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	345353	A. BUILDING _____ B. WING _____	C 03/08/2023

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

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 3/7/23 to 3/8/23. Event 0I0G11 The following intakes were investigated NC00198809, NC00197300, NC00194714, NC00194476 Two of the nine complaint allegations resulted in deficiency.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days of admission to hospice services. This was for one (Resident # 6) of eight sampled residents whose MDS assessments were reviewed. The findings included: Resident # 6 was admitted to the facility on 10/26/22.	F 637	F637 Comprehensive Assessment after Significant Change For resident #6 a corrective action was initiated on 03/25/23. A Significant Change in Status Minimum Data Set Assessment with an Assessment Reference Date of 02/21/23 was completed by the Regional Minimum Data Set Consultant on 03/25/23. Corrective action for residents with the potential to be affected by the alleged	3/28/23

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

Electronically Signed | 03/27/2023

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F 637	Continued From page 1 According to orders, on 2/8/23, Resident # 6 was admitted to hospice services. Review of the record on 3/8/23 revealed Resident # 6 had been scheduled to have a significant change MDS assessment completed with an (ARD) assessment reference date set to be 2/21/23, and the assessment had never been completed. The MDS Coordinator was interviewed on 3/8/23 at 2:40 PM and reported the following. She had been the only MDS Coordinator since May 2022. Prior to that date, there had been another nurse to assist her. She was trying her best to keep up but was not able to meet all the MDS deadlines. She confirmed that it had been identified that Resident # 6 was due a significant change assessment, and the ARD had been set up. The MDS Coordinator also confirmed that the assessment should have been completed but had not been. The Administrator was interviewed on 3/8/23 at 5:00 PM and reported the following. At the current time, the facility did not have any plan in place to catch up late MDS assessments. He felt they needed another employee to help the one MDS nurse they had, but that nurses trained in the MDS process were hard to find.	F 637	deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Regional Minimum Data Set Consultant completed a 100% audit of all current residents who are receiving hospice services in order to ensure that a Significant Change Minimum Data Set assessment was completed. This audit was completed on 03/25/23. Audit Results: 3 total residents currently receiving hospice services. 3 of 3 residents receiving hospice services have had a Significant Change Assessment completed. Systemic Changes The Minimum Data Set Nurse Consultant will provide education to the facility Minimum Data Set Nurse on the requirement for and importance of completing a Significant Change Minimum Data Set assessment for all residents who are admitted to hospice services. The education will emphasize the importance of completing the assessment as required in order to identify and address any changes in the resident's condition and care, which will then allow for optimal coordination of resident care. The Assessment Reference Date for the MDS may be set up to 14 days after the significant change in status has been identified. The significant change MDS must then be completed no later than 14	

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F 637	Continued From page 2	F 637	days after the Assessment Reference Date. This educational in-service will be provided to the facility Minimum Data Set Nurse no later than 03/28/23. This information will be integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Regional Minimum Data Set Consultant or designee will review all current hospice residents to ensure that a Significant Change in Status Minimum Data Set assessment has been completed as required by RAI Manual. This will be done using the quality assurance tool entitled “Significant Change in Status MDS Completion Audit Tool.” This audit will be done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Nurse, Unit Manager, Therapy, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/28/23	

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F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date. This was for one (Resident # 8) of eight sampled residents whose MDS assessments were reviewed. The findings included: Resident # 8 was admitted to the facility on 3/4/21. Resident #8 had a quarterly MDS assessment done on 11/16/22. Review of the record on 3/8/23 revealed Resident # 8 had a quarterly MDS assessment with a ARD (Assessment Reference Date) of 2/8/23 scheduled to be completed, but it had not been completed. The MDS Coordinator was interviewed on 3/8/23 at 2:40 PM and reported the following. She had been the only MDS Coordinator since May 2022. Prior to that date, there had been another nurse to assist her. She as trying her best to keep up, but was not able to meet all the MDS deadlines. She confirmed that Resident # 8 should have had a quarterly MDS assessment completed seven days following the ARD date of 2/8/23, but it had not been completed.	F 638	F638 Quarterly Assessment at Least Every 3 Months Corrective Action Corrective action was taken for Resident #8 on 03/08/23. The Quarterly Minimum Data Set assessment with an Assessment Reference Date of 02/08/23 was completed by the facility Minimum Data Set Nurse on 03/08/23. Identification of other residents who have the potential to be affected by this alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. The Regional Minimum Data Set Consultant will complete a 100% audit on all current residents in order to determine if they have had a Minimum Data Set Assessment scheduled and completed within the past 3 months, including ensuring that the Assessment Reference Date is not greater than 92 days since prior assessment's reference date. Any resident identified as not having had a Minimum Data Set assessment scheduled and completed within the past 92 days as required by the RAI manual will have a corrective action taken. This will include scheduling and completing a	3/31/23

