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 10/10/2019

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
E 000	Initial Comments An unannounced Recertification & Complaint Survey was conducted on 10/7/2019 through 10/10/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Q4CY11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification & Complaint Survey was conducted on 10/7/2019 through 10/10/2019. Of the two allegations investigated, one was substantiated with deficiency.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 1 of 13 (Resident #2) sampled residents. The findings included: Resident #2 was admitted to the facility on 4/21/17 with diagnoses that included dementia and arthritis. A review of Resident #2's medical record revealed a quarterly MDS assessment dated 4/26/19. This was the last MDS assessment	F 638	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 638 483.20(c) 1. The missing MDS was completed and transmitted by the MDS nurse before 10/25/19. 2. All current resident charts will be	11/6/19

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

Electronically Signed | 10/27/2019

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F 638	Continued From page 1 observed in Resident #2's medical record. An interview was conducted with the MDS nurse on 10/10/19 at 10:50 AM. She stated Resident #2 should have had a quarterly assessment done in July of 2019 that did not get done. She stated the assessment got missed. An interview was conducted with the Director of Nursing on 10/10/19 at 2:12 PM. She stated there should have been an MDS assessment completed for Resident #2 in July 2019 and that her expectation was that MDS assessments be completed within the required timeframes.	F 638	audited by the Administrator and Director of Nursing by 10/30/19 to ensure have a current MDS completed. Any not completed will be done and transmitted by 11/6/19. 3. The MDS nurses and scheduler will be re-educated as to the requirement of the quarterly assessment regulation by the Administrator before 11/6/19. 4. Charts will be audited weekly by the Administrator for 4 weeks beginning 11/6/19, monthly for 3 months and then quarterly to insure compliance. The written results will be included as part of our monthly Quality Assurance and Process Improvement program.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to include administration instructions in the physician's orders to specify when to administer two different dosages of the same pain medication ordered for 1 of 1 residents (Resident #155) reviewed for pain management. Findings included:	F 658	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.	11/6/19

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F 658	Continued From page 2 Resident #155 was admitted to the facility on 10/2/2019, with diagnoses that included in part, multiple wedge compression fractures in her back, osteoporosis, and Parkinson's Disease. Review of Resident #155's record revealed that she was cognitively intact, required 1-2-person extensive assistance with activities of daily living, and was receiving therapy services. Review of Resident #155's baseline care plan dated for 10/2/19 was noted to address pain management due to compression fractures. Review of Physician Orders revealed that both of the following orders were placed on 10/2/19: Oxycodone 5 mg tablet (10mg =2 tabs) orally as needed every three hours and Oxycodone 5 mg tablet orally as needed every three hours. There were no further instructions included in the orders. Review of Resident #155's October 2019 Medication Administration Record (MAR) revealed that the resident had received Oxycodone 5 mg tablet starting on 10/3/19 through 10/7/19 for pain levels ranging from 6 out 10 pain to 10 out of 10 pain. The MAR documented that the resident was not administered the Oxycodone 5 mg tablet (10mg =2 tabs) dosage until 10/6/19 at 8:58 AM for a pain level of 10 out of 10. All follow-up pain assessments for both Oxycodone dosages administered from 10/2/19 to 10/7/19 were documented as effective for pain management within an hour of administration. During an observation and interview with Resident #155 on 10/7/19 at 2:00PM she was	F 658	Tag F 658 483.21(b) (3) (i) 1. Administration instructions were added to the orders cited in the 2567 immediately after the exit conference on 10/10/19. 2. All pain medication orders will be audited and needed administration instructions added by 10/30/19. 2. Directed inservice training for the prescribers and transcribing nurses on administration instructions required with pain medication orders will be conducted by 11/6/19 by our Staff Development Coordinator and Director of Nursing. 3. Each chart will be inspected weekly for 4 weeks, monthly for 3 months beginning 11/5/19 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.	

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F 658	Continued From page 3 observed wearing her back brace while sitting up in her recliner. She stated that she had significant pain in her back at times but staff was giving her pain medications every three hours or so when she asked for it. She stated that the pain regimen was working for now. During an interview with the Director of Nursing on 10/9/19 at 4:15 PM she stated that as needed pain medication orders for the same medication should have instructions to specify when to give the different ordered doses. During an interview with Nurse #20 on 10/10/19 at 1:21 PM, when asked to review the two Oxycodone orders in place for Resident #155, she stated that most as needed pain medication orders have specific instructions on which one to give based on pain severity. It would usually clarify and order to give the lower dosage for mild to moderate pain and the higher dosage for severe pain. She verified with this surveyor that there were no instructions included in the two as needed orders for Oxycodone. During an interview with the Administrator on 10/10/19 at 4:15 PM she stated that it was her expectation that staff follow physicians' orders and that those orders would have directions to let staff know when to give the correct dose.	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		11/6/19

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F 761	Continued From page 4 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility 1). failed to lock an unattended medication cart for 1 of 4 medication carts (hall 400) and, 2). failed to properly store and dispose of an expired medication and an expired, unlabeled food item in 1 of 2 medication storage rooms that were used to store medications and supplies for the residents residing on the 400, 500 and 600 halls. The findings included: 1. An observation on 10/9/19 at 8:32 AM revealed Nurse #1 walking away out of eyesight from the medication cart on the 400 hall. The medication cart lock was not pushed in indicating a locked position.	F 761	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 761 483.45(g) (h) (1) (2) 1. The unlocked med cart was locked immediately and the expired items were disposed of immediately on 10/10/19. 2. All med carts were checked on	

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F 761	Continued From page 5 An interview on 10/9/19 at 8:47 AM with Nurse #1 revealed he walked away from the medication cart to retrieve a stock medication from the medication room and left the cart unlocked. He stated he knew he was supposed to lock the medication cart when unattended, he just forgot to do so. An interview on 10/10/19 at 1:28 PM with the Director of Nursing revealed she expected the medication carts to be locked when unattended. 2. An observation on 10/10/19 at 8:47 AM of the medication room for the residents residing on the 400, 500 and 600 halls revealed one fleet enema located with the house stock medications available for use with an expiration date of 9/2019. In the medication room refrigerator was observed an unlabeled Yoplait peach yogurt with an expiration date of 10/6/19. An interview conducted on 10/10/19 at 8:59 with Nurse #2 revealed everyone is responsible for the medication room being clean and checked for expired medications. She stated it is a group effort. Nurse #2 stated the yogurt should not have been in the refrigerator. An interview conducted on 10/10/19 at 1:28 PM with the Director of Nursing revealed her and the supply clerk go through the medication room at least every other week thoroughly, they stay on top of it. She stated she checked it yesterday but must have missed the yogurt and expired fleet enema.	F 761	10/11/19 by the Administrator to be sure they were locked and were able to lock properly. All medications, and food items in medication rooms and carts will be checked by 10/30/19 by the Director of Nursing and any other expired items will be discarded. 3. Directed inservice training for the licensed nursing staff will be conducted by the Staff Development Coordinator and the Director of Nursing by 11/1/19 about keeping the medication carts locked and about discarding any expired items. 3. Carts and medication rooms will be audited weekly for 4 weeks, monthly for 3 months and then by the Director of Nursing to ensure compliance. These audit results will be included as part of our monthly Quality Assurance and Process Improvement program.	