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 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 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 000	INITIAL COMMENTS The health survey complaint investigation was initially conducted on May 29, 2014. The facility provided additional information through an interview on June 6, 2014.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan that addressed psychotropic medications for 1 of 5 residents' care plans reviewed (Resident #2). Findings included:	F 279	F000 Disclaimer Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with specific	6/20/14

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

Electronically Signed | 06/17/2014

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F 279	Continued From page 1 Resident #2 was admitted into the facility on 5/15/14. Diagnoses included anxiety with behavioral issues. The admission minimum data set completed on 5/15/14 indicated Resident #2 was cognitively intact. There was no mood, behavioral problems or rejection of care indicated. Antipsychotic and antianxiety medications was listed as received in the last seven days. There was no specific care plan from 5/15 to 5/28/14 that addressed psychotropic drug use. A review of the discus form (an assessment used to monitor/determine adverse side effects from psychotropic medications) completed on 5/15/14 in part read "xanax 0.5 mg, seroquel 100 mg." A review of the medication administration record revealed Resident #2 received the following medications: · Xanax 0.5 mg on 5/16, 5/21/14 for anxiety as needed daily · Seroquel 100 mg daily at 8:00 pm on 5/15/14 through 5/28/14 for anxiety with behaviors In an interview on 5/29/14 at 11:10 am, Nurse #5 acknowledged that she was responsible for Resident #2's care plan. She indicated that she was aware that Resident #2 was taking psychotropic medications; however, she forgot to complete a care plan related to the use of seroquel and xanax. In an interview on 5/29/14 at 5:25 pm, the director of nursing stated that she expected a care plan to have been completed for psychotropic medications.	F 279	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 or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are 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 such remedies are imposed by the Centers for Medicare 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 party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process.	

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F 279	Continued From page 2	F 279	F279 It is this facility's philosophy and normal practice to use the results of the assessment to develop, review and revise the resident□'s comprehensive plan of care. The facility has in place developed written policies and procedures. The Interdisciplinary Care Plan Team are trained during their orientation period the processes for developing a comprehensive plan of care. The nurse consultant, other support advisors provide routine refresher training and in-services. Physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the various components utilized. Interdisciplinary Care Plans are developed for each resident, and are designed to address potential problems, and offer approaches designed to meet specific goals. The facility will continue to endeavor to implement and update care plans as changes occur. Corrective Action- Resident #2'□s plan of care was amended on 05/29/14 to address the psychotropic medication use. Identification of Others- The Care Plan Coordinator, RN supervisor, Wound Care nurse and Director of Nursing (DoN) audited the medical records of those residents who receive antipsychotic and antianxiety medications to ensure inclusion in their	

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F 279	Continued From page 3	F 279	plans of care. There were no other omissions. Measures- The Director of Nursing (DoN) conducted refresher training with Nurse #1 regarding care plans and psychotropic medication use on 06/02/14. Beginning on 06/01/14 the DoN conducted the same refresher training with other clinical nurses involved with reviewing and making care plan revisions regarding psychotropic medication. The facility implemented a change to the psychotropic medication review process to avoid the ability for potential care plan omissions between the scheduled weekly meetings. Orders and progress notes will continue to be reviewed routinely by the administrative nurses for care plan updates when appropriate. Monitor- DoN and/or designee will systematically audit the care plans of ten (10) residents (with orders for psychotropic medications) per week for a month and then once a month for a quarter to ensure care plan protocol is being met. The DoN will report findings monthly to the Quality Assurance Committee (QAA) for four (4) months to monitor effectiveness of the plan.	

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F 281	Continued From page 4	F 281		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to follow-up or consult with the physician for a resident that was unable to swallow a solid medication (trental), which resulted in the resident not receiving the medication as ordered for two days for 1 of 5 residents medications reviewed (Resident #3). Findings included: Resident #3 was admitted into the facility on 5/16/14. Diagnoses included hypertension, coronary artery disease and dementia. The admission minimum data set completed on 5/28/14 indicated Resident #3 short and long term memory was impaired. No rejection of care was indicated. The care plan dated 5/21/14 indicated Resident #3 had a gastrostomy tube. A review of the twenty four hour change in condition report (shift report) revealed on 5/28/14, Nurse #1 wrote on the report sheet that Resident #3 trental (extended release) medication needed to be changed to crush. A review of the medication administration record (MAR) for 5/28/14, reflected that trental 400 mg (extended release) by mouth was circled as not administered at 9:00 am by Nurse #1, without a rationale indicated on the MAR.	F 281	F281 It is this facility's philosophy and practice to ensure the services provided or arranged by the facility meet professional standards of quality. The facility has in place developed written policies and procedures. The clinical staff members are instructed during their orientation period concerning professional standards of quality. The nurse consultant, other support advisors provide routine refresher training and in-services. Physician reviews, consultant reviews, quality assurance monitoring and routine staff training are examples of the various components utilized. Corrective Action- Resident #3'□s physician initiated an order change concerning brand of medication and route of administration on 05/29/14. Nurse #1 was counseled by the Director of Nursing (DoN) on 05/30/14 concerning MAR charting procedures; follow through procedures regarding resident change in condition and how to handle if a physician does not respond within a reasonable	6/18/14

