PRINTED: 03/26/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		345391	B. WING _		C <b>02/16/2019</b>
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401	1 02/10/2013
(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 CORRECTION ( (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENTS	3	F 0	00	
F 600 SS=K	through 2/16/19. Im identified at: CFR 483.12 at tag F K CFR 483.25 at tag F CFR 483.45 at F760 The tags F600, F688 Substandard Quality citations were identifications were identifications were identifications a scope and severity CFR 483.70 for Tags and severity of E.  Immediate Jeopardy 11/5/18 and was rer Immediate Jeopardy and was removed or survey was conducted 3/19/19, the 2567 was disclaimers in the creation in the creation of the commediate jeopardy and F760. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropriand exploitation as dincludes but is not lir corporal punishment.	for F689 began on 2/7/19 in 2/14/19. A partial extended ed.  as amended to remove the edible allegation of removal in tags F600, F689 in Neglect	F6	00	3/12/19
ABORATORY	LECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed 03/11/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345391	B. WING		0.5	C 2/16/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2013
				1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		GREENSBORO, NC 27401		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 1	F 60	00		
	treat the resident's m	edical symptoms.				
	§483.12(a) The facilit	y must-				
	physical abuse, corporinvoluntary seclusion This REQUIREMENT by: Based on observation and physician intervier facility record reviews meet a resident 's car and administer an an to treat cancer (lenality of 3 residents (Resident were reviewed. Resident on 10/12/18 that her progression of her me Lenalidomide was or 10/30/18 from a spect to the facility by Resident The medication was secart (unopened) and	is not met as evidenced ins, resident 's family, staff ews, and oncologist and is, the facility neglected to ire needs by failing to initiate tineoplastic medication used domide) as prescribed for 1 ent #4) whose medications dent #4 's Oncologist noted lab results reflected a jultiple myeloma. dered by the oncologist on isialty pharmacy, and brought dent #4 's family on 11/5/18. stored on the hall medication not administered until		Address how corrective action waccomplished for those residents have been affected by the deficie practice  The resident identified as Reside was seen by the oncologist on 10 and Revlimid (Lenolidomide) 5 m (mg) -take one tab by mouth daily added to the medication list. On 1/10/19, it was discovered that resident had not received Revlim (Lenolidomide) was initially order 10/12/18 appointment. The DNS that the medication was on the cattern of the second of the	ent #4 0/12/2018 hilligrams y was eat hid red at the 6 verified art on	
	conducted on 2/14/19 had been administere Failure to administer prescribed to treat the	e progression of myeloma		1/10/19 and the medication aides documented medication as given 1/10/19-1/31/19 and 2/7/19 to 2/2 however, 22 pills were in the cart morning of 2/14/19 when the sur	n from 14/19; t on the	
	may have delayed the treatment.	e resident 's response to the		counted the medication with the medication aide. The oncologist been notified by the DNS on 2/15		
	lenalidomide was ava administration to Res her oncologist, but the administer the medical Immediate Jeopardy			the discovery of 22 pills and throuverbal communication with the or office (2/15/19) at 12:45pm the obeen rewritten to the following, b 21-day cycle today at 1PM, and tocycle. After the 7-day rest period the next 28-day cycle with nurse	ugh ncologist rder has egin a finish this	

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		345391	B. WING		C 02/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER		_ <b>'</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0=:10:=010	
				1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H		GREENSBORO, NC 27401		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		
F 600	Continued From pag	ne 2	F 600			
	allegation of Immedi	ate Jeopardy removal. The		administration verifying daily dose give	ven en	
	facility remains out o	of compliance at a scope and		The ordered dose was given today at	: 1PM	
		actual harm with potential		and will continue daily at 1PM X 20 d	ays	
		al harm that is not immediate		(ending on 3/7/19)		
	jeopardy) for the fac			The oncologist further stated that the		
		e monitoring systems put into		was no physical harm done in missin	g the	
	place are effective.			ordered doses.		
	The findings include	d:		The morning of 2/15/19, the facility suspended both medication aides wh	0	
	Resident #4 was adı	mitted to the facility on		had access to the medication cart fro		
		to the facility on 2/21/18.		2/14/19 to 2/15/19. The Executive		
	_	nosis included multiple		Director has also completed an initial		
	myeloma (a cancer t	hat forms in a type of white		report to the Department of Health ar	nd	
	blood cell called a pl	asma cell) not having		Human Service for misappropriation	of	
		nalignant neoplasm (tumor)		property as of 2/15/19 and police wer	e	
		f right female breast; and the bone.		notified this AM (2/15/19).		
	Secondary mangnan	theopiasm of the bone.		On 2/15/19 two licensed pharmacists		
	A review of the facilit	ty ' s October 2018 Physician		reviewed every prescription, compare		
		Resident #4 revealed her		each against the MAR to ensure the		
		d 2.5 milligrams (mg)		prescription was available and		
		as one tablet by mouth daily		medications were given. No discrepa	ncies	
	for breast cancer (in	itiated on 2/21/18).		were noted.		
		ent 's medical record		Address how the facility will identify of	ther	
	_	y Consult Progress Note		residents having the potential to be		
		e note indicated Resident #4		affected by the same deficient practic	e	
		ology office by the Nurse				
		10/12/18. The following		100% of all alert and residents able to		
		ed: multiple myeloma in		interviewed were interviewed on 2/14		
		nt neoplasm of breast, Stage		by the Social Worker and/or designed		
		part: "(Resident #4) is here		ensure their rights are being honored	and	
		y member) to discuss her n and starting her on		the resident is free from abuse and neglect. Findings were documented of	nn	
		name of Revlimid). She is		the Resident Rights Audit Tool.		
		(an antineoplastic agent		and resident riights Addit 1001.		
	used to treat multiple			On 2/15/19 two licensed pharmacists		
	administered either			reviewed every prescription, compare		

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		345391	B. WING _				C / <b>16/2019</b>
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2013
					131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H			REENSBORO, NC 27401		
0(1) 15	CLIMMADY C	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORREC			0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pag	je 3	F	600			
	intravenously) every	2 weeks and is tolerating			each against the MAR to ensure the		
		nide is an antineoplastic			prescription was available and		
		reat multiple myeloma in			medications were given. No discrepand	cies	
		mechanisms, including			were noted.		
	· ·	of myeloma cells. The plan					
		the Oncology Consult Note			Address what measures will be put into	)	
		l, "(Resident #4) will start on			place or systemic changes made to		
	lenalidomide 5 mg d	aily. (Name of oncologist)			ensure that the deficient practice will no	ot	
	has prescribed this .	She will receive bortezomib			recur		
		ting that well. I reviewed with					
	-	nber) the labs that we drew			All licensed nursing staff and medication		
	that indicated a slow progression of her myeloma.				aides was in-serviced 2/14/19 on abus	e,	
	I also gave him deta				neglect, and resident rights and the		
	lenalidomide in (resi	dent ' s) after visit summary."			implications for resident □s missing		
	A I I	1 1 11 40/40/40			scheduled medications without physici		
		nade to the 10/12/18			notification. Any staff not in-serviced by		
	Oncology Consult Pr	-			2/14/19 will be in-serviced by the Staff		
		icated he met with Resident nber. At that time, her lab			Development Coordinator/Designee before the next scheduled shift.		
		progression of the multiple			before the flext scheduled shift.		
		ssed, along with the need to			All new hires will be in-serviced on abu	180	
		ent. The oncologist noted,			neglect, and resident rights. All new	30,	
	•	ys of doing this, but I think			licensed nursing staff and medication		
	-	uld be to add lenalidomide"			aides will be made aware of the		
	•	indicated he had discussed			implications for resident⊡s missing		
		their oral chemotherapy			scheduled medications without physicia	an	
		to help obtain the medication			notification.		
	for Resident #4.	·					
					Indicate how the facility plans to monitor	or	
		t #4 ' s electronic medical			its performance to make sure that		
		ed the oncology consult			solutions are sustained		
	· •	8 was scanned into the					
	resident 's EMR at the facility on 10/16/18.  Review of Resident #4s October 2018 Physician				As a monitoring tool, the Random		
					Resident Rights Audit Tool will be		
					completed on 10% of the resident cens		
		ealed there was no order for			weekly x4 and monthly x6 by the Socia		
		ew of the resident 's October			Services Director/ designee. Findings		
		ministration Record (MAR) de was not included on the			be brought to ED (Executive Director) a negative findings will be addressed by		

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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	02/10/2019	
TO THE OT THE	TO VIDER OR OUT FEET			1131 NORTH CHURCH STREET	<i>5</i> _		
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H		GREENSBORO, NC 27401			
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F 600	Continued From pag	e 4	F 60	00			
	record of medication	s administered to Resident		ED.			
	included another On Note dated 10/30/18 Resident #4 was see 10/30/18 with the foll multiple myeloma no lytic bone lesions on damage that result fibuilding up in the boneoplasm of breast, medication list from 5 mg lenalidomide to mouth once daily.  A review of Resident record (EMR) reveal report dated 10/30/1 resident 's EMR at the	en at the oncology office on lowing issues addressed: of having achieved remission; x-ray (areas of bone rom cancerous plasma cells ne marrow); and malignant Stage 4. The resident 's the oncology notes included to be given as one capsule by #4 's electronic medical ed the oncology consult 8 was scanned into the he facility on 11/2/18.		The Medication Carts (at one will be audited by the DNS/de weekly x4 weeks, and as need monthly thereafter x 6 month needed to ensure compliance medication administration produced audit will be monitoring reside medication orders compared medication in the cart and if a medications are not present. medication not be present it wobtained as soon as possible through the facility Omnicell, back-up pharmacy. The DNS will review the resident SM miss doses, and if found a merror report will be completed nurse/med aide will receive the counseling by DNS/designeer notification to charge nurse a	esignee eded, then s, and as e with the otocol. The ents to the any Should a will be e, either pharmacy, or S/designee AR for any edication d and the one-on-one e regarding		
	a Progress Note autiliand dated 11/2/18. Amedications indicate being initiated.  Review of Resident and Physician Order Sundar for lenalidomid November 2018 Medical Record (MAR) reflecting included on the reconding administered to Resident Review of the resident and the resident resident reconding the resident resident resident resident reconding the resident r	nmary revealed there was no e. A review of the resident 's dication Administration ted lenalidomide was not rd of medications ident #4.  nt 's medical record included		of any missing medication.  Audit Compliance (Medicatio be discussed weekly by the DNS/designee during mornin administration meetings whe Assurance (QA) Committee rattend, X 4 weeks, and as no DNS/designee will bring result Medication Cart audit the fact QA meetings for committee rainput monthly X 7 months, ar All discussion will be maintain meeting minute notes. Any non-compliance will be noted corrective actions taken. Any	re the Quality members eeded. The illts of illity monthly eview and nd as needed. ned in		
	_	ress Note dated 12/20/18. Resident #4 was seen for a		corrective actions taken. Any the monitoring plan will requi			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION		SURVEY PLETED
		345391	B. WING _			1	C / <b>16/2019</b>
NAME OF PR	ROVIDER OR SUPPLIER	1 111		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	10/2019
					131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			GREENSBORO, NC 27401		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page 5 nursing facility follow up of chronic medical diagnoses. Her history of present illness (HPI)  F 600 re-inservicing by the DNS/designee and monitoring to begin again at the weekly						
	included the following	g notation, in part: "She was rapy for IgG kappa (a			audits until compliance is met.  Audit Compliance (Resident Rights Au		
	progressing slowly. Soncology 10/12/18; th	She was last seen by			Tool) will be discussed weekly by the ED/designee X 4 weeks, and as neede		
	initiated"	t visit lenalidomide was			during morning administrative meeting followed by monthly X 7 months, and a needed during facility monthly QA		
	-	r4s December 2018 Imary revealed there was no e. A review of the resident ' s			meetings. Any non-compliance will be noted and corrective actions taken. Al discussion will be maintained in meeting.		
	Record (MAR) reflect	lication Administration ted lenalidomide was not			minute notes. Any non-compliance wi noted and corrective actions taken. Ar	ıy	
	included on the recor administered to Resid				change to the monitoring plan will requere-inservicing by the DNS/designee armonitoring to begin again at the weekl	nd	
	Minimum Data Set (M	#4 's most recent quarterly I/DS) dated 1/9/19 revealed			audits until compliance is met.		
	severely impaired coo decision making. She	<u> </u>			The Executive Director is the person responsible for initiating and monitorin the stated plan. In the event the ED is available, the Director of Nursing Serv will continue the plan in ED□s absence The completion date for corrective actions.	not ices e	
	included an Oncology dated 1/10/19. This r "(Resident #4) returns	sident #4 ' s medical record y Consult Progress Note note read, in part: s today for follow-up and ogen receptor positive breast			will be 3/12/19		
	cancer as well as her accompanied by her far as the breast cand	history of multiple myeloma two (family members). As cer is concerned, she					
	receives bortezomib of this with good tolerant prescribed lenalidomi	e, with good tolerance. She every 2 weeks. She takes ace. Also on 10/30/18 we lide at 5 mg daily. Receipt of us confirmed 11/5/18 by our					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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		345391	B. WING			02/	16/2019
HEARTLA		THE MOSES H CONE MEM H		11	TREET ADDRESS, CITY, STATE, ZIP CODE  131 NORTH CHURCH STREET  REENSBORO, NC 27401		040
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	noted, however, that included on the patienthe facility. The plan of Oncology Consult Now "(Resident #4) looks no complaints. However to lab work showing pure myeloma) have been supposed to have stable the first week in Now the first week in	narmacists." The oncologist lenalidomide was not nt's list of medications from of treatment noted in the ste for Resident #4 read, clinically very stable and has ever her numbers (referring progression of the multiple going up. She was arted lenalidomide certainly ovember, but I do not find it written a request to Heartland whether the patient has edication, how much been receiving, whether she is, and whether they have ets." The oncologist also de direct line to his nurse to 's response and asked her quire at the facility as to be medication they delivered the oncologist noted, "If she enalidomide and the labs rogression, we will need to not in and move to weekly, or ching to carfilzomib (another action indicated to treat of course that she has not domide and that is what we follow-up."  M, a physician 's order was see with the oncologist 's initiate the administration of edication order instructed 5 to administered to Resident noted ally for 21 days, stop for	F	600			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345391	B. WING _			1	C <b>16/2019</b>
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	T THE MOSES H CONE MEM H		1131	EET ADDRESS, CITY, STATE, ZIP CODE  NORTH CHURCH STREET  ENSBORO, NC 27401		
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F 600	extra daily dose (22 denalidomide was addue to a transcription physician was notified noted.  On 2/13/19 at 1:00 P conducted with the onurse reported after appointment, addition by the oncologist which her multiple myeloma in for her 10/12/18 as lenalidomide would be reported while her convast reatable and collenalidomide was an dispensed from a specific process of acquiring review of Resident # oncology office was authorization for the Upon further review, records indicated the resident 's family merecalled speaking with 1/10/19 about Reside the delay in getting his She reported there we problem."  A telephone interview, how the delay in receptantially affect Residentially affect Residentiall	dated 1/31/19 revealed one days versus 21 days) of ministered to Resident #4 a error. The resident 's d; no clinical harm was  M, a telephone interview was ncologist 's nurse. The Resident #4 's September hal lab results were received ich indicated progression of a. When the resident came opointment, it was decided be initiated. The nurse ondition was not curable, it introllable. She stated	F	600			

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	345391	B. WING _			1	C 1 <b>16/2019</b>
NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT	THE MOSES H CONE MEM H		1131 NOR	DDRESS, CITY, STATE, ZIP CODE ITH CHURCH STREET BORO, NC 27401	1 02/	10/2013
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
that was not curable, would have preferred the medication) 2-3 m "It's been very difficute the problem was."  A telephone interview at 10:20 AM with a repspecialty pharmacy w's lenalidomide. During representative reported was shipped to the result/3/19; and, a seconfamily member on 2/5 lenalidomide contained.  A telephone interview at 8:20 PM with Reside During the interview, the attended the oncolon Resident #4 on 10/12/16 by the oncologist's onew medication (lenal obtained through the freported the oncologis with the specialty pharprinted prescription for further inquiry, the fand received the medication it to the facility within' delivered to him in earning ave the medication was asked if he could medication to. He state to identify the staff member	to have a chronic condition the oncologist stated, "I she had been started (on onths earlier." He stated, alt for us to understand what was conducted on 2/14/19 presentative from the hich dispensed Resident #4 ng the interview, the ed 1 bottle of lenalidomide sident's family member on d bottle was shipped to the /19. Each bottle of ed 28 capsules.  was conducted on 2/14/18 lent #4's family member. The family member reported ogy consultation with /18. He recalled being told ffice that the resident's	F	600			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401	•	2/16/2019	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	the doctor. The family when he later went is with Resident #4, "Ime" thinking he had to the facility. The fawent to the facility. The fawent to the facility right (1/10/19) and talked facility said they did medication, but they on the med cart. The had been two month asked how he needed medication, he reported him about a was econd bottle of medication a few brought it into the family beautiful facility on 11/5/18.  An interview was conducted the lenalided facility on 11/5/18.  An interview was conducted the New	and that it was coming from ly member reported that back to see the oncologist le (the doctor) was fussing at not brought the medication in amily member reported he ght after that appointment with the DNS. He stated the not have an order for the red did find the medication bottle e family member stated, "It is, that's crazy." When led to obtain refills for the red the specialty pharmacy week before they sent the dication (lenalidomide) out to be received the second bottle days ago, but had not yet cility.  Conducted on 2/16/19 at NS, it was reported Med Aide e was the staff member who attend the first mide was brought in to the landucted on 2/15/19 at 11:05 on the family member's een determined the first mide was brought in to the landucted on 2/15/19 at 11:05 on helped care for Resident #4. Previewed the notation she	F 60				

