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 08/24/2023

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 The surveyor entered the facility on 8/22/23 to conduct a complaint survey and exited on 8/23/23. Additional information was obtained 8/24/23. Therefore, the exit date was changed to 8/24/23. Event ID# PSXL11 The following intakes were investigated: NC 205640; NC 206056; NC 205711 One of three complaint allegations resulted in a deficiency.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform	F 660		9/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/18/2023

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F 660	Continued From page 1	F 660		

required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based

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F 660	Continued From page 2 on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, family Interview, and staff interview, the facility failed to assure a resident they discharged to another facility 1) was transitioned to the receiving facility with orders and 2) the receiving facility knew the specific date the resident was coming in order that a room be prepared for the resident. This was for one (Resident # 7) of one resident reviewed for discharge planning. The findings included: Resident # 7 was admitted to the facility on 4/25/23. The resident's diagnoses in part included Alzheimer's disease. Resident # 7's quarterly MDS (Minimum Data Set) assessment, dated 7/26/23 coded Resident # 7 as severely cognitively impaired. She also required assistance with her activities of daily living. On 8/22/23 at 10:35 AM Resident # 7's family member was observed to be at the resident's bedside and voiced she had requested Resident # 7 be transferred to another facility (Facility # 2). According to the family member, everything about the transfer had been approved and Resident # 7 was planning to discharge that day (8/22/23) from Facility # 1. She and Resident # 7 were just	F 660	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. F660 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to: ensure a resident they discharged to another facility 1) was transitioned to the receiving facility with orders 2) the receiving facility knew the specific date the resident was coming in order that a room be prepared for the reside Corrective action for resident(s) affected by the alleged deficient practice: " The staff responsible for discharge of Resident #7 were educated on 8/23/2023	

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waiting at that time for the actual transfer to take place.

On 8/22/23 at 11:36 AM a progress note was entered into Resident # 7's record noting the resident was transferred to another facility that shift and had departed Facility # 1 by way of Facility # 1's transport system.

During a follow up interview with Resident # 7's family member via phone on 8/24/23 at 10:53 AM the family member reported the transition to Facility # 2 had not gone smoothly as she had thought it would. The family member reported the following events. On 8/21/23 she had received a phone call from Facility # 1's Unit Manager asking if she still wanted Resident # 7 moved. She had let the Unit Manager know she did, but it was her understanding that all had not been finalized. She reported she was confused. She explained when she arrived at Facility # 1 on 8/22/23 the Unit Manger asked the family member what time she wanted Resident # 7 to transfer. The family member had informed them that she was waiting on Facility # 1's staff to let her know that. Facility # 1's Social Worker informed her the facility's transporter could take Resident # 7 in their van. Therefore, she thought everything had been worked out with Facility # 2 and asked if 11:00 AM would work. When Facility # 1's staff came to transport Resident # 7, she thought all the paperwork had been sent to Facility # 2 and that Facility # 2 knew Resident # 7 was coming. Before leaving, the Unit Manager gave her Resident # 7's medications, and she followed the van to Facility # 2 where she found Facility # 2 did not know the resident was coming and they had no paperwork for her. They placed Resident # 7 in an activity room for a short period until they

by the Administrator.
" Resident #7 no longer resides in facility.
A discharge checklist was implemented as a required part of discharging resident(s) from facility
1. Corrective action for residents with the potential to be affected by the alleged deficient practice.
" Beginning on 8/26/23 the Social Services Coordinator performed 100% audits of all current resident□s comprehensive care plans to ensure discharge plans were in place.
" As of 8/29 /2023 the Social Services Director, Minimum Data Set Coordinator and Discharge Planner(s)began updates of all needed Discharge Comprehensive Care plans, Discharge Planning Reviews and Discharge Summaries to reflect residents discharge plans. As of 9/ 5 /2023 all of the above were in compliance with the discharge process.
" On 8/29 /2023 the Director of Nurses audited the last 30 days of discharges to assure physician orders had been sent to the receiving facility timely and that the receiving facility was notified of the resident□s arrival to the receiving facility before discharging the resident.
The results included: 100% all orders were sent

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 8/25/2023 The Administrator/ Director of Nurses began re-educating the Interdisciplinary Team, Social Service

