PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345391	B. WING			01	/12/2018
	ROVIDER OR SUPPLIER ND LIVING & REHAB	AT THE MOSES H CONE MEM H		113	REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636 SS=D	CFR(s): 483.20(b)(s) §483.20 Resident A The facility must of a comprehensive, a reproducible asses functional capacity §483.20(b) Compre §483.20(b)(1) Res A facility must mak assessment of a re goals, life history a resident assessme by CMS. The asse the following: (i) Identification and (ii) Customary rout (iii) Cognitive patte (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological (viii) Physical funct (ix) Continence. (x) Disease diagno (xi) Dental and nut (xii) Skin Condition (xiii) Activity pursui (xiv) Medications. (xv) Special treatm (xvi) Discharge pla (xvii) Documentatio regarding the addit on the care areas t the Minimum Data (xviii) Documentatio	Assessment onduct initially and periodically accurate, standardized asment of each resident's accurate. Standardized asment of each resident's accurate. Standardized asment of each resident's accurate. Standardized assessment Instrument. Standardized accurate accomprehensive asident's needs, strengths, and preferences, using the antinstrument (RAI) specified assessment must include at least ad demographic information and demographic information accurate accu	F	536			1/31/18
		assessment process must rvation and communication					
ARORATORY I	DIRECTOR'S OR PROVIDE	FR/SUPPLIER REPRESENTATIVE'S SIGNATUR	DE .		TITI F		(X6) DATE

Electronically Signed 01/31/2018

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:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345391	B. WING			01/	12/2018	
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		11	TREET ADDRESS, CITY, STATE, ZIP CODE 131 NORTH CHURCH STREET REENSBORO, NC 27401			
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F 636	licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribe chapter, a facility meassessment of a restimeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissis significant change in mental condition. (For "readmission" mean following a temporar or therapeutic leave (iii) Not less than one This REQUIREMEN by: Based on resident a record review, the factomprehensive asset Assessment and Cathoday after admissing (Resident #90) for reviewed for comprehensive asset (Resident #90) for reviewed for comprehension includes the findings included the find	well as communication with ensed direct care staff is. required. Subject to the ed in §413.343(b) of this last conduct a comprehensive ident in accordance with the din paragraphs (b)(2)(i) ection. The timeframes (43(b)) of this chapter do not ar days after admission, ons in which there is no in the resident's physical or for purposes of this section, is a return to the facility by absence for hospitalization (a) the every 12 months. T is not met as evidenced and staff interviews and incility failed to complete a desiment (Minimum Data Set are Area Assessment) within sion to the facility for one of 21 sampled residents enersive assessments.	F	636	F 636 The root cause that led to the deficient practice was one individual fait to follow the established protocol for MI assessments as referenced in the RAI manual. The CAA for resident 90 was rompleted during the time of the MDS assessment. Plan of correction and procedure for implementing: ¿ The CAA for resident 90 was completed ¿ Inservice Education will be provided for IDT to ensure understanding of CAA completion guidelines as referenced in RAI manual	DS not or		

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F 636	had no speech and had no speech and had no speech and had rarely understood understands. A review of the Care Summary dated 12/1 area triggered for cocommunication, how completed. An observation and in was completed on 1/490 was sitting in his communication cards his bedside table. Theyes/no to questions to the sed and the sed	Area Assessment (CAA) 8/17 revealed that the care gnitive loss and ever, the CAA was not nterview with Resident #90 9/18 at 10:37 AM. Resident room and there were two s with letters and pictures on ne resident shook his head out was unable to verbalize. Inpleted with Nurse Aide #2 t 9:01 AM. He stated ne call light to summon and then used hand I to the communication board	F 6	¿ An audit of the most recassessments for 100% of residents will be complete CAAs that triggered during assessment were worked planned ¿ Monitoring We will audit all comprehe assessments X 4 weeks to that triggered were worked planned. Then we will audit assessments weekly X 4 villous random assessments in year. All results will be rep Quality Assurance Commit continued monitoring and Quality Assurance commit plan if the improvement is ¿ Person responsible for the plan of correction is the coordinator.	ensive to ensure CAA d and/or care dit 10 random weeks, and th monthly X one ported to the ittee for improvement ittee will alter to not evident r implementing	en e :	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		1 '	(X3) DATE SURVEY COMPLETED		
