JUL 0 8 2013

PRINTED: 06/28/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345353	B. WING			06/	14/2013
	ROVIDER OR SUPPLIER D HOUSE REHABILITATI	ON AND HEALTHCARE		17	EET ADDRESS, CITY, STATE, ZIP CODE 700 PAMALEE DR PO BOX 35881 AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 203 SS=D	Before a facility transfresident, the facility mif known, a family merof the resident of the manager and manner the reasons for the manager and manner the reasons in the resinclude in the notice the paragraph (a)(6) of the Except when specifies this section, the notice required under paragraph to the made by the before the resident is Notice may be made before transfer or discindividuals in the facility under (a)(2)(iv) of this health improves sufficing in medical needs, under section; or a resident facility for 30 days. The written notice specifies the section must include the made of the State long terms of the State long terms.	fers or discharges a nust notify the resident and, mber or legal representative transfer or discharge and ove in writing and in a rethey understand; recordident's clinical record; and he items described in is section. If in paragraph (a)(5)(ii) of e of transfer or discharge raph (a)(4) of this section facility at least 30 days transferred or discharged. It would be endangered exection; the resident's ciently to allow a more discharge, under paragraph and immediate transfer or by the resident's urgent reparagraph (a)(2)(ii) of this has not resided in the exified in paragraph (a)(4) of the reason for transfer or not which the resident is ged; a statement that the to appeal the action to the ress and telephone number care ombudsman; for		000	Highland House Rehabilitation & Health submits this Plan of Correction (PoC) in accordance with the provisions of Health Safety Code Section 1280 and C.F.R. 40 It shall not be construed as an admission alleged deficiency cited. The Provider su this PoC with the intention that it be inad by any third party in any civil or crimina against the Provider or any employee, ag officer, director, or shareholder of the Provider hereby reserves the right to challenge the findings of this survey if at time the Provider determines that the disfindings: (1) are relied upon to adversely influence or serve as a basis, in any way, selection and/or imposition of future rem for any increase in future remedies, whet remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), State of North Carolina or any other entit serve, in any way, to facilitate or promote by any third party against the Provider. A changes to Provider policy or procedures be considered to be subsequent remedial measures as that concept is employed in of the Federal Rules of Evidence and sho inadmissible in any proceeding on that be Provider has not had any remedies imposagainst it as a result of the alleged deficiency without such remedies, the Provider will granted an appeal before the U.S. Depart Health and Human Services Departmenta Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initit Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (II process.	and 5 1907. of any bmits lmissible l action ent, ovider. any puted for the edies, or her such the ty; or (2) e action any should Rule 407 ould be asis. The ted encies, not be ment of all ally the o DR)	
ABURAIURY		SUPPLIER REPRESENTATIVE'S SIGNATUR	Œ		TITLE Administrator	((X6) DATE 07/02/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G0UR11