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F 660	Continued From page 4 could get paperwork and a room cleaned for her. Facility # 2's Admission Coordinator was interviewed via phone on 8/23/23 at 10:30 AM and reported the following. Facility # 1 and Facility # 2 were "sister facilities" (owned by the same corporation), and Facility # 2 had been talking to Facility # 1 about accepting Resident # 7 as an admission when a bed became available. On 8/21/23 she had talked to Facility # 1's Social Worker and informed him that a bed had become available. Facility # 1's SW told her that he would get the paperwork to her. No date of transfer was ever confirmed. On 8/22/23 Resident # 7 arrived at Facility # 2 without her knowing about it. There were no orders accompanying Resident # 7, and the room that had become available had not yet been cleaned. It took Facility # 2 about 30 to 45 minutes to deep clean the room, and then they placed Resident # 7 in her new room. They also contacted Facility # 1 and obtained Resident # 7's orders. She indicated that did not take very long. On 8/23/23 at 3:05 PM Facility # 1's Unit Manager was interviewed and reported the following. The week prior to Resident # 7's discharge, there had been a discussion about Resident # 7 being discharged to another facility. On 8/21/23 Resident # 7's family member informed her that Resident # 7 was going to Facility # 2, and she would like for the transfer to take place on 8/22/23. She confirmed with Resident # 7's Responsible Party (RP) that he also wanted this. She (the Unit Manager) explained medications to the family member and the family member signed for the medications. The Social Worker usually went through discharge paperwork with residents before they leave, and therefore she thought he (the Social Worker) had done so and everything	F 660	Director and Minimum Data Set Coordinator, all full time, part time nurses, including agency nurses on the following topics: " The facility discharge process to include physician orders and notification of the receiving facility before discharging the resident to the new facility. " Utilization of the discharge process checklist for all discharges to assure a safe and orderly discharge for residents. " The Minimum Data Set Coordinator, Social Worker & Discharge Planner(s) will be educated on discharge process comprehensive care plans, discharge planning review & discharge summary completion for future discharges from the facility as of 9/17/2023. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Clinical staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. As of 9/17/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 660	Continued From page 5 had been done correctly. Facility # 1's Social Worker was interviewed on 8/23/23 at 1:05 PM and reported the following information. Resident # 7's RP (Responsible Party) on record was Resident # 7's husband, but the RP always deferred to the family member for decision making about Resident # 7's care. While Resident # 7 had resided at Facility # 1, Resident # 7 was also followed by hospice services, which were provided by their corporation's hospice provider. The hospice Social Worker had alerted him on 8/18/23 that Resident # 7's family member wanted her transferred to Facility # 2. He had talked to Facility # 1's Business Office Manager, who had alerted him that there were no open beds at Facility # 2. Then on 8/21/23 he received a call from the hospice Social Worker asking if they could move forward with Resident # 7's discharge to Facility # 2. The hospice Social Worker let him know at that time Facility # 2 had a bed open. He informed the hospice Social Worker they could move forward. Later that day (8/21/23) he received a phone call from the Admissions Coordinator at Facility # 2 letting him also know they had a bed which just came available. No definite plans were made at that time for a specific transfer time. On 8/21/23 he talked to the Unit Manger at Facility # 1, who let him know the family member would like Resident # 7 transferred on 8/22/23. The next morning before he arrived at work, he received a text message from the hospice Social Worker asking what time Resident # 7 was going to transfer. He interpreted that "was a go." During the morning clinical meeting on 8/22/23 he was informed by the Administrator to ask Facility # 1's transport staff member when they could transport Resident # 7.	F 660	and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F660 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The monitoring will ensure that discharge plans are in place, physician orders are sent timely and that the receiving facility is prepared to admit the discharged resident. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with Discharge Process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: September 19 2023	

