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 10/01/2021

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

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/29/2021 through 10/01/2021. Event ID# T30R11-10/01/2021 One of the 12 complaint allegations was substantiated.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		10/26/21

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

Electronically Signed | 10/23/2021

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F 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an abuse allegation to the State Agency within the required time frame for 1 of 3 residents reviewed for abuse. (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/17/2021 with diagnoses including cognitive communication deficit, muscle weakness, major depressive disorder, psychosis, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 7/15/21 had Resident #1 coded as moderately cognitively impaired and was independent for bed mobility, transfers, locomotion on/off the unit, dressing, eating, toilet use, and personal hygiene. Resident #1 no longer resided at the facility. Record review of the nursing notes written by Nurse #1 dated 8/07/21 at 2:45 PM read "Resident was observed being sexually inappropriate with another resident. Physician was notified and gave orders to be sent to hospital for psych evaluation." The facility ' s Director of Nursing (DON) completed an Initial Allegation Report to the State Agency on 8/09/21. The report designated the type of allegation as "Resident Abuse" and reported the facility became aware of the incident/allegation at 3:30 PM on 8/07/21. Allegation details noted Resident #1 was observed "having overly affectionate behavior towards an assisted living resident." The transmission Verification Report was dated and timed as 8/09/21 at 4:37 PM. This report	F 609	The following represents Highland House Nursing and Rehabilitation's plan of correction. The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices relative to timely reporting allegations of abuse to the State Agency. Please accept this plan of correction for Reporting Allegations of Violations/Abuse. 1. The Director of Nursing submitted the allegation of abuse report to the State Agency on 8/9/21. 2. An internal review was conducted by the Administrator and Director of Nursing on 10/5/2021 to determine if other allegations of abuse had been reported timely to the State Agency. All other allegations were reported timely. The Administrator and/or DON will report all allegations of violations/abuse within 2 hours to the State Agency as they occur. The Administrator and DON have the capability of completing the reports remotely if an event occurs after normal business hours or at a time they are not at the facility and can sign the reports digitally. 3. All staff were educated/in-serviced on the process for reporting allegations of violations/abuse that included: Staff are to report alleged abuse to their direct supervisor. The direct supervisor	

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F 609	Continued From page 2 revealed the Initial allegation Report was faxed to the State Agency approximately 49 hours after the facility became aware of the resident ' s behavior. During an interview on 9/29/21 at 2:30 PM, the Administrator revealed the alleged abuse happened on the weekend and that was probably why it was not reported timely. She explained she was aware of the reporting time frames and the report should have been sent timely. In an interview on 9/30/21 at 10:00 AM, with Staff Member #1 that witnessed the alleged actions, Staff Member #1 stated Resident #1 had his hands on Resident #2 butt rubbing it. Resident #1 ' s hands were not in her briefs but was on top of her pants. When Resident #1 saw Staff Member #1, stopped and took his hands away. Staff Member #1 reported it to the Nurse on B-Hall, and she came and got Resident #2. Resident #1 refused to leave the area. Staff Member #1 wrote a statement for the Director of Nursing on Monday about the incident. During a telephone interview on 10/01/21 at 12:52 PM, the Director of Nursing stated she was aware of the reporting time frames and the Initial Allegation Report should have been faxed timely. During a telephone interview on 10/01/21 at 1:52 PM, the Evening Nursing Supervisor (that was on shift for 8/07/21) revealed once an alleged abuse was reported to the Administration and the Provider, she waited for guidance. She stated no one told her to fax anything to the State Agency.	F 609	will report to the Director of Nursing and/or the Administrator of the allegation. The facility has provided step by step instructions on how to complete the report with guidance from the Director of Nursing and/or administrator. staff not attending the in-service by 10/26/ 2021 will not be allowed to work until the in-service is completed. 4. The Director of Nursing and/or designee will monitor all allegations of violations/abuse weekly for 4 weeks and monthly for 3 months to determine if the reports were filed timely. Weekly audits results will be reviewed with Quality Assurance Committee and monthly 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.	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2)	F 626		10/28/21

