PRINTED: 12/07/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l l	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345006	B. WING _		C 10/31/2017	
	ROVIDER OR SUPPLIER  THAL NURSING & REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3724 WIRELESS DRIVE  GREENSBORO, NC 27455	1 10/01/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 000	INITIAL COMMENTS	3	FO	00		
F 157 SS=J	from 10/29/17 throug Jeopardy was identificated the CFR 483.10 at tag F (J) CFR 483.45 at tag F (J) CFR 483.45 at tag F (J) The tags F329J and Substandard Quality Immediate Jeopardy removed on 10/30/11 was conducted. NOTIFY OF CHANG (INJURY/DECLINE/ICFR(s): 483.10(g)(14) Notification of (i) A facility must immediate the residual consistent with the residual consistent with his or representative(s) where the consistent in injury and in physician intervention (B) A significant chair mental, or psychosodeterioration in health	157 at a scope and severity 329 at a scope and severity 333 at a scope and severity I F333J constituted of Care. began on 10/25/17 and was 7. A Partial extended survey GES ROOM, ETC) 4) f Changes. hediately inform the resident; dent's physician; and notify, r her authority, the resident en there is- lving the resident which has the potential for requiring n; high in the resident's physical, cial status (that is, a h, mental, or psychosocial preatening conditions or	F1	57	11/1/17	
		/CLIDDLIED DEDDECENTATIVE'S SIGNATUR		TITLE	(Y6) DATE	

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

(X6) DATE

11/15/2017 **Electronically Signed** 

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345006	B. WING		C 10/31/2017
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3724 WIRELESS DRIVE  GREENSBORO, NC 27455	10/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 157	Continued From pa	nge 1	F 15	7	
	a need to discontin treatment due to accommence a new f  (D) A decision to transident from the fa §483.15(c)(1)(ii).  (ii) When making n (14)(i) of this sectionall pertinent informatis available and prophysician.  (iii) The facility must resident and the re	treatment significantly (that is, we an existing form of dverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the stalso promptly notify the sident representative, if any,			
	as specified in §48  (B) A change in res State law or regula (e)(10) of this secti  (iv) The facility musupdate the address	sident rights under Federal or tions as specified in paragraph on.  St record and periodically (mailing and email) and			
	phone number of the This REQUIREMENT by: Based on record return the medical director pharmacy services the physician immeresident received 2 morphine (a narcot	ne resident representative(s).  NT is not met as evidenced  eview and interviews with staff, r and the director of clinical the facility staff failed to notify ediately after discovering that a 0 times the amount of ic pain medication) prescribed the resident did receive two		The creation and submission of this p of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to	of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<i>'</i>			(X3) DATE SURVEY COMPLETED	
			12			С	
		345006	B. WING _		1	0/31/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
				3724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & RE	HABILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	Continued From p	page 2	F 1	57			
	additional schedu excessive dose.	led doses of morphine after the This was evident in 1 (Resident		continue to provide a quality residents.	of life for our		
	#1) of 3 sampled residents receiving narcomedications.			The processes that lead to the	ne deficiency:		
	Resident #1's phy excessive dose in Resident #1 receidose of morphine removed on 10/30 an acceptable crefacility will remain and severity of no of no more than nimmediate jeopart process of full correlations included Resident #1 was 4/17/15. The resifibrillation, implantalls, diabetes and	admitted to the facility on dent's diagnoses included atrial table cardiac fibrillator, repeated d ataxic gait, dementia without		On 10/29/2017 at approxima the Licensed Nurse #2 who a two doses of Morphine Sulfarnight on 10/26/2017 (1am an resident #6677 was interview Administrator. She revealed her shift on 10/26/2017, resident showed signs and symptoms she administered 0.25mL of physician order. She stated, 5ml was documented on the Drug Receipt form for resident 1am when she was signing for Morphine she administered. It think 5ml was administered the resident #6677 was still moal and showed no symptoms of overdose. She interpreted the documentation error. She also	administered te during the id 5am) to ved by the that during dent #6677 s of pain and Morphine per she noticed Controlled int #6677 at or the She did not because ning with pain i medication e entry as so indicated		
	Review of the res Set (MDS) of 9/11 for Mental Status resident was seve MDS indicated the pain medication re the look behind po MDS. A Care plan was i the resident's risk to osteoarthritis. T	ident's annual Minimum Data /17 revealed the Brief Interview score was 7 which indicated the erely cognitively impaired. The eresident received a scheduled egimen in the last 5 days during eriod. Pain did not trigger on the  nitiated on 9/19/17 to address for alteration in comfort related The goal was the resident will non-verbal (no grimacing, no		resident #6677 did not show change in condition to warrar the physician. Licensed Nurs be allowed to work until re-ed physician notification require Coordinator #1 attempted to licensed nurse #2 with no res 10/26/2017 at 9:30AM. Direct Services attempted to contact 10/30/2017 at 5:52PM, and reduced Nurse #2 will not be work until re-educated on phynotification requirements. On 10/25/2017, Licensed Nurse #3 Morphine 10/25/2017, Licensed Nurse 10/25/2	nt contacting se #2 will not ducated on ments. Unit contact sponse on tor of Health ct nurse #2 on no responses. e allowed to ysician rse #1		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25				С	
		345006	B. WING _				/31/2017	
NAME OF PI	ROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 .0	70112011	
				37	24 WIRELESS DRIVE			
BLUMENT	HAL NURSING & RE	HABILITATION CENTER		GI	REENSBORO, NC 27455			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		(X5)			
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 157	Continued From p	page 3	F ′	157				
		ef of pain 45 minutes to an hour			(100mg) instead of 0.25mL (5mg) as			
	after administering	g of medications through the			ordered by physician to resident #667	7.		
	next review. The i	nterventions included to			No adverse effects were noted in relat	ion		
		loving care (i.e. change in			to this medication error. Resident #66			
		etc.) as needed, encourage			had a terminal diagnosis, and elected	to		
		any pain (noting location,			receive Hospice services, with the life			
		and severity), give medication			expectancy of six months or less.			
		ve for effectiveness of pain			On 10/26/2017, resident #6677 was			
		e control of pain, handle gently			moaning with pain at 1am and 5am;			
		te any environmental stimuli,			Licensed Nurse #2 administered			
		ress fears and concerns, erbal signs of pain (i.e.			Morphine 0.25mL per Physician order without contacting the Physician. Lice			
		ng, moaning, restlessness,			Nurse #2 recognized the previous shift			
		y Medical Doctor as needed,			documented Morphine 5mL instead of			
		assessment routinely.			0.25mL. Licensed nurse #2 did not ha			
		· · · · · · · · · · · · · · · · · · ·			the ability to contact Licensed nurse #			
	Review of the res	ident's Departmental Notes			verify whether Morphine 5mL docume			
	revealed that on 1	0/23/17, the resident started			on the Controlled Drug receipt form wa	as		
	hospice services.				administered to resident #6677 or not.	Per		
					licensed nurse #2 no signs or symptor			
		sician's Telephone Order			of distress was noted during the night.			
		ian order dated 10/25/17 at 4:40			The attending Physician was notified			
		hine 20 mg (milligram) /ml			about this medication error on 10/26/2			
	, ,	mg PO (by mouth)/SL			at 3:30Pm, this was done within 24 ho			
		rery) 4 h (hour) scheduled and Q			At 11pm on 10/25/2017 controlled drug			
	(shortness of brea	s needed) (for) pain/SOB			receipt for resident #6677 indicated th remaining quantity of Morphine Sulfate			
	(SHORRIESS OF DIE	au i ).			was 24.5mL. This amount matched the			
	Review of Reside	nt #1's "eMAR (electronic			amount of Morphine sulfate remaining			
		istration record) -Medication			resident #6677 dispensed medication			
		onth of October, 2017 revealed			bottle.			
		he left side of the page,			On 10/26/2017 at approximately 9:00	am,		
		ml-oral syringe, Give 5 mg			during controlled drug reconciliation for			
		2 hours as needed for shortness			resident #6677, a discrepancy was no			
	of breath/pain." O	n the same row as the order, on			on the Controlled Drug Receipt form b	у		
		e page, and under the column			the facility Administrator. The control			
		was a check mark and the			sheet indicated resident received 5ml	of		
		1 indicating Nurse #1			Morphine sulfate instead of 0.25ml of			
	administered mor	phine at 8:14 PM on 10/25/17.			Morphine as ordered by the Physician			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	c
		345006	B. WING			10/:	31/2017
NAME OF PR	ROVIDER OR SUPPLIER	-	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
DILIMENT		DU ITATION OFNITED		37	724 WIRELESS DRIVE		
BLUMENI	HAL NURSING & REHA	ABILITATION CENTER		G	REENSBORO, NC 27455		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 157	Continued From pag	e 4	F	157			
					On 10/26/2017 at approximately 3:00pi		
	Review of the "Contr	_			the Licensed Nurse #1, who administer	ed	
		osition Form" revealed			the stated medication to resident #6677		
		5 ml of morphine were given			was interviewed by the Administrator.	3he	
		4.50 ml of morphine were left			revealed that during the medication		
		on 10/25/17. The resident			administration on the previous day, she	;	
		nl) of morphine instead of 5			noted medication order change for resident #6677. She verified the writter		
		or 10/25/17. This resident prescribed			order in resident □s record and read it a		
	by the physician.	ore morphine than prescribed		5ml instead of 5mg.		13	
	by the physician.				On 10/29/2017 at approximately 4:30pi	m	
	Review of Resident #	#1's "eMAR-Medication			the Licensed Nurse #2 who administer		
		th of October, 2017 revealed			two doses of Morphine Sulfate during t		
		left side of the page that			night on 10/26/2017 (1am and 5am) to		
	- ·	Omg/ml oral syringe, Give			resident #6677 was interviewed by the		
	every 4 hours subling	gual for pain." There was no			Administrator. She revealed that during	J	
		this order. On the same row			her shift on 10/26/2017, resident #6677		
		ight side of the page, and			showed signs and symptoms of pain ar		
		10/26/17, there were check			she administered 0.25mL of Morphine		
	_	se #2 administered morphine			physician order. She started, she notice		
	at 1:00 AM and 5:00	AM on 10/26/17.			5ml was documented on the Controlled		
	Davious of the "Contr	alled Drug			Drug Receipt form for resident #6677 a	.L	
	Review of the "Contr	osition Form" revealed			1am when she was signing for the Morphine she administered. She did no	nt	
		0.25 ml of morphine were			think 5ml was administered because	,	
		and 24.25 ml of morphine			resident #6677 was still moaning with p	oain	
	•	e at 1:00 AM on 10/26/17.			and showed no symptoms of medication		
	There was also docu	mentation that 0.25 ml of			overdose. She interpreted the entry as		
	morphine were given	to the resident and 24.00 ml			documentation error. She also indicate		
	of morphine were lef	t in the bottle at 5:00 AM on			resident #6677 did not show any signs	or	
	10/26/17.				change in condition to warrant contacti		
		nt's Departmental Notes			the physician. Licensed Nurse #2 will n		
		aled the Resident died at			be allowed to work until re-educated or	on	
	9:10 AM.				physician notification requirements.		
		rse #1 was conducted on			Procedure for implementing the		
		She worked with the			acceptable plan of correction for the		
		on the 3-11 shift. The nurse norphine dose around 8:00			specific deficiency cited:		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	<del></del>			
		345006	B. WING _			10/3	1/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE	1 10/0		
				3724 WIRELES	SS DRIVE			
BLUMENT	HAL NURSING & REHA	BILITATION CENTER			RO, NC 27455			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(E	EACH CORRECTIVE ACTION SHOULD E DSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE	
F 157	Continued From page	e 5	F 1	57				
	PM on 10/25/17. At a	round 10:45 PM, the		100% au	idit of all active resident contro	olled		
		g" and her breathing was		medication	on was completed on 10/27/2	017		
	slow. The nurse liste	ned to her heart and		by Direct	tor of Health Services to identi	ify		
	checked her pulse ar	nd repositioned her. The		any other	r resident with an order for			
	nurse gave report at	11:00 -11:15 PM. Nurse #1		controlled	d medication (Schedule II $\square$ V	<b>'</b> )		
		se (Nurse #4) about the			not transcribed correctly and/	or		
		ning and the nurse said that			ered per physician order. All			
	was normal for the re				rders for controlled medication			
		left the facility for the day.			rified for accuracy in electronic	;		
	_	#1 came to the facility at			ecords and on the electronic			
		d that the resident passed			on administration record. Then			
	_	ator told Nurse #1 that she nl of morphine instead of 5			other discrepancies in any oth Controlled medication orders.	iei		
	_	at contributed to the error,			udit of all current residents			
	_	ead the physician order			locumentation within the last 7	,		
	wrong.	au and projection of uo.			mpleted by the Director of			
	, <b>.</b>				Quality assurance nurse, Nur	se		
	An interview was con	ducted with Nurse #2 on		_	sor, MDS nurse #1 and/or MDS			
	10/29/17 at 6:15 PM.	Nurse #2 provided care to		nurse #2	and to determine any identifie	ed		
	Resident #1 on the 1	1 PM - 7 AM shift that		need for	notification of changes was			
	started on 10/25/17.			complete	ed in a timely manner. The aud	dit		
		of morphine at 1:00 AM as			I no other incident of			
		ysician. Then, she went to			delayed notification of change			
	_	Receipt Record to record the			sician and responsible party.	This		
		morphine to the resident and			s completed on 10/30/17.			