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completed the MDS is CAA at the same time were due on the 14th thought it was an over cognitive loss and correctly completed. An interview was come Administrator on 1/12 he expected that if a from the MDS that the completed and a deciproceed to care plan Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehens Planning §483.21(a) (1) The fact implement a baseline that includes the instressed in the baseline care plan (i) Be developed with admission. (ii) Include the minimum necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendations and over the same time to the same time that includes the minimum necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (E) Social services.	she typically completed the e. She stated the CAA's day after admission and dersight that the CAA's for mmunication were not expleted with the 2/18 at 12:59 PM. He said care area was triggered e CAA worksheet be desion made whether to for that particular care area. (3) Sive Person-Centered Care Care Plans Care Plans Care plan for each resident extended to provide centered care of the resident all standards of quality care. In mustin 48 hours of a resident's example of the resident of the care for a resident ted to-domain and the care for a resident ted to-domain an				2/9/18
§483.21(a)(2) The fac	cility may develop a				
	CORRECTION ROVIDER OR SUPPLIER ND LIVING & REHAB AT SUMMARY ST. (EACH DEFICIENC REGULATORY OR IT Continued From page completed the MDS is CAA at the same time were due on the 14th thought it was an overcognitive loss and concompleted. An interview was come Administrator on 1/12 he expected that if a from the MDS that the completed and a deciproceed to care plan Baseline Care Plan CFR(s): 483.21(a)(1) §483.21 Comprehens Planning §483.21(a) Baseline (§483.21(a)(1) The fact implement a baseline that includes the instruction of the series of the developed with admission. (ii) Include the minimum necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation or the services.	ROVIDER OR SUPPLIER ND LIVING & REHAB AT THE MOSES H CONE MEM H SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 completed the MDS she typically completed the CAA at the same time. She stated the CAA's were due on the 14th day after admission and thought it was an oversight that the CAA's for cognitive loss and communication were not completed. An interview was completed with the Administrator on 1/12/18 at 12:59 PM. He said he expected that if a care area was triggered from the MDS that the CAA worksheet be completed and a decision made whether to proceed to care plan for that particular care area. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	ROVIDER OR SUPPLIER ND LIVING & REHAB AT THE MOSES H CONE MEM H SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 completed the MDS she typically completed the CAA at the same time. 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(C) Dietary o	A BUILDING 345391 A STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORD, NC 27401 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSG DENTFYING INFORMATION) COntinued From page 3 Completed the MDS she typically completed the CAA at the same time. She stated the CAA's were due on the 14th day after admission and thought it was an oversight that the CAA's for cognitive loss and communication were not completed. An interview was completed with the Administrator on 1/12/18 at 12:59 PM. He said he expected that if a care area was triggered from the MDS that the CAA worksheet be completed and a decision made whether to proceed to care plan for that particular care area. 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comprehensive care care plan if the comp (i) Is developed with admission. (ii) Meets the require (b) of this section (exthis section). §483.21(a)(3) The fixesident and their report the baseline care limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the conbehalf of the facility) Any updated inform the comprehensive This REQUIREMENT by: Based on observation urse practitioner into complete the baseline #142) of four sample admissions. Resident #142 was a 12/28/17 with diagnot the left shin bone with pressure ulcers on the same care care plan if the comprehensive the baseline #142 was a 12/28/17 with diagnot the left shin bone with pressure ulcers on the same care care plan if the comprehensive the baseline #142 was a 12/28/17 with diagnot the left shin bone with pressure ulcers on the care care plan in the ca	plan in place of the baseline orehensive care plan- in 48 hours of the resident's ements set forth in paragraph (cepting paragraph (b)(2)(i) of acility must provide the presentative with a summary plan that includes but is not of the resident. The resident is resident's medications and determined the care plan, as necessary. The is not met as evidenced ones, record review staff and the erviews the facility failed to the care plan for one (Resident and residents that were new and #142 was assessed as a mobilizer and was at risk for fulcers. The different controlled to the facility on the care plan for one including a fracture of the surgical repair on 11/26/17, the sacrum and left foot,	F 68	F655 ¿ Plan for correcting specific de oResident #142 was admitted to with a knee immobilizer in place baseline care plan did not includinstructions for knee immobilize cause of this situation was that immobilizer was not addressed discharge summary supplied by hospital. o The baseline care plan for reswas updated to include the care	o facility e. The de r. The root the knee in the the the		