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F 660	Continued From page 6 The physician was scheduled to be at the facility that morning (8/22/23) but did not come till later that day. The plan had been for the physician to sign all the paperwork when she arrived the morning of 8/22/23, but that had not happened. He had not realized that Resident # 7's paperwork had not been signed by the physician and sent to Facility # 2 until after Resident # 7 was sent. At around 11:46 AM on 8/22/23, he received a phone call from Facility # 2's Admission's Coordinator letting him know they had no paperwork and they had not realized she was coming. He immediately went to medical records and Resident # 7's order summary and other paperwork was sent at that time. They used the orders they had on file for Resident # 7. When the physician arrived shortly thereafter on 8/22/23, she signed the paperwork and did not change any of Resident # 7's orders. Therefore, there had been no problems with the orders which had been sent to Facility # 2 being inaccurate since the physician did not change anything. On 8/23/23 at 5:25 PM Facility # 1's Administrator was interviewed and reported the following. Prior to Resident # 7 leaving on 8/22/23, she thought everything had been in place for Resident # 7 to discharge with appropriate paperwork and notification to Facility # 2.	F 660		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		9/19/23

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F 690	Continued From page 7 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and Nurse Practitioner and Physician interviews the facility failed to provide services for two of three sampled residents (Resident #3 and Resident #5) with a urinary catheter or symptoms of urinary tract infection. For Resident #3 the facility failed to 1) assure an accurate monitoring of his output after a newly placed catheter per the plan of care	F 690	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	

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F 690	Continued From page 8 2) assure that nursing staff communicated about problems the resident was having with the catheter and 3) clarify with the physician and urologist what measures should be taken if the catheter became occluded or leaking when they became aware Resident #3 had the catheter and was experiencing these problems. For Resident #5 the facility failed to 1) obtain a urine specimen until two days after it was ordered and 2) communicate urinalysis results to the Physician or Nurse Practitioner so an evaluation for possible treatment could be done. The findings included: 1. Resident #3 was admitted to the facility on 7/2/19. Resident #3's diagnoses included in part Parkinsons disease, benign prostrate hypertrophy with a history of urinary retention and a history of TURP (transurethral resection of the prostate- a surgery where part of an enlarged prostate is removed.) Resident #3's annual Minimum Data Set (MDS) assessment, dated 5/31/23, coded Resident #3 as cognitively intact. The resident was also coded as needing supervision for hygiene and occasionally incontinent of bladder. Resident #3's care plan, last reviewed on 8/2/23, included the information that Resident #3 was at risk for UTI due to having a history of recurrent indwelling urinary catheter use and a history of ESBL (Extended Spectrum Beta-Lactamase-which are enzymes produced by some bacteria that make them resistant to antibiotics). This had been added to Resident #3's care plan on 1/8/20 and remained part of his active care plan. One of the interventions was to monitor Resident #3's output per the facility's	F 690	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to provide services for Resident #3 and Resident #5 with a urinary catheter or symptoms of urinary tract infection. For Resident #3 the facility failed to: 1) assure an accurate monitoring of his output after a newly placed catheter per the plan of care 2) assure that nursing staff communicated about problems the resident was having with the catheter 3) clarify with the physician and urologist what measures should be taken if the catheter became occluded or leaking when they became aware For Resident #5 the facility failed to: 1) obtain a urine specimen until two days after it was ordered and 2) communicate urinalysis results to the Physician or Nurse Practitioner so an evaluation for possible treatment could be done Corrective action for resident(s) affected by the alleged deficient practice: Resident #3 1)Facility immediately contacted the urologist on 8/24/2023 and obtained orders to ensure accurate monitoring of output of the indwelling catheter was in	