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F 281	Continued From page 5 A review of Resident #3's blood pressure taken on 5/28/14 at 11:40 am, revealed a blood pressure of 160/68 and a heart rate of 93, recorded in the nurses notes by Nurse #1. During a medication pass observation on 5/29/14 at 9:05 am, Nurse #3 administered trental 400 mg (extended release) one tablet by mouth. Resident #3 was observed unable to swallow the tablet. Nurse #1 removed the tablet from the resident's mouth and discarded the medication. A review of the MAR for 5/29/14, reflected that trental 400 mg (extended release) by mouth was circled as not administered at 9:00 am by Nurse #1, due to the resident "refused." A review of Resident #3's blood pressure taken on 5/29/14 at 2:50 pm indicated a blood pressure of 138/80 recorded in the nurses notes by Nurse #1. In an interview on 5/29/14 at 9:13 am, Nurse #1 when questioned revealed that Resident #3 for two days has been having trouble swallowing trental 400 mg (extended release) by mouth whole. Nurse #1 indicated that she did not administer the medication on 5/28/14, due to the resident could not swallow the medication. She stated that on 5/28/14, she left a message after lunch on the physician's office voice mail, informing that she need clarification on some medications, but did not leave the resident's name that she needed clarification for, nor did she receive a return call from the physician or his office. Nurse #1 acknowledged that she did not follow-up with the physician office/physician prior to leaving to go home on 5/28/14. She indicated that she just documented the concern on the shift	F 281	period of time. Pharmacy consultant conducted one-on-one observations with nurse #1 on 05/31/14. Identification of Others- The DoN and designees reviewed communication reports, MARs and corresponding physician's orders of other residents to assure that there were no other incidents that required a physician consult or follow-up. This was completed on 6/12/14. There were no other omissions found. Measures- The Pharmacy Consultant provided one-on-one training with nurse #1 on 05/31/14 regarding how to obtain various consult information or follow-up; providing specifics when contacting a physician; how to handle if don't receive a response within a reasonable period of time; communication/procedures on what to do if can't get a task completed before leaving and MAR charting procedures. The DoN and Pharmacy Consultant provided in-service training to other licensed nurses regarding the same topics as reviewed with nurse #1. This was completed on 6/09/14. Procedural changes were made regarding notification and 24-hour report follow-through to include a DoN alert procedure.	

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F 281	Continued From page 6 report. In an interview on 5/29/14 at 4:20 pm, the director of nursing (DON) stated that she expected Nurse #1 to have followed back up with the office/physician. The DON indicated that if the physician office did not return Nurse #1's call; to ensure the resident received medication via an alternate route she expected Nurse #1 to have attempted a recall, and/or notified nursing administration so she (DON) could have intervened.	F 281	Monitor- Pharmacy consultant will provide one-on-one observations with clinical nurses over the next 30 days to monitor effectiveness of the plan. Pharmacy Consultant and SDC will conduct random observations monthly for the next 3 months and then quarterly for the next 2 quarters to monitor effectiveness of the plan. The monitoring reports will be provided to the Quality Assurance Committee (QAA).	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate less than 5% for 1 of 4 residents observed during a medication pass, by not administering medication as ordered. There were 6 medication errors out of 29 opportunities, which resulted in a 20.68% medication error rate (Resident #4, #5). Findings included: 1. Resident #4 was readmitted into the facility on 5/29/14 at 1:00 am. Diagnoses included chronic obstructive pulmonary disease (COPD) and Methicillin-resistant Staphylococcus aureus	F 332	F332 It is this facility's normal practice to ensure that the error rate is less than the established 5 percent standard. The facility has in place developed written policies and procedures. The clinical nurses are instructed and observed during their orientation period for technique and administration practices. The Staff Development Coordinator (SDC), pharmacy consultant, nurse consultant, other support advisors provide routine	6/20/14