Facility ID: 923255

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XD PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED			
		345353	B. WING			C 06/14/2013	
	OVIDER OR SUPPLIER D HOUSE REHABILITA	TION AND HEALTHCARE	٤	TREET ADDRESS, CITY, STATE, ZIP CODE 1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 203	disabilities, the mail number of the agen protection and advo disabled individuals the Developmental of Rights Act; and for who are mentally ill telephone number of the protection and a individuals establish Advocacy for Mental Advocacy for Mental This REQUIREMENT by: Based on medical staff and resident in give a notice of discresident or legal repfrom the facility for was discharged to a findings include: Resident was adminificated to a finding include: Resident (CVA), Syn Response Syndrom Fallure, Dehydration and Difficulty Walking dated 5/14/2013 includes the facility, transfer eating and bathing, resident needed limuse, not steady but assist. MDS further	ge 1 Idents with developmental ling address and telephone acy responsible for the locacy of developmentally a established under Part C of Disabilities Assistance and Bill or nursing facility residents and line agency responsible for advocacy of mentally ill med under the Protection and ally Ill Individuals Act. In it is not met as evidenced record reviews, interviews with a laterview, the facility failed to charge in writing to the presentative prior to discharge in 61 sampled resident who a Motel (Resident #70). The lated to the facility on 3/18/2013 nemia, Cerebrovascular stemic Inflammatory are (SIRS), Acute Renal and Nausea, Muscle Weakness and Minimum Data Set (MDS) dicated the resident's cognition dent was independent with lears, locomotion, personal care, The MDS also indicated the lated assistance with toileting able to stabilize without indicated the resident used mair and MDS further indicated	F 20	It is the facility's normal pract discharge planning at the time using as a guideline the prior I function, rehab potential and, importantly, the desires and go resident and/or their family/rex Resident #70 was alert and oriexcellent therapy potential. Restated discharge goal upon addischarge was to receive short and then return to the communistated he was not interested in arrangements to stay at the fact The facility was under the impeday notice of discharge was not since the resident was indicative turn to the community upon therapy. Identified Resident- Resident discharged to the location of h 5/23/13. Also refer to Measure Potential Residents- Any fact discharge has the potential to a the facility initiated discharges for planning and documentation prodischarge. Also refer to Measure Measures- Since this discharge thought to be a voluntary discharge on all voluntary discharge on all voluntary discoutlining resident and/or responsation, orientation and participation, orientation and participation will monitor president and/or responsations.	of admission, evel of most oals of the sponsible party, ented with sident #70's mission through term therapy aity. Resident making sility long-term, oression a 30-obt required and a desire to completion of #70 was is choosing on es. If the interest is a party of a party of the ares. If was a marge, ented to ensure rior to the charges onsible party olanning.	07/15/13	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		LETED
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	OVIDER OR SUPPLIER D HOUSE REHABILITAT	ON AND HEALTHCARE	· · · · · · · · · · · · · · · · · · ·	17	EET ADDRESS, CITY, STATE, ZIP CODE 700 PAMALEE DR PO BOX 35881 AYETTEVILLE, NG 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 203	Incontinent of bowel. Nurse's note dated 5/ "Resident left facility vehicle with staff mer Social services note of documented "Reside facility to the Motel or to make his needs and During the interview of 6/11/2013 at 2:00PM was told he owe the five welcomed to stay at that the resident decibecause he did not we comply with the facility check. The Administr was not given a 30 do because the facility done. She further addedischarged to the Mo	23/2013 documented in wheelchair to private other." dated 5/28/2013 and was discharged from a 5/23/2013. Resident is able at wants known verbally." with Administrator on She reported the resident acility money but was the facility. She further added ded to leave the facility and to give up his retirement ator also added the resident ays discharge notice id not see the reason to give	F	203	Continued from Page 2 Clinical Consultant re-addressed with Administrator, Director of Nursing, So Worker, Admissions/Discharge staff ar other Clinical Care Team members the requirements found at 483.12 during th 07/02/13 Clinical Care Team meeting a then one-on-one with the Social Worke same day. The Admissions/Discharge staff will the each discharge to determine whether princtice was given to a resident and/or the family/responsible party. Any notice is will be brought to the attention of the Administrator. Monitor- Discharge forms/documentat will be audited by the Administrator or designee once per week for three month Any notice issues will be discussed in the next Quality Assessment and Assurance (QAA) Committee meeting.	notice e and or the ack roper eir sues	
F 204 \$S=D	Against Medical Advi- 483.12(a)(7) PREPAI SAFE/ORDERLY TR A facility must provide	did not leave the facility ce (AMA). RATION FOR tANSFER/DISCHRG e sufficient preparation and ts to ensure safe and orderly	F	204	It is the facility's normal practice to be discharge planning at the time of admis using as a guideline the prior level of function, rehab potential and, most importantly, the desires and goals of the resident and/or their family/responsible Resident #70 was alert and oriented wiexcellent therapy potential. Resident #70	e party.	07/15/13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345353	B. WING_		· · · · · ·	C 06/14/2013	
	ROVIDER OR SUPPLIER D HOUSE REHABILITAT	TION AND HEALTHCARE		176	EET ADDRESS, CITY, STATE, ZIP CODE 00 PAMALEE DR PO BOX 35881 YETTEVILLE, NC 28301	<u> </u>	14/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 204	by: Based on medical restaff and resident into provide sufficient preto discharge for 1 of discharged to a mote findings include: Resident # 70 was a 3/18/2013 with diaground Cerebrovascular Accounflammatory Response Renal Failure, Dehyo Weakness and Diffic current Minimum Data 5/14/2013 indicated intact. The resident wobility, transfers, lo eating and bathing. The resident needed limit use, not steady but a assist. MDS further in walker and wheelchathe resident was contincentinent of bowel. Review of the Social versident's family mer any of them were will their home and non resident in their home. Nurse's note dated 5	cord reviews, interviews with erview, the facility failed to paration to the resident prior 1 sampled resident who was all (Resident # 70). The dmitted to the facility on loses of Anemia, sident (CVA), Systemic lose Syndrome (SIRS), Acute dration, Nausea, Muscle lulty Walking. The most las Set (MDS) dated the resident's cognition was was independent with bed comotion, personal care, The MDS also indicated the led assistance with foileting lible to stabilize without indicated the resident used air and MDS further indicated tinent of bladder and always Work's note dated 5/3/2013 Worker (SW) spoke with the inbers on the phone asking if ling to take the resident in e was willing to take the e.	F2		stated discharge goal upon admission to discharge was to receive short-term the and then return to the community. Resistated he was not interested in making arrangements to stay at the facility long. Identified Resident- Resident #70 was discharged to a location of his choosing extended stay facility) on 5/23/13. Facisocial Worker and Admissions/Discha Worker attempted to ensure a safe and orderly transition by assisting Resident with obtaining personal income checks former landlord, providing transportation the bank to ensure available cash for secare, provided transportation to the extistay facility, arranged for meals, and as with contacting brother to pick up medications at a nearby pharmacy. On 05/28/13 Social Worker made a follow visit at the resident's location where sh found him well groomed with no stated needs. On 06/12/13 Admission/Discha Worker again followed up with family they stated resident had medications, in closer to them, had new cell #, and was fine. Family had relocated resident to a closer to their home so that they could better with transportation needs. DSS C Worker was inadvertently not notified resident's decision until 05/28/13. Also to Measures. Potential Residents- All residents and they choose, their families will be inviting planning meeting which typically takes within 3 days following an admission. meeting is designed to further develop	grapy ident g-term. g (an illity rge #70 from on to olf- ended sisted -up e and noved adoing place assist Case of refer ed to a g place The	