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F 690	Continued From page 9 policy. According to hospital records and urology notes, Resident #3 was hospitalized from 6/11/23 to 6/13/23 after experiencing suprapubic pain and dysuria (painful urination). A bladder scan upon admission showed he had greater than 500 ml (milliliters) in his bladder and a urinary catheter was inserted for retention. He was evaluated by a hospital infectious disease physician and treated with intravenous fluids and antibiotics. Prior to his discharge on 6/13/23, he was able to successfully void without the urinary catheter, and he was discharged back to the facility with instructions for a urology follow up. According to the Urologist's 7/6/23, "After Visit Summary," Resident # 3 was noted to have "BPH (an enlarged prostate) with obstruction/lower urinary tract symptoms; urinary retention due to BPH, and recurrent UTI. The summary also noted he was to take an antibiotic for seven days and follow up with the urologist "in about 4 weeks around 8/3/23." There were no directions on the Urology summary regarding measures to take if the urinary catheter began to leak or became occluded. On 7/6/23 at 1:32 PM the Unit Nurse Manager made the following notation in the nursing notes. Resident #3 had gone to his urology appointment and returned with a 16 French/ 10 cc indwelling urinary catheter draining clear amber colored urine into a leg bag. The resident also had orders for Flomax 0.4 mg (milligrams) to be administered at bedtime. From 7/6/23 through 7/18/23 there were no recorded urine output measurements for	F 690	place and that the physician was notified of the resident's concerns related to the indwelling catheter. 2)On 8/24/2023 the Urologist was contacted by the Unit Manager and order clarification was received for occlusion or leaking of the indwelling catheter. Resident #5 On 8/ 16 /2023 the Unit Manager notified the physician that the lab had not been obtained timely and of the results of the lab once completed for any additional orders. On 8/17/2023 orders were received and implemented from the physician for measures to relieve the resident's symptoms. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 9/13/23 the nurse manager audited all current residents with Indwelling Urinary Catheters to ensure that urinary output was being monitored and recorded as ordered and that the physician was notified if the resident had any concerns regarding the indwelling urinary catheter. The results included:100% of Residents with Indwelling Urinary Catheters urinary output was being monitoring. Beginning on 9/13/2023 the nurse manager audited all labs orders for the last 14 days for timely collection of the specimen and timely notification of the physician of ordered lab results. The results included: All lab orders were timely reported to Physician	

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F 690	Continued From page 10 Resident #3 per the plan of care. The Director of Nursing (DON) was interviewed on 8/24/23 at 10:25 AM and reported that per policy residents with new catheters were to have output measured for the first 30 days after insertion. On 7/18/23 at 10:25 PM Nurse #2 documented in Resident #3's Medication Administration Record that she had administered Oxycodone 5 mg (milligrams) per a PRN (as needed order) for pain. On 7/19/23 at 1:47 AM Nurse #2 entered the following information into Resident #3's nursing notes. Resident #3 was complaining of abdominal pain and the pain medication had only been effective for a short while. He was insisting on going to the hospital, had approximately 250 ml of dark urine in his urinary catheter bag, and had positive bowel sounds in all four abdominal quadrants. Nurse #2 further noted his abdomen was soft with some tenderness around his umbilicus. The physician was contacted, and orders received to send the resident to the hospital. Nurse #2 was interviewed on 8/22/23 at 11:08 AM and reported the following. She had started caring for Resident # 3 on 7/18/23 at 7:00 PM. That night he complained of "discomfort in his belly." He also reported "he could not pee." The Nurse Aide had reported that he had urine output during the day. She had thought the problem could possibly be related to his bowels but was "more focused" on his bladder being the issue. She did change the urinary drainage bag at 7:00 PM on 7/18/23 so she could determine if any	F 690	On 8/ 17/2023 the unit manager assessed all residents with an indwelling catheter for signs and symptoms of a urinary tract infection or concerns with their indwelling catheter. The results included: 100% were audited no concerns As of 9/19/23 all residents with indwelling catheters were in compliance. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 8/23/2023 the Director of Nurses/ RN nurse manager began educating all full time, part time, and prn nurses and CNA's on the following topics: • Indwelling urinary catheter care, sign or symptoms that are indicative of adverse changes and appropriate notification to Nursing Supervisor, oncoming nursing staff member(s) and physician. • Utilization of the Suspected Urinary Tract Infection User Defined Assessment (SBAR). On 8/22/2023 Education was initiated by the Director of Nurses/Assistant Director on the following with all licensed nurses to include agency nurses: • The nurse who receives the lab results will need to prioritize the lab to be obtained on specified date and notify the physician. • The nurse will call the physician immediately to notify them of the results and document the notification in the resident's chart including the current condition of the resident. • Any new orders received as a result of the lab result should be transcribed into	

