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	345353	A. BUILDING _____ B. WING _____	C 04/26/2023

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

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey was conducted from 4/25/23 to 4/26/23. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# K5HP11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 04/25/2023 & 04/26/2023. The facility was found out of compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# K5HP11The following intakes were investigated NC00200554 and NC0000199814. One of the two complaint allegations resulted in deficiency.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		6/9/23

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

Electronically Signed | 05/20/2023

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F 880	Continued From page 1 §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 (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.	F 880		

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F 880	Continued From page 2 §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 and staff interview the facility 1) failed to implement their policy for transmission-based precautions when Resident #8 presented with fever and cough and 2) perform hand hygiene during meal delivery and set up which required a Nurse Aide to position residents or their personal belongings on 1 of 2 units. The findings included: Review of the facility's policy, entitled "2022 COVID-19 Response Program" revealed the policy originated on 10/2022 and was last reviewed in 4/2023. The policy noted it referenced the CDC's (Centers for Disease Control) recommendations in their policy. The policy directed that health care personnel should initiate transmission- based precautions when there is suspected or confirmed COVID 19 (Coronavirus Disease). 1. Resident # 8 was admitted to the facility on 3/31/22. Resident # 8's diagnoses included in part cancer and epilepsy. Resident # 8's quarterly MDS (Minimum Data	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 INFECTION CONTROL The facility failed to initiate Isolation precautions for a resident with Covid like symptoms. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3 / 14 /2023 resident # 8 was placed on isolation precautions per facility policy, upon return from the x 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. hospital, with a COVID	

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F 880	Continued From page 3 Set) assessment, dated 12/22/22, coded the resident as cognitively impaired and as not moving around or off the unit on which he resided during the assessment period. On 3/1/23 at 4:09 PM Nurse # 1 made an entry noting the following. "Nurse called to resident's room per family request to get his temperature which was 99.7. Resident also noted to have congested non-productive cough. VS (vital signs) 129/87, p (pulse)84- R (Respirations) 18, O2-93% on RA (room air). There was no documentation that Resident # 8 was placed on transmission- based precautions when he started showing signs of a cough and fever. Nursing notes on 3/2/23 at 3:15 PM revealed Resident # 8 was transferred to the hospital on 3/2/23 when he had a change in responsiveness. Hospital records revealed Resident # 8 was evaluated in the hospital on 3/2/23 and found to be COVID positive. Nurse # 1 was interviewed on 4/25/23 at 2:44 PM and again on 4/26/23 at 3:20 PM and reported the following. Resident # 8's family was concerned about Resident # 8 on 3/1/23 because of a cough and low- grade fever. While in the room assessing Resident # 8, she also heard the resident cough, and the resident had a low- grade fever. She had not suspected that Resident # 8 had COVID and did not initiate transmission-based precautions. The facility's DON (Director of Nursing) was interviewed on 4/25/23 at 2:10 PM and 4 PM and again on 4/26/23 at 1:20 PM. The DON reported	F 880	positive diagnosis. All current residents and staff have the potential to be affected by the deficient infection control practice. On 4/27/2023 the Infection Control Preventionist completed monitored ofresident change in condition to determine if deficient practices were noted related to initiating isolation precautions for any residents with symptoms of Covid 19. The results include: No residents were noted with Covid 19 related symptoms. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/1/2023 the corporate Quality Assurance (QA) Nurse Consultant completed Covid 19 Response policy education for the Administrator and Director of Nursing which included hand hygiene, initiating transmission-based precautions, appropriate utilization of personal protective equipment. On 5/1/2023 the Director of Nursing/Infection Control Preventionist began education with all nursing staff to include agency, on initiating the facility Covid 19 Response Program which includes when to initiate transmission -based precautions for residents with Covid 19 symptoms. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 6/09/2023, any staff who does not receive scheduled	

