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 10/22/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 10/20/2020 through 10/22/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID#7LNE11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation was conducted on 10/20/2020 through 10/22/2020. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# 7LNE11. 15 of the 17 complaint allegation were not substantiated.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		11/18/20

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

Electronically Signed | 11/12/2020

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facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for

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example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 585	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, and resident, family and staff interviews, the facility failed to provide a written grievance summary for grievances reported for one of one resident reviewed for grievances (Resident #1). Findings include: Resident #1 was admitted to the facility on 11/03/17 with diagnoses of hypertension, muscle weakness, atherosclerotic heart disease, polyneuropathy, edema, schizoaffective disorders, insomnia, chronic pain, and gastro-esophageal reflux disease. Resident #1's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 7/27/20. The resident was coded as being cognitively intact and needed extensive assistance or was totally dependent for activities of daily living. Review of the Resident's Grievance listing for July 2020 through October 2020 revealed three grievances had been recorded for Resident #1. Grievance #1 dated 8/10/20 referenced wheelchair not returned, bed not fixed, meds given incorrectly, staff not answering calls, and request to speak to Director of Nursing submitted by a family member had been submitted. There was no written response to the family for this grievance provided by the facility. Grievance #2 dated 8/14/20 referenced "continued concerns r/t (related to) nursing care" submitted by a family member. There was no	F 585	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for each resident found to have been affected by the deficient practice - A written grievance summary was provided to Resident #1 on 11/13/20 by the Grievance Official. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – The grievance officer will review all grievances received in the last 90 days to ensure a written summary has been provided to the resident and/or RP as appropriate. If a written summary has not been completed, the grievance officer will provide one at that time. The grievance audit tool will be reviewed by the Don and Administrator for compliance.11/18/20	

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F 585	Continued From page 4 written response to the family for this grievance provided by the facility. Grievance #3 dated 9/3/20 referenced clothing submitted by a family member had been resolved by the Social Worker and a written letter sent dated 9/3/20. An interview with Resident #1 on 10/20/20 at 12:55 PM revealed she had not received any written resolutions or summary of the grievances filed on her behalf by her family members. An interview was conducted with the Social Worker (SW) on 10/20/20 at 12:23 PM regarding the grievances filed by family members of Resident #1. The SW stated the follow up for Grievance #1 and Grievance #2 was given to the Director of Nursing (DON) since they were related to nursing issues. Grievance #3 was investigated, completed and a written letter had been sent to the person filing the grievance. In a telephone interview with Family Member #1 on 10/21/20 at 8:15 AM, she revealed she had not received a written summary or response from the facility regarding grievances submitted on 8/10/20 and 8/14/20. She stated the Director of Nursing would not speak to her until the Zoom meeting with the Ombudsman. A telephone interview was conducted with the Director of Nursing on 10/21/20 at 3:46 PM. The Director of Nursing stated she had not completed the investigation, did not have the grievance forms and did not have knowledge of a written response to the family and/or resident for Resident #1's grievances dated 8/10/20 and 8/14/20.	F 585	Measures to be put in place or systemic changes made to ensure practice will not re-occur - The Director of Nursing or Assistant Director of Nursing will in-service the Department Managers/leaders and licensed nurses on the grievance policy. Those who have not attended the in-services will be required to receive training prior to beginning their next work shift. The Grievance Official will provide a written summary for all grievances within 7 business days and will record on the grievance log the date the written summary was provided and to whom it was provided to. The Grievance Official will complete the grievance log weekly and will submit to the DON and Administrator prior to morning stand up meeting every Monday morning. How the corrective actions will be monitored to ensure that solutions are achieved and sustained. i.e. quality assurance measures implemented – The Administrator and/or Nurse Consultant will review the Grievance Log weekly for 4 weeks to assure compliance with providing written summaries of reported grievances. The results will be documented on an Audit Tool titled “Grievance Summary”. Results will be reviewed and discussed in	

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F 585	Continued From page 5 A telephone interview with the Ombudsman on 10/22/20 at 10:00 AM revealed there had been a Zoom meeting regarding the grievances for Resident #1. The report of that meeting had been sent to the facility's Administrator. The Ombudsman had no knowledge of any written resolutions and/or summary sent to the family. A telephone interview with the Admission Coordinator on 10/22/20 at 1:01 PM revealed the grievances dated 8/10/20 and 8/14/20 were in her office and she was not sure if there had been any written letters sent to the family. The Admission Coordinator stated she knew the Ombudsman was involved during a Zoom meeting, but had no written documentation sent to the family regarding the concerns. In a telephone interview with the Administrator on 10/22/20 at 3:25 PM, she reported that she resolved the resident's family grievances verbally during the Zoom meeting with the Ombudsman. She explained she had not provided a written resolution and summary for grievances dated 8/10/20 and 8/14/20. She acknowledged the family should have been provided a written resolution and summary by the facility.	F 585	the QAPI/QA monthly meeting. The QAPI/QA committee will modify the plan of correction as needed to ensure continued compliance. Analysis and summary of grievances is provided at the QAPI meeting monthly.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		11/18/20

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F 757	Continued From page 6 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interview, for one (Resident #1) of one sampled resident whose medications were reviewed, the facility failed to reference a resident ' s medical record to assure a medication was appropriate to administer before initiating a standing order for the medication. Findings include: Resident #1 was admitted to the facility on 11/03/17 with diagnoses of hypertension, muscle weakness, atherosclerotic heart disease, polyneuropathy, edema, schizoaffective disorders, insomnia, chronic pain, and gastro-esophageal reflux disease. Resident #1 ' s most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 7/27/20. The resident was coded as being cognitively intact and needed extensive assistance or was totally dependent for activities of daily living.	F 757	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ The nurse practitioner was notified and the order for the Tylenol was discontinued	