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F 626	Continued From page 3 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, family interview,	F 626	The following represents Highland House	

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F 626	Continued From page 4 hospital and facility staff interviews, the facility failed to permit a resident to return to the facility from the hospital for 1 of 3 residents reviewed for discharge (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/17/2021 with diagnoses which included, in part, cognitive communication deficit, major depressive disorder, psychosis, and anxiety disorder. Review of his quarterly Minimum Data Set (MDS) assessment dated 5/24/21 indicated Resident #1 had moderately impaired cognition and no behaviors. Record review of nursing notes written by Nurse #1 dated 8/07/21 at 2:45 PM read "Resident was observed being sexually inappropriate with another resident. Physician was notified and gave orders to be sent to hospital for psych evaluation." A provider ' s telephone order was written on 8/07/21 and indicated "to send resident to hospital for psych evaluation" with indication of behavioral problems. A late entry psychosocial note written 8/09/21 at 9:08 AM by Social Worker (SW) #1 read: "the SW completed Resident #1 ' s Discharge Return Anticipated MDS assessment sections. Resident #1 was alert and oriented x 3 prior to him being sent to the hospital. He verbally communicates his wants and needs. There are no signs of delirium and no signs of psychosis. The Brief Interview for Mental Status was not completed due to him being sent to the hospital. However, Resident #1 presented with a memory problem,	F 626	Nursing and Rehabilitation's plan of correction. The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices relative to permitting residents to return to the facility. 1. Resident #1 was discharged on 08/07/2021 and is now residing at another facility. 2. The Highland House Discharge Planner audited all transfers and discharges over the past 30 days to identify any other residents that may not have received the required discharge notice or been permitted to return to the facility. This audit was completed on 10/7/2021. Results showed residents received appropriate notification and all residents who wished to return to the facility returned. 3. The facility developed a Discharge Transfer Planning policy that addresses involuntary transfers and discharges and permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy was approved and implemented by administration on 10/19/2021. An in-service was provided by the Administrator and/or designee for the Admissions Director, Discharge Planner, Social Worker, and all Licensed Nurses regarding the new Discharge Transfer Planning policy. Topics included	

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F 626	Continued From page 5 and he moderately impaired with his daily decision making due to Resident #1 making unsafe decisions regarding his care. Therefore, he required staff assistance or cues with his daily decision making. Resident #1 was sent to the hospital due to a staff member observing hugging a female resident with his hands on her buttocks. He does not exhibit any wandering behaviors. His plans did include staying at facility as a long-term care resident. However, as a result of his behavior, he will be discharged from the hospital to his previous place of residence in the community." Record review of the Discharge Planning Note dated 8/9/21 at 7:44 PM written by Hospital Case Management Social Worker (SW #2) read: "[SW #2] spoke with the Administrator and Nursing Supervisor at [the facility] in regard to return placement for the patient. The Administrator informed [SW #2] that the facility would not be able to accept the patient back this date. [SW #2] called Department of Health and Human Services (DHHS) and filed a report in regard to alleged sexual assault by [Resident #1] to another resident at the facility. [SW #2] informed DHHS representative that per documentation the patient was given the option to come to the hospital or have law enforcement called on him. The patient was sent to the hospital for psychiatric evaluation was cleared by psychiatry. The facility refused to accept [Resident #1] after being cleared by psychiatry. The patient will need new placement unless the facility accepts the patient back." Record review of Resident #1 ' s chart revealed Resident #1 never returned as a resident to the facility.	F 626	involuntary transfers and discharges, timing and content of the transfer notice, and the process for permitting residents to return to the facility. Any staff not attending the in-service by 10/26/2021 will not be allowed to work until the in-service is completed. 4. The facility Discharge Planner or designee will review all hospital transfers to assure the resident was permitted to return to the facility according to the facility's policy. This will be completed for 30 days. Results of the audit will be documented and presented by the D/C Planner to the Quality Assurance Performance Improvement Committee meetings monthly. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. 10/28/2021	

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F 626	Continued From page 6	F 626		

A review on 9/29/21 of Resident #1 ' s comprehensive plan of care, last revised 6/17/21, included no care plan related to behavioral symptoms.