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F 690	Continued From page 11 urine was coming out. He did have 250 cc of dark yellow urine before she sent him to the hospital. She had encouraged him to drink fluids, and she thought he drank approximately 32 oz of fluid prior to going out to the hospital. She palpated his bladder, and it was not distended before she sent him out. He seemed to have some relief at intervals prior to being sent out and was not hurting the entire time. Resident #3 was interviewed on 8/22/23 at 2:30 PM and reported the following about the dates of 7/18/23 and 7/19/23. Around 3:00 PM on 7/18/23 they had changed his urinary drainage bag. That evening around 6:00 PM he noticed he was having pain over his bladder. He talked to Nurse #2 who felt of his abdomen and thought it might be related to his bowels. She also encouraged him to drink fluids, and she gave him something for pain. He drank two 500 ml water bottles that evening, but then stopped because the pain was getting much worse and nothing was going into the urinary bag any longer after 7:00 PM that night. He felt the catheter "had failed." Finally, he could not take the pain anymore and they sent him to the hospital around midnight. Once they changed the catheter at the hospital, he got relief. According to Resident #3's hospital ED (Emergency Department) notes, dated 7/19/23, Resident #3 arrived at the hospital at 2:44 AM on 7/19/23 and the urinary catheter was able to be replaced by a nurse. The ED physician specifically noted the following in the ED notes. At 4:15 AM he evaluated Resident #3, and the resident was complaining of suprapubic pain and bladder fullness since his catheter bag had been changed around 3:00 PM the previous day. There was 100 ml of urine in his urinary bag. At 4:16	F 690	electronic medical record (EMAR). • The resident and/or the responsible party will also need to be notified of the results and any new orders. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 9/19/2023/any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F690 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The Director of Nursing/Assistant Director of Nurses will monitor to ensure that the indwelling catheter process and lab process with physician notification are in place. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with F 690. The	

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F 690	Continued From page 12 AM the physician talked to the nurse who reported Resident #3's bladder scan showed he had greater than 1275 ml of urine in his bladder. At 4:26 AM the physician noted Resident #3 had a firm mass consistent with a distended bladder palpated to his umbilicus. His plan was to have the urinary catheter replaced and labs completed. At 4:41 AM the physician noted the hospital nurse had successfully replaced the urinary catheter and there was approximately 1400 ml of urine in the urinary drainage bag after replacement of the catheter. The physician further noted the suprapubic pain had resolved. Resident #3 was discharged on 7/19/23 from the hospital ED at 11:38 AM with instructions to follow up with his physician. He was placed on an antibiotic and also instructed to follow up with urology in two weeks. On 7/19/23 Resident #3 returned to the facility and orders were entered for the first time into the electronic record for the Resident to have a 16 French 10 cc balloon indwelling urinary catheter. The bag was to be replaced every two weeks. There was no indication in the record that it was confirmed if the catheter could be replaced or measures to take if it became obstructed again or was found to be leaking. Beginning on 7/19/23 urine output started to be recorded every shift in Resident #3's record. For the date of 8/1/23, there was no urine output recorded. Resident #3 was interviewed on 8/22/23 at 2:30 PM and reported the following. On 8/1/23 he had an appointment for a diagnostic test (a magnetic resonance imaging-MRI) not related to his catheter that morning. He was accompanied by a	F 690	weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/19/2023	

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friend. The appointment was out of town. On the way, he noted there was nothing draining in his urinary bag and mentioned it to the friend who indicated that they would be back at the facility around 1:00 PM to have it checked. When he arrived for his MRI and laid down, suddenly a lot of urine came around his catheter tubing and the staff had to clean the floor and MRI table because of the amount of urine. His RP was made aware of the problem and called before he went back to the facility, to alert the facility staff that there had been problems with his catheter again. He thought that once he arrived back at the facility, someone would check it and make sure things were taken care of. He arrived back at 3:00 PM on 8/1/23, and no one came to check his catheter. The friend, who had accompanied him, also spoke to someone at the nursing desk about him needing to be checked. He laid down because he was in pain again. No one came to check about his catheter until around 6:00 PM that night. He thought the Unit Manager would come and check on his catheter, but she did not do so, and he had been upset about that.

Resident #3's RP was interviewed on 8/23/23 at 10:11 AM and reported the following. She felt the staff were not caring for the urinary catheter correctly, and he had experienced problems with it. The date of 8/1/23 was in particular a problem, as he started to have problems early in the morning with the catheter not draining correctly.

