	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED	
		245204	B. WING		С
	ROVIDER OR SUPPLIER	345391		TREET ADDRESS, CITY, STATE, ZIP CODE	06/04/2014
NAME OF P	ROVIDER OR SUPPLIER			131 NORTH CHURCH STREET	
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		REENSBORO, NC 27401	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
	05/27/2014 through 0 interviews were cond	nt investigation survey on 5/30/2014. Telephone			
F 253 SS=E	HOUSEKEEPING & I CFR(s): 483.15(h)(2)	MAINTENANCE SERVICES	F 253		7/2/14
		ide housekeeping and necessary to maintain a comfortable interior.			
	by: Based on observatio and record reviews th adequate maintenance to ensure a safe, orde for 3 of 3 resident hal findings included: A) On 05/27/2014 at the facility was condu following areas were	is not met as evidenced ns, facility staff interviews, the facility failed to ensure se services were preformed erly, and comfortable interior ls (100, 200, and 300). The 9:55 a.m. an initial tour of cted. During the tour the observed to be in need of		 A. The toilets in the 200 hall shower roc was repaired at the time of survey. The light bulb in the 200 hall shower room w replaced at the time of survey. B. The loose toilet in the 100 hall shower room was repaired at the time of the survey. The ceramic tile in the 100 hall shower room will be repaired by an outside contractor. 	vas er
	repair: The resident commor nursing station - the to mount and could be e either direction side to was placed on the toi stall next to the toilet/ operational and would switch was turned on	a shower room by 200 hall oilet was loose on floor easily moved 2-3 inches in o side when light pressure let. The light in the shower sink area was not d not come on when the		C. The faucet in the 300 hall nourishme room will be repaired by facility maintenance staff.D. The toilet in therapy ADL bathroom be repaired by facility maintenance staff The grab bar in the therapy ADL bathro will be repaired by facility maintenance staff.	will f.

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.

CENTER		ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI I			APPROVE 0. 0938-039 SURVEY			
	CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING					
		345391	B. WING	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER		S	B. WING 06/04/201 STREET ADDRESS, CITY, STATE, ZIP CODE					
HEARTLA	ND LIVING & REHAB A	T THE MOSES H CONE MEM H		131 NORTH CHURCH STREET 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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE			
F 253	Continued From page	e 1	F 253						
	was made of the 200 hall's resident common shower room. The toilet was still loose on floor mount and could be easily moved and the light in the shower stall next to the toilet/sink area still would not come on when the switch was turned			E. The headboard and foot board for resident in room 306 will be repaire facility maintenance staff. The wall behind the B bed in room 306 will repaired by facility maintenance st	ed by ls be				
		05/29/2014 at 10:40 a.m. a 3rd observation made of the 200 hall's resident common		F. The headboard in room 228A w repaired by facility maintenance st	aff.				
	mount and could be the shower stall next	bilet was still loose on floor easily moved and the light in to the toilet/sink area still when the switch was turned		G. Facility maintenance staff will re drawer handles on the night stand 304B					
		:00 a.m. and interview and onducted with the facility's		H. Facility maintenance staff will re drawer handle on the nightstand in 305A.					
	maintenance director indicated he still had things as he had only weeks. The mainten was his goal to put m	r. The maintenance director not had a chance to fix y been at the facility for four ance director indicated it		Facility maintenance staff will conc full audit of all resident rooms and resident care areas and identify an toilets, headboards, faucets, footbo blinds, ceramic tiles, walls, grab ba and nightstands in need of repair.	ıy lights, oards,				
	maintenance director very familiar with the it until coming to this	o get anything in yet. The r also indicated he was not program as he had not used facility and the staff had not ned to use the program yet		All items identified to be in need of will be entered into the facilities ele work order system.					
	The maintenance dir ways he and or his a	in electronic work orders yet. ector indicated there were 3 ssistant were notified of eplacement work requested one:		Facility maintenance staff with mal identified repairs and sign them off complete in the facility's electronic order system.	fas				
		ff would keep notes on their		Facility administrative and nursing will be trained on identifying head footboards, faucets, blinds, cerami walls, toilets, lights, grab bars and nightstands in need of repair and h	boards, ic tile,				
	2) By word of mouth,	staff would stop the		enter work orders for needed repa					