During a telephone interview with the Hospital Case Management SW (SW #2) on 9/29/21 at 2:45 PM, it was revealed Resident #1 had been evaluated by psychiatry at the hospital on 8/08/21. SW #2 explained he had contacted the facility after Resident #1 was cleared by psychiatry and ready for discharge. SW #2 was told Resident #1 could not be readmitted because of his past behaviors. SW #2 stated Resident #1 was discharged to another care agency -an Adult Care Home where he resided prior to going to the facility. SW #2 also stated Resident #1 was readmitted to the Hospital for other issues later and signed out against medical advice.

A telephone interview with Resident #1 ' s Responsible Party (RP) was conducted on 10/01/21 at 1:38 PM. The Responsible Party confirmed someone from the facility, unable to recall who, had called him during the beginning of August 2021 and told him Resident #1 could not return to the facility due to his behaviors. The RP did not recall getting a 30-day notice. The Responsible Party further stated he expected Resident #1 would have been able to return to the facility because he thought Resident #1 was enjoying it there and he wanted his brother to "finally find a place to stay and be still."

The Admissions Coordinator was interviewed on 9/29/21 at 3:15 PM. The Admissions Coordinator stated she received a telephone call in the beginning of August 2021 while on vacation from the Hospital ' s Case Management Social Worker

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F 626	Continued From page 7	F 626		

#2 regarding the readmission of Resident #1. She explained she had been out of town and referred the Hospital ' s Case Management Social Worker to Administration at the facility. She stated usually the resident is allowed back in the facility and a 30-day notice is given to the resident/responsible party.

On 9/29/21 at 2:30 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The Administrator explained Resident #1 was not readmitted due to his behaviors. The Administrator and DON were unable to explain why the facility was unable to meet the resident ' s needs after he was cleared by psychiatry at the hospital and was ready for discharge. The Administrator indicated the facility had no policy that addressed permitting residents to return to the facility after hospitalization.

On 9/29/21 at 3:00 PM, an interview with Nurse #1 was conducted. Nurse #1 stated it was reported that Resident #1 had been inappropriate with an assisted living resident on 8/07/21. Nurse #1 stated it was documented in the medical records and the Director of Nursing (DON) had been notified. Nurse #1 also stated she was told by the Administrator not to readmit Resident #1 back to the facility.

On 9/30/21 at 9:00 AM, an interview was conducted with the Facility Medical Provider. The Medical Provider revealed no orders were given to not readmit the resident to the facility. He was unaware Resident #1 was refused readmission to the facility.

On 9/30/21 at 9:15 AM, an interview with Nurse

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F 626	Continued From page 8 Practitioner (NP) #1 was conducted regarding Resident #1. NP #1 explained the order to send to the hospital for psych evaluation was given on 8/07/21 for his behaviors that day. NP #1 stated there were no orders given to not readmit back to the facility. She was unaware Resident #1 was refused readmission to the facility. On 9/30/21 at 10:30 AM, an interview with the Facility Social Worker (SW#1) was conducted. SW #1 provided a copy of the correspondence sent to the Responsible Party. SW #1 explained the correspondences included a Bed Hold Notice and a Summary of Discharge for Resident #1 dated 8/9/21. A copy of the envelop was post marked 8/09/21 and addressed to the RP in Flatonic, Texas. SW #1 also provided correspondence to the Ombudsman regarding Resident #1 discharge to the hospital. In a telephone interview with the DON on 10/01/21 at 12:52 PM, the DON stated Resident #1 should have been given a 30-day notice and have been allowed to return to the facility.	F 626		
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 -	F 656		10/28/21

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F 656	Continued From page 9 (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 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 comprehensive care plan for behaviors for one of three residents reviewed for abuse. (Resident #1) Findings included: Resident #1 was admitted to the facility 5/17/2021. Cumulative diagnoses included	F 656	The following represents Highland House Nursing and Rehabilitation's plan of correction. The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices relative to care plans.	