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F 638	Continued From page 4 The Administrator was interviewed on 3/8/23 at 5:00 PM and reported the following. At the current time, the facility did not have any plan in place to catch up late MDS assessments. He felt they needed another employee to help the one MDS nurse they had, but that nurses trained in the MDS process were hard to find.	F 638	Minimum Data Set Assessment for each of the affected residents. This corrective action will be taken by the Regional Minimum Data Set Consultant and the facility Minimum Data Set Nurse. The 100% audit by the Regional Minimum Data Set Consultant will be completed no later than 03/27/23. Any necessary corrective actions based on audit results will be completed no later than 03/31/23. Systemic Changes The Regional Minimum Data Set Nurse Consultant will provide an in-service training for the facility Minimum Data Set Nurse on the importance of scheduling and completing a Minimum Data Set assessment for all residents at least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education will emphasize that all residents must have no more than 92 days between Assessment Reference Dates of each Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change). Focus was also placed on the importance of ensuring that all Minimum Data Set assessments be completed, encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual. This education will be provided to the facility Minimum Data Set Nurse no later than 03/28/23.	

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F 638	Continued From page 5	F 638	Additional steps taken to ensure that MDS assessments are completed by required timeframes set forth in the RAI manual include: • Removing the MDS nurse from the clinical nursing on-call rotation. • Monitoring The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance within the regulatory requirements; The Regional Minimum Data Set Nurse Consultant will review 5 random (current) residents who have been in the facility for at least 6 months to validate whether or not they have had an Minimum Data Set assessment completed at least once every 3 months per the Resident Assessment Manual, including whether or not the assessment was completed within the required timeframe. This will be completed using the Quality Assurance tool entitled “Quarterly Completion of Minimum Data Set Assessments.” This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Nurse, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator	

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F 638	Continued From page 6	F 638	The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/31/23	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and Physician Assistant interview the facility failed to assess a pressure sore and communicate about the assessment to assure a specific treatment to the area where the pressure sore was located would be provided. This was for one (Resident # 7) of three sampled residents with pressure sores. The findings included: Resident # 7 was initially admitted to the facility on 12/21/22. Following a hospitalization, he was readmitted on 2/7/23. Resident # 7's diagnoses included in part diabetes, dementia, ischemic cardiomyopathy, and Parkinson's disease.	F 686	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 dates indicated. F686 The total body skin assessment revealed	4/15/23