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		345391	B. WING _				C 1 <b>16/2019</b>
	ROVIDER OR SUPPLIER	THE MOSES H CONE MEM H		1131	EET ADDRESS, CITY, STATE, ZIP CODE  NORTH CHURCH STREET  EENSBORO, NC 27401	1 02/	10/2013
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	provider such as once go over to the med list reported the next time on 1/14/19. Lenalido the current meds on list at that time.  An interview was cortained the resident was cortained the resident of the re	on the list (even by another ology), it would automatically st for her note. The NP e she saw the resident was unide was included as one of the resident's medication  aducted on 2/12/18 at 11:30 s Medical Director (who was onysician). During the all Director reported his officially note on 11/2/18 domide on Resident #4's physician also reported he note he himself authored on ded lenalidomide on the on list (he was unsure why e resident was not receiving it redered for administration at sician reported the facility or order unless he or the NP did not recall doing so until med administration for ntified on 1/10/19. The whether the delay in the would have made a not #4.  Inducted on 2/12/19 at 9:15 is Director of Nursing it presence of the Executive interview, the nurse was a facility's process of outside consultants. The	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345391	B. WING _			C 02/16/2019	
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		52710/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	consultation. Upon rappointment, a pack back with the reside may be a note writte form brought back to there was a new ord consultation informal in the provider box of physician to review. Was a new medication the order to the facil When asked who would order recommended the DNS stated the back would usually of the delay in Resider on 1/10/19. The resident was sufficiently from the ond date over to the facil because the oncologithe resident was sufficiently from the ond the med list sent to stated she understo obtained a prescript the oncologist because the facility. She recould not recall who The DNS stated after a physician 's order to order the oncologist because the facility. She recould not recall who The DNS stated after a physician 's order to the facility of the physician 's order to the stated after a physician 's order to the stated and the stated after a physician 's order to the stated and the stated after a physician 's order to the stated and th	return from the consult set of information would come ont. The DNS reported there are at the bottom of the consult of the facility. Whether or not alter for the resident, the ation was supposed to be put for the facility 's NP or She reported that if there con order, the nurse would fax atity 's contracted pharmacy. Sould initiate a new medication of the part of the facility is consultation, nurse receiving the consultation, nurse receiving the consult do so.  If was conducted on 2/12/19 facility 's DNS. The DNS at informed of a problem with the facility is family member came cologist 's office visit on that lity. He was concerned gist 's office made him aware coposed to be taking some of noticed was not included on them by the facility. The DNS and the family member had in for the lenalidomide from the instance through another the first part of November, on for lenalidomide was filled ber brought the medication in eported the family member he gave the medication to.	F				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING	B. WING		C <b>02/16/2019</b>	
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H	•	11	TREET ADDRESS, CITY, STATE, ZIP CODE  131 NORTH CHURCH STREET  REENSBORO, NC 27401	1 021	10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 600	unopened bottle of le Resident #4 was stor if anyone had questio on the med cart, she reported she called the talked with his nurse received a verbal ord the lenalidomide and DNS was uncertain a had not been aware of lenalidomide for Resident A second follow-up in 2/15/19 at 4:20 PM we reported upon investion resident 's oncology facility. She reported sent from the oncological physician, in addition the facility via the transported in the second follow to the second follow the second follow the transported in the second follow the second follow the second follow the transported in the second follow	cart, she discovered an nalidomide labeled for ed on the cart. When asked oned why the medication was stated, "No." The DNS ne oncologist's office and on 1/10/19. The DNS er for the administration of a fax with the order. The that time why the facility of the need to initiate dent #4.  terview was conducted on ith the DNS. The DNS gation, they discovered the consults did come to the consultation reports were gist to the attending to paperwork being sent to a problem with the consult	F	600			
	nurse, the NP, or the A telephone interview at 12:54 PM with the member. During the reported when she pr Resident #4 back fror would typically put the information from the of at the nursing station has recently been chainstructed to now place	was conducted on 2/16/19 facility 's transportation staff interview, the staff member eviously transported m an outside consult, she e consult packet (containing outside consult) on the desk . She reported this process anged and she has been ce this packet of information of the nurse on duty to					

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		345391	B. WING	B. WING			02/16/2019	
	NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401	1 02/	10/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 600	mg lenalidomide was once daily at 5:00 PM (representing 7 capsules administered MARs, a total of 29 led documented as admithe following staff meadministered 2 capsuladministered 2 capsuladministered 2 capsuladministered 4 capsuladministered 1 capsuladministered 2 capsuladministered 1 capsuladministered 1 capsuladministered 2 capsuladministered 1 capsuladministered 2 capsuladministered 1 capsuladministered 1 capsuladministered 2 capsuladministered 1 capsuladministered 2 capsuladministered 2 capsuladministered 1 capsuladministered 2 capsuladministered	lary 2019 MAR indicated 5 administered to Resident #4 If on 2/7/19 through 2/13/19 alles for a total of 29 d to date). According to the enalidomide capsules were inistered to the resident by imbers: Med Aide #1 alles; Med Aide #2 alles; Med Aide #3 alles; and Med Aide #4 alles; and Med Aide #5 alle.  Interview was conducted on with Med Aide #1. Med Aide allesident #4 's hall and time, one bottle of for Resident #4 was all on the med cart. Labeling attle also included an original 0/30/18 and the date armacy (11/2/18). Upon counted the lenalidomide and the medication bottle. The ared as she poured the ariginal container one at a into two medication cups. Associated and contained and medication cup was and 11 capsules. After the ared into the two counting, two additional ared to be left at the bottom are and were added to the Aide confirmed the counts.	F	600				

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345391 B. WING 02/16/	C 02/16/2019	
NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H  STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401	012019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Continued From page 14 capsules, Med Aide #1 was observed as she returned all capsules back to the original medication bottle, secured the cap on the bottle, and returned the lenalidomide medication bottle to a drawer on the medication cart.  An observation and interview was again conducted on 2/15/19 at 8:35 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 's hall medication cart. At that time, the resident 's bottle of lenalidomide stored on the med cart was observed. Upon opening the bottle of lenalidomide, only 7 capsules were seen lying on the bottom of the bottle. The 7 capsules were clearly visible and easily counted without removing them from the container. The labeling on the medication bottle was confirmed to be the same as that observed on 2/14/19, and included the resident 's amme, an original prescription date of 10/30/18, and the date dispensed by the pharmacy (11/2/18). When asked, the Med Aide reported she did not recall the exact number of capsules that were counted from Resident #4 's lenalidomide bottle the previous morning (2/14/19). Upon further inquiry, however, Med Aide #1 stated, "It was more." A thorough inspection of all drawers and compartments in the medication cart conducted by Med Aide #1 revealed there were no other bottles of lenalidomide stored on the med cart.  An interview on 2/15/19 at 9:10 AM with the DNS and facility 's Executive Director (ED). During the interview, the count discrepancy of Resident #4 's lenalidomide medication from 2/14/19 (22 capsules) to 2/15/19 (7 capsules) was discussed. At the time 22 capsules of lenalidomide were		

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NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	originally contained the resident could h lenalidomide capsul they had not been ir of lenalidomide. Ho medication audit wa 2/14/19. The DNS reapsules of lenalido bottle at approximat Based on the MAR medication, the DNS identified a concern have been any capsulenalidomide. The Educumented that Medication to Resid the DNS confirmed lenalidomide was or reported Resident # in the second bottle morning (on 2/15/19 her possession. The lenalidomide was of (unopened). This mandate of 2/4/19.  A telephone intervie at 10:30 AM with Medication to Medication to Resident #4 's namedate of 2/4/19.  A telephone intervie at 10:30 AM with Medication the medication to two difference into two di	the lenalidomide bottle 28 capsules, which indicated ave only received a total of 6 es. The DNS and ED stated informed of the 2/14/19 count wever, the DNS reported a sconducted the evening of reported she observed 7 mide were remaining in the ely 9:30 PM on 2/14/19. Indicated that she, too, had because there should not sules remaining in the bottle of DNS reported the MAR and Aide #1, Med Aide #2, Med de #4 had administered this ent #4. During the interview, only one bottle of the medication cart. She 4's family member brought of lenalidomide earlier that by, which the DNS still had in e second bottle of	F 60				

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NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				STREET ADDRESS, CITY, STATE, ZIP 0 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	CODE	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	· ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 600	reported she could added, "But I know"  Med Aide #1 was al process she used to resident. The med pull up the resident make sure she had med, right dose, and She would then pull hold it up against the the resident 's nam After she administed resident, the med ai off that the resident electronic MAR.  A telephone intervie at 10:41 AM with Minterview, the med ai 's family member he medication (lenalido November 2018. Some a bottlethe (finentioned about (R Although she was not thought this probablemed aide stated sin since sident in the could be stated sin though the same and though the same and though this probablemed aide stated sin the same and the same an	ning of 2/14/19, the med aide not remember. However she	F	600	CY)			
	Med Aide #2 stated had a bottle of medi him he could bring i thought it might hav when she saw the n (lenalidomide) on the reported sometime	tion he was talking about. the family member told her he cation at home and she told t in. The med aide stated she e been the next weekend nedication bottle e med cart. Med Aide #2 later (maybe in January), she ation bottle and saw this med						

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		345391	B. WING			02/	16/2019
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H	•	11	TREET ADDRESS, CITY, STATE, ZIP CODE 131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	receiving. The med at this medication order see one, "but didn't did not follow-up on the Med Aide #2 was ask she used to administe. The med aide reporter computer, look at the receiving it. After she the right medication, sput check on the "pre electronic MAR. After to the resident, she wadministered on the eresident refused the record the med as "reasked, Med Aide #2 ron the MAR to indicate administered, the resmedication.  A telephone interview at 10:58 AM with Medinterview, Med Aide #2 process he used to a resident. The med aid the electronic MAR formedication from the roame of the resident, and the dose; and the to the resident. Once medication, he would and record the medice electronic MAR.	e one the resident had been aide reported she looked for in the computer and didn't think anything about it" and his. During the interview, ed to describe the process or medications to a resident. It is deshe would log into the medication and the person of edouble checked that it was she would pop the med and pped" button in the she administered the medication, she would record the med was electronic MAR. If the medication, she would offused" on the MAR. When reported if her initials were the a medication was ident did receive the standard as a sked to describe the diminister medications to a de reported he would pull up or the resident; pull the medication en administer the medication on the administered the then ame of the medication on the administered the then come back to the cart attention administration on the that a telephone interview with	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		2110/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	PM with the DNS. D was asked what her to Resident #4's ler by stating the facility consult reports were medical record befor staff, the NP, or the pindicated she would have reviewed this ir lenalidomide was init would have been aw medication, she coul When asked, the DN Resident #4's lenali would have expected MARs to be accurate have been administed ordered.  An interview was corp M with the facility is presence of the Corp Quality and Education Operations and Corp Upon inquiry, the Exfacility last conducted during their all-staff reporting for these is On 2/14/19 at 2:11 P Director of Operation were informed of the facility provided the facility prov	uring the interview, the DNS expectation was in regards halidomide. She responded determined the oncology scanned into the electronic electroni	F 6				

NAME OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE   131 NORTH CHURCH STREET   CREENSBORO, NC 27401			345391	B. WING _					
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 600  Continued From page 19 1. The resident identified as Resident #4 was seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams (mg) -take one tab by mouth daily was added to the medication list.  On 1/10/19, it was discovered that resident had not received Revlimid (Lenolidomide) was initially ordered at the 10/12/18 appointment. The DNS verified that the medication was on the card on 1/10/19 and the medication aides documented medication as given from 1/10/19-1/31/19 and 27/19 to 2/14/19; however, 22 pills were in the card on the morning of 2/14/19 when the surveyor counted the medication with the medication aide. The oncologist has been notified by the DNS on 2/15/19 of the discovery of 22 pills and through verbal communication with the noncologist office (2/15/19) at 12-45pm the order has been rewritten to the following, "begin a 21-day cycle today at 1PM", and finish this cycle. After the 7-day rest period, begin the next 28-day cycle with nurse administration verifying daily dose given" The ordered dose was given today at 1PM and will continue daily at 1PM X 20 days (ending on 3/7/19)  The oncologist further stated that there was no physical harm done in missing the ordered doses  The morning of 2/15/19, the facility suspended					1131 NORTH CHURCH STREET	CODE	<b>32</b> /-		
1. The resident identified as Resident #4 was seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams (mg) -take one tab by mouth daily was added to the medication list.  On 1/10/19, it was discovered that resident had not received Revlimid (Lenolidomide) was initially ordered at the 10/12/18 appointment. The DNS verified that the medication was on the cart on 1/10/19 and the medication aides documented medication as given from 1/10/19-1/31/19 and 277/19 to 2/14/19; however, 22 pills were in the cart on the morning of 2/14/19 when the surveyor counted the medication with the medication aide. The oncologist has been notified by the DNS on 2/15/19 of the discovery of 22 pills and through verbal communication with the oncologist office (2/15/19) at 12:45pm the order has been rewritten to the following, "begin a 21-day cycle today at 1 PM", and finish this cycle. After the 7-day rest period, begin the next 28-day cycle with nurse administration verifying daily dose given" The ordered dose was given today at 1PM and will continue daily at 1PM X 20 days (ending on 3/7/19)  The oncologist further stated that there was no physical harm done in missing the ordered doses  The morning of 2/15/19, the facility suspended	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIAT	E	COMPLETION	
medication aides who had access to the medication cart from 2/14/19 to 2/15/19. The Executive Director has also completed an initial report to the Department of Health and Human Service for misappropriation of property as of 2/15/19 and police were notified this AM (2/15/19).  On 2/15/19 two licensed pharmacists reviewed every prescription, compared each against the	F 600	1. The resident idea seen by the oncolog Revlimid (Lenolidon one tab by mouth dimedication list. On 1/10/19, it was contreceived Revlimic ordered at the 10/12 verified that the medication as given 2/7/19 to 2/14/19; ho cart on the morning counted the medication the morning counted the medication as 2/15/19 of the discoverbal communication (2/15/19) at 12:45pt to the following, "be 1PM", and finish this period, begin the neadministration verify ordered dose was goontinue daily at 1P 3/7/19). The oncologist further physical harm done. The morning of 2/15 both medication cart from Executive Director for the Depart Service for misappin 2/15/19 and police of (2/15/19).	ntified as Resident #4 was gist on 10/12/2018 and hide) 5 milligrams (mg) -take aily was added to the discovered that resident had id (Lenolidomide) was initially 2/18 appointment. The DNS dication was on the cart on dication aides documented of from 1/10/19-1/31/19 and lowever, 22 pills were in the of 2/14/19 when the surveyor tion with the medication aide. In the order has been rewritten gin a 21-day cycle today at so cycle. After the 7-day rest lext 28-day cycle with nurse living daily dose given The iven today at 1PM and will M X 20 days (ending on ler stated that there was no in missing the ordered doses so 19, the facility suspended les who had access to the la 2/14/19 to 2/15/19. The lass also completed an initial ment of Health and Human opriation of property as of were notified this AM	F	500				

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		345391	B. WING			C 02/46/2049	
NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				STREET ADDRESS, CITY, STATE, ZIP COD 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	<b>02/16/2019</b> DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	ge 20	F 6	00			
	MAR to ensure the	orescription was available and ven. No discrepancies were					
	affected by neglect at therefore, the follow 100% of al interviewed were int Social Worker and/orights are being hon from abuse and neg documented on the On 2/15/19 reviewed every presagainst the MAR to available and medic discrepancies were All licensed nursi was in-serviced 2/14 resident rights and the missing scheduled resident rights and rights	Resident Rights Audit Tool.  It two licensed pharmacists scription, compared each ensure the prescription was ations were given. No noted.  Ing staff and medication aides 4/19 on abuse, neglect, and he implications for resident 's medications without physician ff not in-serviced by 2/14/19 by the Staff Development ee before the next scheduled in-serviced on abuse, at rights. All new licensed					
	aware of the implica scheduled medication notification.  4. As a monitoring to	edication aides will be made tions for resident 's missing ons without physician					
		I be completed on 10% of the ekly x4 and monthly x6 by the					