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F 880	Continued From page 4 the following. Testing for other residents and staff had begun on 3/3/23 and transmission- based precautions were put in place on that date for those residents who tested positive. The facility had been able to contain the virus from spreading to their other wing. 2. Meal observations were made on the long -term care wing beginning on 4/26/23 at 12:10 PM and ending at 12:22 PM. Nurse Aide (NA) #1 was observed as he delivered meal trays to residents who were in their rooms. Between the time of 12:10 PM and 12:22 PM, the following was observed. NA # 1 was observed to obtain the meal tray for Resident # 16 and set up the meal tray for Resident # 16 in her room. In doing so, he handled personal items in her room. He then went to the meal cart, obtained Resident # 15's tray and set her meal tray up. NA # 1 then went back to the meal cart, obtained Resident # 17's meal tray. He set up Resident # 17's meal tray. He then helped Resident # 17 to begin eating by placing the spoon in her hand. He then guided her hand and spoon to her mouth several times to encourage her to begin eating. He then went back to the meal cart and obtained Resident # 19's meal tray, assisted her to sit up on the side of the bed and set her meal tray up. He then went back to the meal cart and obtained Resident # 18's meal tray and set her meal tray up for her. He then went to the meal cart and obtained Resident # 21's meal tray, took it to his room, assisted him to sit up and position in bed to eat, and then set his meal tray up. He then went back to the meal cart, obtained Resident # 20's meal tray, and set it up for Resident # 20. Between assisting these residents and going back and forth to the meal cart, NA # 1 did not perform any hand hygiene. It was observed that there were	F 880	in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator, Director of Nursing or designee will observe and monitor the timely initiation of isolation precautions for any residents with symptoms of Covid 19 using QA screening tool for Monitoring Isolation Precautions. The monitoring will be completed 5 x week weekly x 4 then monthly x 3. QA Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director. Date of Compliance 6/9/2023 F880 INFECTION CONTROL The facility failed to wash hands between Resident 1. Corrective action for resident(s) affected by the alleged deficient practice: On 4/27/23 Certified Nursing Assistant #2	

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F 880	Continued From page 5 multiple hand sanitizing dispensers on the hallway between the rooms where the residents were served. NA # 1 was interviewed on 4/26/23 at 12:38 PM about the lack of hand hygiene as he was assisting with meal set up between multiple residents, which required him to help position some of them or touch their personal items. NA # 1 acknowledged he had not performed hand hygiene and apologized. NA # 1 reported he needed to get used to doing that. The DON was interviewed on 4/26/23 at 1:20 PM and validated Nurse Aides should be performing hand hygiene between resident contacts. The DON stated the reason the hand sanitizer was on the hallway walls was so the staff would use it.	F 880	was educated regarding hand hygiene between residents when passing meal trays by the staff and observed with no further concerns identified. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All current residents and staff have potential to be affected by deficient infection control practices related to the performance of hand hygiene practices. On 4/27/23 the Assistant Director of Nursing completed Infection Control Rounds to determine if deficient practices were noted related to hand hygiene during meal tray pass. The results included: 100%. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/27/23, a root cause analysis was completed for failure to perform hand hygiene, by the Director of Nursing, the root cause found for failure to provide hand hygiene between the passes of trays was lack of knowledge, and lack of supervision and monitoring. On 4/27/23 the Director of Nursing/Assistant Director of Nursing began education with all staff on hand hygiene the education was started using provided you tube videos and Spice education videos on hand hygiene education series for both hand washing with soap and water and use of hand sanitizer. On 4/27/2023 the Director of Nursing/Assistant Director of Nurses began skill observation validations of hand	

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F 880	Continued From page 6	F 880	hygiene of all staff. On 05/18/2023, the Corporate Quality Assurance (QA) nurse consultant completed education for the Administrator and Director of Nursing which included hand hygiene practices. On 4/27/23 the Director of Nursing/Infection Control Preventionist began education and on hand hygiene practices to educate 100% of the staff to include agency. This education will be incorporated into new hire training for all staff. Education for all facility Registered nurses, Licensed practical nurse, medication aides, nursing aides, nonclinical staff, department heads, therapy department environmental services, maintenance, dietary staff and agency will be completed by 6/08/2023. Any of the above staff who does not receive scheduled in-service training by 6/8/2023 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator, Director of Nursing or designee will observe and monitor hand hygiene practices during tray pass for 2 day shift and 2 evening shift 3 x a week to ensure that proper hand hygiene is occurring. This audit will be completed weekly x4 and then monthly x3 or until resolved. Quality assurance reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the	

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F 880	Continued From page 7	F 880	Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, Activities Director, Maintenance Director and Rehab Director.	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this	F 886		6/9/23

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F 886	Continued From page 8	F 886		

paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:

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F 886	Continued From page 9 Based on staff, family, and physician interviews, and record review the facility failed to implement their policy for COVID-19 testing when 1 of 1 sampled resident (Residents # 8) presented with symptoms consistent with possible COVID-19 on 3/1/23 and did not initiate testing of other residents and staff who had been exposed to Resident #8 on 3/1/23 until 3/3/23. On 3/3/23 when testing occurred, twelve residents and three staff members tested COVID positive. The outbreak was contained to one of two facility skilled nursing wings. Findings included: Review of the facility's policy, entitled "2022 COVID-19 Response Program" revealed the policy originated on 10/2022 and was last reviewed in 4/2023. The policy noted it referenced the CDC's (Centers for Disease Control) recommendations in their policy. The policy directed that "anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible." The policy also noted the facility should perform testing for all residents and health care personnel identified as close contacts or on the affected unit if using a broad-based approach regardless of vaccination status. The testing was recommended to start immediately (but not earlier than 24 hours after the exposure). Resident # 8 was admitted to the facility on 3/31/22. Resident # 8's diagnoses included in part cancer and epilepsy. Resident # 8's quarterly Minimum Data Set (MDS) assessment, dated 12/22/22, coded the resident as cognitively impaired and as not moving around or off the unit on which he resided during the assessment period.	F 886	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F886 Covid Testing Corrective Action for Resident Corrective Action for resident potentially affected by the deficient practice. On 05/02/23 the Director of Nursing identified staff and residents that were potentially impacted by this deficient practice of not following the policy and procedure for COVID testing residents with COVID Symptoms by completing audits of the progress notes and change of condition reports times 30 days. The results included 1 resident was identified who had COVID symptoms and were not tested according to the Policy and Procedure. The resident identified were immediately tested per the Covid policy to Perform SARS-CoV-2 Viral Testing. Systemic Changes On 05/02/2023 the DON/ADON began in-servicing all staff (including agency) on the Covid 19 Program policy for Covid testing for all who have COVID	

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F 886	Continued From page 10 A review of activity notes revealed Resident# 8 was one of thirteen residents who attended Bingo at 2:00 PM on 3/1/23. On 3/1/23 at 4:09 PM Nurse # 1 made an entry noting the following. "Nurse called to resident's room per family request to get his temperature which was 99.7. Resident also noted to have congested non-productive cough. (Physician) notified of resident's condition. Chest x-ray suggested by nurse, but MD gave order for Mucinex 600 mg (milligrams) BID (twice per day) x 2 weeks instead because of no history of PNA (pneumonia) or COPD (chronic obstructive pulmonary disease). Resident given 1 dose of Tylenol 1000 mg (milligrams) for fever and standing order of 15 ml (milliliters) Robitussin for cough and tolerated well. Will continue to provide care. VS (vital signs) 129/87, p (pulse)84- R (Respirations) 18, O2-93% on RA (room air). Nurse # 1 was interviewed on 4/25/23 at 2:44 PM and again on 4/26/23 at 3:20 PM and reported the following. Resident # 8's family was concerned about Resident # 8 on 3/1/23 because of a cough and low-grade fever. While in the room assessing Resident # 8, she heard the resident cough one time, and it was "like a cold cough;" but not severe. When Resident # 8 had coughed, he sounded congested. She had called the on- call physician and let the physician know the family was concerned, she also heard the resident cough, and the resident had a low-grade fever. Nurse # 1 had also asked the physician if they could get an x-ray, but at that time the physician did not want to do one. When Resident # 1 started with the cough, there had been no COVID cases in the facility for a very long time. There	F 886	symptoms. This training will include all current staff including agency. This training included: Following the policy for COVID testing.: Perform SARS-CoV-2 Viral Testing Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. The Director of Nursing will ensure that any of the above identified staff/agency who does not complete the in-service training by 6/9/2023 will not be allowed to work until the training is completed. Quality Assurance The Administrator/DON will monitor the Covid 19 testing process weekly for 2 weeks and monthly for 3 months or until resolved for compliance with the process and facility policy. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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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
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were supplies to test for COVID in the facility, but she had not thought to perform one or ask the physician about one. In retrospect she felt she should have done so.