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F 686	Continued From page 7 On 2/7/23 at 1:06 PM Nurse # 1 documented Resident # 7 had "redness and opening to Sacrum" when he was readmitted from the hospital. No further description was found of the opening to Resident # 7's sacrum on that date or prior to the date of 2/14/23. On 2/7/23 an order was initiated for Zinc Oxide Ointment to be applied to Resident # 7's buttocks topically every day and night shift for redness. Nurse # 1 was interviewed on 3/8/23 at 3:45 PM and reported the following. When Resident # 7 was admitted the "opening" she had documented was small and appeared as if the top layer of skin had been scratched off from shearing. Resident # 7's admission Minimum Data Set assessment, dated 12/28/22, coded Resident # 7 as unable to complete the brief interview for mental status. He was coded as needing extensive assistance for his bed mobility, always incontinent, and as having no pressure sores. Resident # 7's care plan, last updated on 2/22/23, included the information that Resident # 7 was at risk for pressure sores. An intervention, which had been added to Resident # 7's care plan on the readmission date of 2/7/23, was as follows. "Observe/document/ report to MD PRN (as needed) changes in skin status; appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length X width X depth), stage." The care plan also included that staff should consult with the wound physician as needed/ordered. Review of orders and the February 2023	F 686	that Resident #7 has current wounds on the left and right buttocks and a treatment was in place that was being managed by the treatment nurse or the staff nurse according to the physician's order. On 3/7/23 the Director of Nursing/Designee reviewed Resident #7's orders and care plan to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds. On 3/8/2023 the nursing team verified the resident 7's weight and adjusted the alternating pressure reducing air mattress setting accordingly to assure it was set correctly. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/8/2023, the Director of Nursing's Designee (The Wound Nurse) began identification of residents that were potentially impacted by this practice by completing total body skin assessments on all current residents. This audit was completed by reviewing 100% of current residents to identify any residents with new pressure wounds or skin integrity alterations. From 3/20/2023 to 3/23./23, the Director of Nursing assessed and audited 100% of all current pressure wounds to assure current wound measurements were	

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F 686	Continued From page 8 Treatment Administration Record (TAR) revealed no specific order for the opening to Resident # 7's sacrum until the date of 2/14/23. On this date, Nurse # 2 documented the first assessment of the sacral pressure sore; which was noted to be a Stage II, measuring 4 cm (centimeters) X 4 cm X .03 cm. The treatment, which was ordered on 2/14/23, was to cleanse the pressure sore with normal saline and apply Silver Alginate with a foam dressing covering. According to the February 2023 TAR, this was the first treatment provided which was specific to the pressure sore on Resident # 7's sacrum. On 2/16/23, Resident # 7 was seen by the facility's Wound Physician Assistant (PA) for the first time. The Wound PA documented Resident # 7's sacral pressure sore was a Stage III with 70 % Yellow/black necrotic slough. It measured 4 cm X 4.3 cm X 0.3 cm. The Wound PA noted the pressure sore would benefit from debridement and consent would be obtained. The PA further noted follow up would occur in one week. On 2/23/23, the Wound PA noted he completed debridement of Resident # 7's sacral pressure sore and the status of the wound was improving. Most recent Wound PA notes, dated 3/2/23, noted the sacral pressure sore continued to improve and had 95 % granulation tissue. Nurse # 2 was the Manager of the unit where Resident # 7 resides. Nurse # 2 was interviewed on 3/8/23 at 11:10 AM and again on 3/8/23 at 4:40 PM and reported the following. When Resident # 7 was readmitted on 2/7/23, Nurse # 1 reported he had some redness to his bottom. Nurse # 2 did not recall Nurse # 1 saying there	F 686	completed. The results were as follows: 3/16/23 all measurements were complete. Next scheduled measurements were to be completed on 3/23/23. These were completed. On 3/10/2023, the Director of Nursing audited 100% of all residents with identified pressure wounds to assure a current treatment order was correct and in place on the electronic treatment record. The results were as follows: All have orders. On 3/23/2023, 100% of residents with pressure wounds or at risk for pressure ulcers were audited by the Minimum DatDiet nurse to ensure preventative measures were currently in place to prevent new skin breakdown and address the current pressure wound. On 3 /23 /2023 the nursing team audited all residents with ordered alternating pressure reducing air mattresses to assure that the mattress was at the correct setting based on the resident's weight. Results were: of 3/23/2023 all residents with ordered alternating pressure reducing air mattresses were in compliance. On 3 /10/2023 the Director of Nursing educated the wound nurse on the expectation that alternating pressure reducing mattresses will be set following the manufacturer recommendation with the resident's weight. On 2/17/2023 the DON/RN Manager audited documented wound treatments for	

