses listed. • Beginning 06/29/22 the Director of Nursing and/or Administrator will communicate with appropriate leaders and/or instructors and visit Fayetteville Technical Community College at least monthly to enhance recruitment of Licensed Nurses and Registered Nurses. How the corrective actions will be	

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F 727	Continued From page 40	F 727	monitored to ensure the practice will not recur, i.e., what Quality Assurance program will be put into place: The Administrator will meet with the Director of Nursing weekly to • Review Registered Nurse coverage for at least 8 hours/day 7days/week; • Audit tool • The number of Registered Nurse vacancies. • The number of applications received and date of scheduled interview. If an interview was not conducted an acceptable reason must be documented. • The number of newly hired Registered Nurses. • The results will be recorded on an audit tool titled “Registered Nurse Staffing”. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee (Administrator, Director of Nursing, Medical Director, Quality Assurance nurse, Infection Preventionist nurse, Minimum Data Set nurse, Social Worker, Maintenance, Therapy, Pharmacy) will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 07/22/22	
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	F 880		7/22/22

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F 880	Continued From page 41	F 880		

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, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 42 (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 observation, record review and staff interviews, the facility failed to implement their infection control policy when 1 of 3 staff (Nursing Assistant #5) failed to wear a mask in resident rooms. The failure occurred when the facility was in a Covid outbreak status. Findings included: Facility infection prevention and control policy dated 2/16/22 titled, "Personal Protective Equipment (PPE) Policy" indicated the type of PPE used would vary based on the level of precautions required, such as standard, droplet or	F 880	F880 Disclaimer Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. Any changes	

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F 880	Continued From page 43 airborne. The facility would provide appropriate PPE for staff, residents, and visitors. The policy indicated a surgical mask should be used for droplet precaution. Mask and goggles or face shield should be used for standard precautions during patient care activities. During facility tour on 6/20/22 at 10:44 am Nursing Assistant #5 (NA#5) was observed sitting behind the curtain next to Resident #13's bed without a mask on. NA#5 was drinking a soda and Resident #13 was lying in bed with eyes closed. NA#5's personal handbag was observed hanging on the doorknob of Resident #13's room. During an interview on 6/20/22 at 10:44 am with NA#5, she stated she had completed rounding on her assigned residents and was taking a break. NA#5 indicated she was aware she was supposed to keep her mask on while in residents' rooms, but she needed to take a break and did not know if the breakroom was open. An interview was conducted with A-Hall Unit Manager (UM) on 6/20/22 at 11:15 am. The UM stated nursing staff were to always don a mask in residents' rooms. She further stated NA#5 should not have taken a break, eat or drink in a resident's room. An interview was conducted on 6/20/22 at 11:40 am with facility Infection Preventionist (IP). The IP indicated facility staff were to don mask and eye protection while in residents' rooms since the facility was in outbreak status. An interview was conducted with Director of Nursing (DON) on 6/20/22 at 12:30 pm. The DON stated she expected all staff to don a mask in all	F 880	to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Nurse aide # 5 was immediately re-educated by the Infection Preventionist on June 22, 2022, on the requirement that Personal Protective Equipment (surgical masks) and protective eye wear must be worn while in resident care areas while the facility is in Covid outbreak status, inappropriateness of taking a break (consuming a soda) in resident rooms, and inappropriateness of placing personal items (handbag) in resident's room. The Director of Nursing contacted the Staffing Agency on June 22, 2022 to report the deficient practice to ensure the Nurse Aide #5 received counseling/disciplinary action by her supervisor for failing to wear the appropriate Personal Protective Equipment, taking a break (consuming food/beverages) while in a resident's room, placing her personal handbag on the resident's room doorknob. The Administrator contacted the Staffing Agency for a copy of the disciplinary action/counseling for Nurse Aide #5 on July 6, 2022. How will the corrective action be accomplished for those residents having the potential to be affected by the same	

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F 880	Continued From page 44 residents' rooms. She indicated NA#5 should have gone to the break room to take a break and drink the soda. During an interview on 6/20/22 at 12:30 pm with Facility Administrator, she indicated NA#5 should not have taken her break in Resident 13's room. She expected all staff to keep mask and eye protection on while in residents' rooms.	F 880	deficient practice: On June 22, 2022, the Infection Preventionist made rounds observing employees to determine if the Personal Protective Mask and eye protective equipment were worn appropriately. During the rounds, the supervisory staff also observed to ensure no staff were taking breaks in resident’s room and staff personal items were not in resident rooms. During the rounds no deficient practices noted. What measures will be put into place or systemic changes made to ensure the deficient practice does not recur: Facility staff in all departments, including contracted Dietary and Housekeeping/ Laundry, and Agency employees were re-educated by the Infection Preventionist beginning June 28, 2022 and concluded on July 1, 2022 on the Employee and Essential Healthcare Personnel (HCP) requirements for utilizing personal protective equipment, including surgical facemasks and protective eyewear. Newly hired staff members and agency staff will continue to be in-serviced on this requirement by the Infection Preventionist or designee as part of the facility orientation. Staff not present for these in-services will be in-serviced prior to working their next scheduled shift. How the corrective actions will be monitored to ensure the practice will not recur, i.e., what Quality Assurance program will be put into place: To ensure ongoing compliance, daily audits of staff practices of wearing surgical masks and protective eyewear	

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F 880	Continued From page 45	F 880	will be performed for one week, then weekly for 2 weeks and documented on an audit tool title “Personal Protective Equipment (PPE) Mask Audit Tool” beginning June 22, 2022 by the, Infection Preventionist, Unit Managers, Department Managers and/or designated nursing staff. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee (Administrator, Director of Nursing, Medical Director, Quality Assurance nurse, Infection Preventionist nurse, Minimum Data Set nurse, Social Worker, Maintenance, Therapy, Pharmacy) will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 07/22/22	