		on that the resident received		_	of this audit are documented			
		at 8:00 PM. Nurse #2 said ine in the bottle matched the			ecords audit tool located in the	9		
		of morphine left on the		lacility CC	ompliance binder.			
		eipt Record. Nurse #2		On 10/30	0/2017, 100% audit was			
	_	way the resident received			ed by the Director of Nursing,			
		since the resident was still			assurance nurse, Nurse			
	·	#2 went to look at the			sor, MDS nurse #1 and/or MDS	s		
		aid she gave the resident the			? of all incidents reports			
		mg of morphine at 1:00 AM			ed within the last 30 days to			
		1. Nurse #2 said she left the			otifications were done in a tim	nely		
	facility at 7:15 AM.			manner.	The audit revealed no other	-		
				incident of	of missing/delayed notification	n of		
	Nurse #2 was interview	ewed again via telephone on		changes	to both physician and			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING				C
NAME OF D	DOVIDED OD CLIDDLIED	343000	B: Willo		TREET ARRESCO CITY STATE ZIR CORE	10/	31/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER			724 WIRELESS DRIVE		
				G	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	e 6	F 1	157			
	10/30/17 at 6:35 AM. call the doctor because moaning, so she dou	The nurse said she did not se the resident was still bted that the resident got 5 e #2 said she did not assess			responsible party. This audit was completed on 10/30/17. Findings of this audit are documented on incident repo audit tool located in the facility complia binder.	rts	
	never worked with Re 10/25/17 around 11:0 drug count with Nurse Controlled Drug Rece amount in the medica Nurse #3 said she did Drug Receipt Record because she was not that around 1:00 AM, told her that documer Drug Receipt Form in ml instead of 5 mg of #3 said she did not gi on what she should det Unit Coordinator # Nurse #3 said if this h gave a resident an inwould let her supervise there was no superviseall the doctor.	e #3. Nurse #3 said she esident #1. Nurse #3 said on #5 PM to 11:10 PM, she did a # #1 and the count on the eipt Record matched the ation bottle for Resident #1. If not look at the Controlled so during the drug count a supposed to. Nurse #3 said Nurse #2 came to her and intation on the Controlled adicated Resident #1 got 5 morphine at 8 PM. Nurse five Nurse #2 any direction five. Nurse #2 said she would fix know in the morning. Inappened to her and she correct dose, Nurse #3 sor know immediately. If fisor in the facility she would			Effective 10/27/2017, and moving forwall liquid medication orders will be writt with the specificity of the amount of liquit to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, direction on the order entered in electron Medication administration record will include give 0.25ml as part of order instruction instead of giving 5Mg. This mitigate errors in medication administration.  Effective 10/30/2017, the facilities nursiadministrative team, which includes DO ADON, and/or SDC, initiated a process reviewing clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours ar Physician orders written in the last 24 hours to ensure any needed notification changes to the physician, and/or responsible party was done in a timely manner. This systemic process will tak place daily (Monday through Friday). A identified issues will be addressed	en uid the the onic will ing ON, s for e and n of	
	Nurse #2 came to he 10/26/17 and said sha Resident #1 morphine Unit Coordinator #1 lo Receipt Record and t	AM -3 PM shift. She said r about 8:00 or 8:30 AM on e (Nurse #2) did not know if e dose was given correctly. boked at the Controlled Drug he morphine bottle. The ne bottle matched what was			promptly and appropriate actions will be implemented by the DON, ADON, SDO and/or Registered Nurse supervisor. To process will be incorporated in daily clinical rounds. Any negative findings we be documented on the daily checklist frand maintained in the daily clinical	c his vill	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING			1	C	
NAME OF D		343000	D: WING_		TREET ADDRESS SITY STATE 7/D SORE	10/	31/2017	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BLUMENT	HAL NURSING & REHA	ABILITATION CENTER		3	724 WIRELESS DRIVE			
				G	GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 157	Continued From pag	ge 7	F '	157				
	documented as left of	on the Controlled Drug			meeting binder.			
		n she told the administrator.			3			
	•	observed the resident and			Effective 10/30/2017, week end			
		ving some and she was not			Registered Nurse supervisor and/or			
		Coordinator #1 stated, when			designated licensed nurse will review			
	~	ent got more than the			clinical documentation for the last 24			
		norphine, then she would			hours, 24 hour report sheets, incident			
		and notify the doctor			reports for the last 24 hours and Physic	cian		
	immediately and get	an order for Narcan. Narcan			orders written in the last 24 hours to			
	is a medication used	I to treat an opioid overdose.			ensure any needed notification of chan	ges		
					to the physician, and/or responsible pa	rty		
	An interview was co	nducted with the physician on			was done in a timely manner. This			
	10/30/17 at 10:32 Af	M via telephone. He said he			systemic process will take place every			
	was familiar with Re	sident #1 situation. He was			Saturday & Sunday. Any identified issu	es		
	notified of the medic	ation error on the morning of			will be addressed promptly and			
	10/26/17 after the fa	cility's administrator became			appropriate actions will be implemente	d		
	aware of the error. I	He said that adverse effect of			by the DON, ADON, SDC and/or			
	a morphine overdos	e would appear during the			Registered Nurse supervisor. This			
	first 60 minutes to tw	o hours after administration			process will be incorporated in daily			
	of the overdose. His	expectation was the			clinical rounds. Any negative findings v	vill		
	physician would be r	notified immediately when a			be documented on the daily checklist for	orm		
	medication error occ	curred. He expected the			and maintained in the daily clinical			
	nursing staff to moni	tor vital signs, may be every			meeting binder.			
	15 minutes, monitor	breathing, and check clinical						
		nce the first nurse (Nurse #1)			Monitoring procedure and education to			
		re of the error before the end			ensure plan of correction is effective ar	ıd		
		PM, he stated "we missed the			that specific deficiency cited remains			
		ty for monitoring and			corrected and/or in compliance with			
		t was to happen) since the			regulatory compliance:			
		peared during the first two						
		dose." If he was notified			Effective 10/30/2017, Director of Nursii	•		
		overed the error around 1:00			Assistant Director of Nursing, and/or S			
		ould not have given the			Development Coordinator, will monitor			
		t away, unless she was			compliance with notification of changes	; to		
	• • •	blems. At that time, the			Physician and/or responsible party by			
		he resident's level of			conducting clinical meeting daily (M-F)			
		sedation. The physician			review the daily clinical meeting checkl			
		ot see any problem with the			to ensure completion and proper follow			
	nurse (Nurse #2) giv	ring the resident the			through to include notification to Physic	ıan		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345006	B. WING		C
NAME OF D	ROVIDER OR SUPPLIER	343000		STREET ADDRESS, CITY, STATE, ZIP CODE	10/31/2017
NAIVIE OF PI	ROVIDER OR SUPPLIER				
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		3724 WIRELESS DRIVE	
				GREENSBORO, NC 27455	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 157	Continued From page scheduled morphine	e 8 doses at 1:00 AM and 5:00	F 15	7 and responsible party, will review an	y
		#2 became aware that the		admission/discharges occurred from	
		times more morphine than		last clinical meeting and/or any incident	
		sician thought the resident		or accidents occurred from the prior	5110
		orphine and that was why		clinical meeting to include any medic	ation
		typical overdose symptoms.		error happened from the previous cli	
	The physician did not	• •		meeting. Any issues identified during	
	overdose hastened th	·		monitoring process will be addressed	· I
				promptly. Findings from this meeting	
	The administrator was	s interviewed on 10/31/17 at		be documented on a daily clinical rep	
	10:30 AM. The admir	nistrator stated that Nurse		form and filed in a clinical meeting bi	
		use five 1-ml syringe full of		in the Director of Health Services offi	
		er 5 ml of morphine to			
	Resident #1.	•			
				Director of Nursing will review the	
	The administrator wa	as notified of immediate		completion of daily clinical report, an	d
	jeopardy on 10/30/17	at 1 PM. The facility		daily clinical checklist forms daily Mo	nday
	provided the following	g acceptable allegation of		to Friday for two weeks, weekly for tw	vo
	removal of the immed	liate jeopardy on 10/31/17 at		more weeks, then monthly for three	
	1:26 PM:			months or until a pattern of complian	ce is
				maintained.	
		ximately 4:30pm, Nurse #2		Effective 10/31/2017, Director of Nur	sing
		o doses of Morphine Sulfate		will report findings of this monitoring	
		0/26/17 (1am and 5am) to		process to the facility Quality Assura	nce
		rviewed by the Administrator.		and Performance Improvement	
		ring her shift on 10/26/17,		Committee for any additional monito	-
		signs and symptoms of pain		or modification of this plan monthly for	or
		0.25mL of Morphine per		three months, or until a pattern of	
		stated, she noticed 5ml was		compliance is maintained. The QAP	
		Controlled Drug Receipt form		committee can modify this plan to en	sure
		m when she was signing for		the facility remains in substantial	
		ninistered. She did not think		compliance.	
