PRINTED: 11/12/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR BUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY PAGE SOUTH HOLDER ROAD GREENSBORD, NC 27407 RECOLUTION OR SUMMARY STATEMENT OF DEPCISIONES PUBLIC PROVIDERS PLAN OF CORRECTION (PROVIDERS PLAN OF CORRECTION) RECOLUTION OR USE PREVEDED BY FULL PROVIDER READ OR PROVIDERS PLAN OF CORRECTION (PROVIDERS PLAN OF CORRECTION) RECOLUTION OR USE OR PROVIDER AND A UNABHOLD STATE AND A	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY (PA) ID (PA) ID (PA) ID (PA) ID (PRODUCTION OF THE PROCESS AND ASSESSMENT ASSESSMENT AND ASSESSMENT ASS	345506		B. WING				
PREFIX TAG T					700 SOUTH HOLDEN ROAD	IP CODE	10,10,2010
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. F 000 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, one was substantiated with deficiency. F 638 SS=D \$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 Ten findings included: Tag 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION
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. 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 638 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 2 Survey was conducted on 10/72019 brough F 000 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	E 000	Initial Comments		EC	00		
Survey was conducted on 10/7/2019 through 10/10/2019. Of the two allegations investigated, one was substantiated with deficiency. F 638 SS=D 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 Ten findings included: A review of Resident #2's medical record revealed a quarterly MDS assessment dated 4/26/19. This was the last MDS assessment Ten findings included: A review of Resident #2's medical record revealed a quarterly MDS assessment dated 4/26/19. This was the last MDS assessment Ten findings included: 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	F 000	Survey was conducted 10/10/2019. The facing with the requirement Preparedness. Even	d on 10/7/2019 through lity was found in compliance CFR 483.73, Emergency t ID #Q4CY11.	FC	00		
SS=D 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 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) 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	5 000	Survey was conducted 10/10/2019. Of the two one was substantiated	d on 10/7/2019 through wo allegations investigated, d with deficiency.				14/2/42
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 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		-	Least Every 3 Months	Fb	38		11/6/19
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 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		A facility must assess quarterly review instru- and approved by CM- once every 3 months This REQUIREMENT	a resident using the ument specified by the State S not less frequently than				
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 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		Based on record rev facility failed to comp Data Set (MDS) asse Assessment Referen- previous MDS assess	lete a quarterly Minimum ssment within 92 days of the ce Date (ARD) of the sment for 1 of 13 (Resident		required by State and F provider maintains that deficiencies do not indiv collectively jeopardize the safety of the residents, it	ederal law. The the alleged vidually or he health and nor are they of	,
4/21/17 with diagnoses that included dementia and arthritis. 1. The missing MDS was completed and transmitted by the MDS nurse before 10/25/19. 1. The missing MDS was completed and transmitted by the MDS nurse before 10/25/19. 1. The missing MDS was completed and transmitted by the MDS nurse before 20/25/19. 1. The missing MDS was completed and transmitted by the MDS nurse before 20/25/19.		The findings included	:			•	
revealed a quarterly MDS assessment dated 4/26/19. This was the last MDS assessment 2. All current resident charts will be		4/21/17 with diagnose	-		The missing MDS was	•	
		revealed a quarterly I 4/26/19. This was the	MDS assessment dated last MDS assessment		All current resident c	harts will be	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

10/27/2019

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

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 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
MHITESTONE A MASONIC AND EASTERN STAR COMMUNITY (X4) ID PREFIX TAG (XA) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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. STREET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSORO, NC 27407 To SOUTH HOLDEN ROAD GREENSORO, NC 27407 ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 there should have been an MDS assessment completed within the required timeframes. An interview was conducted with the 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 or 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			345506	B. WING			