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F 600	observes/monitors the a. Observation b. Is the facility need for privacy c. Is the reside and respect by staff d. Is the reside in their plan of care e. Determine plan of care meeting f. Has the resperceive they have be physically abused g. Are any grifthe staff h. Has the respense abused or mis i. Is the resident medications j. Does the respense in the staff medications of the staff hereigned the staff medications is the resident medications of the staff hereigned the staff medications is the resident medications of the staff medications is the staff medications in the staff medications is the staff medication in the staff medication is the staff medication in the staff medication in the staff medication is the staff medication in the staff medication in the staff medication in the staff medication is the staff medication in the staff medication i	ctor/ designee. This audit ne following: n of staff/resident interaction by meeting the resident 's ent being treated with dignity ent being informed of changes if resident and/or family attend is sident or does the resident open verbally, sexually, or evances being addressed by sident seen any other resident treated ent receiving their ordered esident feel the staff is	F	600			
	audited by the DNS/ and as needed, ther months, and as need with the medication audit will be monitor orders compared to and if any medication medication not be proposed as possible, eithor Omnicell, pharmacy	es (at one cart a day) will be designee weekly x4 weeks, a monthly thereafter x 6 ded to ensure compliance administration protocol. The ing residents medication the medication in the cart as are not present. Should a resent it will be obtained as ther through the facility, or back-up pharmacy. The eview the resident 's MAR for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345391	B. WING_			C 02/16/2019	
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(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDLINED TO	SHOULD BE	(X5) COMPLETION DATE	
F 600	report will be comple will receive one-on-on-on-on-on-on-on-on-on-on-on-on-on-	If if found a medication error eted and the nurse/med aide one counseling by rading notification to charge of any missing medication.  Medication Carts) will be of the DNS/designee during from meetings where the QA) Committee members and as needed. The ring results of Medication of monthly QA meetings for and input monthly X 7 months, discussion will be maintained oftes. Any non-compliance prective actions taken. Any coring plan will require DNS/designee and again at the weekly audits met.  Resident Rights Audit Tool) will of the product of	F	300			
	months, and as nee meetings. Any non-corrective actions ta maintained in meetin non-compliance will actions taken. Any cwill require re-inservand monitoring to be audits until compliar.  The Executive Director initiating and monitoring and monito	ded during facility monthly QA compliance will be noted and ken. All discussion will be ng minute notes. Any be noted and corrective hange to the monitoring plan icing by the DNS/designee egin again at the weekly					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345391	B. WING		C <b>02/16/2019</b>	
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401	02/10/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 602 SS=D	absence Effective of IJ remova The facility 's credibly Jeopardy removal wat 1:20 PM. The validation interviews with both If Med Aides on the 6 riadministration and the when a resident return consultation. Review records revealed lice were in-serviced prior review of the pharma Appointment Tracking conducted as part of Free from Misapprop CFR(s): 483.12 The resident has the neglect, misappropria and exploitation as deincludes but is not lim corporal punishment, any physical or chemitreat the resident's m This REQUIREMENT by: Based on observation facility record reviews the misappropriation antineoplastic medica (lenalidomide) for 1 or	e allegation of Immediate is validated on 2/16/19 at ion was evidenced by censed nursing staff and ghts of medication e facility process expected ned form an outside of on-going in-service insed and unlicensed staff to working on the floor. A cy cart audit report and Daily g Log was also was also the validation process. riation/Exploitation  right to be free from abuse, ition of resident property, efined in this subpart. This inted to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  T is not met as evidenced ins, staff interviews, and is, the facility failed to prevent	F 60		3/12/19	
	The findings included			was seen by the oncologist on 10/12/2 and Revlimid (Lenolidomide) 5 milligra		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '			(X3) DATE SURVEY COMPLETED	
345391	B. WING			C 2/16/2019	
I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	2/10/2013	
AB AT THE MOSES H CONE MEM H		GREENSBORO, NC 27401			
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
page 24	F 60	02			
admitted to the facility on entry to the facility on 2/21/18. diagnosis included multiple ving achieve remission; asm (tumor) of unspecified site of ast; and secondary malignant bone.  sident 's medical record cian 's order was written at the 9 at 3:27 PM to initiate 5 lenalidomide to be administered once daily for 21 days, stop for 7 rt the same cycle.  dent #4 's January 2019 MAR enalidomide was administered to scheduled at 5:00 PM on 1/10/19 esenting 22 capsules The resident 's February 2019 img lenalidomide was Resident #4 once daily at 5:00 rough 2/13/19 (representing 7 oral of 29 capsules documented to date).  and interview was conducted on AM with Med Aide #1. Med Aide it to Resident #4 's hall At that time, one bottle of eled for Resident #4 was stored on the med cart. Labeling in bottle also included an original et of 10/30/18 and the date is pharmacy (11/2/18). Upon		(mg) -take one tab by mouth dadded to the medication list. On 1/10/19, it was discovered resident had not received Revi (Lenolidomide) was initially or 10/12/18 appointment. The DI that the medication was on the 1/10/19 and the medication as giv 1/10/19-1/31/19 and 2/7/19 to however, 22 pills were in the comorning of 2/14/19 when the scounted the medication with the medication aide. The oncolog been notified by the DNS on 2 the discovery of 22 pills and the verbal communication with the office (2/15/19) at 12:45pm the been rewritten to the following 21-day cycle today at 1PM, and cycle. After the 7-day rest perform the next 28-day cycle with nurse administration verifying daily done and will continue daily at 1PM (ending on 3/7/19). The oncologist further stated the was no physical harm done in ordered doses.  The morning of 2/15/19, the fact suspended both medication aid had access to the medication aid had access to the medication aid had access to the Department of Heisenberg and the december of the Department of Heisenberg and the december of the Department of Heisenberg and the Department of Heisenbe	that imid dered at the NS verified e cart on des en from 2/14/19; art on the urveyor e gist has /15/19 of rough oncologist e order has begin a d finish this iod, begin se ose given oday at 1PM X 20 days there missing the cility des who cart from utive in initial ealth and		
	IDENTIFICATION NUMBER:	A BUILDING  345391  R  AB AT THE MOSES H CONE MEM H  RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)  page 24  F 60  s admitted to the facility on entry to the facility on 2/21/18. diagnosis included multiple ving achieve remission; asm (tumor) of unspecified site of ast; and secondary malignant bone.  sident 's medical record cian 's order was written at the 9 at 3:27 PM to initiate 5 lenalidomide to be administered once daily for 21 days, stop for 7 rt the same cycle.  dent #4 's January 2019 MAR enalidomide was administered to incheduled at 5:00 PM on 1/10/19 esenting 22 capsules The resident 's February 2019 is mg lenalidomide was Resident #4 once daily at 5:00 rough 2/13/19 (representing 7 otal of 29 capsules documented to date).  and interview was conducted on AM with Med Aide #1. Med Aide of to Resident #4 's hall At that time, one bottle of eled for Resident #4 was stored on the med cart. Labeling in bottle also included an original e of 10/30/18 and the date e pharmacy (11/2/18). Upon de #1 counted the lenalidomide ing in the medication bottle. The	RAB AT THE MOSES H CONE MEM H  AS BAT THE MOSES H CONE MEM H  AS AGAINT HE MOSES H CONE ACT ATION  AND HAVE AGAINT HE MOSING HAVE ACTION  CROSS-REFERENCED TO THE A  GREENSBORO, NC 27401  PREFIX  FREFIX  FREFIX  FREFIX  FROW JOAN HA  Added to the medication SIST.  On 1/10/19, it was discovered resident had not received Rev (Lenolidomide) was initially or closed Testing H  Added to the medication as given to counted the medication as given to counted the medication with the morning of 2/14/19 to 12/14/19 to 2/14/19 to 12/14/19 to 12/14/	ABUILDING  345391  B. WIND  STREET ADDRESS, CITY, STATE, ZIP CODE  1331 NORTH CHURCH STREET  GREENSBORO, NC 27401  PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  FOR ISC IDENTIFYING INFORMATION)  PAGE  FOR STATEMENT OF DEFICIENCIES DIPPOY MUST BE PRECEDED BY FULL TAG  PREVIX	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING _				C / <b>16/2019</b>
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2013
	10 1.52.1 011 00. 1 2.2.1				131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H					
				G	REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 602	Continued From pag	je 25	F 6	502			
	· -	original container one at a					
		) into two medication cups.			On 2/15/19 two licensed pharmacists		
	-	was counted and contained			reviewed every prescription, compared	I	
		cond medication cup was			each against the MAR to ensure the	•	
		ed 11 capsules. After the			prescription was available and		
	capsules had been p				medications were given. No discrepan-	cies	
		counting, two additional			were noted.	0.00	
	•	rved to be left at the bottom					
	of the original contai			Address how the facility will identify oth	ner		
	total count. The Me	d Aide confirmed the counts.			residents having the potential to be		
	It was determined a total of 22 capsules				affected by the same deficient practice		
	remained in the med	lication bottle originally					
		les. After counting the			100% of all alert and residents able to	be	
		#1 was observed as she			interviewed were interviewed on 2/14/		
	returned all capsules				by the Social Worker and/or designee		
		ecured the cap on the bottle,			ensure their rights are being honored a	and	
		alidomide medication bottle			the resident is free from abuse and		
	to a drawer on the m				neglect. Findings were documented or the Resident Rights Audit Tool.	1	
	An observation and						
		9 at 8:35 AM with Med Aide			On 2/15/19 two licensed pharmacists	_	
		is assigned to Resident #4 's			reviewed every prescription, compared		
		At that time, the resident 's			each against the MAR to ensure the		
	observed. Upon ope	e stored on the med cart was			prescription was available and medications were given. No discrepand	nina	
		capsules were seen lying on				cies	
		ttle. The 7 capsules were			were noted.		
		asily counted without			Address what measures will be put into	,	
		the container. The labeling			place or systemic changes made to	,	
		ottle was confirmed to be the			ensure that the deficient practice will n	ot	
		red on 2/14/19, and included			recur		
		e, an original prescription					
		d the date dispensed by the			All licensed nursing staff and medication	on	
		When asked, the Med Aide			aides was in-serviced 2/14/19 on abus		
		recall the exact number of			neglect, and resident rights and the	•	] ]
		counted from Resident #4 's			implications for resident⊡s missing		
	lenalidomide bottle t				scheduled medications without physici	an	
		her inquiry, however, Med			notification. Any staff not in-serviced by		
		as more." A thorough			2/14/19 will be in-serviced by the Staff		

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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		345391	B. WING _			02/	16/2019
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				11	131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB	AT THE MOSES H CONE MEM H		G	REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	Continued From pa	age 26	F 6	502			
	inspection of all dra medication cart cor	awers and compartments in the inducted by Med Aide #1 e no other bottles of			Development Coordinator/Designee before the next scheduled shift.		
	lenalidomide stored	d on the med cart.			All new hires will be in-serviced on abuneglect, and resident rights. All new	ıse,	
		5/19 at 9:10 AM with the of Nursing Services (DNS) and			licensed nursing staff and medication aides will be made aware of the		
	· ·	(ED). During the interview, the			implications for resident⊟s missing		
		of Resident #4 's lenalidomide			scheduled medications without physicia	an	
		14/19 (22 capsules) to 2/15/19			notification.		
		iscussed. The DNS and ED					
		t been informed of the 2/14/19			Indicate how the facility plans to monitor its performance to make sure that	וכ	
	count of lenalidomide. However, the DNS reported a medication audit was conducted the				solutions are sustained		
	·	. The DNS reported she					
	observed 7 capsule	es of lenalidomide were			As a monitoring tool, the Random		
		ottle at approximately 9:30 PM			Resident Rights Audit Tool will be		
		on the MAR documentation			completed on 10% of the resident cens		
		the DNS indicated that she,			weekly x4 and monthly x6 by the Socia		
	· ·	a concern because there			Services Director/ designee. Findings		
		en any capsules remaining in lomide. During the interview,			be brought to ED (Executive Director) a negative findings will be addressed by ED.		
	lenalidomide was o	on the medication cart. She					
		#4 's family member brought			The Medication Carts (at one cart a da	y)	
		e of lenalidomide earlier that			will be audited by the DNS/designee		
		9), which the DNS still had in			weekly x4 weeks, and as needed, then		
	her possession. The				monthly thereafter x 6 months, and as		
		observed to be sealed medication was labeled with			needed to ensure compliance with the medication administration protocol. The		
	' '	ne and a pharmacy dispensed			audit will be monitoring residents	5	
	date of 2/4/19.	по апи а рпаннасу изренѕеи			medication orders compared to the		
	GGIO 01 2/7/10.				medication in the cart and if any		
	A 24-hour Initial All	egation Report faxed to the			medications are not present. Should a	1	
		/15/19 at 11:17 AM was			medication not be present it will be	ſ	
		submitted the report which			obtained as soon as possible, either	ĺ	
		tion of misappropriation of			through the facility Omnicell, pharmacy	, or	
	_	as being investigated. The			back-up pharmacy. The DNS/designed	е	
		t was 2/14/19. The description			will review the resident s MAR for any		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345391	B. WING		0.	C 2/ <b>16/2019</b>	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	2/10/2019	
	10 115211 011 001 1 21211			1131 NORTH CHURCH STREET			
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		GREENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 602	Continued From page	e 27	F 60	02			
	counted on 2/14/19 a accounted for. As of remaining in resident notation made on the	, "Resident medication was and initially 22 pills were 2/15/19, 7 pills were 's medication bottle." A report revealed the incident g with the local police		miss doses, and if found a mederror report will be completed a nurse/med aide will receive one counseling by DNS/designee renotification to charge nurse and of any missing medication.  Audit Compliance (Medication	and the e-on-one egarding d pharmacy		
	12:37 PM from the poreport of larceny was to the missing medical			be discussed weekly by the DNS/designee during morning administration meetings where Assurance (QA) Committee meattend, X 4 weeks, and as need	the Quality embers eded. The		
	at 4:20 PM with the D the DNS reported on #2 had keys to Resid cart on 2/14/19 betwee capsules of lenalidon med cart) and 9:30 P capsules of lenalidon Both medication aide the results of the faci DNS also indicated s	was conducted on 2/15/19 DNS. During the interview, by Med Aide #1 and Med Aide ent #4 's hall medication een 10:10 AM (when 22 nide were counted on the by (when she counted 7 nide left on the med cart). by were suspended pended lity 's investigation. The he would expect the be correct when reconciled		DNS/designee will bring results Medication Cart audit the facilit QA meetings for committee revinput monthly X 7 months, and All discussion will be maintaine meeting minute notes. Any non-compliance will be noted a corrective actions taken. Any c the monitoring plan will require re-inservicing by the DNS/design monitoring to begin again at the audits until compliance is met.	ty monthly view and as needed. ed in and change to gnee and e weekly		
	at 10:30 AM with Med DNS and ED. During was asked to describ Resident #4's lenalided #1 reported the poured into two differ of the med cart as the When asked if she rewere in the bottle of I counted on the morning.	was conducted on 2/16/19 d Aide #1 in presence of the the interview, the med aide e the process used to count domide on 2/14/19. Med lenalidomide capsules were tent medication cups on top e capsules were counted. ecalled how many capsules enalidomide when they were ing of 2/14/19, the med aide of remember. However she		Audit Compliance (Resident Ri Tool) will be discussed weekly ED/designee X 4 weeks, and a during morning administrative r followed by monthly X 7 month needed during facility monthly meetings. Any non-compliance noted and corrective actions ta discussion will be maintained ir minute notes. Any non-complianced and corrective actions ta change to the monitoring plan re-inservicing by the DNS/designation.	by the as needed meeting as, and as QA will be aken. All n meeting ance will be aken. Any will require		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING			1	C
NAME OF PI	ROVIDER OR SUPPLIER	345351	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE			16/2019
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		1131 NORTH CHURCH STREET GREENSBORO, NC 27401			
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 SS=J	Continued From page added, "But I know it Free of Accident Haza CFR(s): 483.25(d)(1)	was more than 7." ards/Supervision/Devices		6602	monitoring to begin again at the weekly audits until compliance is met.  The Executive Director is the person responsible for initiating and monitoring the stated plan. In the event the ED is available, the Director of Nursing Servi will continue the plan in ED□s absence The date the corrective action will be completed is 3/12/19.	g not ces	3/12/19
	as free of accident has \$483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on observation and record reviews, the required safety prof 3 sampled resident (Resident #6 and Resexperienced a fall from being given a bed bat 1/13/19, resulting in a and a closed displace phalanx (the bone cloth hand) of the right little fall, the facility determ two person assistance receiving ADL care.	sident environment remains izards as is possible; and sident receives adequate stance devices to prevent is not met as evidenced ins, facility staff interviews, he facility failed to ensure ecautions were taken for 2 is reviewed for accidents sident #8). Resident #6 in his bed while he was the by a nursing assistant on a laceration of the forehead and fracture of the proximal issest to the palm of the finger. After the 1/13/19 inned the resident required			Address how corrective action will be accomplished for those residents found have been affected by the deficient practice  Resident #6 experienced a fall from be on 1/13/19 during the 7-3am shift while Activities of Daily Living (ADL) care was being provided by CNA. The resident initial plan of care related to ADL bed mobility stipulated assistance needed where the bed mobility.  The plan of care was not clear if the assistance needed required one-person or two-person assistance.	d s s s with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII		<del></del>		c l	
		345391	B. WING _				/16/2019	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	710/2019	
					31 NORTH CHURCH STREET			
HEARTLA	ND LIVING & REHAE	B AT THE MOSES H CONE MEM H			REENSBORO, NC 27401			
(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	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 689	Continued From p	page 29	F	689				
		e resident experienced another and sustained a laceration			Resident Representative (RR) and attending physician notified and reside	nt		
	above his left eye	brow and a skin tear on his right			transported to Emergency Department			
	middle finger. The	e facility failed to follow the			(ED) for evaluation on 1/13/19 and			
		struction to safely transfer			returned same day with a report			
	Resident #8 out o	f bed with a mechanical lift.			sustaining a closed displaced fracture of			
					the proximal phalanx of right little finge	r.		
		rdy began on 2/7/19 when			Report was given to the RR following			
		rienced his second fall from the			resident ☐s return from ED.			
		ing provided incontinence care one. This fall occurred after			Upon return to the facility, Resident #6 was re-assessed for care needs that w			
		termined the resident required			addressed through care planning and	CIC		
	•	two staff members to provide			KARDEX.			
		liate Jeopardy was removed as			Interventions initiated were as follows:			
		ne facility implemented an			Resident to be a 2 person assist with			
		tion of Immediate Jeopardy			ADLs added to resident plan of care ar	nd		
	removal. The facil	ity remains out of compliance			KARDEX			
		ower scope and severity level of			Intervention was communicated to			
	·	m with the potential for more			line-staff by the Staff Development			
		n that is not immediate			Coordinator (SDC) through the facility	S		
		nple number 2 where a plan of			Communication Log on 1/13/19			
	correction is requi	rea.			Resident #6 experienced a subsequen	ι		
	The findings inclu	dod			fall from bed on 2/7/19 during the			
	The findings inclu	ueu.			11pm-7am (12:58AM) shift while CNA providing peri-care.	Nas		
	1) Resident #6 wa	as admitted to the facility on			Nurse was notified by CNA prior to move	vina		
		nulative diagnoses which			resident for proper assessment and	riig		
		urgical repair of a right hip			determined to have sustained a skin te	ar		
	fracture.	3 - 3			to left eyebrow and right middle finger.			
					Physician notified and resident sent to	ED		
	A review of Reside	ent #6 ' s baseline care plan			for evaluation. RR notified of fall with			
		cated the resident required staff			transport on 2/7/19 to the ED for furthe			
	assist of one for b				evaluation Resident returned from ED			
		g, eating, and toileting. The			the facility on 2/7/19 6:55AM with a rep	ort		
		n noted this resident required			of laceration to left eye. Resident			
		two staff members for			discharged home on 2/8/19.	_		
	ambulation and tra	ansiers.			The facility administrator interviewed th	ie		
	A review of the	sident 's most recent			CNA involved in the incident of 2/7/19 regarding care delivery. When asked it	f		
	,	JIGOTE 3 111031 1505111	1		regarding care delivery. Willell asked I	1	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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		345391	B. WING _			/16/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
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HEARILA	ND LIVING & REHAD AT	THE MOSES IT CONE MEM IT		GREENSBORO, NC 27401			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From page	e 30	F 6	89			
F 689	individualized care plareas of focus, in par1/12/19 (Resident) to aspirin use1/12/19 (Resident) activities of daily livin interventions included adequate staff support compromising activities. (Not dated) (Resident to multiple factors. The included, in part: "Pradequate staff support compromising activities. Included, in part: "Pradequate staff support compromising activities. In adequate staff support activities and ensure parameters and proper maximize safety."  Review of an Incident 11:20 AM revealed Resident in his room while batt written on this report described the incident assistant (NA) called some after the residuceration was noted eyebrow and a pressent bleeding to stop. What happened (authors) are part of the was on his side to get a towel and the (in the case of the ca	an included the following t: is at risk for bleeding related requires assistance with g (ADLs). The care plan d: "Provide assistance with rt for all safety estransfers, toileting, etc." ent) is at risk for falls related the care plan interventions ovide assistance with rt for all safety escheck for needs often it to summon assistance for ing activities;" and, "Ensure rt for safety compromising safe positioning, safe	F 6	the CNA had reviewed the KARDEX prior to deliverin responded that he did not care, but did review it afte When further questioned at that reviewing the resident to delivery of care is proto responded he did, but did KARDEX. The CNA's empterminated.  Resident #8 remains in the not experienced any falls transfers with the mechan Address how the facility we residents having the poter affected by the same defice.  The facility is interdiscipling re-assessed 100% of all residents with regards to be positioning on 2/13/19 to ensure the indiversidents are met without comprominated identified needs, including assistance (one-person/two-person) were and updated on the resident and Care Plan on 2/14/19 Any resident identified through the indiversal assessment by the IDT needing assistance with be positioning will be referred to therapy for screen.	g care, the CNA review it prior to r the incident. as to knowledge t KARDEX prior col, he not review the ployment was e facility and has related to ical lift.  ill identify other ntial to be cient practice hary team bed mobility and vidual needs of sing safety. The required documented ent s Kardex cough the team as ed mobility and		
	and head on the A/C unit). Further falling	unit (heating/air conditioning off the unit hitting his face oor" The resident was		to assure the amount of a accurate.  In addition to the audit of I	ssistance is		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ND I DUNG O DELLAD A	T THE MOOFE II COME MEM II		11	131 NORTH CHURCH STREET		
HEARILA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H		G	REENSBORO, NC 27401		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 689	Continued From pag	ue 31	F	689			
	transported to the Er	mergency Department (ED)			mobility/KARDEX/CNA, all		
	for evaluation and tre	- · · · · · · · · · · · · · · · · · · ·			lifts, and accompanying lift pads were		
					examined by the DNS/designee on/bef	ore	
	A telephone interviev	w was conducted with NA #1			3/6/19 for operating order, condition of		
	on 2/13/19 at 9:10 A	M. During the interview, the			pads and		
	NA was asked to des	scribe the incident that			correct lift pads. Any equipment		
	occurred with Reside	ent #6 on 1/13/19. The NA			determined to be faulty or not compatib	ole	
	•	o the resident 's room to help			will be taken out of operation by the		
		and dressed; the resident was			DNS/designee until		
	lying in bed at the time. When the NA had				repaired or the ordered lift pads arrive.		
		esident the 1st part of his full					
_		o work on his lower body and			Address what measures will be put into	,	
	•	e on the resident 's backside.			place or systemic changes made to	<b>.</b> +	
		sheet to turn the resident at he was lying on his left			ensure that the deficient practice will no recur	אנ	
	· ·	ed he himself was standing			lecui		
	-	ne bed (towards the door). At			All CNAs (direct care) will be audited fo	)r	
		nt was lying on his side and			referring to resident KARDEX before	"	
		bly at all." The NA reported			conducting bed mobility/positioning as		
	· ·	t on the edge of the bed and I			identified in the resident □s KARDEX.		
		I within reach." The NA			This audit will be conducted by the		
	stated he took his ha	and to grab a washcloth			Director of Nursing Service(DNS), and		
	which had been place	ed within reach. As he			designees on 2/13/19-2/14/19. The		
	turned to the right to	grab the cloth, the resident			audit will monitor CNAs□ ability to ched	ck	
		hen he rolled, his upper body			KARDEX for resident□s care guides,		
	_	nditioning unit, then he hit the			positioning resident, the use		
		r face down after that. NA #1			of lifts and lift pads if applicable.		
	_	ppened when I turned my					
		. I wasn ' t away from himI			Any staff not observed on/before 2/14/	19	
	-	aps, and towels all within			will be observed/audited by nursing	tho	
		ed back towards him I saw ne NA reported the resident '			administrative staff prior to the start of t employees next scheduled shift	.i ie	
		position at the time of the fall			Any staff not observed on/before 3/11/	10	
		viding a bath. When asked if			with regards to properly using lifts/lift	10	
	•	resident as he rolled off the			pads/ care guides will be audited prior	to	
		e dropped the towel and			the beginning of their next scheduled s		
		at that point he was already			by the DNS/ designee.		
		ch. The NA reported after			, , , , , , , , , , , , , , , , , , ,		
		ulled the call light cord out of			Staff education will be given to all CNA	s	

