STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(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 survey was conducted on 7/11/22 through 7/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OFOZ11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted in conjunction with a recertification survey on 7/11/22 through 7/14/22. Event ID# OFOZ11. The following intakes were investigated NC00188844, NC00188096, NC00187966, NC00186611, NC00179703, NC00179602, NC00179552. One of 21 complaint allegations was substantiated.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility's medication error rate was greater than 5% as evidenced by 2 medication errors out of 33 opportunities. There were medication errors for 1 of 4 residents (Resident # 42) during medication pass observations. The medication error rate was 6.06%. Review of current physician orders for Resident # 42 indicated the following medications were due to administer during the morning medication pass:	F 759	2567 Response F759 Free of Medication Error " How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #42 was assessed by the charge nurse on and there was no negative outcome (7/13/22). The MD was on-site and notified of medication error by the Director of Nursing Services (DNS)-(7/13/22).	8/10/22

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

Electronically Signed | 08/11/2022

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F 759	Continued From page 1 Carbidopa-Levodopa 25-100 tab let via gastric tube three times a day. Ezetimibe 10 mg tablet via gastric tube once daily. Review of records revealed there were no physician orders or progress notes to indicate Resident #42 could have medications crushed and administered at the same time via gastric tube. During observations of a medication pass on 7/13/22 at 8:58 am, Nurse #1 indicated Resident # 42 had a gastric tube and her medications were to be administrated via this route. Nurse #1 crushed 2 pills and mixed with 10 milliliters (mL) water in the same medication cup. After checking placement of the gastric tube per facility policy, Nurse # 1 administered the crushed medications via gastric tube. This writer asked Nurse # 1 if there was a physician's order to administer medications at the same time without a specified amount of water flush in between, in which she responded, "I don't think so". This writer and Nurse # 1 checked the physician's orders together outside of Resident # 42's room, and no orders were found to indicate the medications could be crushed and administered at the same time. Nurse #1 explained at that time that she was aware she was supposed to administer pill medications separately with a specified water flush in between medications. An interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) together on 7/13/22 at 2:00 pm. The NHA and the DON both indicated all medications intended for gastric tube	F 759	Pharmacist on-site and reviewed all crushable medications and made recommendation that medications could be crushed (7/13/22). The Director of Nursing Services made MD aware of pharmacy recommendations, and MD gave order that medications could be crushed and administered together via g-tube (7/13/22). Orders were transcribed by the charge nurse and Resident #42 receives medication as ordered as of 7/13/22. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 7/14/22, 100% of all residents who received crushed medications were reviewed by the pharmacist. Recommendations were made for all medications that could be crushed and administered together. Medications that are not crushable were substituted and a Do Not Crush list is on each medication cart and accessible for every charge nurse and medication aide. Physician orders were approved by the MD based on the pharmacy recommendations for resident medication changes regarding crushing and administering medication via g-tube or by mouth. Orders were transcribed on each resident medication administration record (MAR) to ensure medications were administered without error. (7/14/22)	

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F 759	Continued From page 2 administration should be prepared and given separately according to their facility policy and procedures. The NHA further indicated the manner in which Nurse # 1 administered medication on 7/13/22 to Resident # 42 was a medication error due to improper administration via gastric tube.	F 759	" What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 8/10/2022 Staff Development Coordinator (SDC) provided education that was completed with all nurses and medication aides. All nurses and med aides completed the education prior to their next scheduled shift, regarding medication administration, and the Do Not Crush list On 8/10/2022 Education provided by pharmacist to all nurses and med aides scheduled regarding . Nurses and medication aides not in-serviced by 8/10/2022, will in-serviced by the DNS or designee prior to their next scheduled working shift. Beginning 8/10/22 SDC will include review of medication administration policy during orientation for all nurses and medication aides. " How does the facility plan to monitor its performance to make sure that solutions are sustained? Weekly medications observations pass will be conducted by the DNS or designee of the weekly x 6 and then monthly x 6 thereafter. Findings will be documented on the Medication Observation Audit tool. Pharmacist will review residents monthly MAR to ensure crushable medications are ordered and administered properly. Findings will be documented in the Pharmacy Review report and reported to the DNS/designee. The DNS/designee will	

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F 759	Continued From page 3	F 759	ensure recommendations are communicated to the MD and corrected accordingly (8/10/2022) Any issues and or trends will be monitored by Quality Assurance and Performance Improvement (QAPI) team monthly x3 and then quarterly thereafter. Duration and frequency of monitoring will be extended until substantial compliance is achieved. Date of compliance is 8/10/2022.	