	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE	SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AN (X4) ID PREFIX (EACH DEFICIENCY MUST IN REGULATORY OR LSC IDEN	T OF DEFICIENCIES BE PRECEDED BY FULL	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CO 1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301 PROVIDER'S PLAN CO (EACH CORRECTIVE ACC CROSS-REFERENCED TO DEFICIENT	ODE OF CORRECTION CTION SHOULD BE OTHEAPPROPRIATE	(X5) COMPLETION DATE
F 204 Continued From page 4 Social services note dated 5 documented "Resident was facility to the Motel on 5/23/2 to make his needs and want Review of the fax dated 5/29 Protection Agency (APS) wa resident being at the Motel of Social worker (SW)'s note of documented "SW spoke wit 5/23/2013 in regards to disc Resident states he refuses to shelter. Resident does not han apartment started." SW's note dated 5/29/2013 referral was done for resident During the interview with Ad 6/11/2013 at 2:00PM, She re was told he owe the facility is welcomed to stay at the facility and the resident decided to because he did not want to a comply with the facility to give check. The Administrator als was not given a 30 days dis there was no documentation resident left the facility Again (AMA). She further added the discharged to the Motel becomember was willing to take home. During the interview with SV 2:30 PM, she reported the re discharged to the motel becomember was to the motel become the resident per control of the motel become the motel the motel become the motel the motel the motel	discharged from 2013. Resident is able is known verbally." 2/2013 revealed Adult as notified about the on 5/28/2013. ated 5/29/2013 th resident on harged plans. To go to a homeless have the income to get documented "APS into n 5/28/2013." ministrator on apported the resident money but was lity. She further added leave the facility give up his retirement so added the resident charge notice and indicating the net Medical Advise he resident was ause no family the resident in their	F 24	ongoing plan for the reside meeting will include disc. Notes on this meeting will the Admissions/Discharg Worker. Discharge plann identify any needs or bandischarge and will be use with any outside agencies safe and orderly transition DME, etc.). Administrator will review appropriate coordination discharge. Also refer to Measures- Since this was voluntary discharge, additing lemented to ensure do completed prior to dischard discharges outlining resideresponsible party participand planning for safe and Administrator will monite. Each discharge will be diday prior to the discharge services are set-up and to any additional services for might need to be addressed. Clinical Consultant re-adadaministrator, Director of Worker, Admissions/Discother Clinical Care Team sufficient preparation guides. Team meeting and then of	harge planning. Il be documented by e staff or Social ing will attempt to riers involving a d to communicate s needed to provide a in (i.e. home health, v discharges for prior to the Measures. s believed to be a ational steps were ocumentation is arge on all voluntary lent and/or ration, orientation or process. scussed at least one to validate if all identify if there are or the resident that ed. dressed with of Nursing, Social charge staff and members the delines outlined for 13 Clinical Care	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345353	B. WING				14/2013	
	SUMMARY ST (EACH DEFICIENC	ION AND HEALTHCARE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1: F.	REET ADDRESS, CITY, STATE, ZIP CODE 700 PAMALEE DR PO BOX 35881 AYETTEVILLE, NC 28301 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
F 204	the Admission Coord from the facility to the that she did not chec whether he will pick u resident from the pha had no transportation. Home health agency the facility on 5/28/20 reason why the home notification were faxed discharge on 5/23/20 she could not answer faxing the paperwork Protection Agency (A of the facility on 5/23/5/24/2013. During the interview on 6/12/2013 at 2:00 had a discussion with payment at the facility waiting to hear from the services in reference money before the resident did not want further reported that a resident about the lia would become upset.	m. She added that she and inator drove the resident a motel. She further added k with the brother to find out up the prescription for the armacist since the resident a. SW also reported that paper work was faxed from 13. SW was asked the e health notification and APS and after the resident's 13. The SW answered that why there was a delay in to home health and Adult PS). She added she was out 12013 and came back on with the Business Manager PM, she reported that she in the resident about the y. She stated that she was he Department of Social to the resident's liability sident's was discharged to Manager also reported the to give up his money. She anytime she asked the billity money, the resident	L	204		plan ll his pt to a cate sure a catth, y will e to st one all re are that		
	to the Motel on 5/23/2 way to the Motel, the		The state of the s		Discharges will be discussed during the morning Administrative meetings to ide any additional needs. Within one to two days following a resi discharge home, the interdisciplinary te call the resident and/or family/responsil	entify dent's am will		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/28/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING _ COMPLETED C 345353 B. WING NAME OF PROVIDER OR SUPPLIER 06/14/2013 STREET ADDRESS, CITY, STATE, ZIP CODE HIGHLAND HOUSE REHABILITATION AND HEALTHCARE 1700 PAMALEE DR PO BOX 35881 **FAYETTEVILLE, NC 28301** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 204 Continued From page 6 Continued from Page 6 F 204 party to inquire if the resident needs assistance During the interview with Nurse #1 on 6/12/2013 with making arrangements for any additional at 3:00 PM, she reported that she called in the resident's medications to the pharmacy on the services. day he was discharged on 5/23/2013. She added she did not confirm with the resident or the family Any transition issues identified will be member to find out as to whether they will be able discussed in the next Quality Assessment and to pick his medication from the pharmacist. Assurance (QAA) Committee meeting. During the phone interview with Pharmacist on 6/13/2013 at 11:00 AM, she stated the medication was called in on 5/23/2013 by the facility 's staff. The Pharmacist also added the resident 's prescription was not filled due to lack of financial information from the resident or family member. During the phone interview with APS worker on 6/13/2013 at 11:16 AM, she reported that facility s SW notified her about the resident being at the motel on 5/28/2013. She added that she visited the resident on 5/29/2013and found the resident without medication and had feces in his bed. The APS worker added that the day he visited the resident he had a bad case of diarrhea at the Motel and the staff at the Motel were asking the