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F 332	Continued From page 7 (MRSA) sepsis. MRSA is a bacterial infection. Sepsis is a severe bacterial infection in which there is systemic inflammation (infection). A review the admission physician orders signed on 5/29/14 indicated the following medications were ordered to be administered: · Spiriva 18 mcg (micrograms) with inhalation device one capsule every day (9:00 am) for COPD. · Advair 230 - 21 mcg two puffs inhaled twice daily (9:00 am, 8:00 pm) for COPD. · Artificial tears 1% - 0.2% (9:00 am, 8:00 pm) to both eyes. Indication for use not indicated per medical record review. · Vancomycin 1 gm (gram) intravenous every 36 hours x 14 days (9:00 am) for MRSA sepsis. During a medication pass observation on 5/29/14 at 9:36 am, Nurse #1 indicated that after searching the medication cart that she could not locate spiriva 18 mg, advair 230 - 21 mcg and artificial tears 1% - 0.2%, that was ordered to be administered at 9:00 am. Nurse #1 then proceeded into Resident #4's room and informed the resident that the medications were not available. In an interview on 5/29/14 at 9:50 am, Nurse #1 when questioned about the medications (spiriva, advair, artificial tears) not administered, she stated that she was going to call the pharmacy to obtain the medications. When further questioned why she did not administer the vancomycin as ordered, Nurse #1 replied that she would have to check the medical record, to see when the resident was last administered the medication and would follow back up.	F 332	refresher training and in-services. Routine medication pass observations by SDC, pharmacy consultant, nurse consultant, quality assurance monitoring and routine staff training are examples of the various components utilized. Corrective Action- A Pharmacy Consultant provided one-on-one re-training with nurses #1; #2 and #3 on 05/31/14. Medication pass observations were conducted with each nurse following training. Each nurse demonstrated correct technique during tasks involving procedures and medication administration. As part of the Quality Assurance process, nurse #1; #2 and #3 were counseled by the Director of Nurses (DoN) on 05/30/14, 06/04/14, 06/02/14 respectively. Identification of Others- Re-fresher training with other nurses was conducted by the consulting pharmacist on 05/31/14 through 06/20/14. Measures- Quality Assurance (QA) nurse; Staff Development Coordinator (SDC) or designee will observe medication passes with nurse #1; #2 and #3 weekly for a month and random observations with two (2) other nurses bi-weekly for 3 months. The consulting pharmacist will observe medication passes with nurse #1; #2 and #3 monthly for three months and random with other nurses. The consulting	

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F 332	Continued From page 8 A review of the medication administration record (MAR) for 5/29/14, Nurse #1 documented spiriva 18 mcg capsule (ordered at 9:00 am), advair 230 - 21 mcg two puffs (ordered at 9:00 am) and artificial tears 1% - 0.2% (ordered at 9:00 am) as "not administered/awaiting from pharmacy." No explanation was indicated on the MAR related to the vancomycin by Nurse #1, why the medication was not administered. In a follow-up interview on 5/29/14 at 11:56 am, Nurse #1 when questioned regarding the status of Resident #4's medications (vancomycin, spiriva, advair), stated that she was still awaiting the medications and that she had not heard anything from the pharmacy since her initial call placed at 9:50 am. On 5/29/14 at 1:00 pm, Nurse #1 indicated that Resident #4's medications (spiriva, advair) had arrived from the back-up pharmacy. Nurse #1 added that she was instructed by the physician to use what was available (artificial tears 1.4%) from the facility stock meds. She indicated that the advair was scheduled to be administered again at 8:00 pm. Nurse #1 did not comment related to the vancomycin. During an observation on 5/29/14 at 1:10 pm, Nurse #1 administered spiriva 18 mcg one capsule via oral inhaler to Resident #4. In an interview on 5/29/14 at 2:27 pm, the director of nursing (DON) stated that she expected the resident meds to have been administered as ordered per the physician orders. The DON added that Nurse #1 acknowledged to her (DON), that she did not administer the vancomycin. The	F 332	pharmacist will vary their consulting times quarterly to observe various nurses. Monitor- Reports will be provided to the Quality Assurance Committee (QAA) regarding each audited nurse'□s error rate to monitor effectiveness of the plan.	

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DON concluded that she expected Nurse #1 to have consulted with her and/or any other nursing personnel, if she was unsure concerning the ordered vancomycin.

In an interview on 5/29/14 at 6:20 pm, Nurse #4 stated that she had reviewed Resident #4's medical record/admission papers and that he was suppose to receive the vancomycin as ordered at 9:00 am. She added that she (Nurse #4) had contacted the physician and notified him of the missed dose and the physician gave an order for the medication to be administered at 6:00 pm, as a result of the missed dose ordered at 9:00 am.