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F 686	Continued From page 9 was any open area. The nursing staff were accustomed to having a facility Wound Nurse to assess pressure sores and assure treatments were in place, and they relied on her to do so. Around the time of 2/7/23, the facility's previous Wound Nurse had just stopped coming to work and they were unsure if she would return or not. The facility had standing orders that they could utilize Zinc Oxide for redness, and therefore she (Nurse # 2) initiated the standing order for Resident # 7 when Nurse # 1 told her Resident # 7 had redness. She did not look at Resident # 7's skin between the dates of 2/7/23 and 2/14/23. On 2/14/23, the facility had a new treatment nurse (Nurse # 3). On 2/14/23 she and Nurse # 3 learned that Resident # 7 had more than just redness to his buttocks. Nurse # 3 (the current facility Wound Nurse) was interviewed with Nurse # 2 on 3/8/23 at 11:10 AM. Nurse # 3 reported the following. She had begun work on 2/9/23 and went through training. She had not known until 2/14/23 that Resident # 7 had a pressure sore. On that date, a Nurse Aide had let her know that there was a soiled dressing to Resident # 7's sacral area that they had removed. On 2/14/23 she looked at Resident # 7's record and found there were no treatment orders for the pressure sore. She felt as if some of the nursing staff had been placing some type of dressing on Resident # 7's pressure sore since there had been a dressing found by the Nurse Aide. She assessed the pressure sore for the first time that day and obtained orders. On 2/14/23, the wound bed appeared mostly pink but there was a small amount of yellow slough. On 2/16/23, she asked the Wound PA to look at it. The Wound PA was interviewed via phone on	F 686	compliance on the previous 3 days. The results were: All wound treatments were in compliance. On 03/10./2023 all wound treatments were in compliance. 2. Systemic changes Root Cause Analysis was completed on 3/14/2023 with the following staff in attendance: Administrator, Director of Nurses, Regional Operations Manager, the Quality Assurance Nurse Consultant and the Medical Director. Root cause analysis was done related to not clarifying that there is a physician's treatment order for each wound and ensuring the accurate and correct order is transcribed and followed by the nurses providing treatments to the wounds and initiating interventions/treatments for a resident at risk for skin breakdown. Upon interview of the nursing staff/agency it was determined that the root cause was the facility administration failure to provide effective oversight and leadership to ensure effective systems were in place to provide wound care and dressing changes per physician's orders. Ensure review and provision of needed treatment from physician referrals regarding identified wounds. Ensure physician's orders for wound care followed. On 3/9/2023, the Director of Nursing/Quality Assurance Nurse Consultant/Senior Regional Staff Education Specialist began in-service of 100% of all licensed nurses, full time, part time, as needed nurses, including agency	

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F 686	Continued From page 10 3/8/23 at 1:25 PM and reported the following. He was at the facility every Thursday, and Resident # 7 was not immediately "sent his way" for evaluation. He saw him for the first time on 2/16/23. In general, at times off loading and barrier cream could be an appropriate treatment for Stage II pressure sores. He could not say what would have been an appropriate treatment for Resident # 7 between the dates of 2/7/23 and 2/16/23 without an assessment of the pressure sore. Resident # 7 did have comorbidities which could predispose him to the development and decline of the pressure sore. The pressure sore could have declined in a very short time span to the point where it had the necrotic tissue. The facility's Nurse Consultant was interviewed on 3/8/23 at 4:00 PM. According to the Nurse Consultant, when Resident # 7 was readmitted on 2/7/23, the nursing staff should have assessed and measured the pressure sore. On 3/8/23 at 10:15 AM, Resident # 7 was observed as Nurse # 3 cared for his pressures sore. Resident # 7 was observed to have a pressure sore to the sacral area which appeared predominantly red and healthy.	F 686	to include: Identification of New Orders and Provision of Ordered Treatments. Wound/Skin/Treatment/Order Documentation Process, the Post Follow Up of Appointment Orders Process and the Order Clarification Process, and Documentation and notification of the Administrator/Director of Nurses if a treatment cannot be completed for any reason. On 03/09/23 education was initiated by the Staff Development Coordinator/Director of Nursing for 100% of all licensed nurses, including agency nurses, on the Nurse Practice Act and North Carolina Board of Nursing Position statement on Wound Care. In addition, on 03/09/23, the Staff Development Coordinator and Director of Nursing began direct observation, with return demonstration, of how to complete a skin assessment/wound assessment utilizing a competency check list of the steps of the skin/wound/order/treatment process and the nurses were instructed to identify on the skin assessment, for residents with immobilizers/braces, the condition of the skin under or surrounding the immobilizer or brace. Including notification of the physician and wound nurse for further and assessment and treatment orders for any new or worsening changes to the skin. On 3/10/23 the Quality Assurance Nurse Consultant educated the Director of Nursing and Staff Development	