resident to leave. APS worker further reported that Home Health Agency had not visited the resident as of 5/28/2013. She also stated that her concern was that she did not understand why she

was not notified about the resident being discharged to Motel prior to the resident's date of discharge of 5/23/2013. APS worker stated that the facility's SW was aware that she was the resident's case worker as they had communicated regularly before the resident's discharge. APS worker also reported currently the resident is residing at a different Motel and she is in the process of finding the resident a permanent

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345353	B. WING				C /1 4/2013	
	ROVIDER OR SUPPLIER D HOUSE REHABILITATI	ON AND HEALTHCARE		1700	FADDRESS, CITY, STATE, ZIP CODE PAMALEE DR PO BOX 35881 ETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	I .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 204	6/13/2013 at 11:39 At not want to leave the added that he was for Administrator. The reday he was discharge mentioned to the SW and he did not want to shelter. He added that would rather die in the homeless shelter. The he would have still like because at the motel, medicine or place to residency. He also redischarged he had no Currently he reported permanent residency Motel. He also reported Agency never came to because they told him could not see him because he still did not paying for his medicar. During a phone interv Agency staff on 6/13/2 reported that they rectacility to follow up with on 5/28/2013. She fur not provide home hear	iew with the resident on M, he reported that he did facility on 5/23/2013. He coed to leave by the sident also reported that the ed from the facility he that he had no where to go of end up in a homeless of the told the SW that he estreet than go to a cersident further reported ed to be at the facility he did not have his move to for a permanent corted that the day he was money in his pocket. That he is still leaving in a lead that the Home Health to see him at the Motel over the phone that they cause he did not have a The resident also added he tall to get his medication of know how to go about the pharmacy. The with Home Health 2013 at 2: 00PM. She eived the referral from the hother reported that they did lith services to the resident ave a permanent address or	F	204				