Facility ID: 943494

If continuation sheet Page 2 of 49

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	OATE SURVEY OMPLETED
		345391	B. WING			C 06/04/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/04/2014
				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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 253	Continued From page	e 2	F 2!	53		
	maintenance director	or his assistant in hallway down the information		the facility's electronic work or as needed repairs are identifie		
	•	ed repairs/replacements.				
				Housekeeping staff will be trai	ned in	
	3) The maintenance			identifying head boards, footb		
		access to the facility's		faucets, blinds, ceramic tile, w	•	
	· · ·	access to the software		toilets, grab bars and nightsta		
		ally place work order		of repair and will continue to n		
	requests in the system	t when the facility's staff		need for any repairs on their d	any sneets	
		d about a maintenance				
		or replacement etc. they		Maintenance director will revie	w the notes	
		ormation into the computer		from the housekeepers daily s		
	program and this bec	ame the electronic work		ongoing, and enter any repairs		
		nce director indicated he		the daily sheets in the facility's	electronic	
		gram and see what needed aced on a daily basis.		work order system.		
				Facility maintenance staff with		
		Il outstanding work orders		identified repairs and sign the		
		tronic, notes etc.) was made.		complete in the facility's electr	ONIC WORK	
		ector indicated there was d work order in the facility's		order system ongoing.		
		program and four completed				
		w of the electronic work		Administrative staff will comple	ete rounds	
	orders indicated there			audits three times weekly iden		
	uncompleted/deferre	d work order for the facility's		headboard, footboard, grab ba	ar, toilets,	
		were four completed work		faucets, blinds, walls, lights, co		
		aintenance director indicated		and nightstands in need of rep	air . A QI	
	he had no paper main			rounds tool will be utilized.		
		cumentation to show he or tified of any items pooding		Maintonanco director will revis	wroundo	
	repair or replacemen	tified of any items needing		Maintenance director will revie tools three times weeks to ens		
		e had some notes in a		item identified on administrativ		
	-	ems however he could not		have been entered in the facili		
		notebook or other written		electronic work order system.	J =	
		ow he had a list of facility				
	maintenance issues/i	items needing repair or		All rounds tools and a report o		
		aintenance director indicated		and open work orders will be r		
	he kept a lot of the in	formation in his head but it		the Quality Committee Monthl	v	

Facility ID: 943494

If continuation sheet Page 3 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345391	B. WING				C 04/2014
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	conducted with the fa and his regional main facility's maintenance were more work orde order software progra maintenance manage work orders was conor maintenance director maintenance director maintenance manage work order software p indicating all work or uncompleted). There work orders. The ma there was no other pla- information was store of any of the current i repair or replacement On 05/30/2014 at 11:: specifically looking at identified above was maintenance director maintenance director maintenance manage identified of all of the and noted above. Th director indicated the above were not docur electronic work order other place and he did documentation to sho	anywhere. 50 a.m. an interview was cility's maintenance director tenance manager. The director indicated there rs found in the facilities work im by his regional er. A review of the electronic ducted with the facility's and his regional er. The regional er. The regional er pulled up the facility's brogram to the page ders (completed and e were no new uncompleted intenance director indicated ace any work order to show they were aware terms identified that needed t. 55 a.m. a tour of the facility, the items noted and conducted with the facility's and his regional er. The tour observation items previously identified e facility's maintenance items observed/noted mented on the facility's software program or any	F	253			
	the facility was condu	9:55 a.m. an initial tour of cted. During the tour the observed to be in need of					

If continuation sheet Page 4 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED			
		345391	B. WING				C 104/2014			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>				
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 253	repair: The resident common nursing station - the ti mount and could be a rocking front to back a in either direction whe on the toilet. Six (6) to be broken/missing floor between the sho Additional ceramic tile broken on the adjace above the floor. On 05/28/2014 at 3:2 was made of the 100 shower room. The to mount, the six (6) cer and the additional cer shower stall were still On 05/29/2014 at 10: was made of the 100 shower room. The to mount, the six (6) cer and the additional cer shower stall were still On 05/29/2014 at 11: record review was co maintenance director indicated he still had things as he had only weeks. The maintenance was his goal to put m information into the fa he hadn't had time to maintenance director very familiar with the	 a shower room by 100 hall oilet was loose on floor easily moved 1- 2 inches and 1 - 2 inches side to side en light pressure was placed ceramic tiles were observed on the wall just above the ower stall and tub area. As were observed to be not shower stall wall just 0 p.m. a 2nd observation hall's resident common ilet was loose on floor amic tiles were still missing ramic tiles by the adjacent broken. 43 a.m. a 3rd observation hall's resident common ilet was loose on floor amic tiles were still missing ramic tiles by the adjacent broken. 00 a.m. and interview and nducted with the facility's . The maintenance director not had a chance to fix been at the facility for four ance director indicated it 	F	253						