2. Resident #5 was admitted into the facility on 6/11/13. Diagnoses included diabetes.

A review the physician orders signed on 4/28/14 indicated the following medications were ordered to be administered:

· Novolin regular insulin 2 units subcutaneous at 5:00 pm for a blood sugar of 201 - 240 with meals. (Novolin regular is short acting insulin that helps manage blood sugars. Onset (how soon the insulin starts to lower the blood sugar) is within 30 -60 minutes).
· Novolog insulin 7 units subcutaneous at 4:30 pm with meals. (Novolog is rapid acting insulin that helps manage high blood sugars. Onset is within 15 minutes).

During a medication pass observation on 5/29/14 at 3:45 pm, Nurse #6 assessed Resident #5's blood sugar at 215. Nurse #5 administered 2 units of novolin regular insulin into the left lower abdomen and novolog 7 units into the right lower abdomen. There was no meal or food item

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F 332	Continued From page 10	F 332		

observed available prior or after the administration of the insulin.

In an interview on 5/29/14 at 3:47 pm, Nurse #6 when questioned what time would the resident's meal tray arrive, she stated around 6:00 pm.

During an observation on 5/29/14 at 3:55 pm, Nurse #6 continued with her med pass to other residents, without providing Resident #5 with a snack or food.

In an interview on 5/29/14 at 4:00 pm, Nurse #6 when questioned related to the physician order, Nurse #6 acknowledged that she had given the novolin insulin (2 units) too early and the novolog insulin (7 units) without food.

In an interview on 5/29/14 at 4:43 pm, accompanied by the director of nursing (DON), Resident #5 stated that he had not received anything to eat since his insulin was administered by Nurse #6. There was no snack or food observed.

In a follow-up interview on 5/29/14 at 4:44 pm, accompanied by the DON, Nurse #6 who was still in progress of administering medication to residents, when questioned had she provided Resident #5 with a snack or food since she administered his insulin, she replied "no."

In an interview on 5/29/14 at 4:47 pm, the DON stated that she expected Nurse #6 to administer medications according to the physician orders. She concluded that she expected Resident #5 to have been provided food with his insulin as order by the physician.

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F 333	Continued From page 11	F 333		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to 1) administer intravenous vancomycin (antibiotic used to treat bacterial infections) as ordered, and 2) failed to administer respiratory medications as ordered and to follow-up with the pharmacy regarding respiratory medications that were not available, which resulted in delay of the medications being administered, which resulted in a significant medication error for 1 of 4 residents observed during a medication pass (Resident #4). Findings included: Resident #4 was readmitted into the facility on 5/29/14 at 1:00 am. Diagnoses included Methicillin-resistant Staphylococcus aureus (MRSA) sepsis, chronic obstructive pulmonary disease and dementia. MRSA is a bacterial infection. Sepsis is a severe bacterial infection in which there is systemic inflammation (infection). The minimum data set was in process of being completed. The FL2 (a level of care screening tool) dated 4/23/14 indicated that Resident #4 mental status was listed as intermittent to person and not to place/time. The medication discharge list dated 5/29/14, instructed upon admission into the nursing facility, continued medication included intravenous vancomycin, spiriva and advair inhalers. The plan of care completed on 5/29/14 indicated Resident #4 was alert, confused and	F 333	F333 It is this facility's normal practice to ensure that residents are free of significant medication errors. The facility has in place developed written policies and procedures. The clinical nurses are instructed and observed during their orientation period for technique and administration practices. The Staff Development Coordinator (SDC), pharmacy consultant, nurse consultant, other support advisors provide routine refresher training and in-services. Routine medication pass observations by SDC, pharmacy consultant, nurse consultant, quality assurance monitoring and routine staff training are examples of the various components utilized. Corrective Action- A Pharmacy Consultant provided one-on-one re-training with nurses #1; #2 and #3 on 05/31/14. Medication pass observations were conducted with each nurse following training. Each nurse demonstrated correct technique during tasks involving procedures and medication administration.	6/20/14