OLITIC	OT OIT MEDIO/ ITE G	MEDIO/ ND CEITTIOEC				CIVID ITC	<del>2. 0000 000 1</del>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 689	Continued From page		F	689		_		
		elp. Upon inquiry, NA #1			by the DNS/designee on/before 2/14/1	9		
		e in the room when the fall			regarding the following:			
		nurse came, he assisted her			Staff (CNA) to review each resident □s			
		nt ' s vital signs. Then when cal Technicians (EMTs)			KARDEX prior to care.  The importance and necessity to monit	or		
		em transfer the resident onto			staff under their supervision for following			
		the interview with NA #1,			protocol in referencing the resident	19		
	_	w he knew what needed to			KARDEX for guidelines of care.			
		sident safe while providing			Tall (2 = 2 Clor galaciii) co ci carci			
	_ ·	eported he sometimes asked			Staff education will be provided to the			
	questions of the resid	dent and/or the nurse if he			CNAs by the DNS/designee on/before			
	was not familiar with	the resident. He also			3/8/19 with regards to proper use of lift			
		formation from the Kardex			and accompanying pads.			
		ne notes listed in regards to			Any staff not inserviced will be inserviced	ed		
		At the time of Resident #6 's			prior to start of the employee □s next			
		/13/19, however, the facility			scheduled shift.			
		ined the resident required			Any abanca in a vasidanta alam af			
	2-person assistance	with his ADL care.			Any change in a resident s plan of	_		
	An interview was con	ducted on 2/14/19 at 3:27			care/KARDEX affecting delivery of care will be communicated directly to the	5		
		lurse #1 was the 1st shift			charge nurse by a member of the IDT			
		ned to Resident #6 's hall			team using the Interdisciplinary form.			
	_	resident fell. The nurse			The charge nurse will advised that it w	II		
		ng the room, the resident			be their responsibility to inform the dire			
	was bleeding above h	nis right eye brow with blood			care staff of the change and updated			
	all over his face. Wh	en asked if she identified			KARDEX as evidenced by applicable s	taff		
		hat time, she stated she did			signatures on the Communication Forr	n.		
	not. Nurse #1 reporte							
	_	ns taken, and tried to stop			DNS/Designee will inservice on/ before	;		
		nquiry, the nurse reported			2/16/19 all licensed nurses regarding:	_		
		en additional staff to assist			The importance of referring to resident			
		ADL care, if needed. After e nurse reported seeing NAs			KARDEX prior to resident care to be gi	ven		
		to help provide care to the			added emphasis in New Employee Orientation for CNAs			
		to help provide care to the the was uncertain if 2-person			The importance for licensed nurses to			
		ys used to provide ADL care			oversee and monitor the staff under the	eir		
	to Resident #6 after t	· · · · · · · · · · · · · · · · · · ·			supervision to assure the care protocol			
					are followed will be given added emph			
	Hospital Emergency	Department (ED) records			in the New Employee Orientation for			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER:  A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 689	Continued From page	e 33	F	689			
F 689	dated 1/13/19 indicate laceration of the forely Dermabond (a skin and edges together) and a of the proximal phala. The resident's right 5 reduced (setting of the properly) using gentle was applied. The resident ED to the facility of A review of the facility 1/13/19 incident read to facility. Resident who position on his side. Resident sent to ER (evaluation related to and already right ferm two person assist who A review of Resident Data Set (MDS) dates.	ed the resident had a nead with repair using dhesive that holds wound a closed displaced fracture nx of the right little finger. th finger fracture was e bone to ensure it healed e traction and a finger splint sident was discharged from	F	689	Licensed Nurses.  Any staff not inserviced will be inservice prior to start of the employee □s next scheduled shift.  Indicate how the facility plans to monitor its performance to make sure that solutions are sustained  This Bed Mobility Audit will be completed at a minimum of 10 times weekly for for weeks, and as needed by the DNS/designee. Transfer audit will be completed at a minimum of 10 times weekly for four weeks and as needed by the Therapy Manager/Designee.  Outcomes of the scheduled audits will discussed during the facility morning administrative (which members of the facility Quality Assurance (QA) Commit are present).  Any non-compliance will be addressed	ed ur by be	
	for daily decision make nor rejection of care. assessment indicated extensive assistance assist for bed mobility personal hygiene. He assist from staff for load dressing, and eating, incontinent of bowel at the MDS revealed Reand weighed 237 pour A review of the facility book kept on Resider documented changes	king. He had no behaviors Section G of the MDS If the resident required with 2+ person physical we transfers, toileting and the also required extensive becomotion on the unit, The resident was and bladder. Section K of the besident #6 was 72 inches tall			observed.  Outcomes of compliance with establish plan will also be brought to the facility monthly QA by the DNS/designee for committee review, discussion and changes needed in plan should they occur.  All discussion will be included in the QA meeting minutes.  Following the 4 weeks of Bed Mobility a Transfer audits, audits will continue wit minimum of 10 audits per month x 7 months, and as needed.  The outcomes of audits will be brought the facility monthly QA meetings by the DNS to be reviewed by the QA Commit	A and h a	

HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689 Continued From page 34 is a summary of individual patient needs, which		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 34 F 689 is a summary of individual patient needs, which		С	
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Continued From page 34   F 689   Continued From page 34   is a summary of individual patient needs, which   GREE   GREE	ET ADDRESS, CITY, STATE, ZIP CODE		
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is a summary of individual patient needs, which	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
regarding the assistance required to meet the ADL care needs for a resident. A review of the Communication Log book included a sheet for Resident #6 and revealed a change was made on 1/13/19 to indicate the resident required 2-person assist with ADL care.  A printed copy of Resident #6 's most recent (undated) Kardex was provided by the facility for the surveyor to review at 4:45 PM on 2/12/19. Each resident 's Kardex was made available to the nursing assistants electronically via a Kiosk on the hall. Resident #6 's Kardex read in part, "Resident will be a two person assist with care."  Review of an Incident Report dated 2/7/19 at 12:01 PM revealed Resident #6 experienced a fall in his room. The Nurse 's Note on this report described the incident and revealed NA #2 notified the hall nurse (Nurse #2) after Resident #6, "fell on the floor while he was log rolling him to change him." The note indicated Resident #6 hit his head against the heating/air conditioning unit. Nurse #2 assessed the resident while he was lying on his left side. The nurse reported the resident had a laceration with bleeding above his left eyebrow and a skin tear on his right middle finger. A Witness Statement of what happened revealed NA #2 stated the resident fell while he was trying to log roll him. The resident was reported to have moved suddenly and rolled off the bed, hitting his head against the heating/air	nembers for compliance. In discussion and/or revisions to the lan will be contained in the meeting ninutes. In revisions to the plan will require elinservicing to applicable staff by the NS/designee and require monitoring the land again at 4b and continue as utilined. It icensed nursing staff will be monitored sing the Nurse Monitor Sheet and will conducted by the DNS/designee 10 times week times 4 weeks, and as needed butcomes of the scheduled audits will discussed during the facility morning diministrative (which members of the acility Quality Assurance (QA) Commit re present). Any non-compliance will didressed as observed. In ollowing the initial 4 weeks, the Nurse donitor Sheet will continue to be used minimum of 10 times per month X 7 nonths, or as needed. This monitoring will be conducted by the DNS/designee the outcomes of audits will be brought the facility monthly QA meetings by the NS/designee to be reviewed by the Qametings by the land will be contained in the meeting ninutes. In y revisions to the plan will require elinservicing to applicable staff by the NS/designee and require monitoring the land will again at the 4 k and continue as	d be hes hes hed. be titee be he hes he	
to ED for evaluation and treatment.  Out The Hospital Emergency Department (ED) records  re	utlined.  he facility administrator will be esponsible for implementing this plan a ssuring monitoring is done as outlined	<u> </u>	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 689	Continued From page	e 35	F	589			
	wound repaired with were taken and show fracture. Resident #6 facility for continued r	Dermabond. X-ray films red no evidence of a swas discharged back to the rehabilitation.			In the event of the administrator □s absence, the DNS is responsible for assuring compliance with plan. The dathe corrective action will be completed 3/12/19.		
	2/7/19 incident read, recent fall in facility a prior to admission. (Nell on the floor while change him. (NA) reagainst heating unit (Nurse assessed residon his left side. Neur ER (Emergency Roof fall and laceration on middle finger. Reside (Computerized Tomocm (centimeter) lacer	y's follow-up report from the "Resident noted with a and a history of recurrent falls NA) notified nurse resident he was log rolling him to ported he hit his head heating/air conditioning unit). Ident, while resident was lying to checks initiated. Sent to m) for evaluation related to left forehead and right ent return with negative CT graphy) Scan results and 1 return to the left forehead in Dermabond. Resident will st with ADL care."					
	at 11:22 AM with NA: the NA who was carir time of his fall on 2/7/incident that occurred reported he came in trounds and then wen care for him. NA #2 s resident so he was on to describe the log rodraw sheet, had the rover the left and used roll the resident on his he was on the right sidoor) and the resident NA. As the NA reach	was conducted on 2/13/19 #2. NA #2 was identified as an for Resident #6 at the 19. NA #2 described the 10 on 2/7/19. The NA 10 ocheck on the resident for 11 on to provide incontinence 12 on the resident for 13 on the resident for 14 on the provide incontinence 15 on the resident for 16 on the resident for 17 on to provide incontinence 18 on the resident for 18 on the resident for 19 on t					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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F 689	get over more or re-p the resident, "plunge lifted up and dipped r he went over to his si resident basically roll heating/air conditioni then went down on tr so quick." When ask touch the resident as responded by saying Upon further inquiry, in the room at the tim  During the telephone #2 on 2/13/19 at 11:2 ran to get the nurse is occurred. He reporte from the left side of h appeared he had hit heating/air conditioni The nurse came back assessed the resident under the resident ar the bed. The NA rep "we stayed with him i arrived. Resident #6 hospital. When NA # aware (before the fall 2-person assistance stated he was not. N checked the Kardex I think he needed 2 pe After the fall, howeve the Kardex and saw i required 2-person as	the right (like he was trying to sosition). At that moment, dover and off of the bed. He more to his left and whoop de." The NA reported the ed forward and hit the ng unit with part of his body, he floor. He stated, "It went ed if the NA was able to he fell off the bed, he, "It happened too fast." the NA stated he was alone e of the incident.  Interview conducted with NA 122 AM, the NA reported he mmediately after the fall ed the resident was bleeding is head above the eye and it his hand on either the ng unit or the window sill. At to the room with him, she at, and they put a draw sheet and used it to slide him back to corted 911 was called and in the room" until EMS was then transported to the 12 was asked if he was 12 that the resident required for ADL care in the bed, he 14 #2 reported he had not opele to provide the care.  The NA stated he looked at to indicated the resident	F	589				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345391	B. WING			02/	16/2019
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F 689	(the date of the reside the interview, the nut to assist the NA #2 a bed the NA reported log-rolled the resider the bed. The nurse is the resident continue off of the bed. When the resident was lyin the heating unit (hea had a laceration ove and a skin tear on hi hand. His little finge nurse reported she wand he was talking wanything was hurting Once he said that, the for her and the NA to Once safely on the bassessed him. The resident out "for safe provider was contact send him to the ED.  During the interview PM with Nurse #2, simembers were requiwith his ADLs such a nurse reported that for in the room together and bed mobility. Whave been two NAs care on 2/7/19, she is have been." The number a care guide in the people were needed	e for Resident #6 on 2/7/19 ent 's second fall). During rese recalled when she went ffer Resident #6 fell off of the to her that he had a at to do incontinence care in tated she had understood at to roll, and rolled over and at the nurse got to the room, g on his left side and next to ting/air conditioning unit). He r his left eye brow (bleeding) s middle finger of the right r appeared swollen. The vas talking with the resident with her. When asked if on him, he said it was not. the nurse figured it was safe to put him back on the bed. the did nother nurse came and turses decided to send the ty sake." The on-call the dand an order received to  conducted on 2/12/19 at 2:56 the was asked how many staff there to assist the resident to incontinence care. The the male aides always had two to do his incontinence care then asked if there should the conducted that there should	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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F 689	Therapy Manager (a the interview, the PT (OT) notes for Resident therapy staff reported evaluation was compa resident's admiss admitted to the facility therapist (one who wassessment. Upon for therapists reported a mobility and ADL car addressed by therapia lying down to sitting An interview was corp PM with the facility's Services (DNS). Duri	ysical Therapist (PT) and Speech Therapist). During and Occupational Therapist ent #6 were reviewed. The da PT and OT therapy eleted on day 1 or day 2 after on. Since Resident #6 was yon a weekend, a PRN orks as needed) did the earther inquiry, however, the resident 's needs for bed the within the bed were not ey, except when moving from grup position.  Inducted on 2/13/19 at 4:40 as Director of Nursing ring the interview, the book from Resident #6 's	F 6	89				
	and was intended to that were made to a electronic Kardex to reported that nursing to review the Communication any changes had been after reviewing a chartest was supposed to book to indicate he/s made to the resident for Resident #6 in the revealed a change windicated the resident with ADL care. Howe two NAs had signed the information. The Communication Log	book was kept on each hall communicate any changes resident's care plan and the nursing staff. The DNS assistants were supposed unication Log book to see if en made for their residents. Inge noted in the log book, to sign the form in the log he was aware of the change 's care. Review of a form the Communication Log book as made on 1/13/19 which the required 2-person assist ever, the DNS noted that only this form as having reviewed DNS stated the Book was the facility's each of the state of the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345391	B. WING _			l	C <b>16/2019</b>
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	CODE	, <u> </u>	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 689	at 4:20 PM with the D the DNS was asked he she would have expecare to Resident #6 of stating, "It should have Kardex." The DNS and acknowledged this in the Kardex at the time 2/7/19.  On 2/14/19 at 10:30 A Director, DNS, and D Compliance Officer with immediate jeopardy. Following acceptable Immediate Jeopardy AM:  1) Resident #6 experent/13/19 during the 7-Daily Living (ADL) can CNA. The resident 's ADL bed mobility stip with bed mobility". The if the assistance need two-person assistance (RR) and attending president transported (ED) for evaluation of day with a report "sus fracture of the proximitinger". Report was gresident 's return from Upon return to the factories.	was conducted on 2/15/19 DNS. During the interview, now many staff members icted to provide incontinence on 2/7/19. She responded by we been two like in the dded that NA #2 formation was available in the the resident 's fell on  AM, the facility 's Executive irector of Operations and were informed of the The facility provided the credible allegation of removal on 2/16/19 at 9:03  ienced a fall from bed on 3 am shift while Activities of re was being provided by sinitial plan of care related to ulated "assistance needed the plan of care was not clear ded required one-person or the. Resident Representative thysician notified and to Emergency Department on 1/13/19 and returned same staining a closed displaced thal phalanx of right little given to the RR following	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345391	B. WING			1	C <b>16/2019</b>
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		11	TREET ADDRESS, CITY, STATE, ZIP CODE  31 NORTH CHURCH STREET  REENSBORO, NC 27401	1 02/	10/2013
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page		F	689			
	added to resident pla Intervention was by the Staff Developer through the facility 's 1/13/19  Resident #6 experier bed on 2/7/19 during shift while CNA was p was notified by CNA proper assessment a sustained a skin tear middle finger. Physic sent to ED for evalua transport on 2/7/19 to evaluation Resident facility on 2/7/19 6:55 laceration to left eye.  The facility administra involved in the incide delivery. When aske the resident 's KARD the CNA responded t to care, but did review further questioned as	were as follows:  2 person assist with ADLs n of care and KARDEX communicated to line-staff nent Coordinator (SDC) Communication Log on  ced a subsequent fall from the 11pm-7am (12:58AM) providing peri-care. Nurse prior to moving resident for nd determined to have to left eyebrow and right cian notified and resident tion. RR notified of fall with the ED for further returned from ED to the					
	protocol, he responde the KARDEX. The C counseling from the f regarding reviewing t suspended at this tim 2) Corrected Action to potential to be affected	ed he did, but did not review NA received one-on-one acility administrator he KARDEX and remains e. for Residents with the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED		
		345391	B. WING			C 2/16/2019		
	ROVIDER OR SUPPLIER	BAT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CO 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		2/16/2019		
(X4) ID PREFIX TAG	(EACH DEFICI	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 689	function, physical and/or effects of scorrection will add After review of the it was identified th amount of assista Based upon this, it team re-assessed regards to bed moto ensure the indimet without compneeds, including the consultation of the resultation of the start of the star	due to impaired cognitive limitations, comorbidities, ome medications. This plan of dress this potential for accident.  Resident #6 initial plan of care the plan was not clear on the nace needed by the resident. The facility 's interdisciplinary 100% of all residents with abbility and positioning on 2/13/19 widual needs of residents are romising safety. Identified the required assistance person) were documented and sident 's Kardex and Care Plan diffied through the re-assessment is needing assistance with bed oning will be referred to therapy tion to assure the amount of	F	589				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345391	B. WING _				C <b>16/2019</b>		
NAME OF PROVIDER OR	SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		10.2010		
HEARTI AND LIVING	& RFHAR AT	THE MOSES H CONE MEM H		1	131 NORTH CHURCH STREET				
TIEARTEAND EIVING	a KENAD AI	THE MICOEC IT COME MEM IT		G	GREENSBORO, NC 27401				
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
s KARDE. Any staff start of the All Licens DNS/designer in the important of care. A prior to standard care/KAR communion member of Interdiscip advised the important in the direct KARDEX signatures The important in the important in the important in the important in the facility be monitoded in the facility be monitoded in the control of the control o	e employee sed Staff wil gnee on/ber sed Staff wil gnee on/ber ortance and ir supervision of the resident of the enge in a resident of the IDT terms of the IDT terms of the IDT terms of the IDT terms on the Color tance of respiration of the staff or the staff of the care protous of the care protous of the staff of t	re. red will be inserviced prior to 's next scheduled shift. I be inserviced by the fore 2/14/19 regarding: necessity to monitor staff on for following protocol in ent KARDEX for guidelines inserviced will be inserviced inployee 's next dent 's plan of ing delivery of care will be y to the charge nurse by a am using the The charge nurse will their responsibility to inform if the change and updated ed by applicable staff immunication Form. Inferring to resident 's dent care to be given added ployee Orientation for CNAs censed nurses to oversee under their supervision to cols are followed will be s in the New Employee ed Nurses.  The eaction plan established by the staff of concern will theduled and routine basis. The dit which includes the  If person visually observing mobility osition of resident was	F	689					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345391	B. WING			C <b>)2/16/2019</b>		
	ROVIDER OR SUPPLIER	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		211012010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 689	o Height of book on Any issues how was the issue at This Bed Mobility Auminimum of 10 time as needed by the Double the scheduled audit facility morning admitted facility and by the Double facility and the part of the	mpleted per plan of care  med appropriate s with performance and if so, addressed udit will be completed at a s weekly for four weeks, and NS/designee. Outcomes of s will be discussed during the ministrative (which members of ssurance (QA) Committee are compliance will be addressed omes of compliance with I also be brought to the facility DNS/designee for committee and changes needed in plan All discussion will be included minutes.  Leks of Bed Mobility audits, Bed continue with a minimum of 10 of months, and as needed. Idits will be brought to the meetings by the DNS to be Committee members for scussion and/or revisions to mained in the meeting minutes. plan will require Dicable staff by the require monitoring to begin s per week times 4 weeks.  aff will be monitored using the et" and will be conducted by 10 times per week times 4 led. This monitoring tool will	F 68	9				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTR		(X3) DATE SURVEY COMPLETED		
		345391	B. WING_			1	C 1 <b>6/2019</b>	
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		1131 NOR	DDRESS, CITY, STATE, ZIP CODE  TH CHURCH STREET  BORO, NC 27401	1 02/	10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 689	scheduled audits will facility morning adm the facility Quality As present). Any non- as observed.	pe 44 Diance. Outcomes of the I be discussed during the inistrative (which members of ssurance (QA) Committee are compliance will be addressed	Fé	89				
	Sheet will continue to times per month X 7 monitoring will be concerned brought to the facility DNS/designee to be Committee members discussion and/or recontained in the meet to the plan will requistaff by the DNS/designee.	o be used at a minimum of 10 months, or as needed. This						
	implementing this pl	ence, the DNS is responsible						
		imeline of actions outlined, removal will be obtained by						
	Jeopardy removal w 1:20 PM. The validatinterviews with both non-licensed nursing information regardin	ole allegation of Immediate as validated on 2/16/19 at ation was evidenced by licensed nursing staff and g staff on where to locate g safety measures necessary e, including the number of						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS		(X3) DATE SURVEY COMPLETED		
		345391	B. WING				C / <b>16/2019</b>	
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		1131 NC	ADDRESS, CITY, STATE, ZIP CODE ORTH CHURCH STREET ISBORO, NC 27401	1 02/	10/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE	
F 689	on-going in-service reunlicensed staff were on the floor. A review Tool and the assessmed regards to bed mobiliconducted as part of  2) Review of the mark facility's mechanical I specified all three strilifting pad must be use bar to safely lift a resemble. Resident #8 was admoundative diagnoses hypertension and and Review of the quarter assessment dated 11 alert and oriented whof 1 (one) staff for bed into and out of bed. I weak, and his balance indicated Resident #69 inches and a weige Record review reveat trying to transfer Resident and was unable to the floor and no inject mechanical lifting determined to use this resident transfers.	provide ADL care. Review of ecords revealed licensed and in-serviced prior to working of the Bed Mobility Audit ments of residents (with ty and positioning) was also the validation process.  Infacturer's instruction for the lift used for resident transfers aps on both sides of the lift and attached to the lift's ident.  In the Minimum Data Set (MDS) (A/18 coded the resident as o required limited assistance of mobility and the transfer lis lower extremities were exactly was recorded as the recorded as 392 pounds.  In the Minimum Data Set (MDS) (A/18 coded the resident was unsteady. Section K as height was recorded as the recorded as 392 pounds.  In the Minimum Data Set (MDS) (A/18 coded the resident was the light was recorded as the recorded as the recorded as 392 pounds.  In the Minimum Data Set (MDS) (A/18 coded the resident was the light was recorded as the recorded as the recorded as 392 pounds.  In the Minimum Data Set (MDS) (A/18 coded the resident was the light was recorded as the recorded as the recorded as the recorded as 392 pounds.  In the Minimum Data Set (MDS) (MD	F	689				
		an dated 12/25/18 revealed mechanical lift for transfers.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345391	B. WING		C 02/16/2019	
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401	1 02/10/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 689	his bed to the wheelch lift, performed by Nur NA #7. The lifting pacifit was placed underrulifting pad had 3 loope. The straps at the end bar. The middle strap attached to the lifting resident with the medinquiry was made about the middle strap to the and NA #6 then secu		F 68	39		
F 760 SS=K	stated he does not us pad to secure the res reason was provided.  Interview on 2/16/19 Administrator and Dir conducted. The DON each strap on the pad mechanical lift and foi instruction.  Residents are Free of CFR(s): 483.45(f)(2)  The facility must ensu §483.45(f)(2) Resident medication errors.  This REQUIREMENT by: Based on resident 's	at 10:52 AM with the ector of Nurses (DON) was I expected the staff to attach it to the bar of the llow the manufacturer's f Significant Med Errors	F 76	Address how corrective action will be accomplished for those residents found	3/12/19 d to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI			، ا	С
		345391	B. WING				′ 16/2019
NAME OF PI	ROVIDER OR SUPPLIER	<u>I</u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2013
					131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			REENSBORO, NC 27401		
	CLIMMADY CT	TATEMENT OF DEFICIENCIES	- 15		·		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	e 47	F	760			
		ailed to prevent a significant			have been affected by the deficient		
	medication error by fa				practice		
	_	to correctly administer an			P		
		ation used to treat cancer			The resident identified as Resident #4,		
	(lenalidomide) for 1 o				was admitted to Heartland Living and		
	medications were rev	riewed (Resident #4). The			Rehabilitation Center on 8/28/17. As of		
	_	st noted on 10/12/18 that her			2/21/18, Resident #4 presented with th		
		a progression of her multiple			following diagnoses: multiple myeloma	not	
	•	cation was ordered by the			having achieved remission, malignant		
	oncologist on 10/30/1	· · · · · · · · · · · · · · · · · · ·			neoplasm of unspecified of right female	9	
		to the facility by Resident			breast, and secondary malignant	_	
	_	18. The medication was			neoplasm of the bone. The resident wa		
		dication cart (unopened) and I 1/10/19. A count of the			seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams (I		
		es conducted on 2/14/19			-take one tab by mouth daily was order		
	1	ules had been administered			The DNS in-serviced transport driver o		
		e. Failure to receive the			2/14/19 that all consult paperwork mus		
		d due to the progression of			be given to the charge nurse upon retu		
	-	delayed the resident 's			to the facility. This medication aide was		
	response to the treati				in-serviced by the DNS on the importar		
	•				of receiving medications and reporting		
	Immediate Jeopardy	began on 11/5/18 when			the charge nurse on 1/10/19 and		
	lenalidomide was ava	ailable at the facility for			re-inserviced on 2/14/19 regarding the		
	I .	sident #4 as prescribed by			process of receiving any new medication		
	her oncologist. Imme	ediate Jeopardy was			or consults, the medication aide must of	jive	
	removed as of 2/15/1	•			both to the charge nurse.		
	implemented an acce						
	Immediate Jeopardy				On 1/10/19, Resident #4, had a follow-	•	
	remains out of compl				appointment at the oncologist. Upon the		
		actual harm with potential			resident□ return it was discovered that		
		al harm that is not immediate			resident had not received Revlimid	tho	
	jeopardy) for the facil	e monitoring systems put into			(Lenolidomide) was initially ordered at 10/12/18 appointment. The DNS verifi		
	place are effective.	- monitoring systems put into			that the medication was on the cart on	<del>-</del> u	
	place are ellective.				1/10/19 and the medication aides		
	The findings included			documented medication as given from			
	The mange moduce	<del>.</del>			1/10/19-1/31/19 and 2/7/19 to 2/14/19;		
	Resident #4 was adm	nitted to the facility on			however, 22 pills were in the cart on th		
	Resident #4 was admitted to the facility on 8/28/17 with re-entry to the facility on 2/21/18.				morning of 2/14/19 when the surveyor	-	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTIO	ON	(X3) DATE SURVEY COMPLETED
			D MANAGO			С
		345391	B. WING _			02/16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE	
UEADTI A	ND LIVING & DELIAE	AT THE MOSES H COME MEM H		1131 NORTH CH	IURCH STREET	
HEARILA	IND LIVING & REHAD	B AT THE MOSES H CONE MEM H		GREENSBOR	O, NC 27401	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFI)		PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E	` '
TAG		OR LSC IDENTIFYING INFORMATION)	TAG		SS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 760	Continued From p	_	F 7	60		
		agnosis included multiple		counted th	he medication with the	
	myeloma (a cance	er that forms in a type of white		medication	n aide. The oncologist has	
		plasma cell) not having		been notif	fied by the DNS on 2/15/19 o	f
		; malignant neoplasm (tumor)			ery of 22 pills and through	
		of right female breast; and			mmunication with the oncoloເ	gist
	secondary maligna	ant neoplasm of the bone.			ay (2/15/19) at 12:45pm the	
					been rewritten to the following	J
		cility 's October 2018 Physician			1-day cycle today at 1PM, ar	ıd
	· ·	or Resident #4 revealed her			cycle. After the 7-day rest	
		ded 2.5 milligrams (mg)			egin the next 28-day cycle wit	
		en as one tablet by mouth daily			ministration verifying daily dos	
	for breast cancer (	(initiated on 2/21/18).		-	ordered dose was given tod	-
	A rovious of the rea	sident 's medical record			nd will continue daily at 1PM	^
		logy Consult Progress Note		20 days (e	ending on 3/7/19)	
		he note indicated Resident #4		Pesident t	#4 will continue follow-up	
		ncology office by the Nurse			ent with oncologist as	
		on 10/12/18. The following			d. Resident will be sent to he	r
	, ,	essed: multiple myeloma in			ent with the carbon Consultat	
		nant neoplasm of breast, Stage		1 ' '	consulting MD to transcribe a	
		, in part: "(Resident #4) is here			rs, treatments, and follow-up	,
		mily member) to discuss her			ents. The form will be receive	ed l
		sion and starting her on			nsportation driver in a sealed	
		nd name of Revlimid). She is		•	and brought back to the facil	
		nib (an antineoplastic agent			ed to the charge nurse for the	•
		ple myeloma that is			The nurse will read consultat	
		er subcutaneously or		form thoro	oughly and notify attending	
	intravenously) eve	ery 2 weeks and is tolerating		physician	of new orders, and transcrib	e
	that well." Lenalid	lomide is an antineoplastic		orders ont	to the Resident #4□s MAR a	S
	medication used to	o treat multiple myeloma in		ordered.	The pink copy of the	
	patients by multipl	e mechanisms, including		Consultati	ion Form will be placed in the	÷
		th of myeloma cells. The plan			and reviewed at the Morning	
		I in the Oncology Consult Note		_	o ensure orders and direction	is of
		ad, "(Resident #4) will start on		the consul	Iting MD are followed.	
		daily. (Name of oncologist)				
		sShe will receive bortezomib			ointment scheduled for 2/21/1	
		rating that well. I reviewed with			elled by the son. Appointmen	
		ember) the labs that we drew			neduled for 2/25/19 and resid	ent
	that indicated a slo	ow progression of her myeloma.		was seen	by the oncologist. Consult	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345391	B. WING			C <b>02/16/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		02/16/2019
TO WILL OF TH	(OVIDER OIL OOI 1 EIER			1131 NORTH CHURCH STREET	52	
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H				
				GREENSBORO, NC 27401		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 760	Continued From pag	ge 49	F 76	60		
	I also gave him deta	iled info about the		sheet was received by the D	NS and new	
		dent ' s) after visit summary."		orders were initiated. Reside		
				to receive medications/treatr	nents as	
	An addendum was n	made to the 10/12/18		ordered by the attending phy	ysician and	
	Oncology Consult P	-		oncologist.		
		icated he met with Resident				
		nber. At that time, her lab		Address how the facility will	-	
		progression of the multiple		residents having the potentia		
		ssed, along with the need to		affected by the same deficie	nt practice	
		ent. The oncologist noted,		A 100% review was conduct	end on 2/14/10	
		ys of doing this, but I think uld be to add lenalidomide"		by the DNS /designee on all		
		indicated he had discussed		who have had appointments		
	_	their oral chemotherapy		October 1, 2018 to ensure a		
		to help obtain the medication		medications, labs, and follow		
	for Resident #4.	·		followed according the MD of	•	
				Appointment Tracking Log w	ill be filled out	
	A review of Resident	t #4 ' s electronic medical		with the resident name, date	, Provider	
		led the oncology consult		name, new orders, description		
		8 was scanned into the		order, f/u appointment, f/u da		
		the facility on 10/16/18.		results to attending MD and		
		#4s October 2018 Physician		MD, MD signed results, new		
		ealed there was no order for		the initials of the person rece		
		ew of the resident 's October		order. These logs will be pla		
		ministration Record (MAR) de was not included on the		notebook and kept in the DN DNS will be responsible for f		
		is administered to Resident		logs daily (Mon-Fri) and the		
	#4.	is administered to resident		(weekends).	Tay on duty	
	<i>II</i> 1.			A 100% med cart audit was	conducted on	
	A review of the resid	lent 's medical record		2/15/19 by the licensed phar		
		cology Consult Progress		other issues were identified		
		3. The note indicated		resident□s were not currentl	y receiving	
	Resident #4 was see	en at the oncology office on		medications as order.		
		lowing issues addressed:				
		ot having achieved remission;		Address what measures will	•	
		x-ray (areas of bone		place or systemic changes n		
		rom cancerous plasma cells		ensure that the deficient pra-	ctice will not	
		ne marrow); and malignant		recur		
	neoplasm of breast	Stage 4. The resident 's				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345391	B. WING _			02/	16/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		11	131 NORTH CHURCH STREET		
1127 (17.127	NO EIVING G REIIVE			G	REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 760		e 50 he oncology notes included be given as one capsule by	F	760	All licensed nursing staff and medicatio aides have been in-serviced on 2/15/19		
	mouth once daily.  A review of Resident record (EMR) reveals	#4 ' s electronic medical ed the oncology consult			the SDC on diversion, resident rights, a 6 rights of medication administration.  Nurses and med-aides not in-serviced 2/15/19 will be in-serviced prior to the r	and by	
	resident 's EMR at the Review of the resident	nt 's medical record included			scheduled shift.  All new nurses and medication aides w be in-serviced on 2/15/19 on diversion,		
	and dated 11/2/18. A medications indicated	nored by the facility 's NP A review of the resident 's d 5 mg lenalidomide was			resident rights, and 6 rights of medicati administration in facility orientation.		
	Review of Resident # Physician Order Sum	44s November 2018 Imary revealed there was no			Indicate how the facility plans to monitority its performance to make sure that solutions are sustained	<i>n</i>	
	order for lenalidomide November 2018 Med	e. A review of the resident 's lication Administration ted lenalidomide was not do f medications			The Medication Carts (at one cart a day will be audited by the DNS/designee weekly x4 weeks, and as needed, then monthly thereafter x 6 months, and as needed to ensure compliance with the		
	a Physician 's Progre The note indicated R	nt 's medical record included ess Note dated 12/20/18. esident #4 was seen for a up of chronic medical			medication administration protocol. The audit will be monitoring residents medication orders compared to the medication in the cart and if any medications are not present. Should a		
	diagnoses. Her histo included the following receiving infusion the classification) multipl	ory of present illness (HPI) g notation, in part: "She was erapy for IgG kappa (a e myeloma which is			medication not be present it will be obtained as soon as possible, either through the facility Omnicell, pharmacy back-up pharmacy. The DNS/designed	∕, or e	
	progressing slowly. Soncology 10/12/18; the reviewedAt the last initiated"				will review the resident s MAR for any miss doses, and if found a medication error report will be completed and the nurse/med aide will receive one-on-one counseling by DNS/designee regarding	e	
	_	t4s December 2018 Imary revealed there was no			notification to charge nurse and pharms of any missing medication.		