		d because Resident #1 was		Disease of Normal (DON) A 111	
		n and showed no symptoms		Director of Nursing (DON), Assistant	
		se. She interpreted the		Director of Nursing (ADON) and/or S	
	_	on error. She also indicated		Development Coordinator (SDC) will	
		how any signs of change in		complete 100% education for all lice	
	condition to warrant c	contacting the physician.		nurses and Medication aides, to inclu	rae an

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	
		345006	B. WING		<del></del>	10/	31/2017
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
DILIMENT	FUAL MUDOINO O DEUA	DILITATION CENTED		372	24 WIRELESS DRIVE		
BLUMEN	THAL NURSING & REHA	BILITATION CENTER		GR	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	contact Nurse #2 with 9:30AM. Director of He contact Nurse #2 on response. Nurse #2 with 11 re-educated on requirements. On 10/25/17, Nurse is Morphine Sulfate (10 (5mg) as ordered by adverse effects were medication error. Rediagnosis, and elected services, with the life less. On 10/26/17, Reside at 1am and 5am; Nur Morphine 0.25mL per contacting the Physical the previous shift doo instead of 0.25mL. Proper symptoms of distress Although Resident #1 assertion that the restheir terminal illness error approximately the terminal sulfate Phillians and typically absorbed with the peak time of 60 puration of 4-6 he The attending Physically and typically in the previous of 4-6 he The attending Physically in the previous of 4-6 he The attending Physical medication error on the contact of the previous shift documents and th	allowed to work until ician notification oordinator #1 attempted to h no response on 10/26/17 at Health Services attempted to 10/30/17 at 5:52PM, and no will not be allowed to work physician notification  #1 administered 5ml of 10mg) instead of 0.25mL physician to Resident #1. No noted in relation to this sident #1 had a terminal ed to receive Hospice expectancy of six months or 11 ms more #2 administered r Physician order without cian. Nurse #2 recognized cumented Morphine 5ml er Nurse #2, no signs or were noted during the night. If died on 10/26/17 it is our sident's death was a result of and not from the medication hirteen hours prior. Our in the following facts; armacokinetics indicate: ministered medication is	F		full time, part time and as needed staff. The emphasis of this education was on the importance of notifying Physician a the responsible party in a timely manner for any incident/accidents, resident □s change of condition, change of treatment/intervention an injury of unknown source and/or Medication error any, and if there is any evidence or concern of a medication error MD will be notified immediately and patient assess accordingly. This education completed 10/30/2017. Any Licensed Nurse or Medication Aide not educated by 10/31/2017 not allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and Medication Aides effective 10/30/2017.  Title of person responsible for implementing the acceptable plan of correction:  Effective 10/31/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable pof correction to ensure regulatory compliance.  Compliance date: 11/1/2017	nd er or if seed l by	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245000	B. WING				C
		345006	D. WING			10/	31/2017
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		372	4 WIRELESS DRIVE		
				GR	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 157	Continued From page	÷ 10	F	157			
	On 10/26/17 at approcentrolled drug recondiscrepancy was noted Receipt form by the factoric controlled Drug Receipt form by the factoric form factoric factori	eximately 9:00 am, during a ciliation for Resident #1, a and on the Controlled Drug acility Administrator. The sipt form indicated resident thine sulfate instead of sordered by the Physician. Eximately 3:00pm, Nurse #1, stated medication to reviewed by the Administrator. Fing the medication previous day, she noted the property of the resident #1. She der in the resident's record					
	documented on the C for Resident #1 at 1at the Morphine she adr 5ml was administered still moaning with pair of medication overdor as documentation err Resident #1 did not s	ontrolled Drug Receipt form m when she was signing for ninistered. She did not think I because Resident #1 was an and showed no symptoms se. She interpreted the entry or. She also indicated how any signs of change in ontacting the physician.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345006	B. WING			1	31/ <b>2017</b>
	ROVIDER OR SUPPLIER  THAL NURSING & REHA	BILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	medication was comp Director of Health Se resident with an orde (Schedule II - V) that correctly and/or admi All written orders for overified for accuracy in and on the electronic record. There were nother written Controlle 100% audit of all curredocumentation within completed by the Direct assurance nurse, Nur #1 and/or MDS nurse identified need for no- completed in a timely no other incident of more of changes to both proparty. This audit was Findings of this audit records audit tool" lock compliance binder.  On 10/30/17, 100% and Director of Nursing, Control of Nursing, Control of Nurse Supervisor, Minurse #2 of all incident the last 30 days to entine a timely manner. Tincident of missing/dechanges to both physical sudit was compliance to such that was compliance to such physical sudit physical sudit was physical sudit physical su	ve resident controlled pleted on 10/27/17 by rivices to identify any other of for controlled medication was not transcribed inistered per physician order. Controlled medications were in electronic health records medication administration of other discrepancies in any ed medication orders. The sent residents' clinical of the last 7 days were electroned for the last 7 days were electroned for the last 7 days were electroned for the last 8 days were electroned for the last 9 days was of manner. The audit revealed for the last 10 determine any transcription of changes was of manner. The audit revealed for the last 10/30/17 are documented on 10/30/17. The last 10 days were electroned for the last 10 days were electroned for the last 10 days was of manner. The audit revealed for the last 10 days was of manner. The audit revealed in the facility electroned for the last 10 days was electro	F	157			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345006	B. WING _			C 10/31/2017
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	'	1000112011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
F 157	medication orders we specificity of the amadministered based example an order for 20 mg/ml solution, the entered in electronic record will include "ginstruction instead of mitigate errors in modern and/or SDC, initiate clinical documentation to the physician hour report sheets, hours and Physician hours to ensure any changes to the physician process will take play and approximately	and moving forward, all liquid will be written with the count of liquid to be on concentration; for or morphine 5mg, in a ne direction on the order of Medication administration give 0.25ml" as part of order of giving 5Mg. This will edication administration.	F1	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343000	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CO		0/31/2017	
NAME OF F	ROVIDER OR SUFFLIER			3724 WIRELESS DRIVE	ODE		
BLUMENT	THAL NURSING & RE	HABILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETION DATE	
F 157	Continued From p	age 13	F	157			
	promptly and applimplemented by the Registered Nurse incorporated in date findings will be dochecklist form" and meeting binder.	tified issues will be addressed ropriate actions will be ne DON, ADON, SDC and/or supervisor. This process will be ily clinical rounds. Any negative cumented on the "daily d maintained in the daily clinical g (DON), Assistant Director of					
	Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all Nurses and Medication aides, to include full time, part time and as needed staff. The emphasis of this education was on the importance of notifying Physician and the responsible party in a timely manner for any incident/accidents, resident's change of condition, change of treatment/intervention, an injury of						
	This education will Any Nurse or Med 10/30/17 will not be educated. This ed new hires orientat and Medication Ai 10/31/17, Director	and/or Medication error if any. I be completed by 10/30/17. Ilication Aide not educated by the allowed to work until ucation will also be added on ion process for all new Nurses des effective 10/30/17. Effective of Nursing, Assistant Director Staff Development					
	Coordinator, will notification of charesponsible party daily (M-F), review checklist to ensure through to include responsible party, admission/discharelinical meeting an occurred from the	nonitor compliance with nges to Physician and/or by conducting clinical meeting v the daily clinical meeting e completion and proper follow notification to Physician and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIF A. BUILDING			NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345006	B. WING _			C 10/31/2017		
	ROVIDER OR SUPPLIER  THAL NURSING & REHA	BILITATION CENTER		3724	EET ADDRESS, CITY, STATE, ZIP CODE WIRELESS DRIVE EENSBORO, NC 27455	<u>, 10/</u>	0112011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 157	monitoring process we Findings from this may a daily clinical report meeting binder in the office.  Director of Nursing we daily clinical report, a forms daily Monday to weekly for two more	issues identified during this vill be addressed promptly. eeting will be documented on form and filed in a clinical Director of Health Services vill review the completion of and daily clinical checklist of Friday for two weeks, weeks, then monthly for a pattern of compliance is	F	157				
	findings of this monit Quality Assurance ar Improvement Commi monitoring or modific three months, or unti maintained. The QAI plan to ensure the fa compliance.	rirector of Nursing will report oring process to the facility and Performance ittee for any additional reation of this plan monthly for I a pattern of compliance is PI committee can modify this cility remains in substantial						
	and the Director of Hultimately responsible of credible allegation immediate jeopardy.  Validation of the credible 10/31/17 at 11:47 AND The facility provided physician was notified shortly after the facility error. Review of the revealed all records in notification on 10/30/	ealth services will be e to ensure implementation to remove this alleged lible allegation was done on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING			l	C 24/2047	
	ROVIDER OR SUPPLIER			STR 3724	EET ADDRESS, CITY, STATE, ZIP CODE 4 WIRELESS DRIVE EENSBORO, NC 27455	10/	31/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE	
F 157	notification. Interview that she did receive of from the administrator reviewed indicating the interviewed Nurse #2. The statement indicates showing signs and systowing signs of distifuction with the statement of the statement indicates showing signs of distifuction of the statement indicates showing signs of distifuction of the statement indicates showing signs of distifuction of the statement indicates and showing signs of distifuction of the statement indicates and about medication orders and about medication orders and about medication errors. Staff were interviewed received education or notifying the physician Residents who received for medication errors. DRUG REGIMEN IS UNNECESSARY DR CFR(s): 483.45(d)(e).  483.45(d) Unnecessate Each resident's drug unnecessary drugs. Adrug when used	ducation and counselling r. A written statement was nat the administrator on 10/29/17 at 4:30 pm. ted that the resident was reptoms of pain and was not ress. That was why Nurse the 5 ml of morphine on the sipts was accurate. The medication discrepancy  evidence of audits of d inservices provided to staff or and physician notification.  d to validate that they medication error and n.  red morphine were reviewed  FREE FROM UGS (1)-(2)  ary Drugs-General. regimen must be free from An unnecessary drug is any e (including duplicate drug		329			11/1/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		345006	B. WING		10/31/2017	
	ROVIDER OR SUPPLIER  THAL NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3724 WIRELESS DRIVE  GREENSBORO, NC 27455	10/01/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 329	(5) In the presence of which indicate the dodiscontinued; or  (6) Any combinations paragraphs (d)(1) three 483.45(e) Psychotrop Based on a compreher resident, the facility recombination of the comprehension of the compr	e monitoring; or e indications for its use; or f adverse consequences use should be reduced or e of the reasons stated in ough (5) of this section.  Dic Drugs. ensive assessment of a nust ensure that ave not used psychotropic hese drugs unless the	F 32	29		
	condition as diagnosic clinical record;  (2) Residents who us gradual dose reductive interventions, unless an effort to discontinuation this REQUIREMENT by:  Based on record revite medical director apharmacy services, the correct dose of medication) resulting times more morphine by the physician. The immediately assess the effects after facility stimulation in the correct dose of medication and the physician.	clinically contraindicated, in the these drugs;  is not met as evidenced the service of clinical the facility failed to administer to rephine (a narcotic pain in Resident #1 receiving 20 than what was prescribed to the resident for adverse the service of the se		The creation and submission of this pof correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for residents.	of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			(		
		345006	B. WING			1	31/2017	
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DITIMENT	HAL NURSING & REHA	DII ITATION CENTED		3	724 WIRELESS DRIVE			
BLUWEN	HAL NURSING & REHA	BILITATION CENTER		G	REENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 329	Continued From page		F	329	The processes that lead to the deficien	icv.		
	times more morphine resident did receive to doses of morphine aff was evident in 1 (Res residents receiving national limits and the series of morphine, was effects after facility sto documentation that the times more morphine immediate jeopardy when the facility provallegation of removal of compliance at a sea cual harm with the minimal harm that is The facility was in the action at that time.  Findings included: Resident #1 was adm 4/17/15. The resident fibrillation, implantable falls, diabetes and attached the series of the resider set (MDS) of 9/11/17 for Mental Status scores.	than prescribed. The wo additional scheduled for the excessive dose. This sident #1) of 3 sampled arcotic medications.  Degan on 10/25/17 when 120 times the prescribed as not assessed for adverse aff discovered for resident received 20 than prescribed. The was removed on 10/30/17 ided an acceptable credible. The facility will remain out tope and severity of no potential of no more than not immediate jeopardy (D). The process of full corrective initted to the facility on the diagnoses included atrial to the cardiac fibrillator, repeated axic gait, dementia without thial hypertension.  The sannual Minimum Data for evealed the Brief Interview one was 7 which indicated the			On 10/25/2017, Licensed Nurse #1 administered 5ml of Morphine Sulfate 100mg instead of 0.25mL (5mg) as ordered by physician to resident #6677 No adverse effects were noted in relatito this medication error. Resident #667 had a terminal diagnosis, and elected treceive Hospice services, with the life expectancy of six months or less. On 10/29/2017 at approximately 4:30pt the Licensed Nurse #2 who administer two doses of Morphine Sulfate during tright on 10/26/2017 (1am and 5am) to resident #6677 was interviewed by the Administrator. She revealed that during her shift on 10/26/2017, resident #6677 showed signs and symptoms of pain as she administered 0.25mL of Morphine physician order. She started, she notice 5ml was documented on the Controlled Drug Receipt form for resident #6677 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because resident #6677 was still moaning with pand showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicate resident #6677 did not show any signs change in condition to warrant contactions.	m, ed he ot oain on d or		
	MDS indicated the repain medication regir the look behind perio MDS.  A Care plan was initia	y cognitively impaired. The sident received a scheduled men in the last 5 days during d. Pain did not trigger on the ated on 9/19/17 to address atteration in comfort related.			change in condition to warrant contacti the physician. Unit Coordinator #1 attempted to contact licensed nurse #2 with no response on 10/26/2017 at 9:30AM. Director of Health Services attempted to contact nurse #2 on 10/30/2017 at 5:52PM, and no response	ses.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C 0/ <b>31/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP COD		0/31/2017	
TVAIVIL OF T	TOVIDER OR OUT FEILIN			3724 WIRELESS DRIVE	_		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Continued From page	e 18	F 3	29			
	to osteoarthritis. The verbalize or show no moaning etc.) relief of after administering of next review. The inter administer tender lov position, back rub etc resident to report any duration, intensity an as ordered, observe medications for the coand try to eliminate a encourage to express observe for non-verb grimacing, guarding, diaphoresis), notify Mand conduct pain ass	goal was the resident will n-verbal (no grimacing, no f pain 45 minutes to an hour medications through the rventions included to ing care (i.e. change in a.) as needed, encourage r pain (noting location, d severity), give medication for effectiveness of pain control of pain, handle gently ny environmental stimuli, as fears and concerns, al signs of pain (i.e. moaning, restlessness, ledical Doctor as needed,		work until re-educated on phy notification requirements. On 10/26/2017, resident #667 moaning with pain at 1am and Licensed Nurse #2 administer Morphine 0.25mL per Physician Nurse #2 recognized the previous documented Morphine 5mL in 0.25mL. Licensed nurse #2 did the ability to contact Licensed verify whether Morphine 5mL on the Controlled Drug receip administered to resident #667 Licensed nurse #2, no signs of distress noted during the nife resident #6677.  The attending Physician was about this medication error or at 3:30Pm, this was done with At 11pm on 10/25/2017 controreceipt for resident #6677 indicates the sident #6670 indicates the sident #6677 indicate	77 was d 5am; red an order. vious shift instead of id not have I nurse #1 to documented of form was 77 or not. Per or symptoms ight for notified in 10/26/2017 inin 24 hours. colled drugs icated the		
	On 10/23/17, the resiservices.			remaining quantity of Morphin was 24.5mL. This amount ma amount of Morphine sulfate reresident #6677 dispensed me	tched the emaining in		
	some of her medicati			bottle. On 10/26/2017 at approximate during controlled drug reconci	iliation for		
	sleeping most of the	sident was lying in bed day. She mumbled, refused ons by spitting it back out		resident #6677, a discrepancy on the Controlled Drug Receip the facility Administrator. The sheet indicated resident receip Morphine sulfate instead of 0.	pt form by control ved 5ml of		
	revealed a physician "stop all PO (by mousupplements, morphi (milliliter). Give 5 mg	ian's Telephone Orders order dated 10/24/17 to th) meds (medications) and ne 20 mg (milligram)/ml Q (every) 8 hrs (hours) SL for pain/SOB (shortness of		Morphine as ordered by the P On 10/26/2017 at approximate the Licensed Nurse #1, who a the stated medication to resid was interviewed by the Admin revealed that during the medical	ely 3:00pm, administered lent #6677 nistrator. She		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 50.25				С
		345006	B. WING _			1 1	0/31/2017
NAME OF PI	ROVIDER OR SUPPLIER		'	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				37	24 WIRELESS DRIVE		
BLUMENT	THAL NURSING & RE	HABILITATION CENTER		GI	REENSBORO, NC 27455		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 329	Continued From p	age 19	F 3	329			
	breath). Give 5 m	ig SL Q 2hrs prn (as needed)			administration on the previous day, she	е	
	SOB/pain."				noted medication order change for		
					resident #6677. She verified the writter		
		nt #1's "Controlled Drug			order in resident s record and read it a	as	
		isposition Form" revealed			5ml instead of 5mg.		