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F 757	Continued From page 7 Review of the August 2020 Medication Administration Record (MAR) order read "May use Tylenol 650 mg (milligram) PO/GT (oral/gastro-tube) every 6 HRS (hours) as needed for pain if not allergic to Tylenol. If not effective, Call MD (doctor)." The MAR revealed the Tylenol had been given on 8/9/20 at 3:00 AM for back pain by Nurse #1. Review of the allergy section on the MAR revealed the resident was allergic to "APAP (Tylenol)". Review of Nurse ' s Notes dated 8/9/20 at 7:20 AM read "Resident complained of back pain Tylenol 650 given - later pt. (patient) complained of skin burning. On assessment no hives or redness noted. Called the doctor." This entry was written by Nurse #1. Review of telephone order on the Physician/Prescriber ' s Order Record sheet dated 8/9/20 revealed "Discontinue Tylenol 650 mg (milligram) by mouth every 6 hours as needed for pain due to resident complained a burning feeling from Tylenol medication." Review of Nurse ' s Note dated 8/18/20 at 3:20 PM written by Nurse #2 included concerns given by Resident #1 ' s Responsible Party from the previous weekend. The late entry for 8/10/20 read "writer went to hall and noted rsdt (resident) was given Tylenol. Rsdt (resident) allergy listed as APAP. Med error report completed & given to DON." Review of the September 2020 Medication Record revealed a discontinuation of the "May use Tylenol 650 mg (milligram) PO/GT (oral/gastro-tube) every 6 HRS (hours) as needed	F 757	for Resident #1.New orders were received by the charge nurse. 8/09/2020 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ The DON and nurse consultant will review all current residents□ medication administration record to determine if medications they are allergic to have been administered or ordered. Southern Pharmacy will review all current medication profiles and documented allergies to verify medications not contraindicated. If any discrepancies the facility and MD will be notified immediately. 11/18/2020 Measures to be put in place or systemic changes made to ensure practice will not re-occur - Licensed nursing staff will be in-serviced on the need to check allergies before administering a medication from standing orders & new orders by the DON and/or SDC. Any nurse who has not attended the in-services will be required to receive training prior to beginning their next work shift. Upon admission, each MRR review will be checked by pharmacist for any allergies listed along with notification of facility if no	

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F 757	Continued From page 8 for pain if not allergic to Tylenol. If not effective, Call MD (doctor)." An interview with Resident #1 on 10/20/20 at 12:55 PM revealed she did not remember the date or exact time of the reaction to the Tylenol. She remembered the pain she had been in. She did confirm she had received the Tylenol and had a burning sensation. Interview with Nurse #2 on 10/21/20 at 1:32 PM revealed she had been stopped by Resident #1 ' s family when leaving the facility on the weekend following the Tylenol error. The family reported concerns regarding the medication error that had occurred in a previous weekend. She explained she completed a medication error report and gave it to the Director of Nursing. She stated she notified the resident ' s family members that their concerns had been forwarded to nursing administration. Interview with the Director of Nursing (DON) on 10/21/20 at 3:46 PM revealed the supervisor on shift did a medication error report. The DON stated the physician, the responsible parties and the resident were notified. During an interview with the Pharmacist on 10/21/20 at 5:16 PM, she stated the "PRN Tylenol order is part of the standing orders on admission and it reads do not give if allergic." She also revealed Resident #1 Medical Records indicated she was allergic to Tylenol and it was at the bottom of each printed MAR. Interview with the Director of Nursing (DON) on 10/22/20 at 2:46 PM revealed the normal process for medication errors would be the nurse would notify the supervisor on duty and the resident ' s	F 757	allergy information is listed. Admission orders and new orders will also be checked by pharmacist for any allergies to current med profile that could cause negative effects to resident, these findings will be sent to attention of facility RN and attending physician. Documentation of allergies into pharmacy software system shall be accurately verified by pharmacist upon order review. 11/18/2020 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The ADON will review 5 charts weekly for 5 weeks to ensure medications were not administered to a resident if there is a documented allergy to that medication. Consultant Pharmacist will check resident allergies monthly for any meds within current profile that may be contraindicated and will be documented on monthly pharmacy report. Any discrepancies will be reported immediately to charge nurse and DON. Results will be reviewed and discussed in QAPI/QA monthly. The QPI/QA committee will modify the plan of correction as needed to ensure continued compliance.	

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physician. The responsible party would also be notified. A medication error report would be filed and forwarded to her.

Interview with Nurse #1 on 10/22/20 at 3:00 PM revealed she had not realized the resident was allergic to the Tylenol before administering it. She stated when the resident complained of burning and discomfort, she did an assessment and notified the physician. She reported to the on-coming nurse to continue to monitor the resident. She also stated she had reported the error to the on-duty nursing supervisor.

In an interview with the Nurse Practitioner on 10/21/20 at 3:26 PM, she explained the facility had contacted her and the medication order was discontinued, and new orders given.

Attempts were made on 10/21/20 and 10/22/20 to contact Nurse #3 (on-duty nursing supervisor) for the weekend of 8/9/20 but Nurse #3 never returned calls.

In a telephone interview with the Administrator on 10/22/20 at 3:25 PM, she reported that she had knowledge of the medication error and she expected all parties be notified and medications administered as ordered.