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		E SURVEY PLETED
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	345391	B. WING _			/16/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLAND LIVING & REHAB AT	THE MOSES H CONE MEM H		1131 NORTH CHURCH STREET		
			GREENSBORO, NC 27401		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760 Continued From page	51	F 7	60		
December 2018 Medi Record (MAR) reflected included on the record administered to Resident and Minimum Data Set (Mathe resident was assessive severely impaired cog decision making. She assistance by staff for Living (ADLs).  Further review of Resincluded an Oncology dated 1/10/19. This in "(Resident #4) returns treatment of her estrocancer as well as her accompanied by her to far as the breast cance continues on letrozole receives bortezomibed this with good tolerand prescribed lenalidomic this by the patient was oral chemotherapy photoed, however, that lincluded on the patier the facility. The plan concology Consult Not "(Resident #4) looks on complaints. Howe to lab work showing pomyeloma) have been supposed to have staff	cation Administration and lenalidomide was not at of medications ent #4.  #4 's most recent quarterly DS) dated 1/9/19 revealed ssed by staff to have initive skills for daily required extensive all of her Activities of Daily  ident #4 's medical record Consult Progress Note ote read, in part: today for follow-up and gen receptor positive breast history of multiple myeloma wo (family members). As er is concerned, she r, with good tolerance. She every 2 weeks. She takes be. Also on 10/30/18 we de at 5 mg daily. Receipt of s confirmed 11/5/18 by our armacists." The oncologist enalidomide was not it's list of medications from f treatment noted in the er for Resident #4 read, dinically very stable and has ever her numbers (referring rogression of the multiple	F 7	Audit Compliance (Medication be discussed weekly by the DNS/designee during morning administration meetings where Assurance (QA) Committee mattend, X 4 weeks, and as nee DNS/designee will bring result Medication Cart audit the facili QA meetings for committee revinput monthly X 7 months, and All discussion will be maintaine meeting minute notes. Any non-compliance will be noted a corrective actions taken. Any of the monitoring plan will require re-inservicing by the DNS/desimonitoring to begin again at the audits until compliance is met.  Results of audits will be present facility QA committee by the Dmonthly x3 and then quarterly and as needed. All discussions to plan, and additional in-service noted in the QA Committee Memorated in the QA Commi	e the Quality embers ded. The s of ty monthly view and I as needed. ed in and change to gnee and e weekly  nted to the NS during thereafter, s, revisions cing will be eeting  onsible for n. The date	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401		92.10.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	medication she has has missed any dos noticed any side eff noted he provided t document the facilit family members to it what happened to t in early November. has been receiving today show further intensify the borteze	medication, how much been receiving, whether she ses, and whether they have ects." The oncologist also he direct line to his nurse to y's response and asked her nquire at the facility as to he medication they delivered The oncologist noted, "If she lenalidomide and the labs progression, we will need to omib and move to weekly, or	F 7	60		
	antineoplastic medi multiple myeloma). been receiving lena need to do and then On 1/10/19 at 3:27 received in accorda recommendations to lenalidomide. The mg lenalidomide to	PM, a physician 's order was nce with the oncologist's o initiate the administration of medication order instructed 5 be administered to Resident once daily for 21 days, stop for				
	extra daily dose (22 lenalidomide was a due to a transcriptic physician was notifinoted.  On 2/13/19 at 1:00 conducted with the nurse reported after appointment, addition by the oncologist w	dated 1/31/19 revealed one days versus 21 days) of dministered to Resident #4 on error. The resident 's ed; no clinical harm was ed; no clinical harm was oncologist 's nurse. The Resident #4 's September onal lab results were received hich indicated progression of the resident to the resident came.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY
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	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		72/10/2019
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	lenalidomide would reported while her cowas treatable and collenalidomide was a dispensed from a sprocess of acquiring review of Resident # oncology office was authorization for the Upon further review records indicated thousand the delay in getting with the delay in getting in She reported there would have preferred the delay in records indicated thousand the delay in getting in She reported there would have preferred that was not curable would have preferred the medication) 2-3 "It's been very diffication of the problem was."  A telephone interview the medication) 2-3 "It's been very diffication of the problem was."  A telephone interview the medication of the resident was reported that was not curable would have preferred the medication) 2-3 "It's been very diffication of the problem was."  A telephone interview at 10:20 AM with a respecialty pharmacy 's lenalidomide. Durepresentative reported the was reported the problem was."	ppointment, it was decided be initiated. The nurse ondition was not curable, it ontrollable. She stated	F 7			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER  ND LIVING & REHAB A	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODI 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		2/10/2019
(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 COI	SHOULD BE	(X5) COMPLETION DATE
F 760	family member on 2 lenalidomide contain  A telephone intervie at 8:20 PM with Res During the interview he attended the once Resident #4 on 10/1 by the oncologist 's new medication (len obtained through the reported the oncolog with the specialty phyprinted prescription further inquiry, the forceived the medication further inquiry, the forceived the medication put it in the medication put it in the medication put it in the medication to. He sto identify the staff in told the staff member medication bottle, he the medication was the doctor. The family when he later went length with Resident #4, "Heme" thinking he had to the facility. The family went to the facility ri (1/10/19) and talked facility said they did	ond bottle was shipped to the /5/19. Each bottle of	F 76	60		
	on the med cart. The had been two month	e family member stated, "It is, that 's crazy." When ed to obtain refills for the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	TO PLAN OF CORRECTION	STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401			1 02.10.2010	
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	medication, he report called him about a was econd bottle of medication a few of medication and interview of 10:15 AM with the D #2 had indicated she received the first both Resident #4's family reported that based recollection, it had be bottle of the lenalido facility on 11/5/18.  An interview was condamined was list medication list with a When asked, the NF number showed, "The authorization." She firmedication was put of provider such as one go over to the med light reported the next time on 1/14/19. Lenalido the current meds on list at that time.  An interview was condamined was condamined was condamined was condamined was condamined was put of provider such as one go over to the med light reported the next time.  An interview was condamined was c	ted the specialty pharmacy reek before they sent the dication (lenalidomide) out to received the second bottle days ago, but had not yet cility.  Conducted on 2/16/19 at NS, it was reported Med Aide was the staff member who the of lenalidomide from y member. The DNS on the family member 's een determined the first mide was brought in to the inducted on 2/15/19 at 11:05 helped care for Resident #4. Previewed the notation she me NP reported the	F 76	60		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER  ND LIVING & REHAB A	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401		2/16/2019
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	medication list. The could see a progress 12/20/18 which inclures ident's medication this was because the and did not have it of the facility). The phycould not enter a new signed the order; he after the delay in the lenalidomide was identified physician questioned receiving this medical difference for Resides.  An interview was con AM with the facility' Services (DNS) in the Director. During the asked to describe the communication with DNS reported a face medication list (either MAR) was sent with member when she to consultation. Upon reappointment, a pack back with the resider may be a note writter form brought back to there was a new ord consultation information the provider box for physician to review.	domide on Resident #4 's physician also reported he so note he himself authored on ded lenalidomide on the on list (he was unsure why expected for administration at resident was not receiving it ordered for administration at resician reported the facility of worder unless he or the NP did not recall doing so until med administration for entified on 1/10/19. The district would have made a sent #4.  Inducted on 2/12/19 at 9:15 as Director of Nursing expresence of the Executive interview, the nurse was de facility 's process of outside consultants. The	F 7	60		
	When asked who wo	ty 's contracted pharmacy.  buld initiate a new medication by an outside consultation,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345391	B. WING _			02/	C 16/2019
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		1131	EET ADDRESS, CITY, STATE, ZIP CODE  NORTH CHURCH STREET  EENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 760	A follow-up interview at 5:21 PM with the fareported she was first the delay in Resident on 1/10/19. The residurectly from the onco date over to the facility because the oncologist he resident was supply medication that they into the med list sent to the stated she understoo obtained a prescription the oncologist because be covered by insural pharmacy. Around the 2018, the prescription and the family membroto the facility. She recould not recall who had the family membroto the facility. She recould not recall who had the family membroto the facility on the medical she went to	was conducted on 2/12/19 acility's DNS. The DNS t informed of a problem with #4 receiving lenalidomide dent's family member came elogist's office visit on that ty. He was concerned st's office made him aware cosed to be taking some noticed was not included on them by the facility. The DNS d the family member had on for the lenalidomide from see the medication would only note through another the first part of November, on for lenalidomide was filled the brought the medication in ported the family member the gave the medication to. The checked the resident' and her MAR, she station was not given. When coart, she discovered an malidomide labeled for the don the cart. When asked and why the medication was stated, "No." The DNS the oncologist's office and ton 1/10/19. The DNS the oncologist's office and the that time why the facility of the need to initiate	F7	760			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER  ND LIVING & REHAB A	AT THE MOSES H CONE MEM H	STREET ADDRESS, CITY, STATE, Z 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	2/15/19 at 4:20 PM reported upon invest resident 's oncology facility. She reported sent from the oncology physician, in addition the facility via the trafacility has identified reports getting scan medical records befinurse, the NP, or the A telephone intervie at 12:54 PM with the member. During the reported when she part Resident #4 back frow would typically put to information from the at the nursing station has recently been constructed to now pladirectly in the hands ensure the consult of the resident 's February management of the resident 's February management in the resident 's February management in the resident of the res	interview was conducted on with the DNS. The DNS tigation, they discovered the y consults did come to the d consultation reports were egist to the attending in to paperwork being sent to cansport driver. She stated the dia problem with the consult ned into the electronic core they were reviewed by a elephysician.  We was conducted on 2/16/19 elefacility is transportation staff eleinterview, the staff member coreviously transported form an outside consult, she he consult packet (containing eleoutside consult) on the desk in. She reported this process can aged and she has been acce this packet of information is of the nurse on duty to	F7	· · · · · · · · · · · · · · · · · · ·		
	MARs, a total of 29 documented as adm the following staff m administered 2 caps administered 20 cap administered 2 caps	lenalidomide capsules were ninistered to the resident by embers: Med Aide #1 sules; Med Aide #2 psules; Med Aide #3 sules; and Med Aide #4 sules; and Med Aide #5				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		345391	B. WING _		02/1	; 16/2019
	ROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CO 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	•	10/2013
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	Continued From p	page 59	F 7	60		
	2/14/19 at 10:10 A #1 was assigned a medication cart. A lenalidomide labe observed to be sto on the medication prescription date of dispensed by the request, Med Aide capsules remaining Med Aide was obse capsules out of the time (while counti) One medication of 9 capsules. The se counted and contact capsules had bee medication cups for capsules were ob of the original contotal count. The M It was determined remained in the m containing 28 cap capsules, Med Aide returned all capsul medication bottle, and returned the I to a drawer on the An observation ar conducted on 2/19 #1. Med Aide #1 hall medication cap bottle of lenalidom observed. Upon of	and interview was conducted on AM with Med Aide #1. Med Aide to Resident #4's hall At that time, one bottle of led for Resident #4 was bred on the med cart. Labeling bottle also included an original of 10/30/18 and the date pharmacy (11/2/18). Upon at #1 counted the lenalidomide and in the medication bottle. The served as she poured the ele original container one at a mag) into two medication cups. Up was counted and contained second medication cup was anined 11 capsules. After the in poured into the two for counting, two additional served to be left at the bottom tainer and were added to the Aide confirmed the counts. In a total of 22 capsules hedication bottle originally sules. After counting the defended was observed as she alles back to the original secured the cap on the bottle, enalidomide medication bottle in medication cart.  Indication in the medication bottle was assigned to Resident #4's and interview was again 5/19 at 8:35 AM with Med Aide was assigned to Resident #4's and interview was again to the time, the resident should be severed on the medication the was appening the bottle of a 7 capsules were seen lying on				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG	` '	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP COL 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	•	2/16/2019
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 760	clearly visible and removing them from the medication same as that obset the resident 's nadate of 10/30/18, pharmacy (11/2/1 reported she did reported she did reapsules that were lenalidomide bottl (2/14/19). Upon for Aide #1 stated, "It inspection of all dimedication cart conceived there were lenalidomide store."  An interview on 2/2 and facility 's Executed interview, the #4 's lenalidomide capsules) to 2/15/14 At the time 22 capsules. However, originally contained the resident could lenalidomide capsules of lenalidomide. It medication audit to 2/14/19. The DNS capsules of lenalidomide at approximate and the MAI state on the MAI state on the MAI state on the MAI state of the medication audit to 2/14/19. The DNS capsules of lenalidomide at approximate and the MAI state on the MAI state of the medication audit to 2/14/19. The DNS capsules of lenalidomide at approximate and the MAI state of the MAI state of the medication audit to 2/14/19. The DNS capsules of lenalidomide at approximate and the MAI state of the MAI state of the medication audit to 2/14/19. The DNS capsules of lenalidomide at approximate and the MAI state of the MAI state of the medication audit to 2/14/19. The DNS capsules of lenalidomide at approximate and the MAI state of the medication audit to 2/14/19. The DNS capsules of lenalidomide at approximate and the medication audit to 2/14/19.	bottle. The 7 capsules were easily counted without om the container. The labeling bottle was confirmed to be the erved on 2/14/19, and included me, an original prescription and the date dispensed by the 8). When asked, the Med Aide not recall the exact number of ecounted from Resident #4's ethe previous morning urther inquiry, however, Med was more." A thorough rawers and compartments in the orducted by Med Aide #1 ere no other bottles of ed on the med cart.  15/19 at 9:10 AM with the DNS ecutive Director (ED). During count discrepancy of Resident emedication from 2/14/19 (22 ethe 19 (7 capsules) was discussed. It is in the emedication from 2/14/19 (22 ethe 19 (7 capsules) was discussed. It is in the emedication from 2/14/19 (22 ethe 28 capsules, which indicated in have only received a total of 6 sules. The DNS and ED stated in informed of the 2/14/19 count however, the DNS reported a was conducted the evening of S reported she observed 7 domide were remaining in the lately 9:30 PM on 2/14/19. R documentation for this NS indicated that she, too, had	F7	760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345391	B. WING			C )2/16/2019	
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401		02.70.20.10	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	lenalidomide. The D documented that Me Aide #3 and Med Aid medication to Reside the DNS confirmed of lenalidomide was on reported Resident #4 in the second bottle morning (on 2/15/19 her possession. The lenalidomide was ob (unopened). This m Resident #4 's name date of 2/4/19.  A telephone interview at 10:30 AM with Me DNS and ED. Durin was asked to describ Resident #4 's lenal Aide #1 reported the poured into two different of the med cart as the When asked if she rewere in the bottle of counted on the morn reported she could madded, "But I know it Med Aide #1 was als process she used to resident. The med a pull up the resident make sure she had the med, right dose, and She would then pull hold it up against the	ules remaining in the bottle of DNS reported the MAR and Aide #1, Med Aide #2, Med the #4 had administered this tent #4. During the interview, only one bottle of the medication cart. She is family member brought of lenalidomide earlier that he second bottle of served to be sealed edication was labeled with the and a pharmacy dispensed where was conducted on 2/16/19 and Aide #1 in presence of the grade the interview, the med aide on the process used to count idomide on 2/14/19. Med the lenalidomide capsules were rent medication cups on top the capsules were counted. Second of 2/14/19, the med aide not remember. However she	F 76	60			