The friend, who had accompanied Resident #3 on 8/1/23 to the MRI visit, was interviewed on 8/23/23 at 10:10 AM and reported the following. He recalled that when he was driving Resident #3 to his out- of- town appointment on the morning of 8/1/23, that Resident # 3 commented there

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was nothing in his urinary drainage bag. When they arrived, the MRI staff checked it for kinks but could do nothing further. Following the MRI test, the MRI staff had let the friend know that his "bladder had released" from around the catheter tubing while he was on the MRI table and urine had gone everywhere. When they returned to the facility, he signed Resident #3 back in at the nursing desk and let the person at the desk know that he was having trouble with the urinary catheter tubing. Resident #3's RP had already called them before they arrived back to alert them to a problem. He stayed for about 30 minutes before having to leave. No one came to check on Resident #3 during that timeframe.

On 8/23/23 the Unit Manger provided a written statement regarding the events of 8/1/23. The statement in part read, "I spoke to [Resident #3's] RP via telephone regarding MRI appointment on 8/1/23. Per RP, {Resident #3} was placed into MRI machine for procedure when staff noticed large amount of urine leaking from Foley catheter insertion site. RP states staff (from the MRI) informed him that catheter was checked and was noted to be sealed and intact, no urine output was observed in bag possibly due to it being clogged. MRI machine cleaned and test completed."

The Unit Manger was interviewed on 8/22/23 at 4:00 PM and reported she did go to speak to Resident #3 after he returned and before she left on 8/1/23. The Unit Manager reported Resident #3 was upset with her and did not want to talk to her at the time. She did not check his urinary catheter.

NA #1 was interviewed on 8/24/23 at 9:15 AM and reported the following. NA #1 had cared for

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Resident #3 between the hours of 3:00 PM to 7:00 PM on 8/1/23. She had been working on another unit that day up until 3 PM. She arrived on Resident #3's unit around 3:15 PM on 8/1/23 and he was already back from his appointment. She looked in and waved to him. He was on the phone at that time, and she did not disturb him. That was her first time caring for Resident #3. Around 5:00 PM, Nurse #3 told her that Resident #3 had soiled himself with stool and needed to be cleaned. She went immediately. He was having some diarrhea and she cleaned him. He told her his catheter "was hurting really bad." He was in tears. He wanted to talk to the Unit Manager. She could not find the Unit Manager. Resident #3 then asked to speak to a nurse that was on another hall (Nurse #4). She went to speak to Nurse #4 who told her that Nurse #3 was Resident #3's nurse. She went back to Nurse # 3 and told her about Resident # 3's complaints. She knew Nurse #3 went in to see Resident # 3, but she did not know what all she did. Around dinner time Resident #3 seemed better. She checked him at 6:45 PM before she left, and he was asleep.

NA #2, who had cared for Resident # 3 from 7 PM to his transfer to the hospital on 8/1/23, was interviewed on 8/24/23 at 4:55 PM and reported the following. She was aware Resident #3's catheter was "not right" that night and that it was leaking. She did not recall if he was in pain. She knew that Nurse #3 knew about the issue and the resident talked to the nurse.

Nurse #3 was interviewed on 8/23/23 at 11:36 PM and reported the following. She got to work a little after 3:00 PM that day. No one reported anything to her in report about Resident #3 having problems with his catheter earlier that morning

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while he was at the MRI. She also did not know he had gone to the hospital on 7/19/23 with an occlusion of his catheter. If she had known this information, she would have told the NA to note exactly the fluids he was taking in and she would have made more frequent checks to see his output compared to his intake. She recalled that around 5:00 PM, Resident #3 wanted something for constipation, and she administered his medication. At that time, he did not mention problems with the catheter. Later in the evening, she had to administer medications at different times to him so as to spread his medications apart. At some point, he mentioned to her that he thought his catheter was kinked. She looked at the catheter and there was 150 cc in the urinary drainage bag. His abdomen was not distended. She readjusted the strap. He did mention that if he did not make urine, he wanted to be sent out. Sometime around 9:00 PM, she went to give his medications and he was talking on the phone with his RP. The RP wanted to talk to her. She spoke to the RP who informed her that she wanted Resident #3 sent out for not having urine output. The nurse then let her know she would get the paperwork ready. She called the physician and had the resident sent out.