PRINTED: 06/28/2013 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING nh0117 06/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1700 PAMALEE DR PO BOX 35881** HIGHLAND HOUSE REHABILITATION AND HEALTHC **FAYETTEVILLE, NC 28301** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DESIGNERCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Response Preface 10A NCAC 13F .1004(a) Medication D 000 Administration The Provider submits this Plan of Action (PoA) in accordance with specific regulatory requirements. The 10A NCAC 13F .1004 Medication Administration Provider does not denote agreement with the Corrective (a) An adult care home shall assure that the Action Report (CAR) nor does it constitute an admission that the stated citation is accurate. preparation and administration of medications, prescription and non-prescription, and treatments The Provider submits this PoA with the intention that it be by staff are in accordance with: inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, (1) orders by a licensed prescribing practitioner director, or shareholder of the Provider. The Provider which are maintained in the resident's record; and hereby reserves the right to challenge the findings if at any (2) rules in this Section and the facility's policies time the Provider determines that the findings: (1) are and procedures. relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether This Rule is not met as evidenced by: such remedies are imposed by the State of North Carolina Based on observation, record review and staff or any other entity; or (2) serve, in any way, to facilitate or and resident interview, the facility failed to ensure promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be that there were no medication errors for one of considered to be subsequent remedial measures as that four residents sampled (Res. #1). Findings concept is employed in Rule 407 of the Federal Rules of included: Evidence and should be inadmissible in any proceeding on that basis. Resident #1 was admitted to the facility in 2006 with diagnoses of vascular dementia, history of Action Plan Stroke, anxiety, diabetes, depression with 07/15/13 D 358 It is always the goal this facility to maintain error psychotic features, and agitation. The admission free medication administration. The facility had in Minimum Data Set (MDS) noted that Resident #1 place developed policies, procedures and audits. The was cognitively intact, and independent for facility's Administrator, Resident Care Director, activities of daily living (ADLs). pharmacy consultant, and others provide routine reviews, documentation monitoring, staff training On 6/13/2013 at 2:00 PM, in an interview, and refresher in-services. Consultant reviews, Resident #1 stated that on May 4, 2013 a nurse quality assurance monitoring and record audits are came in her room and told the resident that she some examples of various components utilized to had her medicine and asked if she were Resident comply with rules concerning medication administration. #2, Resident #1 replied that she was not, and gave the nurse her name. The nurse gave her the Identified Residents- Resident #1 and #2's cup with the medicine. Resident #1 stated that physician was notified on 05/04/13 of the errors. she did not think it was her medicine, but the Physician instructed staff to observe and follow-up nurse said it was for her and she took it. Resident if necessary. An error investigation was completed #1 stated that later the nurse came in and said I on 06/26/13. There were no negative outcomes as a have your medicine, and called Resident #1 by result of these errors. Nurse #1 is a newly licensed name. Resident #1 told the nurse that she had nurse and this was her first nursing job. Nurse #1 already given the resident her medicine, and that was re-trained on 06/14/13 regarding medication administration, preventing medication errors and

LABORATORY DIRECTOR'S OR PROVIDER'S UPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

07/03/14 (X6) DATE

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING: COMPLET				
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		nh0117		B. WING		06/1	4/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
HIGHLAN	D HOUSE REHABILITATI	ON AND HEALTHC		ALEE DR PO E ILLE, NC 283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	1		D 358	Continued from Page 1		
D 358	the resident thought it The nurse left the root that she had not seen On 6/13/2013 the Med Record (MAR) was re Resident #1 had an of milligram (mg) tablet, twice daily, and sched PM. Resident #2 had: 0.5mg, take ½ tab=0.2 scheduled at 9:00 AM A review of the chart for documentation of any nurse notes. A review error report did not ha or this resident. In an interview on 6/14 #1 stated that she was on 5/4/13, and the me took the med cart and medications. Nurse #1 not have pictures of al had to ask the other no residents were. Nurse came to the cart and at Nurse #1 asked her no stated that she was Re Resident #1 Resident Resident #1 told her th wrong medicine. Nurse	was the wrong medicing and Resident #1 star her since then. Idication Administration viewed and noted that refer for Clonazepam 0. Itake one tablet by moululed at 9:00 AM, and 9 an order for Clonazepa 25mg by mouth twice do and 4:00 PM. For Resident #1 revealed medication error in the of the facility medication error in the error in the started to pass at stated that the MAR of I of the residents, so shourse who some of the #1 stated that Resident #1 esident #2. Nurse#1 grain error in the error in	ted 5 th 5 th 5 on taily, d no the the the the the d	D 358	Continued from Page 1 medication error documentation policies a procedures. Resident #1 and #2's MAR w reviewed to ensure identifying photos were available. Also see Measures. Potential Residents- RCD completed a review and chart review for all remaining on the Adult Care Home unit (ALF). Any errors identified were investigated and do Also see Measures. Measures- ALF Medication Techs were in by senior administrative nursing staff on "Preventing Medication Errors" on 06/28/in-service was the first in a series of educates and/or ALF licensed nurses on medication administration and critical thinking. The SDC or designee will complete a medication and are view the medication licensed nurses during their orientation performs and the sum of	photo residents other cumented. 13. This ational on Techs ational techs or riod. who make al training ting acy ation th with as. Any orted to	
CHARLES TO THE PROPERTY OF THE			And the second s			TO AMERICAN PROPERTY OF THE PR	