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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					700 SOUTH HOLDEN ROAD	10/10/2013	
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. 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE COMPLETION	
F 658 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 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.	F 658	observed in Resident An interview was con on 10/10/19 at 10:50 should have had a question guide assessment got miss. An interview was con Nursing on 10/10/19 at 10:50 should have been an completed for Reside her expectation was at completed within the services provided within the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the commustion of the services provided as outlined by the community of the services provided many the services provided as outlined by the community of the services provided as outlined by the community of the services provided as outlined by the community of the services provided as outlined by the community of the services provided as outlined by the community of the services provided as outlined by the community of the services provided as outlined by the community of the services provided as outlined by the community of the services provided as outlined by the se	#2's medical record. ducted with the MDS nurse AM. She stated Resident #2 larterly assessment done in not get done. She stated the ed. ducted with the Director of at 2:12 PM. She stated there MDS assessment nt #2 in July 2019 and that hat MDS assessments be required timeframes. eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. It is not met as evidenced ans, record review, and erviews, the facility failed to an instructions in the specify when to administer of the same pain or 1 of 1 residents (Resident		audited by the Administrator and Directof Nursing by 10/30/19 to ensure have current MDS completed. Any not completed will be done and transmitted 11/6/19. 3. The MDS nurses and scheduler with 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 the quarterly to insure compliance. The written results will be included as part our monthly Quality Assurance and Process Improvement program. 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 provides.	e a d by ll be he e n of 11/6/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345506	B. WING			1	C
NAME OF D	DOVIDED OD CUIDDUED	343300	1 2: *******		TREET ADDRESS CITY STATE ZID CODE	10	/10/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITEST	ONE A MASONIC AN	D EASTERN STAR COMMUNITY			00 SOUTH HOLDEN ROAD		
				G	GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From p	age 2	F 6	358			
		s admitted to the facility on agnoses that included in part,			Tag F 658 483.21(b) (3) (i)		
	multiple wedge co back, osteoporosis			Administration instructions were add to the orders cited in the 2567 immediately after the exit conference of			
	Review of Resider she was cognitive			10/10/19.			
	extensive assistan			2. All pain medication orders will be			
	and was receiving			audited and needed administration instructions added by 10/30/19.			
	Review of Resider			,			
	dated for 10/2/19 v			2. Directed inservice training for the			
	management due			prescribers and transcribing nurses on			
					administration instructions required wit		
	Review of Physicia			pain medication orders will be conduct	ed		
		rs were placed on 10/2/19:			by 11/6/19 by our Staff Development		
		tablet (10mg =2 tabs) orally as			Coordinator and Director of Nursing.		
		e hours and Oxycodone 5 mg					
	_	eded every three hours. There			3. Each chart will be inspected weekly	y	
	were no further ins			for 4 weeks, monthly for 3 months			
	orders.				beginning 11/5/19 by the Administrator Director of Nursing and then quarterly		
	Review of Resider	nt #155's October 2019			ensure compliance. The written results		
	Medication Admini	istration Record (MAR)			will be included as part of our monthly		
	revealed that the r	resident had received			Quality Assurance and Process		
	Oxycodone 5 mg t	tablet starting on 10/3/19			Improvement program.		
	through 10/7/19 fo	or pain levels ranging from 6 out					
		of 10 pain. The MAR					
		he resident was not					
		Oxycodone 5 mg tablet (10mg					
	, ,	ntil 10/6/19 at 8:58 AM for a					
	-	it of 10. All follow-up pain					
		ooth Oxycodone dosages					
		10/2/19 to 10/7/19 were					
	within an hour of a	fective for pain management					
	within an nour of a	เนาแกรแสแบบ.					