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR Continued From page comprehensive care care plan if the comp (i) Is developed with admission. (ii) Meets the require (b) of this section (extins section). §483.21(a)(3) The faresident and their rep of the baseline care limited to: (i) The initial goals of dietary instructions. (ii) Any services and administered by the on behalf of the facil (iv) Any updated info of the comprehensiv This REQUIREMEN' by: Based on observation nurse practitioner int complete the baselin #142) of four sample admissions. Reside having a left knee im developing pressure The findings included Resident #142 was a 12/28/17 with diagnot the left shin bone wit pressure ulcers on the anemia, gastrointest	ROVIDER OR SUPPLIER ND LIVING & REHAB AT THE MOSES H CONE MEM H SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review staff and nurse practitioner interviews the facility failed to complete the baseline care plan for one (Resident #142) of four sampled residents that were new admissions. Resident #142 was assessed as having a left knee immobilizer and was at risk for developing pressure ulcers. The findings included: Resident #142 was admitted to the facility on 12/28/17 with diagnoses including a fracture of the left shin bone with surgical repair on 11/26/17, pressure ulcers on the sacrum and left foot, anemia, gastrointestinal bleed, chronic lung disease with oxygen use, cirrhosis and chronic	ROVIDER OR SUPPLIER ND LIVING & REHAB AT THE MOSES H CONE MEM H SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 comprehensive care plan in place of the baseline care plan if the comprehensive care plan-(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)/(2)(i) of this section). \$483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (ii) The initial goals of the resident. 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The baseline care plan did not include undershoot in the comprehensive care plan for one (Resident #142 was admitted to the facility on 12/28/17 with diagnoses including a fracture of the left shin bone with surgical repair on 11/26/17, pressure ulcers on the sacrum and left foot, anemia, gastrointestinal bleed, chronic lung disease with oxygen use, circhosis and chronic 345391 STREET ADDRESS, CITY, STATE, ZIP CODE 1311 MORTH CHURCH STREET GREENBORO, N. C 27401 STREET ADDRESS, CITY, STATE, ZIP CODE 1311 MORTH CHURCH STREET GREENBORO, N. C 27401 STATE, ZIP CODE 145655 F655 F655 F655 F655 F655 F655 F655 F656 F655 F656 F655 F655 F655 F656 F656 F657 F657 F657 F658 F657 F658 F658 F657 F658 F657 F658 F658 F657 F658 F658 F659 F659 F659 F659 F	

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F 655	Continued From pag	e 5	F 65	5			
	12/28/17 revealed no immobilizer.	al discharge orders dated orders for use of the		o Baseline care plans will be dev referencing the hospital discharg summary along with the skilled n admissions assessments and res	e ursing		
	dated 12/18/17 revea	g admission assessment aled the immobilizer was in documentation of the skin		family input. ¿Administrative nurses who are responsible for baseline care pla	ns will be		
	condition under the in skin assessment indi	mmobilizer. The admission cated pressure ulcers were m, left heel, top and sides of		educated on the need to reference discharge summary, skilled nursi assessments, and eliciting reside	ce the ing		
	the left foot and the left ankle.			input when developing baseline of plans	care		
	include the use of the	an dated 12/28/17 did not e immobilizer.		oAn audit of baseline care plans conducted for 100% of the reside admitted to the facility in the page 100.	ents		
	after admission revea of the immobilizer. V the admission Pressi	admission orders and orders aled no instructions for use Vound care orders indicated ure ulcers were to be treated		days to ensure the care plan was developed and reflective of the d summary, skilled nursing assess and resident/family input.	ischarge		
	every day.			¿ Monitoring Procedure			
	dated 12/28/17 reveal weight bearing and "	al therapy initial assessment aled Resident #142 was non-required a knee immobilizer nily member 's instructions.		For 3 months, all baseline care p be reviewed within 72 hours to e care plan was completed, accura shared with the family within 48 h. The results of this review will be	nsure the atte, and anours.		
	director of Nursing (E on admission, would orders per the discha	AM, interview with the DON) explained the nurses do a skin assessment, do arge summary and verify the		with the Quality Assurance comm The Quality Assurance committe alter this process should the resu satisfactory.	e will		
	explained there were	ry physician. She further no orders regarding the full not be on the care plan an orders.		"The title of the person responsible implementing this process is the coordinator.			