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345391	B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	0.40001	1	STREET ADDRESS, CITY, STATE, ZIP COD		2/16/2019	
				1131 NORTH CHURCH STREET			
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H		GREENSBORO, NC 27401			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 760	Continued From pag	e 62	F 7	60			
	resident, the med aid	ed the medication to the de reported she would sign received the med on the					
	at 10:41 AM with Me interview, the med a 's family member ha medication (lenalido November 2018. She me a bottlethe (famentioned about (Re Although she was not thought this probably med aide stated since	w was conducted on 2/16/19 and Aide #2. During the dide was asked if Resident #4 and given her a bottle of mide) for the resident in the stated, "No he didn't hand dimily member) had just desident #4) not receiving it." tot sure of the date, she of occurred in December. The the the resident was receiving					
	that was the medical Med Aide #2 stated to had a bottle of medical him he could bring it thought it might have when she saw the midlenalidomide) on the reported sometime is	e med cart. Med Aide #2 ater (maybe in January), she					
	was different from the receiving. The med this medication orde see one, "but didn 't did not follow-up on Med Aide #2 was as she used to administ. The med aide report computer, look at the receiving it. After she the right medication, put check on the "pre-	ation bottle and saw this med e one the resident had been aide reported she looked for r in the computer and didn't think anything about it" and this. During the interview, ked to describe the process ter medications to a resident. The ed she would log into the e medication and the person e double checked that it was she would pop the med and epped" button in the er she administered the med					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		345391	B. WING _			C <b>02/16/2019</b>
	ROVIDER OR SUPPLIER	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP COD 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	•	02,10,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	ge 63	F 7	760		
	administered on the resident refused the record the med as " asked, Med Aide #2 on the MAR to indic administered, the remedication.	would record the med was electronic MAR. If the medication, she would refused" on the MAR. When reported if her initials were ate a medication was sident did receive the  w was conducted on 2/16/19				
	at 10:58 AM with Me interview, Med Aide process he used to resident. The med at the electronic MAR medication from the name of the resident and the dose; and the to the resident. One medication, he would	was conducted on 2/16/19 ed Aide #3. During the #3 was asked to describe the administer medications to a ide reported he would pull up for the resident; pull the med cart; double check the t, the name of the medication nen administer the medication ce he administered the d then come back to the cart ication administration on the				
	An attempt to condu Med Aide #4 was ur	act a telephone interview with nsuccessful.				
	PM with the DNS. It was asked what her to Resident #4 's le by stating the facility consult reports were medical record befor staff, the NP, or the she would have expreviewed this inform was initiated for the been aware of the mass asked what was a state of the new transfer of the new	During the interview, the DNS expectation was in regards nalidomide. She responded determined the oncology escanned into the electronic re being reviewed by nursing physician. The DNS indicated ected the facility to have nation and known lenalidomide resident. If she would have eed for the medication, she up on it. When asked, the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY
		345391	B. WING			C )2/16/2019
	ROVIDER OR SUPPLIER	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 NORTH CHURCH STREET  GREENSBORO, NC 27401		72.110.2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	Continued From pa	ge 64 that once Resident #4 ' s	F 7	60		
	lenalidomide was in expected the documaccurate and for the	itiated, she would have nentation on the MARs to be medication to have been resident as ordered.				
	and the Director of Officer were informed. The facility provided	O AM, the facility 's ED, DNS, Operations and Compliance ed of the immediate jeopardy. If the following acceptable of Immediate Jeopardy at 9:03 AM:				
	admitted to Heartlan Center on 8/28/17. presented with the form myeloma not having malignant neoplasm breast, and second bone. The resident 10/12/2018 and Remilligrams (mg) -take ordered The DNS in-service that all consult paper charge nurse upon medication aide was the importance of reporting to the chare-inserviced on 2/1	ntified as Resident #4, was and Living and Rehabilitation As of 2/21/18, Resident #4 following diagnoses: multiple grachieved remission, an of unspecified of right female ary malignant neoplasm of the awas seen by the oncologist on whimid (Lenolidomide) 5 are one tab by mouth daily was seed transport driver on 2/14/19 are work must be given to the return to the facility. This is in-serviced by the DNS on acceiving medications and arge nurse on 1/10/19 and 4/19 regarding the process of medications or consults, the				
	medication aide munurse.  On 1/10/19, Reappointment at the return it was disco	est give both to the charge esident #4, had a follow-up concologist. Upon the resident evered that resident had not Lenolidomide) was initially				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345391	B. WING _			C )2/16/2019	
	ROVIDER OR SUPPLIER  ND LIVING & REHAB A	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		32/10/2019	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	verified that the med 1/10/19 and the med 1/10/19 and the med medication as given 2/7/19 to 2/14/19; he cart on the morning counted the medicat The oncologist has be 2/15/19 of the discoverbal communication today (2/15/19) at 12 rewritten to the follow today at 1PM", and formal today rest period, be with nurse administragiven. The ordered of and will continue dain on 3/7/19)  Resident #4 will appointment with on appointment with on appointment schedule be sent to her appoint Consultation Form for any new orders, treat appointments. The formal transportation driver brought back to the scharge nurse for the consultation form the physician of new orders in the DNS box and Meeting to ensure or consulting MD are for 2. As all residents here	/18 appointment. The DNS ication was on the cart on dication aides documented from 1/10/19-1/31/19 and owever, 22 pills were in the of 2/14/19 when the surveyor ion with the medication aide. Overn of 22 pills and through on with the oncologist office 2:45pm the order has been wing, "begin a 21-day cycle inish this cycle. After the egin the next 28-day cycle aition verifying daily dose dose was given today at 1PM day at 1PM X 20 days (ending continue follow-up cologist as scheduled. Next led for 2/21/19. Resident will nament with the carbon or consulting MD to transcribe or consulting MD to the in a sealed envelope and facility and handed to the resident. The nurse will read proughly and notify attending ders, and transcribe orders and transcribe orders. The isultation Form will be placed reviewed at the Morning reders and directions of the	F 7	60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345391	B. WING _			C <b>02/16</b> /	/2019
	ROVIDER OR SUPPLIER	THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP OF 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	CODE	<u> </u>	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	_	(X5) COMPLETION DATE
F 760	providers, the following into place to prevent errors as a result of rown the DNS /designee of appointments since (cordered medications, followed according the Appointment Tracking the resident name, dorders, description of flu date and time, resconsulting MD, MD so and the initials of the These logs will be plain the DNS office. The filling these logs daily duty (weekends).  A 100% med care 2/15/19 by the licens issues were identified currently receiving modication, resident rigmedication administration in-serviced by 2/2 to the next scheduled.  All new nurses and modified in-serviced on 2/15/11 rights, and 6 rights of facility orientation.	pointments with outside ng actions have been put residents from medication not following MD orders.  I was conducted on 2/14/19 by n all residents who have had Dctober 1, 2018 to ensure all labs, and follow-up were medicated by the MD orders. The ground by the MD orders. The ground by the filled out with attered to attending MD and igned results, new orders, person receiving the order. The ground by the modern and the RN on the did was conducted on the did was conduc	F7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345391	B. WING			C 2/16/2019	
	ROVIDER OR SUPPLIER	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIF 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		2/10/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	months, and as newith the medication audit will be monitor orders compared to and if any medicat medication not be soon as possible, comnicell, pharmacon DNS/designee will any miss doses, are port will be compared will receive one-one DNS/designee regularse and pharmacon DNS/designee regularse and pharmacon DNS/designee will can audit Compliance discussed weekly morning administration Quality Assurance attend, X 4 weeks, DNS/designee will Cart audit the facilic committee review and as needed. A in meeting minute will be noted and confidence to the monitoring to beging until compliance is Results of audits we QA committee by the discussions, revisions, revisions, revisions.	en monthly thereafter x 6 eded to ensure compliance n administration protocol. The oring residents medication to the medication in the cart ions are not present. Should a present it will be obtained as either through the facility ey, or back-up pharmacy. The review the resident 's MAR for not if found a medication error eleted and the nurse/med aide -one counseling by arding notification to charge ey of any missing medication.  (Medication Carts) will be ony the DNS/designee during ation meetings where the (QA) Committee members and as needed. The bring results of Medication ty monthly QA meetings for and input monthly X 7 months, and discussion will be maintained motes. Any non-compliance corrective actions taken. Any itoring plan will require the DNS/designee and an again at the weekly audits	F	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345391	B. WING		C <b>02/16/2019</b>	
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H	1	TREET ADDRESS, CITY, STATE, ZIP CODE  131 NORTH CHURCH STREET  GREENSBORO, NC 27401	02/10/2013	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 760	implementation of this Effective 2/15/19  The facility 's credible Jeopardy removal wa 1:20 PM. The validate interviews with both li Med Aides on the 6 ri administration and the when a resident return consultation. Review records revealed lices were in-serviced prior review of the pharma Appointment Tracking conducted as part of Administration CFR(s): 483.70  §483.70 Administration A facility must be administration or practicable physical, well-being of each resident to use its refficiently to attain or practicable physical, well-being of each resident to the physical of the physical	e allegation of Immediate s validated on 2/16/19 at ion was evidenced by censed nursing staff and ghts of medication e facility process expected ned form an outside of on-going in-service nsed and unlicensed staff to working on the floor. A cry cart audit report and Daily Log was also was also the validation process.	F 760		3/13/19	
	from neglect and a significant when an antineoplast cancer (lenalidomide) administered in accordance.	gnificant medication error ic medication used to treat		Resident #4 remains in the facility and had a follow-up appointment with the oncologist on 2/25/19. The consult sh was reviewed by the Director of Nursin		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 56.125			С	
		345391	B. WING _		02	/16/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•		
				1131 NORTH CHURCH STREET			
HEARTLA	AND LIVING & REHA	B AT THE MOSES H CONE MEM H		GREENSBORO, NC 27401			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX TAG	,	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 835	Continued From p	<del>-</del>	F 8	335			
		ations were reviewed; and, to		Services (DNS). New orders			
		of Daily Living (ADL) care was		received and reviewed with th			
		ith two person assistance as		physician. Resident had anot			
		3 sampled residents reviewed for		follow-up on 3/7/19 with no ne			
	accidents (Reside	ent #6).		Resident has received medica			
	T. C. I.			ordered by the oncologist and	attending		
	The findings inclu	idea:		physician.	the feeilite to		
	1) Posidont #4 w	as admitted to the facility on		Resident #6 discharged from home on February 8th.	the facility to		
	l '	ntry to the facility on 2/21/18.		nome on February our.			
		agnosis included multiple		Address the facility will identif	v other		
		ing achieve remission;		residents having the potential			
	·	sm (tumor) of unspecified site of		affected by the same deficient			
		st; and secondary malignant					
	neoplasm of the b			A 100% review was conducte	d on 2/14/19		
				by the DNS /designee on all r	esidents		
	A review of the re	sident 's medical records		who have had appointments s	since		
	included an oncol	logy consult dated 10/12/18.		October 1, 2018 to ensure all	ordered		
		d Resident #4 's lab results		medications, labs, and follow-			
		ession of her multiple myeloma,		followed according the MD or			
		atment included initiation of 5		Appointment Tracking Log wil			
	` ` ` ` ` `	enalidomide to intensify her		with the resident name, date,			
		nedication was ordered by the		name, new orders, description			
		30/18 from a specialty rought to the facility by Resident		order, f/u appointment, f/u dat results to attending MD and c			
	#4 's family on 1			MD, MD signed results, new of	•		
	#4 Statility Off 1	173/16.		the initials of the person recei			
	A review of the re	sident 's medical records		order. These logs will be place	-		
		oncology consult dated 1/10/19.		notebook and kept in the DNS			
		d lenalidomide was not included		DNS will be responsible for fil			
	on the patient's lis	st of medications from the facility		logs daily (Mon-Fri) and the R	•		
	•	s made to confirm the resident		(weekends).	•		
	was receiving the	lenalidomide as previously		A 100% med cart audit was co			
	prescribed.			2/15/19 by the licensed pharn			
				other issues were identified in			
		7 PM, a physician 's order was		resident□s were not currently	receiving		
		dance with the oncologist 's		medications as order.			
		s to initiate the administration of		The facility □s interdisciplinary			
	lenalidomide. The	e medication order instructed 5		re-assessed 100% of all resid	ents with		

		ATE SURVEY OMPLETED				
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NAME OF DE	ROVIDER OR SUPPLIER	0.000.		STREET ADDRESS, CITY, STATE, ZIP COL	•	02/16/2019
NAIVIE OF PI	ROVIDER OR SUPPLIER				) <u> </u>	
HEARTLA	ND LIVING & REHAB A	THE MOSES H CONE MEM H		1131 NORTH CHURCH STREET		
				GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 835	Continued From pag	e 70	F 8	35		
F 835	mg lenalidomide to b #4 as one capsule or 7 days; then restart t An interview was cor AM with the facility 's Services (DNS) in the Director. During the asked to describe the communication with a DNS reported a face medication list (eithe MAR) was sent with member when she to consultation. Upon re appointment, a packe back with the resider may be a note writter form brought back to there was a new orde consultation informat in the provider box fo physician to review. was a new medication the order to the facility When asked who wo order recommended the DNS stated the re back would usually d A follow-up interview at 5:21 PM with the f	e administered to Resident nce daily for 21 days, stop for the same cycle.  Inducted on 2/12/19 at 9:15 is Director of Nursing is presence of the Executive interview, the nurse was a facility 's process of putside consultants. The sheet and current is the physician 's orders or the transportation staff took a resident to an outside eturn from the consult et of information would come into the bottom of the consult the facility. Whether or not the facility is NP or She reported that if there is on order, the nurse would fax ity 's contracted pharmacy, uld initiate a new medication by an outside consult the consult in the consult in the facility is no outside consultation, nurse receiving the consult	F 83	regards to bed mobility and p 2/13/19 to ensure the individu residents are met without cor safety. Identified needs, inch required assistance (one-person/two-person) wer documented and updated on resident s Kardex and Care 2/14/19. Any resident identified throug re-assessment by the IDT tea needing assistance with bed positioning will be referred to screen/evaluation to assure t assistance is accurate.  Address what measures will place or systemic changes m ensure that the deficient prace recur DNS and Administrator receiv on the new process for tracki consults on 2/14/19 by the D Operations. New appointmen was put into place on 2/15/19 was made responsible for the process.  Facility Administrator and two members attended a corpora training on February 19th re- lncident/Accident investigation	ual needs of impromising uding the the Plan on the am as mobility and therapy for he amount of the put into the ade to the amount of tracking log on and DNS enew to IDT te led garding ins,	
	the delay in Resident on 1/10/19. The resi directly from the once date over to the facili because the oncolog	t informed of a problem with t #4 receiving lenalidomide dent 's family member came blogist 's office visit on that ty. He was concerned ist 's office made him aware posed to be taking some		identifying root cause, impler proper interventions and mor conducted by the Director of Clinical Education  Checklist was provided to the members on 2/18/19 by the I	nitoring Quality and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345391	B. WING _				16/2019
NAME OF PR	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	, <u>v=</u> ,	10/2010
				11	31 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		G	REENSBORO, NC 27401		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 835	Continued From page	<del>2</del> 71	F 8	335			
	medication that they r	noticed was not included on			Operations to assist them with		
	the med list sent to th	em by the facility. The DNS			investigating incidents/accidents and		
	stated she understoo	d the family member had			ensuring interventions are put into place	e.	
		on for the lenalidomide from					
		se the medication would only			Email alerts will be sent to the		
	be covered by insurar				Administrator, DNS, Clinical Care		
		e first part of November,			Coordinator and Director of Operations	•	
		for lenalidomide was filled			when an incident/accident report is		
		er brought the medication in			opened by the nursing staff.		
	•	ported the family member ne gave the medication to.			Administrator will ensure an immediate		
		she checked the resident '			action is put into place by the nursing staff. IDT members will continue to		
	s physician 's orders				investigate the incident/accident to		
		ation was not given. When			determine the root cause and appropria	ate	
		cart, she discovered an			interventions are put into place and not		
		nalidomide labeled for			on the care plan/Kardex.		
	•	ed on the cart. When asked					
		ned why the medication was			Indicate how the facility plans to monitor	or	
	on the med cart, she	stated, "No." The DNS			its performance to make sure that		
	reported she called th	ne oncologist 's office and			solutions are sustained		
	talked with his nurse	on 1/10/19. The DNS					
	received a verbal orde	er for the administration of			Corporate staff/designee will be onsite		
		a fax with the order. The			days each week for 8 weeks beginning		
		t that time why the facility			the week of 2/18/19 to provide		
	had not been aware o				guidance/education in regards to polici	es,	
	lenalidomide for Resid	dent #4.			procedures and regulations to the		
	An intender	ducted as 0/45/40 -+ 4:00			Administrator, DNS and facility staff.	.	
		ducted on 2/15/19 at 4:20			Administrative visits will be coordinated weekly and documented on the	1	
	PM with the facility 's	ing the interview, the DNS			Administrative Weekly Schedule.		
		expectation was in regards			Weekly reviews of the med cart, reside	nt	
		alidomide. She responded			right and bed mobility audits will be	110	
		determined the oncology			conducted by the Director of		
		scanned into the electronic			Operations/designee for 6 weeks and		
		e being reviewed by nursing			then monthly thereafter for 6 months.		
		tioner, or the physician. The			Findings will be documented Corporate		
		ould have expected the			Verification Audit Checklist.		
	facility to have review	ed this information and			DNS and ED meetings will be held wee	-	
	known lenalidomide s	should have been initiated			for 6 weeks with Director of Operations	to	
ORM CMS-256	7(02-99) Previous Versions Obs	colete Event ID: 689Y11		Fac	cility ID: 943494 If continu	ation sheet	Page 72 of 83