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F 333	Continued From page 12 had poor memory. A review the admission physician orders signed on 5/29/14 indicated the following: · Vancomycin 1 gm (gram) intravenous every 36 hours x 14 days (9:00 am) for MRSA sepsis. · Spiriva 18 mcg (micrograms) with inhalation device one capsule every day (9:00 am) for COPD. · Advair 230 - 21 mcg two puffs inhaled twice daily (9:00 am, 8:00 pm) for COPD. During a medication pass observation on 5/29/14 at 9:36 am, Nurse #1 did not administer vancomycin 1 gm as ordered. Nurse #1 also indicated that after searching the medication cart that she could not locate spiriva 18 mg inhaler and advair 230 - 21 mcg inhaler that was ordered to be administered. Nurse #1 then proceeded into Resident #4's room and informed the resident that the medications were not available. Resident #4 was observed lying in the bed with general weakness. At 9:38 am, Nurse #1 proceeded to C-Hall and inquired from Nurse #2 if Resident #4's respiratory medications (spiriva, advair) were on her medication cart. Nurse #2 replied "no." In an interview on 5/29/14 at 9:50 am, Nurse #1 when questioned why she did not administer the vancomycin as ordered, she replied that she would have to check the medical record to see when the resident was last administered the medication and would follow back up. A review of the medication administration record dated 5/29/14 revealed vancomycin 1 gm was not signed as administered, nor an explanation as to why not by Nurse #1.	F 333	As part of the Quality Assurance process, nurse #1; #2 and #3 were counseled by the Director of Nurses (DoN) on 05/30/14, 06/04/14, 06/02/14 respectively. Identification of Others- Re-fresher training with other nurses was conducted by the consulting pharmacist on 05/31/14 through 06/20/14. Measures- Quality Assurance (QA) nurse; Staff Development Coordinator (SDC) or designee will observe medication passes with nurse #1; #2 and #3 weekly for a month and random observations with two (2) other nurses bi-weekly for 3 months. The consulting pharmacist will observe medication passes with nurse #1; #2 and #3 monthly for three months and random with other nurses. The consulting pharmacist will vary their consulting times quarterly to observe various nurses. Monitor- Reports will be provided to the Quality Assurance Committee (QAA) regarding each audited nurse□'s error rate to monitor effectiveness of the plan.	

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A review of the nurse's note for 5/29/14 completed by Nurse #1 did not address the missed dose of vancomycin, nor any attempted collaboration with the physician, hospital, pharmacy, or the director of nursing concerning clarification of the ordered vancomycin.

A review of the medication administration record for 5/29/14, Nurse #1 documented spiriva 18 mcg capsule (ordered at 9:00 am) and advair 230 - 21 mcg two puffs (ordered at 9:00 am) as "not administered, awaiting from pharmacy."

In a follow-up interview on 5/29/14 at 11:56 am, Nurse #1 when questioned regarding the status of Resident #4's medications (vancomycin, spiriva, advair), stated that she was still awaiting the medications and that she had not heard anything from the pharmacy since her initial call placed at 9:50 am.

On 5/29/14 at 1:00 pm, Nurse #1 indicated that Resident #4's medications (spiriva, advair) had arrived from the back-up pharmacy.

During an observation on 5/29/14 at 1:10 pm, Nurse #1 informed Resident #4 that she now had his breathing inhaler mediation and administered spiriva 18 mcg one capsule via oral inhaler.

In an interview on 5/29/14 at 2:27 pm, the director of nursing (DON) stated that she expected the resident meds to have been verified upon being admitted into the facility by Nurse #3. The DON added that if medications were identified by the nursing staff as not available, she expected the nurse on duty to have contacted the pharmacy/pharmacist, so that the medications

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F 333	Continued From page 14 could have been obtained in a timely manner. In an interview on 5/29/14 at 6:15 pm, accompanied by the DON, Nurse #3 who admitted Resident #4 into the facility on 5/29/14 acknowledged that she became aware that Resident #4 did not have his respiratory medications (spiriva, advair) at 1:00 am on admission. Nurse #3 indicated that prior to her departing her shift at approximately 7:25 am, she did not call the pharmacy regarding the medications; however, she did notify Nurse #1 that the spiriva and advair was not available. The DON stated that based on her internal investigation, Nurse #1 was suppose to administer the vancomycin at 9:00 am as ordered. She added that Nurse #1 acknowledged to her (DON), that she did not administer the vancomycin. The DON concluded that she expected Nurse #1 to have consulted with her and/or any other nursing personnel, if she was unsure concerning the ordered vancomycin. In an interview on 5/29/14 at 6:20 pm, Nurse #4 stated that she had reviewed Resident #4's medical record/admission papers and that he was suppose to receive the vancomycin on 5/29/14 as ordered at 9:00 am. She added that she (Nurse #4) had contacted the physician and notified him of the missed dose and the physician gave an order for the medication to be administered at 6:00 pm, as a result of the missed dose ordered at 9:00 am. A request for an interview on 5/29/14 with the pharmacist was requested, however, no interview was obtained.	F 333		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		6/20/14