On 3/2/23 at 3:15 PM Nurse # 2 made an entry noting the following information. She had been summoned to Resident # 8's room due to the resident being nonresponsive. The resident's eyes were closed, his skin warm and dry and his respirations even and unlabored. The resident's oxygen saturation was 78-80% on room air. The resident was provided with oxygen. The resident's physician was in the facility and made aware of the resident's condition. Orders were received to transfer the resident to the hospital. A call was placed to 911 and the resident was transferred to the hospital.

Nurse # 2 was not available for interview during the survey.

Resident # 8's responsible party was interviewed on 4/26/23 at 11:36 PM and reported the following. On 3/1/23 another family member had been visiting Resident # 8 and had brought to the nursing staff's attention that they felt the resident was running a fever and had a deep cough.

Review of Resident # 8's initial hospital physical exam on 3/2/23 revealed his pulmonary effort was normal and he had adequate air entry. He was oriented to person and place. Hospital records included documentation he was tested on 3/2/23 for COVID and found to be positive. The hospital physician noted that one of Resident # 8's cancer medications could worsen COVID symptoms. The resident was hospitalized for care.

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 04/26/2023

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Resident # 8's hospital discharge summary, dated 3/12/23, revealed Resident # 8's initial chest x-ray upon admission had shown no acute process. At time of hospital discharge, he had been diagnosed with pneumonia due to infectious organism, but the discharge summary did not note the pneumonia had been related to COVID or any other specific organism.

On 3/14/23 Resident # 8 was transferred back to the facility for care.

Review of facility COVID tracking logs revealed the facility identified they were first in a COVID outbreak on 3/3/23. The facility's first date of initial testing was on 3/3/23. On the initial testing date of 3/3/23, twelve residents tested positive for COVID. The last date noting a resident or staff member tested positive during the outbreak was on 3/22/23; by which date 37 residents had tested positive in the skilled nursing facility. No further resident or staff member tested positive following 3/22/23.

A review of records provided by the facility revealed that 83% of residents were currently COVID vaccinated. All staff were vaccinated for COVID or had a documented, approved exemption. Resident # 8's record indicated his Responsible Party reported he was vaccinated prior to admission for COVID. There was no documentation of the vaccine date on the resident's record.

The facility's Director of Nursing) (DON) was interviewed on 4/25/23 at 2:10 PM and 4 PM and again on 4/26/23 at 1:20 PM. The DON reported the following. At the time Resident #8 began

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being symptomatic with a fever and cough on 3/1/23, they had not had COVID in the facility for a long time. At the time, she had been the Infection Preventionist, and it had not occurred to her to test Resident #8 before he was transferred out of the facility on 3/2/23 since they had not had any residents in a long time with COVID. He had resided in a room by himself. The hospital did not let the facility know until 3/3/23 that Resident # 8 was positive for COVID. Therefore, testing for other residents or staff, who had been exposed to Resident # 8 on 3/1/23 when he was coughing and running a fever, did not begin until 3/3/23. On 3/3/23, they tested all their residents and staff in the skilled part of the facility and twelve residents, and three staff members tested COVID positive. Of the twelve residents who tested positive on 3/3/23, only one had mild symptoms of COVID (a runny nose and cough). The residents, who tested positive, were placed on transmission-based precautions. The facility had two wings for their skilled nursing facility. The spread of the infection never traveled to the other skilled nursing wing of the facility, and they were able to contain it once they did start testing and isolating residents. There were no residents hospitalized due to a COVID infection.

Physician # 1 was the on-call physician for the date of 3/1/23. Physician # 1 was interviewed on 4/26/23 at 3:00 PM revealing the following. When Nurse # 1 called her on 3/1/23, it was her understanding that only the family and not the nurse had heard the cough and Resident # 8 was not currently febrile at the time of the call. Remotely, she had looked in Resident # 8's record and found that Resident # 8 had just been seen by his primary physician the previous day. Nurse # 1 had let her know that Resident # 8's

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family members were very supportive and wanted a lot of interventions and services done for any of his problems. At the time, given his history, the fact that he had just been seen by his primary physician, and it appeared that only the family was hearing the cough, she felt Mucinex was the best treatment. She had not ordered a COVID test to be done.

During the interview with the facility's Medical Director (Resident #8's Physician) on 4/26/23 at 5:15 PM, the Medical Director reported the following. She did not feel as if the spread of the COVID outbreak could definitively be attributed to Resident #8 or that the lack of immediate testing had contributed to further problems.