		at 30 ml of Morphine 100mg/5ml			The Administrator explained and	h-4	
		eived at the facility on 10/24/17. on the "Controlled Drug			demonstrated to Licensed Nurse #1 wh was supposed to be administered	nat	
		isposition Form" was to give the			compared to what she signed for on the		
		5 mg) every 8 hours as needed.			Controlled Drug Receipt form. License		
	100100111 0:20 1111 (	o mg/ overy o modro do moddod.			Nurse #1 acknowledged that an incorre		
	Review of Resident #1's "eMAR (electronic				amount of Morphine Sulfate had been		
		istration record)-Medication			administered. Based on the interview		
	Record" for the me	onth of October, 2017 revealed			conducted by the Administrator and the	Э	
	1	on" of the order on the left side			record review of all controlled medication		
		ead as "Morphine 20mg/ml oral			administered by Licensed Nurse #1, it		
		g every 8 hours sublingual for			concluded that this error resulted from	an	
	·	ne row of the order, on the right			honest oversight. Licensed nurse#1	- <b>f</b>	
		and under the column of ere a check mark and the			misread the order, and misinterpreted of Morphine 5mg as Morphine 5mL.	OI	
		ication aide indicating the			Licensed Nurse #1 was re-educated ar	nd	
		inistered morphine at 6:00 AM			counseled by the Director of Health	iu	
	and, again, 2 PM				Services and the Administrator on		
	,g,				10/27/2017. Medication administration		
	Review of the "Co	ntrolled Drug			competency and morphine dosage		
	Receipt/Record/D	isposition Form" revealed			calculation education was provided to		
	documentation that	at 0.25 ml (5 mg) of morphine			Licensed Nurse #1 by the Director of		
	_	resident and 29.75 ml of			Health Services on 10/27/2017.		
		t in the bottle at 6 AM on					
		r 0.25 ml of morphine were			Procedure for implementing the		
		ven to the resident and 29.50			acceptable plan of correction for the		
	10/25/17.	ere left in the bottle at 2 PM on			specific deficiency cited:		
	10/20/17.				100% audit of all active residents		
	Review of the resi	dent's Departmental Notes			controlled medications was completed	on	
		44 on 10/25/17 at 4:15 PM			10/27/2017 by Director of Health Service		
		ntation that the Resident was			to identify any other resident with an or		
		ing, and was given morphine as			for a controlled medication (Schedule I		
		The resident refused breakfast			V) that was transcribed incorrectly and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(	2	
		345006	B. WING			10/	31/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
				37	724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		G	REENSBORO, NC 27455			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION			
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 329	Continued From page	e 20	F;	329				
	and lunch. The reside	ent declined water, when			not administered per physician order. A	All .		
		the straw. The staff will			written orders for controlled medication			
		he resident and provide			were verified for accuracy in electronic			
	comfort, and keep ca	•			health records and on the electronic			
					medication administration record. No			
		ian's Telephone Order			other written Controlled medication ord	er		
		order dated 10/25/17 at 4:40			noted with any discrepancy.			
		irrent morphine order and to			Effective 10/27/2017, and moving forward			
		g/ml. Give 5 mg PO/SL Q 4			all liquid medication orders will be writte			
	, ,	nd Q 2 hr (hour) prn (for)			with the specificity of the amount of liqu	ııd		
	pain/SOB."				to be administered based on			
	Davious of Davidant +	tale "eNAAD Medication			concentration; for example an order for			
		#1's "eMAR-Medication h of October, 2017 revealed			morphine 5mg, in a 20mg/ml solution, t direction on the order entered in electrons.			
		left side of the page read as			Medication administration record will	JIIC		
	• •	oral syringe, Give 5 mg			include give 0.25ml as part of order			
		ours as needed for shortness			instruction instead of give 5Mg. This w	ill		
		ne same row as the order, on			mitigate errors in medication			
		page, and under the column			administration. All Licensed nurses and	i		
	of 10/25/17, there we	ere a check mark and the			Medication aides were educated of this	,		
	initials of Nurse #1 in				new process on 10/26/2017 and			
	administered morphi	ne at 8:14 PM on 10/25/17.			10/27/2017 by the Director of Health			
					Services (DHS), Quality Assurance Nu	rse		
	Review of the "Contr				and/or Staff Development Coordinator			
		osition Form" revealed			(SDC).			
		ml of morphine were given						
		4.50 ml of morphine were left			F#+: 40/07/0047 Linuid			
		PM on 10/25/17. The resident			Effective 10/27/2017 any Liquid			
		nl) of morphine instead of 5 PM on 10/25/17. This			medication ordered and written by the physician will be transcribed in resident	.		
		times more morphine than			Electronic Administration records to ref			
	prescribed by the phy	•			the amount of liquid to be administered			
	p. 300000 by 1110 bit.	,			licensed nurses on duty.	- 3		
	Review of Resident #	#1's "eMAR-Medication						
		h of October, 2017 revealed			Effective 10/27/2017, Director of Health	1		
		left side of the page that			Services, Quality Assurance Nurse, Un			
		Omg/ml oral syringe, Give			Coordinator and/or Staff Development			
		gual for pain." There was no			Coordinator will review all new			
	dosage specified on	this order. On the same row			medication and treatment orders from			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING _			C 10/31/2017		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	01/2017	
					724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REHA	ABILITATION CENTER			REENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 329	Continued From pag	ge 21	F3	329				
F 329	of the order, on the runder the column of mark and the initials #2 administered mor AM on 10/26/17.  Review of the "Contraction Receipt/Record/Disp documentation that digiven to the resident were left in the bottle was also documentation were given to the resident were given to the resident were given to the resident and the resident of the resident would not end in the resident of the resident	right side of the page, and 10/26/17, there were a check of Nurse #2 indicating Nurse rphine at 1:00 AM and 5:00  rolled Drug position Form" revealed 0.25 ml of morphine were at and 24.25 ml of morphine at 1 AM on 10/26/17. There at 1 AM on 10/26/17. There at on that 0.25 ml of morphine sident and 24.00 ml of an the bottle at 5 AM on and the bottle at 5 AM on the bottle at 5 AM on the saled the Resident died at at the 3-11 shift. The at or drink and would yell the resident was not verbal assess the resident's pain by and moaning. The resident amorphine dose around 7. At around 10:45 PM, the ang" and her breathing was ened to her heart and and repositioned her. The 11-11:15 PM. Nurse #1 told	F	3329	prior day (M-F), by comparing new writtelephone orders and written orders to orders transcribed in electronic health record to ensure accuracy. This process will be incorporated in the facility daily Clinical rounds. Any medication not transcribed correctly will be corrected promptly and findings reported to the Director of Health Services. Findings from this process will be maintained in the Director of Health Services office.  Effective 10/27/2017, the center clinical interdisciplinary team, which includes Director of Health Services, Quality Assurance Nurse, Unit Coordinator and Staff Development Coordinator, initiated process for reviewing all new admission/re-admissions Monday through the process for reviewing all new administered per physician orders. Any negative finding will be addressed promptly.  Effective 10/27/2017, the center, weekend RN supervisor and/or designated licensed nurse will review all new admission/re-admissions by comparing new written telephone orders to orders transcribed in electronic health recordinator ensure accuracy every Saturday & Sunday to ensure all new ordered	om paily		
	resident's slow breat was normal for the re morphine. Nurse #1 The next day, Nurse	thing and the nurse said that esident when she got left the facility for the day. #1 came to the facility at 3 the resident passed away.			medication were transcribed appropria and administered per physician orders Any negative finding will be addressed promptly, and reported to the Director Health Services.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345006	B. WING _				C <b>31/2017</b>
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				37	724 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 329	Continued From page	e 22	F3	329			
	The administrator tole Resident #1 5 ml (10 5 mg. When asked wong. When asked wong. Nurse #1 sail her about medication on how to avoid med.  An interview was conto/29/17 at 6:15 PM. Resident #1 on the 1 started on 10/25/17. legs because they we yelled constantly. Not the physician order from 10/25/17 did not how marked to hose. Nurse #2 sawritten physician order dosage. The nurse sof morphine at 1 AM physician. Then, should be morphine to the documentation that the focumentation that the focumentatio	d Nurse #1 that she gave 0 mg) of morphine instead of what contributed to the error, ead the physician order d the administrator educated error and gave her print out ication error on 10/27/17.  Iducted with Nurse #2 on Nurse #2 provided care to 1 PM - 7 AM shift that The resident had pain in her ere contracted and she urse #2 acknowledged that or the scheduled morphine have a dose on the electronic d 20 mg/ml of morphine but aid she looked at the hand er to find out about the aid she administered 0.25 ml as prescribed by the e went to the Controlled to record the administration e resident received 5 ml of mg at 8:00 PM. Nurse #2		529	Director of Health Services (DHS), Quants Assurance Nurse and/or Staff Development Coordinator (SDC) will complete 100% education for all licens nurses and medication aides, to include full time, part time and as needed staff regarding medication administration per physician orders and medication error reporting. The emphasis of this education was on the liquid medication specificall Morphine sulfate. This education will be completed by 10/27/2017. Any licensed nurse and/or Medication aide not educated by 10/27/2017 will not be allowed to work until educated. This education will also be added on new his orientation process for all new Licensed nurses and Medication aides effective 10/27/2017, and will be provided annual Monitoring procedure and education to ensure plan of correction is effective are that specific deficiency cited remains corrected and/or in compliance with regulatory compliance:  Effective 10/27/2017, Director of Health Services, Quality Assurance Nurse, Un Coordinator and/or Staff Development Coordinator will monitor compliance or medication order administration per physician orders, specifically, all morph Controlled Drug Receipts will be review in clinical meeting, 5 times per week time (Monday Friday) for 2 weeks, then 3 time weekly for 2 more weeks, then weekly for 4 weeks then monthly x 3	ed ee e con y ee d res d ally.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD	ıE		
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F 329	Continued From pag	e 23	F 3:	29			
	moaning, so she dou ml of morphine. Nurs the resident.	se the resident was still bted that the resident got 5 ee #2 said she did not assess		months or until the pattern of is maintained. Findings from will be documented on a daily report form and filed in clinical binder in Director of Nursing of	this meeting / clinical al meeting		
	conducted with Nurse never worked with R 10/25/17 around 11:0 drug count with Nurse Controlled Drug Receamount in the medica Nurse #3 said she did Drug Receipt Record because she was not that around 1 AM, Nurse that documentati Receipt Form indicate instead of 5 mg of me #3 stated to Nurse #2 give her 5 ml". Nurse Nurse #2 any direction Nurse #2 said she will know in the morning.	PM, an interview was e #3. Nurse #3 said she esident #1. Nurse #3 said on 05 PM to 11:10 PM, she did a e #1 and the count on the eipt Record matched the ation bottle for Resident #1. d not look at the Controlled is during the drug count at supposed to. Nurse #3 said urse #2 came to her and told on on the Controlled Drug ed Resident #1 got 5 ml prophine at 8:00 PM. Nurse 2, "surely to God, she did not at #3 said she did not give on on what she should do. Dould let Unit Coordinator #1 Nurse #3 said if this		proper follow ups are done.  Executive Director will review completion of daily clinical repaired daily clinical checklist forms of 2 weeks, weekly x 2 more were monthly x 3 months or until the compliance is maintained.  Effective 10/27/2017, Director will report findings of this more process to the facility Quality and Performance Improveme Committee for any additional or modification of this plan more months, or until the pattern of is maintained. The QAPI commodify this plan to ensure the remove the alleged immediate.	the port, and daily (M-F) for eks, then he pattern of the pattern		