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F 686	Continued From page 11	F 686	Coordinator and they began education of all licensed nurses, including agency on the following expectations: the wound nurse or nurse assigned is to complete the weekly pressure ulcers assessment after rounding with the wound doctor. The nurse is responsible to look at the User Defined Assessment in the electronic medical record in order to complete the weekly skin assessment timely. All orders are to be transcribed by the nurse who receives the order. If the nurse needs clarification of the order, the nurse is to contact the physician for clarity of the order. During morning clinical meeting all orders are to be reviewed to ensure clarity. All Staff would be expected to do daily monitoring of the high-risk skin area. Certified Nursing Assistants are to report noted skin integrity alterations to the nurse. As of 3/23/2023, no Licensed Nurses or Certified Nursing Assistants will work without the education/training and competency check off list completed. This is to include agency and new staff. The Director of Nursing and Administrator are responsible to ensure all staff are educated as well as to maintain monitoring and tracking of sustained compliance for staff that still require education to include newly hired licensed nurses, Certified Nursing Assistants and agency. After 3/10/23 the Director of Nursing will be responsible to ensure any new Licensed Nurses, agency and Certified	

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F 686	Continued From page 12	F 686	Nursing Assistances are educated on the applicable policies and procedures related to skin/wound care and the serious complications that might occur for failing to identify and treat a wound in a timely manner to include completion and documentation of ordered wound treatments and appropriately monitoring the functioning/setting of ordered specialty mattresses. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 03/26/2023 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. 3. Quality Assurance monitoring procedure. Utilizing the F686 Quality Assurance Audit Tool, the Director of Nursing or designee will monitor the post appointment process/treatment administration and documentation process and the specialty mattress process for compliance weekly x 4 weeks then monthly x 3 months or until resolved. Appointment follow up will be monitored as part of the Daily Clinical Meeting. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA	

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F 686	Continued From page 13	F 686	Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager POC: 4/15/23	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to prevent a significant medication error to one (Resident #4) of two sampled residents whose medications were reviewed. The findings included: Resident #4 was admitted on 3/9/2022 with a diagnosis of stage 5 chronic kidney disease and received dialysis three days per week. Resident # 4's MDS Assessment, dated 9/5/2022 coded the resident as cognitively intact. Review of orders revealed Resident # 4 had an order, dated 1/23/2023, to administer Calcium Acetate 667 mg with meals for hyperphosphatemia. (Calcium Acetate is used to prevent high blood phosphate levels in patients who are on dialysis due to severe kidney disease.) Resident #4 was interviewed about	F 760	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 dates indicated. F760 Resident # 4 Corrective action was on obtained on 3/7/23 for Resident #4. Medication times were changed to a time when the resident is in the facility. On 3/8/23 the Director of Nurses /Nursing Team began auditing all the Dialysis residents to ensure their medication times are when they are in the facility. The results for the last 14 days are as follows. Resident #4 received his medication at	4/16/23