	· · · · · · · · · · · · · · · · · · ·	AND HUMAN SERVICES & MEDICAID SERVICES		DECEN	RM-APPROVED NO 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION OI AUG 0 1 20 13	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
		345353	B. WING_	CONSTRUCTION SEC	07/09/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CHY, STATE, ZP GODS	Protection and the second
HIGHLA	ND HOUSE REHABILI	TATION AND HEALTHCARE		1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full BC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K 078	This Life Safety Co conducted as per Ti at 42 CFR 483.70(a Health Care section publications. This faconstruction and is a automatic sprinkler: CFR#: 42 CFR 483 NFPA 101 LIFE SAI Smoke barriers are least a one half hour accordance with 8.3 terminate at an atriu protected by fire-rate panels and steel frai separate compartme floor. Dampers are repenetrations of emol heating, ventilating, 19.3.7.3, 19.3.7.5, 10 This STANDARD is Based on the observed uring the tour on 77 was observed as not include: There were rated wall above the room 115 at the sprin CFR#: 42 CFR 483.	de (LSC) survey was ne Code of Federal Register); using the 2000 Existing of the LSC and its referenced icility is Type II protected equipped with a complete system. 70 (a) FETY CODE STANDARD constructed to provide at rifre resistance rating in . Smoke barriers may m wall. Windows are ad glaxing or by wired glass nes. A minimum of two ents are provided on each not required in duct ke barriers in fully ducted and air conditioning systems. 9.1.6.3, 19.1.6.4 Inot met as evidenced by: ations and staff interview 19/2013 the following item incompilant, specific findings unsealed penetrations in the cross corridor doors near inkler piping.	K02	Preface Highland House Rehabilitation and Healthoure rubming this PI Correction (PeC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil orimiosis action against the Provider of any employee, agent, officer, director, or shareholder of the Provider. The Provider bereby reserves the right to challenge the findings of this survey, the selection and/or imposition of future remedies, or any increase in future remedies, whether ruch remedies are miposed by the Centers for Medicane and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third against the Provider. Any changes to Provider polloy or proceed sould be considered to be subsequent remedial messures as a tennes; is employed in Rule 407 of the Federal Rules of Evide and should be inadmissible in any proceeding on that basis. The provider strives to ensure penetrations in any smole barrier are sealed with fire rated material to ensure sme resistance. The facility has policles and procedures dosigned to meintain these goals. Routine maintenance checks, suffery committee audits and meetings, and var quality assurance measures are examples of the many components utilized. Smoke barriers are inspected at inquarterly for non-sealed penetrations as part of the Quarterly for non-sealed penetrations as part of the Quarterly for non-sealed penetrations. Corrective Action- Maintenance used fire rated caulk seal the hole at the sprinkler pipe at the cross corridor doors near room 115 on 07/10/13. Identification of Others- Maintenance re-checked on 07/10/13 the remaining smoke barrier walls for other potential non-scaled aversight. Measures- Maintenance will assess all areas after any outside service/repairs to ensure penetrations are scaled. Monitor- Smoke barrier penetrations are monitored at least qu	to or over the control of the contro
SS=E				monthly.	-
		DISUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	(XA) DATE
L	Varen Con	non NIHA		Administrator (07/31/13