	s office was interview	, from the primary physician ' ved on 1/12/18 at 11:23 AM. ad seen Resident #142 on					

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F 655	be in place until he i	n. She thought the nthe orthopedic and would returned to the orthopedic.	F 6	55			
F 686 SS=D	under the immobilize not require an order	Prevent/Heal Pressure Ulcer	F 6	86	2/9/18		
	resident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the inc demonstrates that th (ii) A resident with p necessary treatmen with professional sta promote healing, pro new ulcers from dev This REQUIREMEN by: Based on observati nurse practitioner in check the skin unde one (Resident #142 risk for developing p ulcers developed or The findings include Resident #142 was 12/28/17 with diagnor the left shin bone wi	rehensive assessment of a must ensure thates care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition ney were unavoidable; and ressure ulcers receives and services, consistent andards of practice, to event infection and prevent reloping. IT is not met as evidenced ons, record review staff and terviews the facility failed to r a left knee immobilizer for of 3 sampled residents at pressure ulcers. Pressure in the top of the knee.		F686 ¿ Plan for correcting specific deficie o Resident 142 was admitted to the from the hospital with a knee immobite the discharge summary and physician orders did not include instructions for care or removal of the immobilizer. As a result, skin assessments were completed but dinclude assessments under the immobilizer.	facility pilizer		

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F 686	Continued From pa	nge 7	F	686			
	anemia, gastrointes	stinal bleed, chronic lung			-Immobilizer was removed and orders		
		n use, cirrhosis and chronic			were obtained for treating the pressure	<u>!</u>	
	kidney disease.				ulcer.		
	Review of the hosp	ital discharge orders dated			¿ Procedure for implementing plan of		
	12/28/17 revealed immobilizer.	no orders for use of the			correction		
	immobilizer.				-For residents admitted with applied		
	Review of the nursi	ing admission assessment			devices, physician orders will be obtain	ned	
		ealed the immobilizer was in			for removal and care of the device.		
		no documentation of the skin			¿ All current residents with applied		
	condition under the	immobilizer. The admission			devices (ie. Splints, immobilizers, etc.)	will	
	skin assessment in	dicated pressure ulcers were			be assessed for skin issues. In addition	٦,	
	present on the sacr	rum, left heel, top and sides of			orders for treatment of skin under those	е	
	the left foot and the	e left ankle.			devices will be verified.		
					oAll residents will receive weekly skin		
	The baseline care	olan dated 12/28/17 did not			assessments that include the evaluatio	'n	
	include the use of t	he immobilizer.			of the skin under applied devices, unle	SS	
	D				contraindicated by physician orders.		
		ty admission orders and orders			-Inservice education regarding correct		
		ealed no instructions for use Wound care orders indicated			skin assessment protocol will be conducted with nurses.		
		sure ulcers were to be treated			conducted with nurses.		
	every day.	sure dicers were to be treated			¿Monitoring Procedure		
	every day.				Zimorinoring i rocedure		
		ical therapy initial assessment			¿Physician orders for new admissions		
		ealed Resident #142 was non-			with applied devices will be audited to		
		"required a knee immobilizer			ensure orders include care and remova	al of	
	at all times" per a fa	amily member 's instructions.			applied device.		
	The "Pressure Ulce	er Risk Observation"			¿Weekly skin assessments for all		
		12/28/17 indicated the resident			residents with applied devices will be		
	was at high risk for	developing pressure ulcers.			reviewed by administrative nurses eacl		
					week for 2 months to ensure assessme	ent	
		e ' s notes dated 1/4/18			completion, and that physician orders		
	revealed the wound	•			were obtained and reflective of care		
		sit and assessment of the			required of resident.		
		#142 had no new wounds on			¿Results of both audits will be submitted	∌d	
	his left leg. Existing	g wounds on the left foot and			to Quality Assurance committee each		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
		345391	B. WING _			01/12/2018	
	ROVIDER OR SUPPLIER ND LIVING & REHAB AT	THE MOSES H CONE MEM H	•	STREET ADDRESS, CITY, STATE, 1131 NORTH CHURCH STREET GREENSBORO, NC 27401			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATI CIENCY)	(X5) COMPLETION DATE	
F 686	sacrum were measur Review of the wound indicated the skin on inspected. This note ulcers on the left foot brace the resident ha admission to the facil Review of the treatme a note dated 1/5/18. documentation of the the immobilizer. Nursing notes from 1 immobilizer was in plant of the treatment nursing note on 1/2 by the treatment nursing note on 1/2 by the treatment nursing centimeter (cm) dark discolored area to the skin that was dark blarepresented a deep to the immobilizer. But come the immobilizer were also the orthopedic surged immobilizer. The ord treatment nurse dates with short and long to be demobility, transfer This MDS indicated he of bowel and bladder developing pressure	progress note dated 1/4/18 the left lower extremity was indicated the pressure were caused by an ortho d previously worn prior to ity. ent nurse 's notes revealed There was no condition of the skin under /5/18 to 1/9/18 indicated the ace on the left leg. /18 at 7:51 PM, documented e, revealed a 2.1 by 2 purple non blanchable eleft knee with surrounding anchable. The area ssue injury possibly related elow the knee a 2.2 by 1.5 area. The immobilizer was ed a telephone order from on to discontinue the er was written by the d 1/10/18. sum Data Set (MDS) dated ident #142 had impairment arm memory, had no extensive to total care with s, hygiene and toileting. In the was frequently incontinent	F 6	month for 2 months. Q committee will alter the improvement not be satisfactory. "The Title of the persor implementing this proof Treatment Nurse.	e plan should		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345391	B. WING _			01/12/2018		