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F 760	Continued From page 14 pharmaceutical services on 3/7/2023 at 10:16 am. In the interview the resident reported that he was not getting his mid-day medication for his kidneys on days he went to dialysis. Review if Resident #4's Medication Administration Record (MAR) for February and first week of March 2023, that the midday dose of Calcium Acetate was not initilaed as administered to the resident on days he went to dialysis (Tuesday, Thursday, Saturday) for 13 of 15 days the medication was ordered. An interview with Nurse # 2 was conducted on 3/8/2023 at 3:20 pm. Nurse #2 stated that the medication times to administer the medication were listed on the MAR as 8:30 am, 12:00 pm and 6:00 pm, and on the days the resident was at dialysis, he was out of the facility at 12:00 pm. She did acknowledge that the times should be changed to accommodate the resident, since the resident's order was to take the medication 3 times a day with meals. The resident was given a mid-day meal after returning from his dialysis appointment. Nurse #2 confirmed that the medication had not been given with the meal when he returned.	F 760	the times on the Medication Administration Record. Results: All Residents received their medications. On 3/7/2023 the DON notified the medical director to change the medication administration times for Resident #4. On 3/7/2023 the Director of Nurses/Nursing Team audited all dialysis resident medication orders to ensure all dialysis resident medication administration times were when the resident was in the facility for the last 30 days. Results: all Dialysis Residents' Medication Administration times were changed to ensure medications were not missed for the last 30 days for compliance with the administration of the medication following the ordered parameters. Results: 1 of 3 residents missed medication when out of the building for dialysis. As of 3/8/2023 all Dialysis resident's medication administrations were in compliance. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/8/2023, the Director of Nurses began identification of residents including new admits and readmits that were potentially impacted by this practice by audit of all Medication Administration Records x 30 days to ensure resident received all their medication prescribed every day. This audit was completed by reviewing 100% of current residents' orders to ensure residents received their medication.	

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F 760	Continued From page 15	F 760	The results included: All 100% residents received their medications On 3 /9 /2023 the DON/RN Manager audited the Medication Administration Records of all residents. The Medication Administration records were documented for compliance the last 14 days. The results included: As of 3/9/2023 all Medication Administration Records were in compliance. 2. Systemic changes Education On 3/24/2023 the DON/SDC began education of all full time, part time, and as needed licensed nurses and agency nurses on the prevention of medication errors and medication safety to include facility policy on compliance with medication orders that contain parameters for administration and the notification of the MD and RP process. The DON will ensure that any of the above identified staff who does not complete the in-service training by 03/28/2023 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. 3. Quality Assurance Plan: The Director of Nursing /Staff Development Coordinator will monitor this utilizing the Medication Administration Record and Quality Assurance Tool for	

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F 760	Continued From page 16	F 760	Monitoring. The monitoring will include review of all residents using the tool in Point Click Care for missed medication alerts. This is done during Daily Clinical Meetings (Monday-Friday) and will include audits of Medication Administration Records for compliance with the facility policy on the administration of medications, weekly x 2 weeks and then monthly for 3 months or until resolved by the Quality Assurance (QA) Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action was 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, Director of Nursing, MDS Coordinator, Unit Manager, Therapy, HIM, and Dietary Manager. DOC: 04/16/2023	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		4/16/23

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§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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F 842	Continued From page 18 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure pressure sore dressing changes were documented for three (Residents # 3, # 6, and #7) of three sampled residents with pressures sores. The findings included. 1. Resident # 6 was admitted to the facility on 10/26/22 with a Stage IV pressure sore. On 2/2/23 treatment orders were changed for the care of Resident # 6's pressure sore. The new order was to cleanse the pressure sore and apply Dakin's .5 % moistening guaze packing; followed by a foam dressing. Review of Resident # 6's 2023 February and March Treatment Administration Records (TARS) revealed there was no documentation Resident # 6's Stage IV pressure sore dressing change occurred on the following dates on the TARS: 2/3/23 through 2/8/23; 2/10/23 through 2/13/23;	F 842	TAG 842 On 3/9/23 the Director of Nursing Audited the TAR and reviewed the TAR records. On 3/9/23 The Director of Nursing reviewed all the Residents to assure that preventative measures were currently in place to prevent Omissions of wound care documentation that were not completed and not documented as being completed.. The Director of Nursing verified that Residents # 3, 6, and 7 with Stage IV pressure sores had dressing changes on the following dates : 2/3/23 thru 2/8/23, 2/10/23 thru 2/13/23; 2/15/23, 2/24/23 thru 2/28/23 and 3/3/23. Corrective action for all Residents with potential to be affected by the deficiency practice: All residents have the potential to be affected by the deficient practice. On 3/9/23 the Director of Nursing began identification of residents that were potentially impacted by this practice by	