On 8/1/23 at 11:30 PM Nurse #3 entered the following notation into Resident #3's nursing notes. "Writer went into resident's room to give medication. Resident was on the phone speaking with [RP}, who requested to speak with writer. Writer explained to RP resident has requested to go to ER if he does not produce urine within a certain amount of time. [RP (Responsible Party)} stated she wanted him to go to the ER (emergency room) as well if he does not urinate. Resident did not produce urine and was

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encouraged to drink fluids. Writer did call EMS they arrived at 11:14 PM. RP was called and made aware."

Review of hospital ED notes revealed Resident #3 had been sent to the ED on 8/1/23 and was there for 12 hours. The ED physician noted Resident # 3 had reported his catheter had not been draining all day, and he was having abdominal pressure. The catheter was exchanged for a new one and drained 1150 ml of urine. He was discharged on 8/2/23 at 12:31 PM with instructions to follow up with his physician.

According to the facility record, Resident # 3 returned to the facility on 8/2/23.

Review of Resident # 3's Medication Administration Record revealed output monitoring resumed on 8/2/23.

Review of a renal ultrasound study, dated 8/4/23, revealed a renal ultrasound was completed on 8/4/23.

Review of a urology office visit note, dated 8/9/23, revealed the Urologist saw the resident that day and discussed possible suprapubic catheter placement in future. The Urologist noted she advised Resident #3 he would have to have a negative urine culture prior to a suprapubic catheter being placed. The resident was to continue an antibiotic for 30 days and follow up with the Urologist on 8/31/23 or sooner if problems.

Resident #3 was interviewed on 8/22/23 at 2:30 PM and reported the following. During the 8/9/23 urology visit, the Urologist talked to him about

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having a suprapubic catheter inserted, but the Urologist wanted him to clear a urinary tract infection prior to the procedure being done. Therefore, as of 8/22/23 he continued with the urinary catheter that had been inserted on 8/1/23 and antibiotics.

On 8/23/23 at 11:30 PM Nurse #5 documented the following in a nursing note. Resident #5 was complaining of lower abdominal pain, discomfort, pressure, and retaining urine. The nurse noted the following outputs. 3:30 PM -500 ml, 6:00 PM 300 ml, 11:30 PM 100 ml. The nurse further noted she called the on- call provider at 11:45 PM and one of the orders she received was to replace the urinary catheter. The nurse further noted she changed the urinary catheter without difficulty and the volume of residual urine was 500 ml.

The Medical Director, who serves as the Resident #3's physician, was interviewed on 8/24/23 at 3:30 PM about the lack of orders in the record for measures to take when the catheter was occluded or leaking given that it had been replaced by a hospital nurse on 7/19/23. The physician reported the following. Typically, with new catheters she wanted the Urologist to be consulted when it needed to be replaced or the resident sent to the emergency department. Given that he had been to the hospital twice with an occlusion/leaking and the facility staff had successfully replaced it after an on- call provider's order on 8/23/23, then she felt the Urologist needed to be consulted and a plan made regarding what to do when it occluded. The Physician reported that at times a catheter can be irrigated rather than replaced and it could be confirmed if that would be an option for Resident

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3. The Physician stated she would clarify that with the urologist. The Physician also reported that every time a catheter is reinserted then there is the potential to introduce bacteria into the bladder. The Physician also reported that if there was build up of urine in the bladder it could potentially cause problems with a resident's ureters, but she was not aware of any harm he had experienced when it had occluded thus far.

The facility Nurse Consultant, DON, and Administrator were interviewed on 8/24/23 at 5 PM. The Nurse Consultant reported that on 8/24/23 they had consulted with Resident #3's Urologist that day and received directions that if Resident #3 experienced occlusion problems when the Urology office was open, they were to send the resident there. If the office was closed, then facility staff could try to reinsert the urinary catheter and if unsuccessful then they could send the resident to the hospital. According to the Nurse Consultant, the staff had not been recording Resident #3's specific output from the dates of 7/6/23 through 7/18/23, but they had been monitoring it. The DON had spoken to staff on 8/24/23 to try to recall the output Resident # 3 had between 7/6/23 and 7/18/23 and although not specific, the staff felt the resident was having sufficient output up until 7/18/23 when the urinary catheter occluded.