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F 656	Continued From page 10 cognitive communication deficit, major depressive disorder, psychosis, and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated 5/24/21 indicated Resident #1 as severely cognitively impaired. He was assessed as having no psychosis, no rejection of care, no wandering, and no behaviors. Record review of Progress Notes written on 6/07/21 at 5:27 PM by Social Worker (SW) #1 documented that Resident #1 had made a few of the female residents uncomfortable due to him touching them. SW #1 asked him not to touch the other residents as it makes them feel uncomfortable. Record review of Progress Notes written on 6/09/21 at 5:39 PM by Social Worker #1 stated Resident #1's Responsible Party (RP) was informed about him having boundary issues with the female residents. The RP stated this had been an issue with Resident #1 in the past. The RP also said he would speak to Resident #1 about his behaviors. Record review of the Psychiatric Assessment dated 6/15/21 read: "Patient has a history of cognitive communication deficit. Staff reports patient displays inappropriate behaviors and anxiety. He is known to follow female residents and try to touch them leaving the female patients to be uncomfortable and anxious. Staff reports patient ' s brother has expressed patient has undiagnosed mental illness and a history of drug use. Staff is requesting a review of medications." The general notes included changing the Quetiapine medication 50 milligrams (an antipsychotic medication) from once daily to twice	F 656	1. Resident #1 was discharged from the facility on 08/07/2021 and resides in another facility. 2. The MDS (Minimum Data Set) Nurses and Social Worker completed an audit on 10/04/2021 of the care plans for all residents with behaviors to ensure each resident had an updated care plan addressing their behaviors. Any care plans requiring updates to reflect the resident's current status were completed by 10/22/2021. 3. The MDS Nurses and Social Worker are responsible for ensuring care plans are developed and implemented to address any current behaviors during weekly care plan meetings. The Administrator re-educated the Social Worker and MDS Nurses on 10/01/2021 on the requirement to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will also address behaviors that may impact the resident's condition or care regimen. 4. The Director of Nursing or designee will review at least 3 care plans weekly for 4 weeks and then monthly for 3 months to determine if care plan accurately	

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F 656	Continued From page 11 daily, monitor the resident for sedation effects, gait disturbances and inappropriate behaviors, and to notify psychiatric services as necessary. The rationale given for changes was noted as management of mood changes and inappropriate behaviors. A review of Resident #1's comprehensive plan of care, last revised 6/17/21, indicated a care plan with a focus area to include depression was resident centered with measurable goals and appropriate interventions. There was no care plan related to behavioral symptoms initiated during his stay at the facility after his psychiatric assessment dated 6/15/21. The quarterly Minimum Data Set (MDS) assessment dated 7/15/21 indicated Resident #1 was moderately cognitively impaired. He was assessed as no psychosis, no behaviors, no wandering, and rejection of care one to three days. On 9/30/21 at 11:30 AM, an interview was conducted with the Social Worker. The Social Worker explained she and the Discharge Planner interviewed Resident #1 in June 2021 after the interdisciplinary rounds. The Social Worker stated she did not think Resident #1 understood his behaviors were inappropriate. She explained a psychiatric assessment was performed on 6/15/21 by the psychiatric staff used by the facility. On 9/30/21 at 2:30 PM an interview was conducted with MDS Nurse #1 and the Director of Nursing (DON). They both stated they thought they revised the care plan, but there was no revision found in the electronic medical record or	F 656	addresses any behaviors displayed by the resident. Results of the weekly audit will be documented and reviewed weekly by the Quality Assurance Committee and monthly audit results will be reviewed 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.	

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 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 12 on the paper handwritten care plan in the paper chart. The MDS Nurse #1 and DON explained after the psychiatric assessment was completed, the care plan of Resident #1 should have been revised and updated. During a follow-up telephone interview on 10/01/21 at 12:52 PM, the DON stated she would have expected his care plan to be have been updated and his care plan developed and implemented for inappropriate behaviors toward female residents.	F 656		