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F 425 SS=D	Continued From page 15 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to have available medication (spiriva inhalant, advair inhalant, artificial tears) to be administered as ordered for 1 of 4 residents observed during a medication pass observation (Resident #4). Findings included: Resident #4 was readmitted into the facility on 5/29/14 at 1:00 am. Diagnoses included chronic obstructive pulmonary disease (COPD). The minimum data set was in the process of being completed. The FL2 (a level of care screening	F 425	F425 The facility utilizes a clinical pharmacy to provide the system and services of licensed pharmacists that are in accordance with state and federal guidelines related to drugs and biologicals, their records, labeling and storage. The pharmacy provides routine and emergency drugs and biologicals to the residents, or through a back-up pharmacy arrangement. There are multiple internal and external checks and	

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F 425	Continued From page 16 tool) dated 4/23/14 indicated that Resident #4 mental status was listed as intermittent to person and not to place/time. A review the admission physician orders signed on 5/29/14 indicated the following: · Spiriva 18 mcg (micrograms) with inhalation device one capsule every day (9:00 am) for COPD. · Advair 230 - 21 mcg two puffs inhaled twice daily (9:00 am, 8:00 pm) for COPD. · Artificial tears 1% - 0.2% (9:00 am, 8:00 pm) to both eyes. Indication for use not indicated per medical record review. During a medication pass observation on 5/29/14 at 9:36 am, Nurse #1 indicated that after searching the medication cart that she could not locate spiriva 18 mg, advair 230 - 21 mcg and artificial tears 1% - 0.2% that was ordered to be administered at 9:00 am. Nurse #1 then proceeded into Resident #4's room and informed the resident that the medications were not available. Resident #4 was observed lying in the bed, with general weakness. At 9:38 am, Nurse #1 proceeded to C-Hall and inquired from Nurse #2 if Resident #4's medications (spiriva, advair, artificial tears) were on her medication cart. Nurse #2 replied "no." At 9:50 am, Nurse #1 stated that she was going to call the pharmacy to obtain the medications. A review of the medication administration record for 5/29/14, Nurse #1 documented spiriva 18 mcg capsule (ordered at 9:00 am) and advair 230 - 21 mcg two puffs (ordered at 9:00 am), artificial tears 1% - 0.2% (ordered at 9:00 am) as "not administered/ awaiting from pharmacy."	F 425	balances established to monitor the various drug and biological systems. Corrective Action- Resident #4'□s physician was contacted on 5/29/14 of the unavailability of certain medications for Resident #4 as a result of the unexpected 1:00 am admission. The medications were obtained from the back-up pharmacy around noon the same day. Medications were administered per directions from physician. As part of the Quality Assurance process, nurse #1 and #2 were counseled by the Director of Nurses (DoN) on 05/30/14, 06/04/14, 06/02/14 respectively. Identification of Others- Unit nurses re-checked medication carts to ensure medication availability. Findings reported to the DoN. All other residents□ medications were available. Measures- Pharmacy Consultant conducted training on 05/31/14 with nurse #1 and #2 on policies and procedures regarding acquiring newly ordered drugs and biologicals from the pharmacy and/or back-up pharmacy. The pharmacy consultant and DoN retrained the licensed nurses on policies and procedures regarding acquiring newly ordered drugs and biologicals from the pharmacy and/or back-up pharmacy. Included with this training was how to	

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F 425	Continued From page 17 In a follow-up interview on 5/29/14 at 11:56 am, Nurse #1 when questioned regarding the status of Resident #4's medications (spiriva, advair, artificial tears), stated that she was still awaiting the medications and that she had not heard anything from the pharmacy since her initial call placed at 9:50 am. On 5/29/14 at 1:00 pm, Nurse #1 indicated that Resident #4's medications (spiriva, advair) had arrived from the back-up pharmacy and that she was instructed by the physician to use what was available (artificial tears 1.4%) from the facility supply stock meds. During an observation on 5/29/14 at 1:10 pm, Nurse #1 informed Resident #4 that she now had his breathing inhalant mediation and administered spiriva 18 mcg one capsule via oral inhaler. She indicated that the advair and artificial tears next administration time would be at 8:00 pm. In an interview on 5/29/14 at 2:27 pm, the director of nursing (DON) stated that she expected the resident meds to have been verified upon being admitted into the facility by Nurse #3. The DON added that if medications were identified by the nursing staff as not available, she expected the nurse on duty to have contacted the pharmacy or pharmacist, so that the medications could have been obtained. The DON elaborated that she also expected Nurse #1 to have followed back up with the pharmacy related to the status of the medications, to ensure the meds were obtain and administered in a timely manner. In an interview on 5/29/14 at 4:33 pm, Nurse #1 acknowledged that she received report from	F 425	handle unexpected situations like the unexpected after hours (1:00 am) admission. This was completed on 6/20/14. Pharmacy consultant will continue to audit medication carts and rooms quarterly as an additional measure. Monitor- Quality review nurse or their designee will randomly audit medication carts for availability of medications weekly for the next three months to ensure effectiveness of the plan. DoN will provide a report to the facility Quality Assurance Committee monthly for the next three (3) months to monitor effectiveness of the plan.	