	incorrect dose, Nurse supervisor know imm supervisor in the faci. An interview was cor #1 on 10/30/17 at 9:2 the 7 AM -3 PM shift her about 8:00 or 8:3 she (Nurse #2) did not morphine dose was a Coordinator #1 looke Receipt Record and amount in the morph	she gave a resident an e #3 said she would let her nediately. If there was no lity she would call the doctor.  Inducted with Unit Coordinator 29 AM. She usually worked a She said Nurse #2 came to 10 AM on 10/26/17 and said out know if Resident #1 given correctly. Unit and at the Controlled Drug the morphine bottle. The ine bottle matched what was an the Controlled Drug		Director of Health Services (I Assurance Nurse and/or Staft Development Coordinator (SI complete 100% education for nurses and medication aides, full time, part time and as nee regarding medication adminis physician orders and medicat reporting, including if there is evidence or concern of a medithe MD will be notified immediated patient assessed accordingly emphasis of this education we liquid medication specifically	f DC) will all licensed to include eded staff, stration per tion error any dication error liately and the as on the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF D	DOVIDED OD CUIDDUED	343000	1 2: *******		TREET ADDRESS CITY STATE ZID CODE	10/	31/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER			724 WIRELESS DRIVE		
		-		G	GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	EIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 329	Continued From page	e 24	F3	329			
F 329	Receipt Record, then Unit Coordinator #1 of the resident was move moaning. The Unit Coshe would realize a represcribed dose of massess the resident a immediately and get a is a medication used.  An interview was con 10/30/17 at 10:32 AM was familiar with Resolution of the medica 10/26/17 after the fact aware of the error. He amorphine overdose first 60 minutes to two of the overdose. His exphysician would be not medication error occurring staff to monito 15 minutes, monitor be status. However, sind did not become award of her shift at 11 PM, window of opportunity preventing harm (if it harm would have apphours after the overdown Nurse #2 discook AM, the physician sait the resident Narcan resid	she told the administrator.  Abserved the resident and ing some and she was not coordinator #1 stated, when esident got more than the corphine, then she would and notify the doctor an order for Narcan. Narcan to treat an opioid overdose.  I will telephone. He said he ident #1 situation. He was attion error on the morning of ility's administrator became the said that adverse effect of would appear during the polytopic hours after administration expectation was the cotified immediately when a surred. He expected the cor vital signs, may be every preathing, and check clinical coe the first nurse (Nurse #1) the of the error before the end the stated "we missed the propose." If he was notified wered the error around 1 did he would not have given	F	329	sulfate. This education completed 10/27/2017. Any licensed nurse and/or Medication aide not educated by 10/27/2017 will not be allowed to work until educated. This education will also added on new hires orientation process for all new Licensed nurses and Medication aides effective 10/27/2017, and will be provided annually.  Title of person responsible for implementing the acceptable plan of correction:  Effective 10/31/17, the center Executiv Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable profice to correction to ensure regulatory compliance.  Compliance date: 11/1/2017	be s e	
	time, the nurse would consciousness and se	check the resident's level of edation. The physician see any problem with the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	04000		STREET ADDRESS, CITY, STATE, ZIP COD		0/31/2017	
				3724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REHA	ABILITATION CENTER		GREENSBORO, NC 27455			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 329	Continued From pag	e 25	F 3	29			
F 329	scheduled morphine even after Nurse #2 resident received 20 prescribed. The phy did not absorb the m she did not have the The physician did no overdose hastened to the physician did not overdose hastened to the physician services. She explain were written on the physician of the eman the facility with a Constant of the eman that would have physician name, the concentration, admirthe number of mI that so nurses would not frequency of administ needed to administe come up on the compare the morphine with a and document on the Record how much will left in the morphine is the solution of the morphine in the morphine is the morphine in the morphine in the morphine is the morphine in the morphine in the morphine is the morphine in the morphine in the morphine in the morphine is the morphine in the morphine in the morphine in the morphine is the morphine in the morphine in the morphine in the morphine is the morphine in the morphine is the morphine in	doses at 1 AM and 5 AM, became aware that the times more morphine than sician thought the resident torphine and that was why typical overdose symptoms. It think the morphine he resident's death.  PM, an interview was lirector of clinical pharmacy ned that physician orders only in the physician order and armacy. The facility's nurses entering the physician order cation Record. If the order on complete, then the nurse e original order to verify and in the eMAR without pharmacy orphine order is delivered to entrolled Drug Receipt Record entering the drug, a histration route, a dose (with the nurse of the drug, a histration. When a nurse or morphine, the order would puter and the nurse should ne dose on the computer with the Controlled Drug Receipt Record hed. Nurses would measure 1 ml syringe and administer it as given and how much was bottle. During the narcotic	F3	29			
	the morphine with a and document on the Record how much w left in the morphine to count at the end of the would be looking only	1 ml syringe and administer it e Controlled Drug Receipt as given and how much was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 3724 WIRELESS DRIVE GREENSBORO, NC 27455	•	0/31/2317	
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F 329	and then they mate nurse would not look Receipt Record unat the drug count at the drug count at director stated the to fill up the 1 ml sy administer 5 ml to look On 10/30/17 at 6:4 conducted with the He said Nurse #2 when she found our incorrect dose of m source of informatic after she received was from interview and the state agen documentation in that the resident way AM shift on 10/25/7 The administrator to 10:30 AM. The administrator to 10:30 AM. The administrator in the sident #1.  The administrator in jeopardy on 10/30/provided the follow removal of the immorphine Sulfate 1 as ordered by physical as ordered by physical effects we	crolled Drug Receipt Record ch them up. The oncoming ok at the Controlled Drug til they administer morphine or t the end of their shift. The nurse (Nurse #1) would have vringe with morphine 5 times to Resident #1.  4 PM, an interview was corporate nurse consultant. did not assess the resident tit that the resident received an arorphine on 10/25/17. The only on of the resident's condition the incorrect dose of morphine as with Nurse #2 by the facility cy. There was no ne medical record by Nurse #2 as moaning during the 11 PM-7	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONS		(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER  THAL NURSING & REHA	BILITATION CENTER		3724 WI	ADDRESS, CITY, STATE, ZIP CODE RELESS DRIVE ISBORO, NC 27455	1 10/	31/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	services, with the life less.  On 10/29/17 at approwho administered twice during the night on 1 Resident #1 was interested that during the night on 1 Resident #1 showed and she administered physician order. She documented on the Cordinator #1 at 1athe Morphine she ad 5ml was administered still moaning with pair of medication overdous documentation or Resident #1 did not condition to warrant of Coordinator #1 attern with no response on of Health Services at on 10/30/17 at 5:52F #2 will not be allowed physician notification On 10/26/17, Reside at 1am and 5am. Nu Morphine 0.25mL perecognized the previous Morphine 5mL instead not have the ability to whether Morphine 5r Controlled Drug received.	ed to receive Hospice expectancy of six months or expectancy of Morphine Sulfate 0/26/17 (1am and 5am) to expectancy of the Administrator. Fing her shift on 10/26/17, signs and symptoms of pain d 0.25mL of Morphine per extated, she noticed 5ml was controlled Drug Receipt form am when she was signing for ministered. She did not think d because Resident #1 was in and showed no symptoms ase. She interpreted the entry expectance of the physician. Unit expectance of the physician of t	F	329			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345006	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3724 WIRELESS DRIVE  GREENSBORO, NC 27455	l	10/31/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	assertion that the retheir terminal illness error approximately assertion is based of Morphine Sulfate Pt " 30% of orally at typically absorbed " Has a half-life of " Peak time of 60 " Duration of 4-6 The attending Physimedication error on done within 24 hour controlled drugs recthe remaining quant 24.5mL. This amoun Morphine sulfate redispensed medication of the remaining quant 24.5mL. This amoun Morphine sulfate redispensed medication on 10/26/17 at approximately approximately as ordered by the Pon 10/26/17 at approximately the control sheet indicated Morphine sulfate insign as ordered by the Pon 10/26/17 at approximately the series of the witten of the trevealed that dispensed the written or the Administration on the read it as 5ml instead the Administrator extends the series of the Administrator extends the series of the series of the written of the Administrator extends the series of the series of the series of the treverse	died on 10/26/17, it is our sident's death was a result of and not from the medication thirteen hours prior. Our in the following facts; narmacokinetics indicate: diministered medication is of 2-4 hours in minutes hours cian was notified about this 10/26/17 at 3:30PM, this was so at 11pm on 10/25/17 eipt for Resident #1 indicated ity of Morphine Sulfate was not matched the amount of maining in Resident #1's on bottle.  In the controlled Drug facility Administrator. The ed resident received 5ml of stead of 0.25ml of Morphine hysician.  In the extra the medication to be erviewed by the Administrator. The entry is stated medication to erviewed by the Administrator. In the extra the medication to be previous day, she noted ange for Resident #1. She order in resident's record and do f 5mg.  In the provious day, she noted angular for the entry is record and do f 5mg.  In the provious day, she noted and the signed for on th	F 3	29		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	343000		STREET ADDRESS, CITY, STATE, ZIP CC		0/31/2017	
TVAINE OF T	TOVIDER OR OUT FEET			3724 WIRELESS DRIVE	.DL		
BLUMENT	HAL NURSING & REHA	ABILITATION CENTER		GREENSBORO, NC 27455			
(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 C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 329	1.3		F 3	329			
	acknowledged that a Morphine Sulfate had on the interview cond and the record review medications administ concluded that this education was re-education of Health Second 10/2717. Medicat competency and modeducation was provided Director of Health Second 10/2717. Medicat competency and modeducation was provided Director of Health Second 100% audit of all act medications was complications was complication with an order (Schedule II - V) that and/or not administed written orders for conditions was for conditionally and the second s	in incorrect amount of d been administered. Based ducted by the Administrator w of all controlled tered by Nurse #1, it was error resulted from an honest misread the order, and nine 5mg as Morphine 5mL. incated and counseled by the ervices and the Administrator ion administration rphine dosage calculation ded to Nurse #1 by the ervices on 10/27/17.  Inverse residents controlled inpleted on 10/27/17 by ervices to identify any other er for a controlled medication is was transcribed incorrectly red per physician order. All introlled medications were					
	and on the electronic record. No other writ order were noted wit Effective 10/27/17, a medication orders wis specificity of the amount administered based example an order for 20mg/ml solution, the entered in electronic record will include "g	nd moving forward, all liquid ill be written with the ount of liquid to be on concentration; for					
	errors in medication nurses and Medication new process on 10/2	administration. All Licensed on aides were notified of this 26/17 and 10/27/17 by an I by the Director of Health					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING _				31/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS 3724 WIRELESS D GREENSBORO,		1 10/	51/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329	Staff Development Control Effective 10/27/17 and and written by the pharesident Electronic Acoreflect the amount of licensed nurses on discensed nurses of discensed nurses on discensed nurses on discensed nurses on discensed nurses on discensed nurses of discensed nurses of discensed nurses of discensed nurses on discensed nurses of discensed n	lity Assurance Nurse and/or coordinator (SDC).  y liquid medication ordered ysician will be transcribed in dministration records to liquid to be administered by	F	329			