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP COD 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	•	, II 12/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(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 686	inches. Review of the Care A the Admission MDS nutritional risk, had n primarily on the foot for pressure ulcer indeveloping further ul indicated he was at malnutrition. Both an care plan. Observations during 11:00 AM revealed the top of the left kneabout the size of a n color. The skin arou slightly swollen. Interview with the treatice of the end of the word discontinued on 1/10 knee were unstageabeen given by the word apply skin prep to the rapist (PT) #1 on PT#1 explained if a repearing, the physicial on the leg and typical orders. Further interwould expect the car would be nursing. The immobilizer would	Area Assessments (CAA) for indicated he was at nultiple pressure wounds, and the sacrum. The CAA dicated he was at risk for cers. The CAA for nutrition risk for weight loss and reas planned to proceed to wound care on 1/11/18 at here were three wounds on e.e. The areas were round, rickel and dark to black in and the wounds was red and reatment nurse on 1/11/18 at he thought the immobilizer has. The immobilizer was 1/18. The wounds on the left ble and treatment orders had bound Nurse Practitioner (NP) the areas. Inducted with physical 1/11/18 at 2:00 PM. The resident was non-weight in would want the immobilizer ally one would expect to see view with PT#1 revealed she re of the knee immobilizer he PT #1 explained care for d include for it to be removed	F 6	,				
	not removed the imm with him. Inspection	nd bathing. The PT#1 had nobilizer when she worked of the immobilizer with the sathlick material with some						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345391	B. WING _			01/12/2018		
	ROVIDER OR SUPPLIER ND LIVING & REHAB	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP COI 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	•			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 686	enabled the leg to a overlapped in front from the back of the When the sides over place. There were the immobilizer to a position of the leg, of the leg, the strapsides would lie flat the leg. On 1/12/18 at 8:59 treatment nurse revergerformed each da around the immobilizer moved the immobilizer of the skin and had not remove of orders that allow on 1/12/18 at 9:18 revealed she had to since admission. So bath since he had to remove the immobilizer move the immobilizer of the skin and had not remove the immobilizer of the skin and had no	de. It was one piece, that rest on it. The sides with Velcro straps that came immobilizer to the front. Erlapped, the straps held it in plastic "stays" in the back of help maintain a straight. To inspect the knee and sides is would be loosened and the exposing the top and sides of the exposing the top and sides	F	586				
	immobilizer. NA#1 Resident #142 required care On 1/12/18 at 10:04 director of Nursing on admission, would orders per the disconders with the prince	explained she knew what care used by the information on her plan. 4 AM, interview with the (DON) explained the nurses d do a skin assessment, do narge summary and verify the nary physician. She further re no orders regarding the						

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345391	B. WING _			01/²	12/2018	
	ROVIDER OR SUPPLIER ND LIVING & REHAB AT	THE MOSES H CONE MEM H	,	STREET ADDRESS, CITY, STATE 1131 NORTH CHURCH STREE GREENSBORO, NC 27401	ET	-	2 2	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		VE ACTION SHOULD BE ED TO THE APPROPRIA		(X5) COMPLETION DATE			
F 686	Nursing would wait u The DON stated Res another facility that s nursing staff thought comfort. The DON e was obtaining orders immobilizer. The therapy manage the DON on 1/12/18 they went by the info family. The DON ex was for comfort, there non- weight bearing. Clarification and/or in orthopedic was not o therapy. Nurse practitioner #2 s office was interview She explained she ha the day of admission completed the skin a arrived. She thought the orthopedic and w returned to the orthop nursing to inspect the as a nursing protocol Interview with the DO revealed the weekly se	and the same seed him. In the same seed him.	F	586				
	aides to remove the i the bath. She would the immobilizer to co assessments.	. She would expect the immobilizer and complete expect the nurses to remove mplete the skin						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY OMPLETED
		345391	B. WING			01/12/2018
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 686	phone was made on message was left for call. Interview with Nurse revealed she did a sk Nurse #1 explained d	e 12 1/12/18 at 1:45 PM. A his assistant to return the #1on 1/12/18 at 1:49 PM in assessment on 1/8/18. uring the skin assessment he immobilizer to check the	F	586		