Administrator 07/31/13

Any deficiency statement adding with an asterdsk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	}	PLE CONSTRUCTION B 01 - MAIN BUILDING 01		ESURVEY (PLETED
This STANDARD is not met as evidenced by: Beasd on the observations and staff interview during the out or or 7/9/2013 the following liters was observed as noncompliant, specific findings include: The "A" hell oxygen storage room empty cylinder section leaves the cylinders unsacured condition. 1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301 FAYETTEVILLE, NC 28301 COMPLET FAYER PLAN OF CORRECTION (CARL PROPRIATE COMPLET TAGE (CARL PROPRIATE COMPLET) CARL PROPRIATE COMPLET TAGE (CARL CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF CARL CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T			345353	B. WING	***	07/	09/2013
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 076 Continued From page 1 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Pacilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside, NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/9/2013 the following item was observed as noncompliant, specific findings include: The "A" hell oxygen storage room empty cylinder section leaves the cylinders unsecured condition. PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE: CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (It has always been the goal and practice of the facility to store fill and empty oxygen cylinders per NPPA guidelines. The facility has en orabilisted designed to maintain this practice, The facility has en orabilisted designed to maintain this practice, The facility has en orabilisted designed to maintain this practice, The facility has entorable designed to maintain this practice, The facility has entorable for evaluated at least monthly as part of the QAM Safety inspections. Corrective Action—Maintenance evaluated remaining oxygen cylinders the other storage areas and 07/9/11/11/11/11/11/11/11/11/11/11/11/11/1		ND HOUSE REHABILI			1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301		
Medical gas storage and administration areas are protected in accordance with NFPA 89, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 98 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/9/2013 the following item was observed as noncompliant, specific findings include: The "A" hall oxygen storage room empty cylinder section leaves the cylinders unsecured condition.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION OATE
	. Pri delle e e e e e e e e e e e e e e e e e	Medical gas storage protected in accorde Standards for Healt (a) Oxygen storage 3,000 cu.ft. are encl separation. (b) Locations for sur 3,000 cu.ft. are vent 4.3.1.1.2, 19.3.2.4 This STANDARD is Based on the observed during the tour on 7 was observed as no include: The "A" hell empty cylinder sections accorded to a condition.	e and administration areas are ance with NFPA 99, h Care Facilities. locations of greater than osed by a one-hour oply systems of greater than ed to the outside. NFPA 98 not met as evidenced by: ations and staff interview /9/2013 the following item ncompliant, specific findings i oxygen storage room on leaves the cylinders	K076	store full and empty oxygen cylinders per NPPA guidelines. The facility has policies and procedur designed to maintain this practice. The facility has oxishished Quality Assessment & Assurance (Qr Program which includes the monitoring of environand physical plans areas. Oxygen cylinder storage evaluated at least monthly as part of the QAA/ Se inspections. Corrective Action- Maintenance secured the emcylinders (observed in the A-Hall Oxygen Storage on 07/10/13. Identification of Others- Maintenance evaluated remaining oxygen cylinders in the other storage a 07/09/13 to ensure they were stored per guideline cylinders were found in a secure condition. Mensures- Cylinder atorage areas are checked meant of the facility safety inspections conducted by Maintenance Director or his designed. Moulter- Maintenance Director or his designed vious of the facility safety inspections conducted by maintenance Director or his designed or cylinders are being stored accurely.	os s an AA) MA) Minental Sis Sety Prosesson Reason Example Minesson Minesson	07/10/13

PRINTED: 07/30/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IOENTIFICATION NUMBER: COMPLETED A BUILDING 02 - BUILDING 02 B. WING 345353 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 1700 PAMALEE DR PO BOX 35881 HIGHLAND HOUSE REHABILITATION AND HEALTHCARE FAYETTEVILLE, NC 28301 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LGO IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY K 000 **INITIAL COMMENTS** KOOO Preface Highland House Rehabilitation and Healthoure submits this Plan of Correction (PoC) in accordance with specific regulatory requirements, it shall not be construed as an admission of any This Life Safety Code (LSC) survey was alleged deficiency cited. The Provider submits this PoC with the conducted as per The Code of Federal Register Intention that it be inadmissible by any third party in any civil or at 42 CFR 483,70(a); using the 2000 Existing criminal action against the Provider or any employee, upont, officer, director, or shareholder of the Provider. The Provider Health Care section of the LSC and its referenced hereby reserves the right to oballange the findings of this survey if publications. This facility is Type II protected at any time the Provider determines that the findings; (1) are relied construction and is equipped with a complete upon to adversely influence or zerve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase automatic sprinkler system. assession amous impossion of rulture remedies, of for any mercase in future remedies, whether such remedies are imposed by the Contern for Medicare and Medicard Services (CMS), the state of North Excelling or any other earlies, or (2) serve, in any way, to Facilitate or promote action by any third party against the Provider, Any changes to Provider policy or procedures should be CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD K 052 considered to be subsequent remedial measures as that concept is SS×D employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. K052 The provider strives to ensure proper Amotioning of the fire 08/05/13 alarm system. The facility has policies and procedures A fire alarm system required for life safety is designed to maintain those goals. Routine maintenance installed, tested, and maintained in accordance checks, sufety committee audits wid meetings, fire marshal with NFPA 70 National Electrical Code and NFPA inspections and various quality assurance measures are 72. The system has an approved maintenance exemples of the many components utilized. The fire alarm and testing program complying with applicable system is checked monthly by the maintenance staff and requirements of NFPA 70 and 72. 9.6.1.4 quarterly by an outside contract vendor as part of the Quality Assessment & Assurance (QAA) Program and safety inspections. The oversight on the pull station height has been missed since the construction of B-Hall and the installation of the fire clarm equipment in the 1980s. Corrective Action-Fire system contract vendor is scheduled to referent the referenced B-Hall pull station to 48 inches above the finished floor by 08/05/13. This STANDARD is not met as evidenced by: Based on the observations and steff interview Maintenance removed the dust and lint from the sampling during the tour on 7/9/2013 the following item tube on the D-Hall mechanical room duct detector on 07/09/13. was observed as noncompliant, specific findings Include: Identification of Others-Maintenance checked remaining pull stations on 07/10/13 to ensure a height 1. The pull station for the fire alarm system on within the outlined NFPA height range, All were within the "B" hall is above 48 inches above the finished placement height. floor. Messures- The remaining duct detectors were inspected for dust or lint by Maintenance on 07/10/13. No other 2. The "D" Hall mechanical room duct detector sampling tubes were found dusty.