	process will be maint round binder located Services office.  Effective 10/27/17, the interdisciplinary team Health Services, Quad Coordinator and/or Services, Quad Coordinator, initiated new admission/re-adfriday to ensure all of transcribed appropriate physician orders. Any addressed promptly.  Effective 10/27/17, the supervisor and/or desireview all new admission.	, which includes Director of lity Assurance Nurse, Unit					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345006	B. WING			C 10/31/2017		
	ROVIDER OR SUPPLIER	ABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP 3724 WIRELESS DRIVE GREENSBORO, NC 27455	CODE	10.0 1.20 1.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 329	accuracy every Satuall new ordered med appropriately and acorders. Any negative promptly, and report Services.  Director of Health Saturance Nurse are Coordinator (SDC) of for all licensed nurse include full time, pair regarding medicatio orders and medicatio orders and medicatio emphasis of this education will be collicensed nurse and/deducated by 10/27/1 until educated. This on new hires orientation in the collicensed nurses and 10/27/17, and will be Effective 10/27/17, I Quality Assurance Notes and 10/27/17, I Quality	conic health record to ensure arday and Sunday to ensure dication were transcribed diministered per physician end finding will be addressed and to the Director of Health dervices (DHS), Quality addor Staff Development will complete 100% education as and medication aides, to a time and as needed staff, an administration per physician con error reporting. The acation was on the liquid ally Morphine sulfate. This impleted by 10/27/17. Any for Medication aide not 7 will not be allowed to work education will also be added attion process for all new differences.	F:	329	NCY)			
	compliance or media per physician orders Controlled Drug Rec clinical meeting, 5 ti Friday) for 2 weeks, more weeks, then w monthly x 3 months compliance is maint meeting will be docureport form and filed	cation order administration is, specifically, all morphine. iseipts will be reviewed in imes per week (Monday - then 3 time weekly for 2 eekly for 4 weeks then or until the pattern of ained. Findings from this imented on a daily clinical in clinical meeting binder in office after proper follow ups						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345006	B. WING		C 10/31/2017
	ROVIDER OR SUPPLIER	HABILITATION CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1724 WIRELESS DRIVE GREENSBORO, NC 27455	10.012017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 329	daily clinical report forms daily (M-F) for weeks, then month pattern of compliar Effective 10/27/17, findings of this mor Quality Assurance Improvement Commonitoring or modi 3 months, or until the maintained. The Quality and the Director of ultimately responsi of credible allegation immediate jeopard. Validation of the credible of	will review the completion of and daily clinical checklist or 2weeks, weekly x 2 more ly x 3 months or until the ace is maintained.  Director of Nursing will report nitoring process to the facility and Performance mittee for any additional fication of this plan monthly for the pattern of compliance is API committee can modify this facility removal of the alleged y.  the center Executive Director Health services will be ble to ensure implementation on to remove this alleged y.	F 329		
	administrator initiat she became aware administrator interview the error occu education on how the error. Interview with did receive education administrator. A windicating that the a Nurse #2 on 10/29 indicated that the research in the same and the same according to the same according	ed an investigation as soon as of the medication error. The viewed Nurse #1 to determine the nurse who avoid future medication with Nurse #1 validated that she con and counselling from the ritten statement was reviewed administrator interviewed with 17 at 4:30 pm. The statement was showing signs and and was not showing signs of			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345006	B. WING			C 10/31/2017	
	ROVIDER OR SUPPLIER	BILITATION CENTER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE REENSBORO, NC 27455		J. 1.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 329 F 333 SS=J	the 5 ml of morphine Receipts was accurated a medication discrepation of the facility provided of medication orders and about medication error.  Staff were interviewed received education or notifying the physicial Resident who received for medication error.  RESIDENTS FREE CERRORS  CFR(s): 483.45(f)(2)  483.45(f) Medication  The facility must ensure from the facility must ensure from the facility must ensure from the medication errors.  This REQUIREMENT by:  Based on record reviewed the medical director apharmacy services, the correct dose of medication) per physical from the facility must ensure fr	ny Nurse #2 did not think that on the Controlled Drug e. The facility has filled out ancy report.  evidence of audits of dinservices provided to staff or and physician notification.  did to validate that they medication error and m.  ed morphine were reviewed  DF SIGNIFICANT MED  Errors.		3333	The creation and submission of this plant of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to		11/1/17
	was prescribed by the medication error. Thi	e physician and a significant s was evident in 1 (Resident eiving narcotic medications.			continue to provide a quality of life for considerts.  The processes that lead to the deficien		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					(	
		345006	B. WING		10/	31/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			;	3724 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER	GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page	e 34	F 333	3		
F 333	Immediate jeopardy by Resident #1 received dose of morphine. The removed on 10/30/17 an acceptable credible facility will remain out and severity of no act of no more than mining immediate jeopardy (process of full correct Findings included: Resident #1 was admediate fibrillation, implantable falls, diabetes and attack behaviors, and essent Review of the resident Set (MDS) of 9/11/17 for Mental Status scoresident was severely MDS indicated the repain medication regin the look behind period MDS.  A Care plan was initiate the resident's risk for to osteoarthritis. The verbalize or show nor moaning etc.) relief or after administering of next review. The interior output acceptable in the interior of the interior	pegan on 10/25/17 when 20 times the prescribed ne immediate jeopardy was when the facility provided le allegation of removal. The cof compliance at a scope that harm with the potential mal harm that is not D). The facility was in the tive action at that time.  Interest of the facility on the diagnoses included atrial e cardiac fibrillator, repeated exic gait, dementia without whital hypertension.  Int's annual Minimum Data revealed the Brief Interview re was 7 which indicated the cognitively impaired. The sident received a scheduled nen in the last 5 days during d. Pain did not trigger on the lated on 9/19/17 to address alteration in comfort related goal was the resident will neverbal (no grimacing, no final 45 minutes to an hour medications through the reventions included to	F 333	On 10/25/2017, Licensed Nurse #1 administered 5ml of Morphine Sulfate 100mg instead of 0.25mL (5mg) as ordered by physician to resident #6677 No adverse effects were noted in relatite to this medication error. Resident #667 had a terminal diagnosis, and elected the receive Hospice services, with the life expectancy of six months or less. On 10/29/2017 at approximately 4:30pt the Licensed Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/2017 (1am and 5am) to resident #6677 was interviewed by the Administrator. She revealed that during her shift on 10/26/2017, resident #6677 showed signs and symptoms of pain and she administered 0.25mL of Morphine physician order. She started, she notice 5ml was documented on the Controlled Drug Receipt form for resident #6677 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because resident #6677 was still moaning with pand showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicate resident #6677 did not show any signs change in condition to warrant contactifute physician. Unit Coordinator #1 attempted to contact licensed nurse #2 with no response on 10/26/2017 at	on 7 o m, ed he g 7 nd per ed d tot or ng	
	position, back rub etc resident to report any duration, intensity and	ing care (i.e. change in c.) as needed, encourage pain (noting location, d severity), give medication for effectiveness of pain		9:30AM. Director of Health Services attempted to contact nurse #2 on 10/30/2017 at 5:52PM, and no respons Licensed Nurse #2 will not be allowed work until re-educated on physician		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDII	_			c l
		345006	B. WING _				) 31/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	01/2017
				3	724 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REI	HABILITATION CENTER		G	GREENSBORO, NC 27455		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 333	Continued From pa	age 35	F 3	333			
	medications for the	e control of pain, handle gently			notification requirements.		
	and try to eliminate	e any environmental stimuli,			On 10/26/2017, resident #6677 was		
		ess fears and concerns,			moaning with pain at 1am and 5am;		
		erbal signs of pain (i.e.			Licensed Nurse #2 administered		
		g, moaning, restlessness,			Morphine 0.25mL per Physician order.		
		/ Medical Doctor as needed,			Nurse #2 recognized the previous shift		
	and conduct pain a	assessment routinely.			documented Morphine 5mL instead of		
					0.25mL. Licensed nurse #2 did not have		
		dent's Departmental Notes			the ability to contact Licensed nurse #		
	revealed on 10/23/17, the resident started hospice services.				verify whether Morphine 5mL documer on the Controlled Drug receipt form was		
	nospice services.				administered to resident #6677 or not.		
	Review of the Phys	sician's Telephone Orders			Licensed nurse #2, no signs or sympto		
		an order dated 10/24/17 to			of distress noted during the night for	1113	
		outh) meds (medications) and			resident #6677.		
		phine 20 mg (milligram)/ml			The attending Physician was notified		
		ng Q (every) 8 hrs (hours) SL			about this medication error on 10/26/20	017	
		ely for pain/SOB (shortness of			at 3:30Pm, this was done within 24 ho	urs.	
	breath). Give 5 mg	g SL Q 2hrs prn (as needed)			At 11pm on 10/25/2017 controlled drug	js	
	SOB/pain."				receipt for resident #6677 indicated the	Э	
					remaining quantity of Morphine Sulfate	<b>;</b>	
		nt #1's "Controlled Drug			was 24.5mL. This amount matched the		
		sposition Form" revealed			amount of Morphine sulfate remaining	in	
		t 30 ml of Morphine 100mg/5ml			resident #6677 dispensed medication		
		ived at the facility on 10/24/17.			bottle.		
		on the "Controlled Drug			On 10/26/2017 at approximately 9:00 a		
		sposition Form" was to give the			during controlled drug reconciliation fo		
	resident 0.25 mi (5	mg) every 8 hours as needed.			resident #6677, a discrepancy was not		
	Poviou of Posidon	nt #1's "eMAR (electronic			on the Controlled Drug Receipt form by the facility Administrator. The control	у	
		stration record) -Medication			sheet indicated resident received 5ml (	of	
		onth of October, 2017 revealed			Morphine sulfate instead of 0.25ml of	J1	
		on" of the order on the left side			Morphine as ordered by the Physician.		
		ad as "Morphine 20mg/ml oral			On 10/26/2017 at approximately 3:00p		
		g every 8 hours sublingual for			the Licensed Nurse #1, who administe		
		e row of the order, on the right			the stated medication to resident #667		
	•	and under the column of			was interviewed by the Administrator.		
		ere a check mark and the			revealed that during the medication		
		cation aide indicating the			administration on the previous day, she	е	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING _			1	C /31/2017
NAME OF P	ROVIDER OR SUPPLIER		<del>                                     </del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	31/2017
TO UNIC OF T	TO VIDER OR OUT FEET				724 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER			GREENSBORO, NC 27455		
()(1) ID	CLIMMADV C	FATEMENT OF DEFICIENCIES	I		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From pag	e 36	F3	333			
	resident was adminis	stered morphine at 6:00 AM			noted medication order change for		
	and, again, 2 PM on	•			resident #6677. She verified the writter	n	
	-				order in resident□s record and read it	as	
	Review of the "Contr	olled Drug			5ml instead of 5mg.		
		osition Form" revealed			The Administrator explained and		
		0.25 ml (5 mg) of morphine			demonstrated to Licensed Nurse #1 wl	hat	
	_	sident and 29.75 ml of			was supposed to be administered		
	morphine were left in the bottle at 6 AM on				compared to what she signed for on th		
		.25 ml of morphine were			Controlled Drug Receipt form. License		
		n to the resident and 29.50			Nurse #1 acknowledged that an incorre	€Ct	
	ml of morphine were left in the bottle at 2 PM on 10/25/17.				amount of Morphine Sulfate had been administered. Based on the interview		
	10/23/17.				conducted by the Administrator and the	_	
	Review of the Physic	cian's Telephone Order			record review of all controlled medicati		
		order dated 10/25/17 at 4:40			administered by Licensed Nurse #1, it		
		irrent morphine order and to			concluded that this error resulted from		
		ıg/ml. Give 5 mg PO/SL Q 4			honest oversight. Licensed nurse#1		
	h (hour) scheduled a	nd Q 2 hr (hour) prn (for)			misread the order, and misinterpreted	of	
	pain/SOB."				Morphine 5mg as Morphine 5mL.		