2. Resident #5 was admitted to the facility on 7/1/11. Resident # 5's diagnoses in part included Alzheimer's disease.

Resident #5's annual MDS (Minimum Data Set) assessment, dated 8/7/23, coded Resident # 5 as cognitively intact. The resident was also assessed to always be incontinent of urine.

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On 8/14/23 at 3:59 PM the Unit Manger entered a nursing note noting the following. Resident #5 had been seen by the medical provider due to complaints of burning and discomfort. Orders were given to obtain a urinalysis.

On 8/14/23 an order was entered into the electronic record for a urinalysis.

Review of documented temperature readings for Resident # 5 between the dates of 8/14/23 and 8/22/23 revealed Resident # 5 was afebrile.

The Unit Manger was interviewed on 8/23/23 at 3:05 PM and reported the following. She was unsure what had happened to delay the collection of the urine and the reporting of the results. She had reviewed the MAR (Medication Administration Record) on 8/23/23 and noted Nurse #6 had checked on the MAR that the urine specimen had been collected on 8/14/23 (the day it had been ordered).

Nurse #6 was interviewed on 8/24/23 at 9:30 AM and reported the following. She recalled there was something in report about a urine specimen for Resident # 5 one day, but she did not recall it coming up in report that she needed to obtain one, and she had not done so on 8/14/23. She did not recall that she had signed that she had collected a urine specimen on 8/14/23.

Two days later, on 8/16/23 at 2:51 PM, Nurse # 2 made a nursing note that she had obtained the urine specimen by performing a straight catheterization. The specimen had a large amount of sediment with a foul odor. The specimen was placed in the refrigerator for lab

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pick up.

Nurse # 2 was interviewed on 8/23/23 at 12:40 PM and reported the following. She had worked with Resident # 5 on 8/14/23 and did not know the resident needed a urine specimen or she would have gotten one. The resident was not difficult to catheterize. She learned about the need for the urine specimen on 8/16/23 and obtained it.

A review of labs revealed the 8/17/23 urinalysis was negative for nitrates. It had 4+ bacteria and to numerous to count white blood cells. The culture showed greater than 100,00 colonies of mixed gram- negative rods. There was no predominant microorganism present. The lab report noted, "Recollection is suggested if clinically indicated."

Between the dates of 8/17/23 and 8/22/23 there was not a notation about follow up regarding the lab or symptoms Resident # 5 was experiencing or that the NP or physician were notified.

Resident #5 was interviewed on 8/22/23 at 10:05 AM and reported the following. She had been experiencing urinary burning since the previous Monday (8/14/23) and told the staff about the problem. The staff had collected a urine specimen on 8/16/23. She had never heard anything further after they collected the urine. She was continuing to have urinary burning, and she felt she had a urinary tract infection.

On 8/22/23 at 10:12 AM Nurse # 4 was interviewed about Resident # 5's complaints and lack of follow up. Nurse # 4, who was assigned to Resident # 5, was observed to go and find the

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 08/24/2023

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 690	Continued From page 22	F 690		

urine specimen results and stated he would see that there was follow up.

On 8/22/23 at 11:57 AM the Unit Manager documented the following in the nursing notes. Results of the urinalysis and culture were called into the Nurse Practitioner. The NP was informed Resident #5 was still complaining of dysuria. The NP gave orders to start Resident #5 on Bactrim DS 800-160 mg (milligrams) daily for five days.

The DON (Director of Nursing) was interviewed on 8/23/23 at 5:20 PM and reported the following. She had not been aware there was a delay in getting a urine specimen for Resident #5 or following up about the results. She did not know why it had occurred. It was the facility's procedure to collect the urine specimen on the day it was ordered. The specimen then was placed in the refrigerator where their lab, which came daily, then picked the specimen up. If the urine specimen needed to be picked up sooner than when the lab arrived for the daily pick up, then the lab could be called, and they would come pick up the specimen earlier. Once the results were returned, there was to be follow up with the provider.

The Nurse Practitioner (NP) was interviewed on 8/23/23 at 3:00 PM and reported the following. The first time the urine result was brought to her attention was on 8/22/23, and she was in the facility two to three times per week. She had not been aware the urine specimen was not done until two days after she ordered it to be done.