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F 425	Continued From page 18 Nurse #3 during shift report this morning, that some of Resident #4's medications were not available. Nurse #1 did not indicate which meds were reported to her as not available. In an interview on 5/29/14 at 6:15 pm, accompanied by the DON, Nurse #3 who admitted Resident #4 into the facility on 5/29/14 acknowledged that she became aware that Resident #4 did not have his respiratory medications (spiriva, advair) and artificial tears at 1:00 am. Nurse #3 indicated that prior to her departing her shift at approximately 7:25 am she did not call the pharmacy regarding the medications; however, she did notify Nurse #1 that the medications were not available. A request for an interview on 5/29/14 with the pharmacist was requested, however, no interview was obtained.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		6/20/14

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F 441	Continued From page 19 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to post notice or signage to alert the staff and visitors and to initiate contact isolation precautions for a resident that was admitted into the facility with Methicillin-resistant Staphylococcus aureus (MRSA) for 1 of 4 residents reviewed for infection control (Resident #4). Findings included: A review of the facility's isolation procedure policy dated 12/2002 in part read "The facility will initiate isolation precautions whenever a resident is suspected of having an infectious/communicable disease to prevent the spread of infection to the fullest extent possible." The policy further reads	F 441	F441 It has been the philosophy and normal practice of this facility to maintain an Infection Control program that provides a safe, sanitary and comfortable environment that helps prevent the development and transmission of disease and infection. The facility has an established Infection Control Program with policies and procedures designed to maintain these goals. Data regarding infections, physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the many	

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F 441	Continued From page 20 "contact isolation is designed to prevent transmission of highly transmissible or epidemiologically important infections (or colonization) that do not warrant strict isolation. All diseases or conditions included in this category are spread primarily by close or direct contact." The type of isolation indicated for MRSA included "contact isolation." Facility specifications for contact isolation in part read: · "Private room is indicated; may group residents similarly infected. · Mask for those in close contact · Gowns are indicated if soiling necessary (If gowns is required, it is put on before entering the room. Gowns are discarded after each use in the precaution trash container) · Gloves are indicated for touching infective materials · Hands washed before and after care · Dispose of contaminated articles in the biohazard box" A review of the hospital discharge summary dated 5/28/14 revealed Resident #4's blood cultures grew MRSA, and it was indicated that the resident was to continue/complete a 4-week course of vancomycin (antibiotic used to treat bacterial infections) for MRSA bacteremia (presence of infectious bacteria in the blood) per recommendation of the infectious disease specialist. It was further indicated that Resident #4's condition at the time of discharge into the nursing facility included an open wound in his inguinal area and groin. The written discharge instruction indicated as faxed on 5/29/14 in part read "sepsis (a strong generalized infection)." Resident #4 was admitted into the facility on	F 441	components utilized. Corrective Action- Precautions per facility□'s current policy were implemented for Resident #4 on 05/29/14. Identification of Others- Other residents□ with potential infections were reviewed by Director of Nursing (DoN), Staff Development Coordinator (SDC) and/or their designee to ensure infection control policies and procedures were implemented and being followed. Measures- Refresher training was provided to nursing staff by DoN, SDC and pharmacy consultant on infection control practices including but not limited to signage posting, PPE use, contact isolation precautions, hand washing procedures, glove use, equipment disinfection technique, utensil handling and handling of soiled items for avoidance of potential cross contamination. Training included how to review orders for potential precautionary measures outside normal universal precautions and ensuring PPE supplies are in place. Admissions Director will work with the hospital supervisor for discharge planners regarding ways to improve communication regarding potential needs of new admission. After training Nurse #1'□s technique was observed by Quality Assurance (QA)	