					Licensed Nurse #1 was re-educated a	nd	
		#1's "eMAR-Medication			counseled by the Director of Health		
		th of October, 2017 revealed			Services and the Administrator on		
		left side of the page read as			10/27/2017. Medication administration		
		oral syringe, Give 5 mg			competency and morphine dosage		
		ours as needed for shortness ne same row as the order, on			calculation education was provided to Licensed Nurse #1 by the Director of		
	·	page, and under the column			Health Services on 10/27/2017.		
		ere a check mark and the			Treatiti Services on 10/27/2017.		
	initials of Nurse #1 in				Procedure for implementing the		
		ne at 8:14 PM on 10/25/17.			acceptable plan of correction for the		
					specific deficiency cited:		
	Review of the "Contr	olled Drug			, , , , , , , , , , , , , , , , , , , ,		
		osition Form" revealed			100% audit of all active residents		
		5 ml of morphine were given			controlled medications was completed	on	
		4.50 ml of morphine were left			10/27/2017 by Director of Health Servi		
		on 10/25/17. The resident			to identify any other resident with an or		
	• ,	nl) of morphine instead of 5			for a controlled medication (Schedule I		
		1 on 10/25/17. This resident			V) that was transcribed incorrectly and		
	received 20 times me	ore morphine than prescribed			not administered per physician order.	<del>1</del>	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345006	B. WING		1	C / <b>31/2017</b>		
NAME OF PI	ROVIDER OR SUPPLIER	1 1111		STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	131/2017		
				3724 WIRELESS DRIVE				
BLUMENT	THAL NURSING & REHA	ABILITATION CENTER		GREENSBORO, NC 27455				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 333	Continued From pag	ge 37	F 33	3				
	Record" for the mona typed order on the read as "Morphine 2 every 4 hours sublin dosage specified on of the order, on the under the column of mark and the initials #2 administered mo AM on 10/26/17.  Review of the "Cont Receipt/Record/Disp documentation that given to the residen were left in the bottle was also documentation were given to the remorphine were left in 10/26/17.  Review of the residentation were left in the bottle was also documentation that given to the remorphine were left in 10/26/17.	#1's "eMAR-Medication th of October, 2017 revealed eleft side of the page that comg/ml oral syringe, Give gual for pain." There was no this order. On the same row right side of the page, and 10/26/17, there were a check of Nurse #2 indicating Nurse rphine at 1:00 AM and 5:00  rolled Drug position Form" revealed 0.25 ml of morphine were at and 24.25 ml of morphine e at 1 AM on 10/26/17. There eation that 0.25 ml of morphine sident and 24.00 ml of the bottle at 5 AM on ent's Departmental Notes aled the Resident died at		written orders for controlled med were verified for accuracy in ele health records and on the electric medication administration record other written Controlled medication orders will be with the specificity of the amount to be administered based on concentration; for example an ormorphine 5mg, in a 20mg/ml so direction on the order entered in Medication administration recording include give 0.25ml as part of orinstruction instead of give 5Mg. mitigate errors in medication administration. All Licensed nursum Medication aides were educated new process on 10/26/2017 and 10/27/2017 by the Director of He Services (DHS), Quality Assurational Controlled	ctronic conic d. No cion order ag forward, be written at of liquid rder for lution, the a electronic d will rder This will ses and d of this d ealth nce Nurse			
	9:10 AM.  An interview with Nurse #1 was conducted on 10/29/17 at 5:30 PM. She worked with the resident on 10/25/17 at the 3-11 shift. The nurse gave the resident a morphine dose around 8 PM on 10/25/17. At around 10:45 PM, the resident "was sleeping" and her breathing was slow. The nurse listened to her heart and checked her pulse and repositioned her. The nurse gave report at 11-11:15 PM. Nurse #1 told the incoming nurse (Nurse #4) about the resident's slow breathing and the nurse said that was normal for the resident when she got morphine. Nurse #1 left			Effective 10/27/2017 any Liquid medication ordered and written physician will be transcribed in r Electronic Administration record the amount of liquid to be admir licensed nurses on duty.  Effective 10/27/2017, Director o Services, Quality Assurance Nu Coordinator and/or Staff Develo Coordinator will review all new medication and treatment orders prior day (M-F), by comparing n	resident s to reflect nistered by  f Health rse, Unit pment s from			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(	
		345006	B. WING			10/	31/2017
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER	3724 WIRELESS DRIVE GREENSBORO, NC 27455				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			COMPLETION DATE	
F 333	Continued From page	e 38	F	333			
		. The next day, Nurse #1			telephone orders and written orders to		
		3 PM and was told that the			orders transcribed in electronic health		
	_	/. The administrator told			record to ensure accuracy. This proces	s	
		ve Resident #1 5 ml (100			will be incorporated in the facility daily		
	mg) of morphine inste	ead of 0.25 ml (5 mg).			Clinical rounds. Any medication not		
	When asked what cor	ntributed to the error, Nurse			transcribed correctly will be corrected		
	# 1 said she read the	physician order wrong.			promptly and findings reported to the		
		ministrator educated her			Director of Health Services. Findings from		
		or and gave her print out on			this process will be maintained in the D	aily	
	how to avoid medicat	ion error on 10/27/17.			Clinical round binder located in the		
	A			Director of Health Services office.			
		ducted with Nurse #2 on			Effective 10/27/2017, the content clinical		
	Resident #1 on the 1	Nurse #2 provided care to			Effective 10/27/2017, the center clinica interdisciplinary team, which includes		
		She said she gave the			Director of Health Services, Quality		
		ed dose of morphine of 5 mg			Assurance Nurse, Unit Coordinator and	l/or	
		6/17. Then she went to the			Staff Development Coordinator, initiate		
		eipt Record to record the			process for reviewing all new	<b>.</b> .	
		ion to the resident and			admission/re-admissions Monday throu	ıgh	
		n that the resident received			Friday to ensure all ordered medication	-	
	5 ml (100 mg) instead	d of 0.25 ml (5 mg) at 8 PM.			were transcribed appropriately and		
	Nurse #2 said the am	ount of morphine in the			administered per physician orders. Any	,	
	bottle matched the do				negative finding will be addressed		
	-	Controlled Drug Receipt			promptly.		
		ought there was no way the					
		5 ml of morphine since the			Effective 10/27/2017, the center , week		
		ning when Nurse #2 went to			end RN supervisor and/or designated		
	resident the schedule	Nurse #2 said she gave the			licensed nurse will review all new		
		d again at 5 AM. Nurse #2			admission/re-admissions by comparing new written telephone orders to orders		
	said she left the facilit	<del>-</del>			transcribed in electronic health record t		
	55.5 5115 1511 till 1401111	.,			ensure accuracy every Saturday &	-	
	Nurse #2 was intervie	ewed again via telephone on			Sunday to ensure all new ordered		
		The nurse said she did not			medication were transcribed appropriat	ely	
		se the resident was still			and administered per physician orders.		
	moaning, so she doul	bted that the resident got 5			Any negative finding will be addressed		
	ml of morphine.				promptly, and reported to the Director of Health Services.	of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C 10/31/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	131/2017	
					724 WIRELESS DRIVE			
BLUMENT	THAL NURSING & REH	ABILITATION CENTER			REENSBORO, NC 27455			
	I							
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
F 333	Continued From page	ge 39	F:	333				
		B PM, an interview was	, ,					
		se #3. Nurse #3 said she			Monitoring procedure and education to ensure plan of correction is effective at			
		Resident #1. Nurse #3 said on			that specific deficiency cited remains	iu		
		:05 PM to 11:10 PM, she did a			corrected and/or in compliance with			
		se #1 and the count on the			regulatory compliance:			
	-	ceipt Record matched the			regulatory compliance.			
		cation bottle for Resident #1.			Effective 10/27/2017, Director of Healt	h		
		did not look at the Controlled			Services, Quality Assurance Nurse, Ur			
		ds during the drug count			Coordinator and/or Staff Development			
		ot supposed to. Nurse #3 said			Coordinator will monitor compliance or			
		lurse #2 came to her and told			medication order administration per			
		tion on the Controlled Drug			physician orders, specifically, all morpl	nine		
		ated Resident #1 got 5 ml			Controlled Drug Receipts will be review			
		norphine at 8 PM. Nurse #3			in clinical meeting, 5 times per week tii			
	_	"surely to God, she did not			(Monday □ Friday) for 2 weeks, then 3			
		e #3 said she did not give			time weekly for 2 more weeks, then			
		ion on what she should do.			weekly for 4 weeks then monthly x 3			
	· ·	vould let Unit Coordinator #1			months or until the pattern of complian	ce		
	know in the morning	g. Nurse #3 said if this			is maintained. Findings from this meet			
	_	d she gave a resident an			will be documented on a daily clinical	•		
	incorrect dose, Nurs	se #3 would let her supervisor			report form and filed in clinical meeting	J		
		If there was no supervisor in			binder in Director of Nursing office after	r		
	the facility she woul	d call the doctor.			proper follow ups are done.			
		onducted with the Unit			Executive Director will review the			
		0/30/17 at 9:29 AM. She			completion of daily clinical report, and			
	1	7 AM -3 PM shift. She said			daily clinical checklist forms daily (M-F	) for		
		er about 8 or 8:30 AM on			2weeks, weekly x 2 more weeks, then			
		he (Nurse #2) did not know if			monthly x 3 months or until the pattern	of		
	1	ne dose was given correctly.			compliance is maintained.			
		looked at the Controlled Drug						
	1	I the morphine bottle. The			Effective 10/27/2017, Director of Nursi	ng		
		hine bottle matched what was			will report findings of this monitoring			
		on the Controlled Drug			process to the facility Quality Assurance	æ		
	1	en she told the administrator.			and Performance Improvement	.~		
		did look at the resident and			Committee for any additional monitoring			
		oving some and she was not			or modification of this plan monthly for			
	_	rdinator #1 stated, when she			months, or until the pattern of complian			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45000	D WING					
		345006	B. WING			10/	31/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RLUMENT	HAL NURSING & REHA	ARII ITATION CENTER		37	724 WIRELESS DRIVE			
DECIMIENT	TIAL NORSING & INLIN	CENTER CENTER		G	REENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 333	Continued From pag	e 40	F:	333				
	prescribed dose of m	norphine, then she would			modify this plan to ensure the facility			
	assess the resident	•			remove the alleged immediate jeopard	٧.		
		an order for Narcan.			, ,	,		
	, ,				Director of Health Services (DHS), Qua	ality		
	An interview was cor	nducted with the physician on			Assurance Nurse and/or Staff	-		
	10/30/17 at 10:32 AM	M via telephone. He said he			Development Coordinator (SDC) will			
	was familiar with Res	sident #1 situation. He said			complete 100% education for all licens	ed		
	that adverse effect o	f a morphine overdose would			nurses and medication aides, to includ	е		
		st 60 minutes to two hours			full time, part time and as needed staff	,		
	after administration of	of the overdose. His			regarding medication administration pe	r		
		physician would be notified			physician orders and medication error			
	immediately when a medication error occurred.				reporting, including if there is any			
		sing staff to monitor vital			evidence or concern of a medication el			
	signs, may be every				the MD will be notified immediately and	t l		
	_	c clinical status. However,			patient assessed accordingly. The			
		(Nurse #1) did not become			emphasis of this education was on the			
		efore the end of her shift at 11			liquid medication specifically Morphine			
	PM, he stated "we m				sulfate. This education completed			
		oring and preventing harm (if			10/27/2017. Any licensed nurse and/or	'		
		ice the harm would have			Medication aide not educated by			
		first two hours after the			10/27/2017 will not be allowed to work			
		s notified when Nurse #2			until educated. This education will also			
		around 1 AM, the physician			added on new hires orientation proces	5		
	_	n the resident Narcan right			for all new Licensed nurses and			
		as having breathing problems. se would check the resident's			Medication aides effective 10/27/2017, and will be provided annually.			
		ss and sedation. The			and will be provided annually.			
		the did not see any problem			Title of person responsible for			
		e #2) giving the resident the			implementing the acceptable plan of			
	,	doses at 1 AM and 5 AM,			correction:			
		became aware that the			correction.			
