STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING _____ B. WING _____	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407

(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 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to post the notice of location and availability of the facility's survey results. Findings included: During a tour of the facility on 11/26/18 at 11:00 AM an observation was made that survey results were located in a notebook binder on the lower	F 577	This plan of correction is submitted as required by State and Federal law. The provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit the providers' capacity to render adequate care. Tag F 577 483.10(g) (10) (11)	12/21/18

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

Electronically Signed | 12/21/2018

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F 577	Continued From page 1 shelf of a table in the reception area of the facility. An observation of the facility on 11/26/18 at 3:47 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. On 11/27/18 at 2:30 PM the Resident Council interview was completed. During the meeting, the Resident Council members stated they had no knowledge of the location of the survey results notebook. An interview with the Resident Council President during the meeting revealed she didn't know what the survey results were, where they were located and had not seen any signage that directed residents to their location. An observation of the facility on 11/27/18 at 3:14 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An observation of the facility on 11/28/18 at 2:20 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An observation of the facility on 11/29/18 at 11:20 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An interview was completed with the Administrator on 11/29/18 at 11:27 AM. She stated she did not have a notice posted in the facility that identified the location of survey results and said she was unaware of the requirement. She said that going forward she expected a notice be posted that directed residents and	F 577	1. The required information was posted in the lobby on 11/29/18 at 11:45am. 2. The location of the posting will be verified by the Administrator weekly for 4 weeks beginning 12/21/18 and then monthly to insure compliance. The written results will be included as part of our monthly Quality Assurance and Process Improvement program.	

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F 577	Continued From page 2 families to the location of the survey results and planned to have the notice posted in the facility.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.	F 578		12/26/18

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F 578	Continued From page 3 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately document code status in both the electronic medical record and paper chart for 1 of 15 residents (Resident #34) reviewed for advance directives. Findings included: Resident #34 was admitted to the facility on 8/2/17 with diagnoses that included, in part, congestive heart failure. A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/20/18 revealed Resident #34 had severe cognitive impairment. A review of the face sheet in the electronic medical record revealed an advance directive that included full code status (initiate cardio-pulmonary resuscitation should respirations and heartbeat stop). A review of the paper chart revealed a yellow form "Do Not Resuscitate" (DNR) order signed by the physician and effective 10/19/17. On 11/28/18 at 9:50 AM an interview was completed with Nurse #2. She said she identified a resident's code status when she looked at the outside of the paper chart. She stated if the writing on the outside of the paper chart was in	F 578	This plan of correction is submitted as required by State and Federal law. The provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit the providers' capacity to render adequate care. Tag F 578 483.10(c) (6) (8) (g) (12) (i)-(v) 1. All items listed in the written deficiency as being inaccurate were corrected immediately on 11/29/18. 2. All resident records were audited on 11/29/18 and any discrepancies corrected on this date. 3. Directed inservice training for the nurse supervisors and medical records coordinator will be conducted on 12/21/18 by our Administrator on proper documentation of Advanced Directives and what a resident's chart should look like to be correct. 4. Weekly, documented reviews of all new admission paperwork for advanced	

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F 578	Continued From page 4 black ink then the resident had a DNR order. She further stated the code status was also located in the electronic medical record on the face sheet. A review of the electronic medical record with Nurse #2 revealed Resident #34 was a full code. Nurse #2 reported if there was a DNR order it appeared next to the resident's name when she accessed the electronic medical record. On 11/19/18 at 9:46 AM an interview was completed with Nursing Supervisor #1. She stated if a resident's code status changed the physician wrote the order and the nurse entered the order in the electronic medical record. She further stated if a resident was admitted with a DNR order, the supervisor entered the order into the electronic medical record. A review of the paper chart with Nursing Supervisor #1 revealed a yellow DNR order dated 10/19/17. A review of the electronic medical record revealed a full code status. Nursing Supervisor #1 said she was not sure why the DNR order was not entered into the computer but that it should have been consistent with the paper chart. On 11/19/18 at 11:29 AM an interview was completed with the Administrator. She expected code status information be consistent in both the paper chart and electronic medical record.	F 578	directives will be done by the Director of Nursing beginning 12/21/18. These audit results will be included as part of our monthly Quality Assurance and Process Improvement program. 5. Each chart will be inspected monthly for 3 months beginning 12/21/18 by the Administrator or Director of Nursing and then quarterly to ensure compliance. The written results will be included as part of our monthly Quality Assurance and Process Improvement program.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		12/26/18

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F 623	Continued From page 5	F 623		

language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;

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F 623	Continued From page 6	F 623		

(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure

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F 623	Continued From page 7 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Ombudsman in writing when 2 of 2 (Resident # 31 and Resident # 258) residents that were sent to the hospital. Findings included: 1). Resident #31 was admitted to the facility on 9/12/18 and discharged to the hospital on 10/1/18. A record review revealed a physician ' s progress note dated 10/1/18 the revealed Resident #31 was seen for swelling in his lower extremities with concern for a blood clot. An order was given to send Resident #31 to the Emergency Department. A nurse ' s note dated 10/1/18 revealed Resident #31 was sent to the Emergency Department. An interview on 11/28/18 at 3:44 PM with the Social Worker revealed the move in coordinator was responsible for sending discharge notices to the ombudsman. An interview on 11/28/18 at 3:49 PM with the Move In Coordinator revealed she sent notices to	F 623	This plan of correction is submitted as required by State and Federal law. The provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit the providers' capacity to render adequate care. Tag F 623 483.15(c) (3)-(6) (8) 1. Notice of discharge for the two identified discharges was given to the Ombudsman on 12/21/18. 2. Directed inservice training for the social services staff was conducted on 12/21/18 by our Administrator on proper notification to the Ombudsman of all discharges. 3. Weekly, documented review of notifications will be done for 3 months beginning 12/21/18 and then monthly for 3 months by the Administrator to ensure compliance. These audit results will be included as part of our monthly Quality	