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDII			С	
		345391	B. WING _	B. WING		02/16/2019	
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		11	REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 835	A telephone interview at 12:54 PM with the member. During the reported when she p Resident #4 back fro would typically put the information from the at the nursing station has recently been chrinstructed to now pladirectly in the hands ensure the consult w.  An interview was cor PM with the facility 's During the interview, regarding the medical Resident #4 were disting the goal of all system to provide optimal callowever, he recognical identified in a system current process was to be implemented to to better meet the new to be the meet the new 11:20 AM revealed Review of an Incident 11:20 AM revealed Review 11:20 AM revealed Review 11:20 AM revealed Review 11:20 AM revealed Rev	was conducted on 2/16/19 facility's transportation staff interview, the staff member reviously transported m an outside consult, she e consult packet (containing outside consult) on the desk b. She reported this process anged and she has been ce this packet of information of the nurse on duty to as reviewed.  Inducted on 2/16/19 at 12:05 as Executive Director (ED). The ED's expectations ation concerns identified for accussed. The ED indicated the sin place at the facility was are for the residents. The problem with the found, interventions needed of improve upon the process	F	335	ensure processes and follow-up assignments are understood and carrie out per facility protocols and state/fede regulations. Meeting documented on Q with QAPI-Team Discussions sheets. Results of weekly reviews and meeting will be presented to the facility monthly committee by the Administrator monthly x3 and then quarterly thereafter, and an needed. All discussions, revisions to pland additional in-servicing will be noted the QA Committee Meeting Minutes. To date the corrective action will be completed is 3/13/19.	ral M s QA y s an,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345391	B. WING _		0.	C 2/ <b>16/2019</b>
	ROVIDER OR SUPPLIER  ND LIVING & REHAB	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP COD 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	•	110/2013
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 835	Continued From pa	<u> </u>	F 8	335		
	dated 1/13/19 indic laceration of the for fracture of the proxito the palm of the h The resident was d facility on 1/14/19.  A review of the faci 1/13/19 incident reat to facility. Resident of Daily Living) care Resident rolled off I (Emergency Room) laceration above rig	y Department (ED) records ated the resident sustained a rehead and a closed displaced simal phalanx (the bone closest and) of the right little finger. ischarged from the ED to the lity 's follow-up report from the ad, "Resident recently admitted to was receiving ADL (Activities while position on his side. Deed. Resident sent to ER of for evaluation related to ght eye and already right femur will be two person assist when				
	A review of the facilibook kept on Resid documented chang Kardex. A Kardex is a summary of included information regarding the assist ADL care needs for Communication Log Resident #6 and re 1/13/19 to indicate assist with ADL carmost recent (undate "Resident will be a Review of an Incide 12:01 PM revealed fall from the bed in	lity 's Communication Log lent #6 's hall revealed the log les made to a resident 's (also known as a Care Guide) lividual patient needs, which in for nursing assistants tance required to meet the ra resident. A review of the g book included a sheet for vealed a change was made on the resident required 2-person le. A review of Resident #6 's led) Kardex read in part, two person assist with care."  Lent Report dated 2/7/19 at Resident #6 experienced a his room when he was lice care by one nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING			C <b>02/16/2019</b>		
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP C 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	ODE	, , ,		
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 835	evaluation and treatment of the treatmen	Department (ED) records d the resident had sustained he fall. Resident #6 was ed back to the facility for on.  ducted on 2/13/19 at 4:40 s Director of Nursing ing the interview, the book from Resident #6 's he DNS explained a book was kept on each hall communicate any changes resident 's care plan and the nursing staff. The DNS assistants were supposed inication Log book to see if the made for their residents. In the log he was aware of the change 's care. Review of the form sident #6 in the book indicated the resident sist with ADL care. Deted that only two NAs had	F	335				
	at 4:20 PM with the I the DNS was asked I	was conducted on 2/15/19 DNS. During the interview, now many staff members cted to provide incontinence						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING	B. WING			C 16/2019
	ROVIDER OR SUPPLIER  ND LIVING & REHAB AT	THE MOSES H CONE MEM H		11	TREET ADDRESS, CITY, STATE, ZIP CODE 131 NORTH CHURCH STREET REENSBORO, NC 27401		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	stating, "It should hav Kardex." An interview was con	on 2/7/19. She responded by we been two like in the ducted on 2/16/19 at 12:05	F	835			
	PM with the facility 's Executive Director (ED).  During the interview, the ED 's expectations regarding the safe provision of ADL care for resident #6 was discussed. The ED indicated the goal of all systems in place at the facility was to provide optimal care for the residents. However, he recognized imperfections may be identified in a system. If a problem with the current process was found, interventions needed to be implemented to improve upon the process to better meet the needs of the residents.						
F 842 SS=E	(i) A facility may not resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co agrees not to use or except to the extent to do so.  §483.70(i) Medical re §483.70(i)(1) In accorprofessional standard must maintain medicathat are- (i) Complete; (ii) Accurately documiii) Readily accessible	at-identifiable information. elease information that is on the public. elease information that is on an agent only in an agent only in an agent only in a more than the facility itself is permitted.  cords. Indicate with accepted and practices, the facility all records on each resident ented; e; and	F	842			3/12/19
	(iv) Systematically org						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345391	B. WING _			C <b>02/16/2019</b>		
	ROVIDER OR SUPPLIER	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	E .	02/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 842	Continued From pa	ge 76	F 8	42				
	all information contaregardless of the forecords, except when (i) To the individual, representative when (ii) Required by Law (iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial ar law enforcement purposes, research medical examiners, a serious threat to help and in compliance \$483.70(i)(3) The farecord information a unauthorized use.	or their resident re permitted by applicable law; /; ayment, or health care itted by and in compliance						
	(ii) Five years from there is no requiren	ears after a resident reaches						
	(ii) Sufficient information (iii) A record of the record of the recomprehent provided;	nedical record must contain- ation to identify the resident; esident's assessments; sive plan of care and services my preadmission screening						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345391		1 ' '	PLE CONSTRUCTION G	I \ /	(X3) DATE SURVEY COMPLETED	
		345391	B. WING_			C 02/16/2019
NAME OF P	ROVIDER OR SUPPLIER	1 111		STREET ADDRESS, CITY, STATE, ZIP CODE		2/10/2019
				1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	Continued From page	e 77	F 8	42		
	and resident review e	evaluations and				
	determinations condu					
		e's, and other licensed				
	professional's progre					
	(vi) Laboratory, radio	logy and other diagnostic				
		equired under §483.50.				
		Γ is not met as evidenced				
	by:					
		ons, record review and staff		Address how corrective action		
	interviews, the facility			accomplished for those resident		
		resident 's Medication ds (MARs) accurately		have been affected by the defici	ent	
		tration of a medication to 1		practice		
		ts (Resident #4) whose		Medication aides documented of	n the	
	medications were rev			MAR that Resident #4 received		
				medication from 1/10/19-1/31/19		
	The findings included	i:		2/7/19 to 2/14/19. Resident #4	had a	
				prescription for 28 pills and 22 p	ills	
		nitted to the facility on		remained which indicates that p		
		to the facility on 2/21/18.		not received medication as the i	nedication	
		osis included multiple		aides had documented.		
		nat forms in a type of white		The attending MD and oncologis		
	blood cell called a pla			notified by the DNS of dose omi		
		alignant neoplasm (tumor) right female breast; and		Revlimid (Lenalidomide) and ne received from the oncologist to		
	-	neoplasm of the bone.		21-day cycle today. Lenalidomi		
	occordary mangnam	neoplasm of the bone.		one tab by mouth daily for 21 da	-	
	A review of Resident	#4 's medical record		hold x 7 days. Then begin 21-da		
		's order dated 1/10/19 at		again. Resident received the do		
		cted 5 milligrams (mg)		on 2/15/19 @ 1 pm as ordered.		
	lenalidomide be initia	ted and given as one				
		r 21 days, stopped for 7		Resident's oncologist stated that		
		28-day cycle repeated.		not cause harm yet resident sho		
		ntineoplastic medication		received medication as ordered		
	used to treat multiple	myeioma.		A = = £ 2/0/40	luainiate -	
	A rovious of Dooidant	#4 ' o Jonuary 2040 MAD		As of 3/8/19, Nurses will now ac		
		#4 ' s January 2019 MAR domide was administered to		cancer drugs for Resident #4. In placed on a controlled substance		
	_	duled at 5:00 PM on 1/10/19		sheet and will be counted daily		
			1		-,	1 I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING_			C <b>02/16/2019</b>	
NAME OF PE	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	02	110/2019
					31 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H			REENSBORO, NC 27401		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From pag	ne 78	F E	342			
	to 1/31/19 (represer	iting 22 capsules			nurses. Any discrepancies will be		
		resident 's February 2019			immediately reported to the DNS.		
	MAR indicated 5 mg	ident #4 once daily at 5:00			Resident completed 21-day cycle on		
		gh 2/13/19 (representing 7			3/7/19 as MD ordered.		
		ig to the MARs, a total of 29			Address how the facility will identify oth	or	
	• •	es were documented as			residents having the potential to be	CI	
	· ·	resident by the following staff			affected by the same deficient practice		
		e #1 administered 2 capsules;			ancolou by the same denoient practice		
		stered 20 capsules; Med Aide			Medication Aides were immediately		
		apsules; and Med Aide #4			suspended upon discovery of incident,		
		ules; and Med Aide #5			and misappropriation of property filed v	vith	
	administered 1 caps	ule. No doses of			the Nurse Aide Registry		
	lenalidomide were d	ocumented on the MAR as					
	having been refused	I by Resident #4.			100% of all medication carts were audi	ted	
					by two licensed pharmacists on 2/15/19	<b>)</b> ;	
		dated 1/31/19 revealed one			pharmacists have counted each		
	•	days versus 21 days) of			prescription against the MAR to ensure		
		en administered to Resident			the prescription was available and		
	-	otion error. The resident 's			medications were given. Results of the		
		ed; no clinical harm was			audit were given to the DNS; no further	•	
	reported.				findings or suspected incidences were		
	A 1				discovered to indicate inaccurate		
		interview was conducted on			documentation.		
		I with Med Aide #1. Med Aide					
	#1 was assigned to				Address what massures will be put into		
		that time, one bottle of days being dispensed from the			Address what measures will be put into	)	
		8 for Resident #4 was stored			place or systemic changes made to ensure that the deficient practice will no	nt.	
		on request, Med Aide #1			recur	) (	
	•	mide capsules remaining in			1000.		
		e. The Med Aide was			All licensed nursing staff and medicatio	n	
		ured the capsules out of the			aides were in-serviced on 2/15/19 on		
	-	e at a time (while counting)			diversion, resident rights, and 6 rights of	of	
	•	cups. One medication cup			medication administration with emphas		
		ntained 9 capsules. The			on not documenting MAR until after the		
		cup was counted and			medication is given.		
		es. After the capsules had			Nurses and med-aides not in-serviced	by	
	been poured into the	e two medication cups for			2/15/19 will be in-serviced prior to the r	ext	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR M	<i>).</i> 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING				C / <b>16/2019</b>	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				11	131 NORTH CHURCH STREET			
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		G	REENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 842	F 842 Continued From page 79 counting, two additional capsules were observed to be left at the bottom of the original container		F	842	scheduled shift. Medication Aides in-serviced on Medic	al		
	confirmed each count the capsules remaining	e total count. The Med Aide t of the medication cups and ng in the bottle. It was			Records procedures to include accura completeness of record, and charting properly when a medication is not administered. If any medication is hele			
	determined a total of 22 capsules had remained in the medication bottle. Manufacturer labeling on the medication bottle indicated the bottle originally contained 28 capsules. After counting				the medication aide the nurse be notifi Med aide will verbally report and document on the Daily Medication Aide	ed.		
	the capsules, Med Aid returned all capsules medication bottle, sed			Report the following: a) resident name medication not administered c) reason administered e) medication aide signa	b) not			
		lidomide medication bottle			f) nurse signature All med aides not in-serviced on the Medical Records procedures were			
	#1. Med Aide #1 was	at 8:35 AM with Med Aide assigned to Resident #4 's			removed from schedule and will be in-serviced prior to next scheduled shi			
	bottle of lenalidomide observed. Upon oper	At that time, the resident 's stored on the med cart was ning the bottle of capsules were seen lying on			Indicate how the facility plans to monit its performance to make sure that solutions are sustained	or		
	clearly visible and ear removing them from t	he container. The labeling			The DNS/designee will review the Medication Aide Report sheets daily x weeks and then bi-weekly x4,, then	4		
	same as that observe and included the resid	ttle was confirmed to be the determined the morning of 2/14/19, dent 's name and the date rmacy as 11/2/18. When			monthly thereafter to address any medication administration issues. All instances in which a medical record is found to be incomplete, inaccurate, an			
	asked, the Med Aide the exact number of o	reported she did not recall capsules that were counted enalidomide bottle the			insufficient will be addressed by the Di Disciplinary action will be enforced as deemed appropriate by the DNS. Be	NS,		
	previous morning. Up Med Aide #1 stated, "	oon further inquiry, however, It was more." A thorough ers and compartments in the			3/7/19  10% of Resident MAR and medication will be audited by the DNS/Designee of	s		
	medication cart condi- revealed there were r lenalidomide stored o	ucted by Med Aide #1 no other bottles of			x4 weeks, bi-weekly x4, and then mon thereafter to ensure medication is give as ordered and as signed by nurses a	thly n		
					medication aides. Findings documente			

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			A. BUILDI	NG _		l ,	0
		345391	B. WING				C / <b>16/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ND I NAMO O DELLAD A	T THE MODES II SOME MEN II		11	131 NORTH CHURCH STREET		
HEARILA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H		G	REENSBORO, NC 27401		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
TAG	REGULATORT OR	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
F 842	Continued From pag	ne 80	F	842			
		nducted on 2/15/19 at 9:10	•	· -	on the Medication Cart Audit Form.		
		s Director of Nursing			Any non-compliance will be noted and		
	-	Executive Director (ED).			corrective actions taken. Any change to	,	
		, the count discrepancy for			the monitoring plan will require re-in	,	
		idomide medication from			servicing by the DNS/designee and		
						,	
		s) to 2/15/19 (7 capsules)			monitoring to begin again at the weekly audits until compliance is met.	′	
		he time, 22 capsules of			audits until compliance is met.		
	lenalidomide were c			Populto of guidita will be presented to the			
	2/14/19), Resident #			Results of audits will be presented to the			
	resident had been a			facility QA committee by the DNS durin	-		
	the medication. How			monthly x3 and then quarterly thereafte			
	lenalidomide capsules remained in the medication bottle as of 10:10 AM on 2/14/19, which indicated the resident could have only				and as needed. All discussions, revisio		
					to plan, and additional in-servicing will	be	
		•			noted in the QA Committee Meeting		
		lenalidomide capsules. The			Minutes.		
		they had not been informed					
		of lenalidomide. However,			The Executive Director is responsible f		
	•	medication audit was			the implementation of this plan. The da		
		ng of 2/14/19. The DNS			the corrective action will be completed	is	
		ed 7 capsules of lenalidomide			3/12/19.		
		e bottle at approximately 9:30					
	PM on 2/14/19. Bas						
		nis medication, the DNS					
	· ·	oo, had identified a concern					
		d not have been any					
		in the bottle of lenalidomide.					
	The DNS reported the	ne MAR documented that					
	Med Aide #1, Med A	ide #2, Med Aide #3 and Med					
	Aide #4 had adminis	stered this medication to					
	Resident #4. During	the interview, the DNS					
	confirmed the bottle	of lenalidomide observed on					
	the medication cart t	the mornings of 2/14/19 and					
	2/15/19 was the first	and only bottle available for					
	Resident #4 at the fa	acility to date. She reported					
Resident #4 ' s family member brought in the							
		alidomide earlier that morning					
		the DNS still had in her					
	, , , , , , , , , , , , , , , , , , , ,	cond bottle of lenalidomide					
	! ·	sealed (unopened). This					

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		345391	B. WING _			C <b>02/16/2019</b>	
	ROVIDER OR SUPPLIER  ND LIVING & REHAB A	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP CO 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	•	02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From page	ge 81 included labeling with	F 8	342			
		e and a pharmacy dispensed					
	at 10:30 AM with Med DNS and ED. During was asked to descrip Resident #4's lena Aide #1 reported the poured into two differs of the med cart as the When asked if shein were in the bottle of counted on the morn reported she could readded, "But I know in Aide #1 was also as she used to administ The med aide report resident's profile on she had the right residose, and right routed.	w was conducted on 2/16/19 ed Aide #1 in presence of the g the interview, the med aide be the process used to count lidomide on 2/14/19. Med e lenalidomide capsules were erent medication cups on top ne capsules were counted. ecalled how many capsules lenalidomide when they were ning of 2/14/19, the med aide not remember. However she t was more than 7." Med ked to describe the process ter medications to a resident. ted she would first pull up the n the computer, make sure sident, the right med, right e of administration. She med from the cart and hold it					
	resident 's name an After she administer resident, the med ai	ronic MAR to ensure the ad medication was correct. The medication to the de reported she would sign received the med on the					
	at 10:41 AM with Me interview, Med Aide process she used to resident. The med a into the computer, lo person receiving it.	w was conducted on 2/16/19 ed Aide #2. During the #2 was asked to describe the administer medications to a aide reported she would log book at the medication and the After she double checked medication, she would pop					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		<b>345391</b> B. WING			C <b>02/16/2019</b>		
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP COD 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		211012013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	in the electronic MAF med to the resident, was administered on resident refused the record the med as "r asked, Med Aide #2 on the MAR to indica administered, the resmedication.  A telephone interview at 10:58 AM with Me interview, Med Aide process he used to a resident. The med at the electronic MAR formedication from the name of the resident and the dose; and the to the resident. Oncomedication, he would and record the medication, he would and record the medication on the material was under the conduction.  An attempt to conduct MAR.  An attempt to conduct Med Aide #4 was under Market MAR.  An interview was corp. Stated she would have documentation on the medication on th	neck on the "prepped" button R. After she administered the she would record the med the electronic MAR. If the medication, she would efused" on the MAR. When reported if her initials were atte a medication was sident did receive the was conducted on 2/16/19 d Aide #3. During the #3 was asked to describe the administer medications to a ide reported he would pull up for the resident; pull the med cart; double check the the name of the medication en administer the medication en he administered the dithen come back to the cart cation administration on the cart cation administration on the successful.	F8	42			