Facility ID: 943494

If continuation sheet Page 5 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345391	B. WING				C 1 04/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	been thoroughly train and were not putting in The maintenance direct ways he and or his as maintenance repair/re and needing to be do 1) Housekeeping staff daily sheets and turn maintenance. 2) By word of mouth, maintenance director and they would write concerning the neede 3) The maintenance of facility's staff having a computer system had program to electronic requests in the syster director indicated that observed, or were tol- issue requiring repair were to enter the info program and this bec- order. The maintenance could access the prog to be repaired or repla A request to review af (in any fashion - elect The maintenance dire only one uncompleted work order software p work orders. A review orders indicated there uncompleted/deferred	ed to use the program yet in electronic work orders yet. ector indicated there were 3 ssistant were notified of eplacement work requested ne: If would keep notes on their them in daily to staff would stop the or his assistant in hallway down the information ed repairs/replacements. director indicated the access to the facility's access to the facility's access to the software ally place work order m. The maintenance t when the facility's staff d about a maintenance or replacement etc. they rmation into the computer ame the electronic work nce director indicated he gram and see what needed aced on a daily basis.	F	253	3		

If continuation sheet Page 6 of 49

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 04/05/201 RM APPROVE O. 0938-039	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY IPLETED	
		345391	B. WING		06/04/2014		
	ROVIDER OR SUPPLIER	THE MOSES H CONE MEM H	1	STREET 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 253	he had no paper main requests or other door his staff had been nor repair or replacement manager indicated he notebook for some its produce any type of r documentation to sho maintenance issues/i replacement. The ma he kept a lot of the in was not written down On 05/30/2014 at 11: conducted with the fa and his regional main facility's maintenance were more work orde order software progra maintenance manage work orders was contor maintenance manage work order software pri indicating all work or uncompleted). There work orders. The ma there was no other pl information was store of any of the current if repair or replacement On 05/30/2014 at 11: specifically looking at identified above was maintenance director	aintenance director indicated neumentation to show he or tified of any items needing the maintenance that some notes in a ems however he could not notebook or other written by he had a list of facility tems needing repair or aintenance director indicated formation in his head but it anywhere. 50 a.m. an interview was collity's maintenance director itenance manager. The e director indicated there rs found in the facilities work am by his regional er. A review of the electronic ducted with the facility's and his regional er. The regional er pulled up the facility's program to the page ders (completed and e were no new uncompleted intenance director indicated ace any work order ed to show they were aware tems identified that needed t. 55 a.m. a tour of the facility, the items noted and conducted with the facility's	F 253				

Facility ID: 943494

If continuation sheet Page 7 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345391	B. WING				04/2014		
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE				
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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 253	identified of all of the and noted above. Th director indicated the above were not docut electronic work order other place and he di documentation to sho identified as needing C) On 05/27/2014 at the facility was condu following areas were repair: The nourishment room nurse's station - the si continuously dripping attempt to turn off the faucet would not shut water. On 05/28/2014 at 3:2 was made of the sink across from the 300 f water was still drippin and the faucet would On 05/29/2014 at 10: was made of the sink across from the 300 f water was still drippin and the faucet would On 05/29/2014 at 11: record review was co maintenance director indicated he still had things as he had only	 items previously identified e facility's maintenance items observed/noted mented on the facility's software program or any d not have any other we the items had been repair or replacement. 9:55 a.m. an initial tour of icted. During the tour the observed to be in need of m across from the 300 hall ink's faucet had water /running from the faucet. An water was made. The off the dripping/running 3 p.m. a 2nd observation in the nourishment room hall's nursing station. The g/running from the faucet not turn the water off. 48 a.m. a 3rd observation in the nourishment room hall's nursing station. The g/running from the faucet not turn the water off. 00 a.m. and interview and nducted with the facility's The maintenance director not had a chance to fix been at the facility for four 	F	253					