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F 842	Continued From page 19 2/15/23; 2/24/23 through 2/28/23; and 3/3/23. Nurse # 2, who was the manager of the unit where Resident # 6 resided, was interviewed on 3/8/23 at 11:10 AM and the blanks on the TARS were reviewed. Nurse # 2 reported the following. Near the first of February 2023, the facility's previous Wound Nurse left employment. There was no Wound Care nurse between 2/3/23 to 2/8/23, but she knew the dressing changes were done by nurses because she oversaw that they were done. They were just not documented as completed. There was a new facility wound nurse (Nurse # 3) who currently alternated with a Nurse Aide (NA # 1) to do dressing changes. NA # 1 was certified as a NA II and was approved to do dressing changes. Also, Nurse # 2 reported the facility was transitioning from paper medical records to electronic records for treatments between February and March 2023. Nurse # 3, who was the facility's new Wound Care Nurse, was interviewed with Nurse 2 on 3/8/23 at 11:10 AM. Nurse # 3 reported she started to work on 2/9/23 and rotated working with a NA # 1 to do dressing changes since 2/9/23. According to Nurse # 3, she and NA # 1 had done Resident # 6's dressing changes but not documented them on the days following 2/9/23 which had incomplete documentation on the TARS. The facility's Nurse Aide II (NA # 1) was interviewed on 3/8/23 at 12:30 PM and corroborated that she alternated working with Nurse # 3 to do dressing changes, and there had been days she had completed Resident # 6's dressing changes but not documented them as complete.	F 842	completing an audit of all current residents on 3/9/23. This audit Was completed by reviewing 100% of current residents to identify any residents without documentation. Results included: All documentation was complete Systematic changes Root cause analysis was done by the Quality Assurance Nurse Consultant and the Medical Director. Root cause analysis was related to not having a wound nurse on staff. A wound nurse resigned on 2/3/23. The facility was transitioning from paper medical records documentation to electronic records. Upon interviewing of nursing staff/agency it was determined that the root cause was the nursing communication failure to provide effective oversight and leadership (staffing) to ensure documentation was done. Measures put into place or systemic-changes made to ensure deficient practice will not recur: On 3/9/23 Documentation training. No Licensed Nurses or Certified Nursing Assistant will work without completing the education/training and competency check off list. This includes agency and new staff. The interim Director of Nurses and Administrator are responsible to ensure all staff are educated and will track compliance of staff that still require education to include newly hired licensed nurses and Certified Nursing Assistants. As of 3/10/23 The Director of Nursing will be responsible to ensure any new Licensed nurses, agency and certified nursing assistances are educated on the	

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F 842	Continued From page 20 2. Resident # 7 was readmitted to the facility on 2/7/23. Orders were obtained on 2/14/23 to apply the following dressing to Resident # 7's Sacral pressure sore. The pressure sore was to be cleansed with normal saline. Silver alginate was then to be applied followed by a foam dressing. The following dates on Resident # 7's February and March treatment administration records revealed no documentation the Sacral pressure sore dressing change was completed: 2/15/23; 2/17/23; 2/25/23 through 2/28/23; and 3/3/23 through 3/4/23. On 3/8/23 at 11:10 AM, the facility's February and March treatment administration records were reviewed with Nurse # 2 (who managed Resident # 7's unit) and Nurse # 3 (who was the facility's current Wound Care Nurse.) Nurse # 3 reported she started to work on 2/9/23 and rotated working with a Nurse Aide II employee (NA # 1) to do dressing changes since 2/9/23. According to Nurse # 3, she and the Nurse Aide II had done Resident # 7's dressing changes but not documented them on the days in February which had incomplete documentation on the TARS. According to Nurse # 2, on the dates of 3/3/23 and 3/4/23, Nurse # 4 would have been responsible for Resident #7's dressing change. The facility's Nurse Aide II was interviewed on 3/8/23 at 12:30 PM and corroborated that she alternated working with Nurse # 3 to do dressing changes, and there had been days she had completed Resident #7's dressing changes but not documented them as complete. Nurse # 4 was interviewed on 3/8/23 at 12:40 PM	F 842	applicable polices and procedures related to Documentation. 3. Quality Assurance monitoring procedure. Utilizing the F842 Quality Assurance Audit Tool, the Director of Nursing or designee will monitor the post appointment process/Documentation and report to the QA Committee weekly. This will be done weekly x 3 then monthly x 2. POC: 4/16/2023	