		ation and interview with 10/7/19 at 2:00PM she was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY
		345506	B. WING			C 10/10/2019
NAME OF PROVIDER OR SUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407		10,10,2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE
F 658	in her recliner. She significant pain in her giving her pain medi so when she asked in pain regimen was with the different ordered. During an interview of at 1:21 PM, when as Oxycodone orders in she stated that most orders have specific give based on pain so clarify and order to go to moderate pain an severe pain. She we there were no instruct needed orders for O During an interview of 10/10/19 at 4:15 PM	er back brace while sitting up stated that she had er back at times but staff was cations every three hours or for it. She stated that the orking for now. with the Director of Nursing M she stated that as needed ers for the same medication ions to specify when to give doses. with Nurse #20 on 10/10/19 sked to review the two in place for Resident #155, as needed pain medication instructions on which one to severity. It would usually give the lower dosage for erified with this surveyor that ctions included in the two as	F 65	58		
F 761 SS=D	staff know when to g Label/Store Drugs a CFR(s): 483.45(g)(h §483.45(g) Labeling Drugs and biological	of Drugs and Biologicals ls used in the facility must be ce with currently accepted es, and include the	F 76	61		11/6/19

` '	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
345506		B. WING _		C 10/10/2019
NAME OF PROVIDER OR SUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CC 700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION IE APPROPRIATE DATE
F 761 Continued From page 4 instructions, and the expirate applicable. §483.45(h) Storage of Druge §483.45(h)(1) In accordance Federal laws, the facility mu biologicals in locked compartemperature controls, and presonnel to have access to §483.45(h)(2) The facility mu locked, permanently affixed storage of controlled drugs I the Comprehensive Drug Ab Control Act of 1976 and other abuse, except when the faci package drug distribution sy quantity stored is minimal and be readily detected. This REQUIREMENT is not by: Based on observations and facility 1). failed to lock an urcart for 1 of 4 medication cafailed to properly store and commedication and an expired, 1 of 2 medication storage round to store medications and surresidents residing on the 40. The findings included: 1. An observation on 10/9/19 Nurse #1 walking away out medication cart on the 400 from the fact of the store medication cart on the 400 from the fact of the store medication cart on the 400 from the fact of the store medication cart on the 400 from the fact of the store medication cart on the 400 from the fact of the fact o	e with State and lest store all drugs and riments under proper ermit only authorized to the keys. Sust provide separately compartments for listed in Schedule II of puse Prevention and er drugs subject to illity uses single unit systems in which the and a missing dose can at met as evidenced If staff interviews, the mattended medication arts (hall 400) and, 2), dispose of an expired unlabeled food item in froms that were used pplies for the 10,500 and 600 halls. If at 8:32 AM revealed of eyesight from the hall. The medication	F	This plan of correction is surequired by State and Feder provider maintains that the adeficiencies do not individua collectively jeopardize the hisafety of the residents, nor a such character so as to limit capacity to render adequate Tag F 761 483.45(g) (h) (1. The unlocked med cart wimmediately and the expired disposed of immediately on	ral law. The alleged ally or ealth and are they of the providers' care. 1) (2) vas locked I items were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345506	B. WING			C	
NAME OF D	DOVIDED OD CURRUER	343300		OTDEET ADDRESS OITY STATE 7	ID CODE	10/10/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
WHITEST	ONE A MASONIC AND	EASTERN STAR COMMUNITY		700 SOUTH HOLDEN ROAD			
				GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIAT		
F 761	Continued From pag	ge 5	F 7	761			
F 761	An interview on 10/s revealed he walked cart to retrieve a sto medication room an stated he knew he was medication cart when to do so. An interview on 10/s medication carts to be served an unlabe an expiration date of the served medication room be expired medications effort. Nurse #2 stat been in the refrigeration date of the served and the served medication served and the served medication room be expired medications effort. Nurse #2 stat been in the refrigeration date of the served medication served medicati	away from the medication ck medication from the defit the cart unlocked. He was supposed to lock the en unattended, he just forgot 10/19 at 1:28 PM with the revealed she expected the be locked when unattended. In 10/10/19 at 8:47 AM of the enthe residents residing on the falls revealed one fleet enemalise stock medications han expiration date of cation room refrigerator was led Yoplait peach yogurt with f 10/6/19. Intel on 10/10/19 at 8:59 with everyone is responsible for the ing clean and checked for so the stated it is a group ed the yogurt should not have after.	F 7	10/11/19 by the Adminis they were locked and we properly. All medication in medication rooms and checked by 10/30/19 by Nursing and any other e be discarded. 3. Directed inservice tralicensed nursing staff we by the Staff Development the Director of Nursing be keeping the medication about discarding any extended and then by the Nursing to ensure compaudit results will be inclumentally Quality Assurant Improvement program.	ere able to lock s, and food item d carts will be the Director of xpired items will be aining for the ill be conducted at Coordinator a coy 11/1/19 about carts locked and pired items. Tooms will be eks, monthly for Director of liance. These aided as part of conducted as part of conducted and pired items.	ns I I I I I I I I I I I I I I I I I I I	
	supply clerk go throuse least every other we top of it. She stated	Nursing revealed her and the ugh the medication room at sek thoroughly, they stay on she checked it yesterday but ne yogurt and expired fleet					