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F 441	Continued From page 21 5/29/14. Diagnoses included MRSA sepsis. MRSA is a bacterial infection. Sepsis is a severe bacterial infection in which there is systemic inflammation (infection). The minimum data set was in process of being completed. The FL2 (a level of care screening tool) dated 4/23/14 indicated that Resident #4 mental status was listed as intermittent to person and not to place/time. MRSA was listed in the thigh. The interim plan of care completed on 5/29/14 indicated Resident #4 was alert, confused, and had poor memory - there was no indication that Resident #4 had MRSA. Total care with grooming and bathing was required. Incontinent of bowel and bladder was indicated. During a medication pass observation on 5/29/14 at 9:36 am, Nurse #1 entered Resident #4's room and handed medications to the resident without gloves in a medication cup. The resident after taking the medications by mouth, handed the medication cup back to Nurse #1. Nurse #1 discarded the medication cup in the trash can in the resident's bathroom, washed her hands with soap and water and exited the room. There was no precautionary signage posted on the door or wall that alerted the staff or visitors of any special precautions to take prior to entering the room, nor was there any personal protective equipment (PPE) located outside the door or inside the room. During an observation on 5/29/14 at 12:30 pm, Resident #4's room continued with no precaution signage or PPE outside the door or inside the room. The resident was alone in the room at this time. During an observation on 5/29/14 at 1:10 pm,	F 441	nurse. Nurse #1 demonstrated correct technique during tasks involving procedures and medication administration. As a QA measure, SDC or designee will review new admission orders to ensure if warranted precautions are in place. The DoN, SDC, consultant pharmacist and/or designee will observe nursing staff infection control practices weekly for a month and then monthly for 6 months to validate practicing accepted technique. Monitor- The QAA committee will review the observation reports monthly for the next three months. Facility will continue to consult/research with the medical director, hospital□s infectious disease doctor, current CDC guidelines regarding MRSA precautions and other available literature to determine if facility□s current policies and procedures are in line with best practices.	

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Nurse #1 upon entering Resident #4's room, the resident was observed in the bed with general weakness, and one non-productive cough. Nurse #1 positioned herself directly beside the resident (standing on the resident's right side) and administered spiriva inhalant medication by mouth to the resident with gloves on, took her stethoscope from around her neck and listened anterior (front upper/lower chest) and posterior (upper/lower back) lungs sounds. Nurse #1 then, placed the stethoscope around her neck, proceeded into the bathroom located in Resident #4's room, removed her gloves and discarded them in the trash can, washed her hands with soap and water, then exited the room. Once at the medication cart she placed the inhalant medication (spiriva) container on the med cart, without disinfecting the container prior to placing it inside the med cart. Nurse #1 also did not disinfect her stethoscope and it remained around her neck. Resident #4's room continued with no precaution signage or PPE outside the door or inside the room.

During an observation on 5/29/14 at 2:05 pm, Resident #4's room continued with no precaution signage or PPE outside the door. Present in the room were the director of nursing (DON), assistant director of nursing and a nursing assistant (NA) #1 standing in close proximity less than 1 foot next to the bed. NA #1 was in the process of taking vital signs with gloves on. The director of nursing stated that she had just completed a head to toe assessment on the resident. There were no isolation gowns or masks observed in the room.

During an observation on 5/29/14 at 6:00 pm, Resident #4's room continued with no precaution

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 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

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F 441	Continued From page 23 signage or PPE outside the door or inside the room. In an interview on 5/29/14 at 6:15 pm, accompanied by the DON, Nurse #3 who admitted Resident #4 into the facility on 5/29/14, acknowledged that it was an oversight that she did not thoroughly review Resident #4's admission records. Nurse #3 added that her focus was completing the admission. In an interview on 6/6/14 at 6:10 pm, the director of nursing (DON) stated that she expected contact isolation to have been initiated for Resident #4 on admission. The DON indicated that the resident was admitted with open wounds (inguinal area, groin), on intravenous antibiotic, which required the facility staff to have protected gear on when providing direct care, according to the facility's policy. The DON stated that she was not aware that the resident had MRSA sepsis, at the time she performed the head to toe assessment, due to she had not had an opportunity to read the resident's chart. The DON added that she expected upon Resident #4 being admitted into the facility, that the admitting nurse (Nurse #3) to have diligently read through the resident's medial record and initiated contact precautions, including the required personal protective equipment. The DON concluded that she also expected the facility admission coordinator to have communicated to the facility staff prior to Resident #4's admission, that a resident was pending admission into the facility; which required special isolation precaution measures, so the infection control signage/notice for the door and PPE could have been initiated prior the resident's arrival into the room.	F 441		