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F 842	Continued From page 21 and reported she had completed dressing changes for Resident #7 in March, 2023 but she thought she missed signing off on some of them. She reported the facility had switched from paper charting to digital charting. She had done paper charting for 25 years, and she had to remember to switch between the Medication Administration and the TAR in the new digital system in order to complete documentation and may have not done so. 3. Resident # 3 resided at the facility from 6/20/22 to 10/28/22. Resident # 3 had an order, dated 9/15/22, to apply a dressing change to a Sacral pressure sore. The order directed the pressure sore was to be cleansed and calcium alginate followed by a foam dressing was to be applied. Resident # 3's September 2022 Treatment Administration Record, revealed no documentation the dressing was completed from 9/28/22 through 9/30/22. According to an interview with Nurse # 2 on 3/8/23 at 11:10 AM, the previous Wound Care Nurse, who had been responsible for Resident # 3's dressing changes during the resident's facility residency, was no longer an employee.	F 842		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the	F 887		4/14/23

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	345353	A. BUILDING _____ B. WING _____	C 03/08/2023

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
F 887	Continued From page 22	F 887		

immunization is medically contraindicated or the resident or staff member has already been immunized;
(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that

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F 887	Continued From page 23 includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to offer all residents a COVID-19 vaccine. This was for 1 of 1 resident (Resident #4) sampled for COVID-19 booster vaccine. The findings included: Resident # 4 was admitted to the facility on 3/9/2022. Resident # 4's quarterly Minimum Data Set assessment, dated 9/5/2022, coded Resident # 4 as having intact cognition. Resident #4 was interviewed on 3/8/2023 at 9:54 am. The resident stated that he had signed paperwork to obtain a COVID-19 booster months ago, but had not received the booster. Record review revealed Resident #4 had given consent for the facility to administer the COVID-19 booster vaccine by signing the facility's COVID-19 Consent Declination Form - Residents on 11/2/2022. An interview with Nurse #2 was held on 3/8/2023	F 887	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 dates indicated. F887 The facility failed to offer resident # 4 a COVID 19 Booster. 1. Corrective action for the resident involved: Resident #4 was educated and offered a Covid 19 Vaccine Booster on 3/24/2023 by the DON. The resident signed the consent. The resident will receive the COVID-19 vaccine Booster on 3/31/2023 . 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 887	Continued From page 24 at 4:16 pm. She stated that the last COVID clinic was conducted on 12/5/2022, which was on a Monday. She continued that Resident #4 was out of the facility due to a dialysis appointment that day, and then Resident #4 continued on to the hospital. She also confirmed currently there was no COVID vaccine booster in the facility. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were not available for interview.	F 887	All residents have the potential to be affected by the alleged deficient practice. On 3/24/2023, the Director of Nurses completed an audit of all current residents COVID 19 vaccination booster status. The results included: only one resident requested a booster. All residents will be surveyed on 3/27/23 for any others requesting booster. Boosters will be administered on 3/31/23. Newly admitted residents will have access to vaccine booster. Upon admission, DON or designee will ask residents not inoculated with booster if they would like one. Vaccine booster will otherwise be available upon request by all residents. There will be a continuous supply of vaccine available. DON will coordinate with McNeil's pharmacy to ensure adequate supply. 3. Systemic changes In-service education was provided by the Nurse Consultant to the Administrator, Director of Nurses and Infection Control Preventionist on 3/24/20223. Topics included: • COVID 19 Vaccination Policy 1333695 • Consent for vaccination or refusal process • Administration of Vaccinations • Post vaccination treatment and considerations This information has been integrated into the standard orientation training and in the	

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F 887	Continued From page 25	F 887	required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Director of Nurses or designee will monitor the COVID 19 Vaccination Process for compliance weekly x 2 weeks then monthly x 3 months using the COVID 19 Vaccination Process QA tool. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 4/14/2023	