		times more morphine than			Effective 10/31/17, the center Executiv	e		
		sician thought the resident			Director and the Director of Health	-		
		orphine that was why she did			services will be ultimately responsible	to		
		overdose symptoms. The			ensure implementation of acceptable p			
		nk the morphine overdose			of correction to ensure regulatory			
	hastened the resider		compliance.		ĺ			
		PM, an interview was			Compliance date: 11/1/2017	ĺ		
		lirector of clinical pharmacy						

PRINTED: 12/07/2017 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
				С			
	345006	B. WING _		1	0/31/2017		
NAME OF PROVIDER OR SUPPLIER  BLUMENTHAL NURSING & REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3724 WIRELESS DRIVE GREENSBORO, NC 27455	E			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
is delivered to the far Receipt Record form resident's name, phorogen dose (with the number administered so numer math) and frequency nurse needed to adwould come up on the should compare the computer with the descript Record to me would measure the and administer it and Drug Receipt Record how much was left in director stated the more to fill up the 1 ml sylund administer 5 ml to Fill up the 1 ml sylund admi	or stated the morphine order acility with a Controlled Drug in that would have the sysician name, the name of the sysician name, the order of military and the nurse of administration. When a minister morphine, the order the computer and the nurse morphine dose on the ose on the Controlled Drug nake sure it matched. Nurses morphine with a 1 ml syringe document on the Controlled of the morphine bottle. The surse (Nurse #1) would have ringe with morphine 5 times to desident #1.  PM, an interview was corporate nurse consultant, do not assess the resident that the resident received an orphine on 10/25/17. The only nof the resident's condition one incorrect dose of morphine with Nurse #2 by the facility sy. There was no e medical record by Nurse #2 is moaning during the 11 PM-7	F3	33				

The administrator was notified of immediate

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(.	(X3) DATE SURVEY COMPLETED		
		345006	B. WING _			C 10/31/2017		
	ROVIDER OR SUPPLIER  THAL NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 3724 WIRELESS DRIVE GREENSBORO, NC 27455	P CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE		
F 333	Continued From pag		F3	333				
	provided the followin	7 at 1 PM. The facility g acceptable allegation of diate jeopardy on 10/31/17 at						
	Morphine Sulfate 100 as ordered by physic adverse effects were medication error. Re diagnosis, and elected	#1 administered 5ml of Omg instead of 0.25mL (5mg) sian to Resident #1. No noted in relation to this sident #1 had a terminal ed to receive Hospice expectancy of six months or						
	who administered tw during the night on 1 Resident #1 was inte She revealed that du Resident #1 showed and she administered physician order. She documented on the 0 for Resident #1 at 1at the Morphine she ad 5ml was administered still moaning with pain of medication overdous as documentation er Resident #1 did not condition to warrant of Coordinator #1 attern with no response on of Health Services at on 10/30/17 at 5:52F #2 will not be allowed physician notification	oximately 4:30pm, Nurse #2 o doses of Morphine Sulfate 0/26/17 (1am and 5am) to erviewed by the Administrator. Iring her shift on 10/26/17, signs and symptoms of pain d 0.25mL of Morphine per stated, she noticed 5ml was Controlled Drug Receipt form am when she was signing for ministered. She did not think d because Resident #1 was in and showed no symptoms bee. She interpreted the entry ror. She also indicated show any signs or change in contacting the physician. Unit repted to contact Nurse #2 10/26/17 at 9:30AM. Director tempted to contact Nurse #2 PM, and no response. Nurse d to work until re-educated on requirements. Int #1 was moaning with pain						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345006	B. WING _			C 10/31/2017	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 3724 WIRELESS DRIVE GREENSBORO, NC 27455		10/01/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 333	Continued From page	ge 43	F	333			
	Morphine 0.25mL per recognized the previous Morphine 5mL instead not have the ability to whether Morphine 5 Controlled Drug recognered Resident #1 or not. I symptoms of distress Resident #1.  Although Resident #1 assertion that the resident #1.	urse #2 administered er Physician order. Nurse #2 ous shift documented ad of 0.25mL. Nurse #2 did o contact Nurse #1 to verify mL documented on the eipt form was administered to Per Nurse #2, no signs or s noted during the night for e1 died on 10/26/17, it is our sident's death was a result of and not from the medication					
	error approximately assertion is based o Morphine Sulfate Pr " 30% of orally ac typically absorbed " Has a half-life o " Peak time of 60 " Duration of 4-6	thirteen hours prior. Our n the following facts; larmacokinetics indicate: dministered medication is f 2-4 hours minutes					
	medication error on done within 24 hours controlled drugs reco the remaining quant 24.5mL. This amour	10/26/17 at 3:30PM, this was s. At 11pm on 10/25/17 eipt for Resident #1 indicated ity of Morphine Sulfate was at matched the amount of naining in Resident #1's					
	controlled drug reco discrepancy was not Receipt form by the control sheet indicat Morphine sulfate ins as ordered by the Pl	oximately 9:00 am, during a nciliation for Resident #1, a ted on the Controlled Drug facility Administrator. The ed resident received 5ml of tead of 0.25ml of Morphine mysician.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345006	B. WING _			C 10/31/2017	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455		10/01/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 333	Resident #1 was into She revealed that duadministration on the medication order chaverified the written oread it as 5ml instead The Administrator ex Nurse #1 what was scompared to what she Controlled Drug Recacknowledged that a Morphine Sulfate has on the interview contand the record review medications administ concluded that this expression on the interview medications administ concluded that this expression. Nurse #1 misinterpreted Morph Nurse #1 was re-edual Director of Health Secon 10/2717. Medicate competency and moeducation was provided Director of Health Secon 100% audit of all actions.	e stated medication to erviewed by the Administrator.  Iring the medication erprevious day, she noted ange for Resident #1. She reder in resident's record and dof 5mg.  Iplained and demonstrated to supposed to be administered are signed for on the eipt form. Nurse #1 an incorrect amount of do been administered. Based ducted by the Administrator of all controlled attered by Nurse #1, it was arror resulted from an honest amisread the order, and anine 5mg as Morphine 5mL. Incated and counseled by the ervices and the Administrator ion administration rephine dosage calculation ded to Nurse #1 by the	F3	333			
	Director of Health Se resident with an order (Schedule II - V) that and/or not administe written orders for converified for accuracy and on the electronic record. No other writt order were noted with the resident of the second	ervices to identify any other er for a controlled medication a was transcribed incorrectly red per physician order. All introlled medications were in electronic health records a medication administration ten Controlled medication h any discrepancy.					

NAME OF PROVIDER OR SUPPLIER  BLUMENTHAL NURSING & REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 333  Continued From page 45 specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include "give 0.25ml" as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication administration. All Licensed nurses and Medication administration will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administration records to reflect the amount of liquid to be administration records to reflect the amount of liquid to be administration records to reflect the amount of liquid to be administrated by licensed nurses and Medication administration records to reflect the amount of liquid to be administered by licensed nurses on duty.  Effective 10/27/17, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED			
DEFICIENCY)  NAME OF PROVIDER OR SUPPLIER  BLUMENTHAL NURSING & REHABILITATION CENTER  (A4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FROM JOB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FROM SPECIAL TAG  Continued From page 45  specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include "give 0.25ml" as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication aides were notified of this new process on 10/26/17 and 10/27/17 by an education conducted by the Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC).  Effective 10/27/17 any liquid medication ordered and written by the physician will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administered by licensed nurses on duty.  Effective 10/27/17, Director of Health Services,			345006	B. WING	NG				
FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 333  Continued From page 45 specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include "give 0.25ml" as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication administration. All Licensed nurses and Medication advises were notified of this new process on 10/26/17 and 10/27/17 by an education conducted by the Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC).  Effective 10/27/17 any liquid medication ordered and written by the physician will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administered by licensed nurses on duty.  Effective 10/27/17, Director of Health Services,			BILITATION CENTER		372	4 WIRELESS DRIVE	1 10/	31/2017	
specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include "give 0.25ml" as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication aides were notified of this new process on 10/26/17 and 10/27/17 by an education conducted by the Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC).  Effective 10/27/17 any liquid medication ordered and written by the physician will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administered by licensed nurses on duty.  Effective 10/27/17, Director of Health Services,	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	COMPLETION	
Staff Development Coordinator will review all new medication and treatment orders from prior day (M-F), by comparing new written telephone orders to orders transcribed in electronic health record to ensure accuracy. This process will be incorporated in the facility daily Clinical rounds.  Any medication not transcribed correctly will be corrected promptly and findings reported to the Director of Health Services. Findings from this process will be maintained in the Daily Clinical round binder located in the Director of Health Services office.  Effective 10/27/17, the center clinical interdisciplinary team, which includes Director of Health Services, Quality Assurance Nurse, Unit	F 333	specificity of the amo administered based of example an order for 20mg/ml solution, the entered in electronic record will include "gi instruction instead of errors in medication and nurses and Medication new process on 10/2 education conducted Services (DHS), Quastaff Development Composition of licensed nurses on discensed in the fath of the process will be maint round binder located Services office.  Effective 10/27/17, the interdisciplinary teams	unt of liquid to be on concentration; for morphine 5mg, in a direction on the order Medication administration ive 0.25ml" as part of order give 5Mg. This will mitigate administration. All Licensed on aides were notified of this 6/17 and 10/27/17 by an by the Director of Health lity Assurance Nurse and/or coordinator (SDC).  Ty liquid medication ordered ysician will be transcribed in dministration records to liquid to be administered by uty.  The coordinator will review all new ment orders from prior day new written telephone scribed in electronic health caracy. This process will be not findings reported to the rvices. Findings from this ained in the Daily Clinical in the Director of Health erector of Health which includes Director of the content of the process	F	333				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345006	B. WING			C <b>10/31/2017</b>		
	ROVIDER OR SUPPLIER  HAL NURSING & REHA	BILITATION CENTER		3724	EET ADDRESS, CITY, STATE, ZIP CODE 4 WIRELESS DRIVE EENSBORO, NC 27455	1 10	0112011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 333	new admission/re-ad Friday to ensure all of transcribed appropria physician orders. An addressed promptly.  Effective 10/27/17, the supervisor and/or dereview all new admission comparing new writte transcribed in electron accuracy every Saturall new ordered media appropriately and addorders. Any negative promptly, and reported Services.  Director of Health Services.  Director of Health Services.  Director of Health Services and Coordinator (SDC) with for all licensed nurse include full time, particely and medication orders and medication orders and medication orders and medication specifical education will be conflicensed nurse and/of educated by 10/27/1 until educated. This connew hires oriental	la process for reviewing all limissions Monday through ordered medication were ately and administered per y negative finding will be the center's week end RN signated licensed nurse will sion/re-admissions by the telephone orders to orders onic health record to ensure orday and Sunday to en	F	333				
	Quality Assurance N	Director of Health Services, urse, Unit Coordinator and/or coordinator will monitor						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345006	B. WING _			C <b>10/31/2017</b>			
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3724 WIRELESS DRIVE  GREENSBORO, NC 27455			10/3//2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 333	per physician orders, Controlled Drug Recolinical meeting, 5 tin Friday) for 2 weeks, 1 more weeks, then we monthly x 3 months of compliance is maintal meeting will be docurreport form and filed Director of Nursing of are done.  Executive Director will daily clinical report, a forms daily (M-F) for weeks, then monthly pattern of compliance Effective 10/27/17, Difindings of this monitor Quality Assurance and Improvement Commitmonitoring or modified 3 months, or until the maintained. The QAF plan to ensure the fair immediate jeopardy.  Effective 10/30/17, the and the Director of Hultimately responsible of credible allegation immediate jeopardy.  Validation of the creditor of the	ation order administration specifically, all morphine. Seipts will be reviewed in nes per week (Monday - hen 3 time weekly for 2 sekly for 4 weeks then or until the pattern of ined. Findings from this mented on a daily clinical in clinical meeting binder in ffice after proper follow ups  Il review the completion of nd daily clinical checklist 2 weeks, weekly x 2 more x 3 months or until the e is maintained.  Sirector of Nursing will report oring process to the facility and Performance tree for any additional ation of this plan monthly for pattern of compliance is PI committee can modify this cility removal of the alleged  The e center Executive Director ealth services will be to ensure implementation to remove this alleged  The individual content is alleged  The individual content is alleged  The individual content is the individual content is alleged  The individual content is alleged	F	33					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING				C <b>10/31/2017</b>
NAME OF PROVIDER OR SUPPLIER  BLUMENTHAL NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  3724 WIRELESS DRIVE  GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	HOULD BE COMPLETION	
F 333	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	333			