LABORATORY DIRECTOR'S OR PROVIDENCEUPPLIER REPRESENTATIVE'S BIGNATURE

TIME Administrator

07/31/1

Any deficiency etalorment and in With an actorise a deficiency which the institution may be excused from correcting providing it is determined that other sufeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 07/30/2013 FORM APPROVED OMS NO 0938-0391

CENTERO FOR MEDICAL	KE & MEDICAID SERVICES			OMS NO C	1699-686
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSUPPLIET/CUA IDENTIFICATION NUMBER:	· ·	PLE CONSTRUCTION B 02 - BUILDING 02	(X3) DATE (COMPL	
	345353	B, WING_		07/09	7/2013
NAME OF PROVIDER OR SUPPLIE HIGHLAND HOUSE REHAE	R ILITATION AND HEALTHCARE		6TREET ADDRESS, CITY, STATE, ZIP CODE 1700 PAMALEE DR PO BOX 36081 FAYETTEVILLE, NC 28301		
PRÉFIX (EACH DEFICIEN	BTATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LGC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION BHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	BE	COMPLETION DATE
CFR#: 42 CFR 4	nt on the sampling tube holes. 83.70 (a)		Continued from Page 1 Monitor- Monthly facility anfety and quarterly inspections are reviewed monthly by the QAA	Committee,	
K 058 SS=E If there is an autoinstalled in accordance with Inspection, Testir Water-Based Fire supply for the systems are equiposed.	matic sprinkler system, it is dance with NFPA 13, Standard to of Sprinkler Systems, to coverage for all portions of the tem is properly maintained in NFPA 25, Standard for the ig, and Maintenance of Protection Systems. It is fully e is a reliable, adequate water tem. Required sprinkler oped with water flow and tamper re electrically connected to the	K056	The provider strives to ensure proper functioning the sprinkler system. The facility has policie procedures designed to meintain these goals. Remaintenance checks, safety committee audits as fire marshal inspections, confract vendor inspections quality assurance measures are example components utilized. The sprinkler system is of by the maintenance staff and quarterly by an ouvendor as part of routine safety inspections and Assessment & Assurance (QAA) Program. Corrective Action-Although the facility had by the sprinkler system installer, Fire Marshal inspector that the system was in compliance up in 06/2012, the light fixture on D-Hall was rele 07/31/13 by Maintenance to avoid a potential of Identification of Others-The sprinklers were in Maintenance on 7/31/13 for placement to ensure is being met. No other areas required relocation Measures-The maintenance staff will continue	s and outins outins, but on and so of the many secked monthly stride contract the Quality con informed and DHSR on completion costed on batraction. To-reviewed by the standard	07/31/13
Based on the obsiduring the tour on was observed as include: The "D" in the "	Is not met as evidenced by: ervations and staff interview 7/9/2013 the following item noncompliant, specific findings nall Lift Room across from the tion has an sprinkler obstructed		sprinkler system monthly. A licensed inspector with the outside contractor the sprinkler system at least quarterly. Monitor- Inspection reports will be reviewed by Administrator. Areas requiring correction will be the next QAA Committee.	will Inspect	
	r Obsolete Event ID: GOUR2	Faci	₩ ID: 923256 (f conilor	77734	