Facility ID: 943494

If continuation sheet Page 8 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED	
		345391	B. WING				C 04/2014	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 253	 information into the fahe hadn't had time to maintenance director very familiar with the it until coming to this is been thoroughly train and were not putting in The maintenance director ways he and or his as maintenance repair/reand needing to be do 1) Housekeeping staff daily sheets and turn maintenance. 2) By word of mouth, maintenance director and they would write concerning the needed 3) The maintenance of facility's staff having a computer system had program to electronic requests in the syster director indicated that observed, or were to issue requiring repair were to enter the info program and this bec order. The maintenance director is the program of the program and the program an	acility's computer system but get anything in yet. The also indicated he was not program as he had not used facility and the staff had not ed to use the program yet in electronic work orders yet. ector indicated there were 3 ssistant were notified of eplacement work requested ne: if would keep notes on their them in daily to staff would stop the or his assistant in hallway down the information ed repairs/replacements. director indicated the faccess to the facility's access to the facility's access to the software ally place work order n. The maintenance t when the facility's staff d about a maintenance or replacement etc. they rmation into the computer ame the electronic work nce director indicated he gram and see what needed	F	253				

Facility ID: 943494

If continuation sheet Page 9 of 49

CENTER STATEMENT (AND PLAN OF NAME OF P	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	· <i>`</i>	S	E CONSTRUCTION		FORM OMB NC (X3) DATE COMP	D: 04/05/2018 MAPPROVED D: 0938-0391 SURVEY LETED C 04/2014
HEARTLA		THE MOSES H CONE MEM H		G	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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 253	work orders. A review orders indicated there uncompleted/deferred kitchen listed. There orders listed. The ma he had no paper main requests or other doct his staff had been not repair or replacement manager indicated he notebook for some ite produce any type of n documentation to sho maintenance issues/it replacement. The ma he kept a lot of the inf was not written down On 05/30/2014 at 11: conducted with the far and his regional main facility's maintenance were more work order order software progra maintenance manage work orders was cono maintenance manage work order software p indicating all work ord uncompleted). There work orders. The main there was no other pla information was store	 by of the electronic work a was one d work order for the facility's were four completed work aintenance director indicated intenance work order umentation to show he or tified of any items needing the Maintenance a had some notes in a ams however he could not notebook or other written bw he had a list of facility tems needing repair or aintenance director indicated formation in his head but it anywhere. 50 a.m. an interview was cility's maintenance director tenance manager. The director indicated there rs found in the facilities work am by his regional er. A review of the electronic ducted with the facility's and his regional er. The regional er pulled up the facility's program to the page ders (completed and were no new uncompleted intenance director indicated and work order di to show they were aware tems identified that needed 	F	253				

If continuation sheet Page 10 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
		345391	B. WING				C 6/ 04/2014		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE				
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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 253	On 05/30/2014 at 11:3 specifically looking at identified above was of maintenance director maintenance director maintenance manage identified of all of the and noted above. Th director indicated the above were not docur electronic work order other place and he did documentation to sho identified as needing D) On 05/27/2014 at the facility was condu following areas were repair: The physical therapy training and activities bathroom used by res occupational therapy floor mount and easily direction when light p toilet. The lower grab physical therapy depa observed to have the causing the grab bar mount and could easi and down. On 05/28/2014 at 4:4 was made of the phys resident training and a bathroom. The toilet and the grab bar was On 05/29/2014 at 10:	 55 a.m. a tour of the facility, the items noted and conducted with the facility's and his regional er. The tour observation items previously identified e facility's maintenance items observed/noted mented in the facility's software program or any d not have any other the items had been repair or replacement. 9:55 a.m. an initial tour of cted. During the tour the observed to be in need of department's resident 	F	253	3				

If continuation sheet Page 11 of 49

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMF	LETED
		345391	B. WING				C 04/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	04/2014
					1131 NORTH CHURCH STREET		
HEARILA	IND LIVING & REHABAI	THE MOSES H CONE MEM H			GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE					(X5) COMPLETION DATE	
F 253	resident training and a bathroom. The toilet and the grab bar was On 05/29/2014 at 11: record review was co maintenance director indicated he still had things as he had only weeks. The mainten was his goal to put m information into the fa he hadn't had time to maintenance director very familiar with the it until coming to this been thoroughly train and were not putting The maintenance director ways he and or his as maintenance repair/re and needing to be do 1) Housekeeping staf daily sheets and turn maintenance. 2) By word of mouth, maintenance director and they would write concerning the neede 3) The maintenance of facility's staff having a computer system had program to electronic requests in the syster director indicated that	activities of daily living (ADL) was still loose on the floor still loose on the wall. 00 a.m. and interview and nducted with the facility's . The maintenance director not had a chance to fix been at the facility for four ance director indicated it aintenance request acility's computer system but get anything in yet. The also indicated he was not program as he had not used facility and the staff had not ed to use the program yet in electronic work orders yet. ector indicated there were 3 asistant were notified of eplacement work requested ne: if would keep notes on their them in daily to staff would stop the or his assistant in hallway down the information ed repairs/replacements. director indicated the access to the facility's I access to the software ally place work order	F	253			