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F 623	Continued From page 8 the Ombudsman when a resident discharged, but did not send them when a resident was sent to the hospital. She revealed she wasn ' t aware she was required to do so. An interview on 11/29/18 at 12:36 PM with the Administrator revealed the Move-in Coordinator wasn ' t aware she needed to send discharge notices to the hospital and it was her expectation that the notices be sent. 2). Resident #258 was admitted to the facility on 8/11/17 and discharged to the hospital on 4/8/18. A record review reveled a nurse ' s note dated 4/8/18 at 7:04 PM revealed the physician was made aware that Resident #258 ' s blood sugars were elevated and resident lethargic. An order was received to send the resident to the hospital for an evaluation. An interview on 11/28/18 at 3:44 PM with the Social Worker revealed the move in coordinator was responsible for sending discharge notices to the ombudsman. An interview on 11/28/18 at 3:49 PM with the Move In Coordinator revealed she sent notices to the Ombudsman when a resident discharged, but did not send them when a resident was sent to the hospital. She revealed she wasn ' t aware she was required to do so. An interview on 11/29/18 at 12:36 PM with the Administrator revealed the Move-in Coordinator wasn ' t aware she needed to send discharge notices to the hospital and it was her expectation that the notices be sent.	F 623	Assurance and Process Improvement program.	

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F 880	Continued From page 9	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		12/27/18

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F 880	Continued From page 10 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure infection control practices were followed by not dating oxygen tubing and nebulizer mask tubing for 1 of 1 of 1 (Resident #44) residents reviewed for respiratory care. Findings included:	F 880	This plan of correction is submitted as required by State and Federal law. The provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit the providers capacity to render adequate care.	

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F 880	Continued From page 11 Resident #44 was re-admitted to the facility on 11/20/18 after a hospitalization for acute hypoxic respiratory failure and an acute on chronic diastolic heart failure exacerbation. Resident #44 also had a diagnosis of dyspnea. A review of the physician ' s orders dated 11/20/18 revealed an order for continuous oxygen via nasal cannula at 2 liters per minute and Ipratropium-albuterol 0.5 milligrams-3 milligrams (2.5 milligram base) per 3 milliliters nebulization solution one vial three times a day. An observation on 11/26/18 at 4:11 PM revealed oxygen at 2 liters per minute via nasal cannula in use. The oxygen tubing connected to an oxygen concentrator was not dated and a nebulizer mask with tubing attached that was on the residents bedside table uncovered and not dated. An observation on 11/28/18 at 9:54 AM revealed oxygen tubing connected to an oxygen tank attached to the back of the residents wheelchair not dated and a nebulizer mask and tubing observed open on bed, uncovered and not dated. An interview on 11/28/18 at 10:46 AM with the Director of Nursing revealed the oxygen tubing was changed weekly on Thursday by one of the restorative aides and she brings her a list upon completion. She stated she didn ' t know if there was a policy. A follow up interview on 11/28/18 at 11:06 with the Director of Nursing revealed the restorative aide also changes the nebulizer masks weekly on Thursday. She stated she expected this to be done.	F 880	Tag F 880 483.80(a) (1) (2) (4) (e) (f) 1. All items listed in the written deficiency as not being covered or dated were covered and dated immediately. 2. All residents utilizing oxygen and/or nebulizers were audited on 12/21/18 and any discrepancies corrected on this date. 3. Directed inservice training for the Restorative Aide #1 and Restorative Aide #2 (the backup) was conducted on 12/27/18 by our Staff Development Coordinator on proper labeling and dating of oxygen/nebulizer tubing. Additionally, they were instructed to check with the nursing supervisor each day to obtain a list of new or re-admissions for follow up. They are to physically check in the resident□s room for oxygen or nebulizer use. 4. Weekly, documented inspections of the oxygen and nebulizer tubing will be done by the Staff Development Coordinator or Director of Nursing beginning 12/27/18 weekly for 4 weeks and then monthly to ensure compliance. These audit results will be included as part of our monthly Quality Assurance and Process Improvement program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING _____ B. WING _____	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	**700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407**

(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 880	Continued From page 12 An interview on 11/28/18 at 11:45 with Restorative Aide #1 revealed she goes around to each room and changes the oxygen tubing, nebulizer tubing and sterile water for oxygen use every Thursday. She stated she gives a list to the Director of Nursing when she is through. She stated she doesn ' t know when new or re-admissions arrive so it ' s difficult to keep track. She stated when she is not working, the other restorative aide does the changing of the tubing. She did not know that Resident #44 was back from the hospital, so his tubing did not get changed.	F 880		