Facility ID: 943494

If continuation sheet Page 12 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/05/2 FORM APPROV OMB NO. 0938-03	VED	
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345391	B. WING		06/04/2014		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETI		
F 253	issue requiring repair were to enter the info program and this bed order. The maintenal could access the pro- to be repaired or repl A request to review a (in any fashion - elect The maintenance dire only one uncompleted work order software p work orders. A review orders indicated there uncompleted/deferred kitchen listed. The re- orders listed. The maintenance he had no paper main requests or other door his staff had been no repair or replacement manager indicated here notebook for some ite produce any type of r documentation to sho maintenance issues/i replacement. The maintenance was not written down On 05/30/2014 at 11: conducted with the fa and his regional maintenance were more work order order software progra- maintenance manage	 or replacement etc. they primation into the computer same the electronic work ince director indicated he gram and see what needed aced on a daily basis. Il outstanding work orders tronic, notes etc.) was made. ector indicated there was d work order in the facility's program and four completed work order for the facility's were four completed work aintenance director indicated intenance work order cumentation to show he or tified of any items needing t. The Maintenance e had some notes in a ems however he could not notebook or other written ow he had a list of facility tems needing repair or aintenance director indicated formation in his head but it anywhere. 50 a.m. an interview was neility's maintenance director indicated there ers found in the facilities work am by his regional er. A review of the electronic ducted with the facility's 	F 253	3			

Facility ID: 943494

If continuation sheet Page 13 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345391	B. WING			C 06/04/2014		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 253	work order software p indicating all work ord uncompleted). There work orders. The ma there was no other pla- information was store of any of the current in repair or replacement On 05/30/2014 at 11: specifically looking at identified above was maintenance director maintenance director maintenance director identified of all of the and noted above. The director indicated the above were not docume electronic work order other place and he did documentation to sho identified as needing E) On 05/27/2014 at the headboard and for bed in room 306B was the bed frame and co and forth 5-6 inches. was observed to have broken off the wall in window blinds in room broken/bent and woul access from the street On 05/28/2014 at 4:3 was made of the head	er. The regional er pulled up the facility's program to the page lers (completed and were no new uncompleted intenance director indicated ace any work order d to show they were aware tems identified that needed 55 a.m. a tour of the facility, the items noted and conducted with the facility's and his regional er. The tour observation items previously identified e facility's maintenance items observed/noted mented on the facility's software program or any d not have any other w the items had been repair or replacement. 4:30 p.m. an observation of otboard of the resident's s observed to be loose on uld be easily moved back The wall behind the B bed e the sheetrock cracked and a 1 foot x 1 foot area. The n 306 were observed to be ld not close allowing viewing et into the resident ' s room.	F	253				
		dboard and footboard of the						

If continuation sheet Page 14 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 04/05/2018 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345391	B. WING			C 04/2014
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 253	bed frame. The wall if the sheetrock cracked and the window blinds would not close allow street into the residen On 05/29/2014 at 10:3 was made of the head bed in room 306B. The footboards were obset bed frame. The wall if the sheetrock cracked and the window blinds would not close allow street into the residen On 05/29/2014 at 11:0 record review was con maintenance director, indicated he still had of things as he had only weeks. The maintenan was his goal to put mainformation into the fai he hadn't had time to maintenance director very familiar with the it until coming to this fai been thoroughly traine and were not putting if The maintenance director ways he and or his as maintenance repair/re and needing to be dou	erved to still be loose on the behind the B bed still had d and broken off the wall s were still broken/bent and ing viewing access from the it's room. 30 a.m. a 3rd observation dboard and footboard of the he headboard and erved to still be loose on the behind the B bed still had d and broken off the wall s were still broken/bent and ing viewing access from the it's room. 00 a.m. and interview and nducted with the facility's . The maintenance director not had a chance to fix been at the facility for four ance director indicated it aintenance request icility's computer system but get anything in yet. The also indicated he was not program as he had not used facility and the staff had not ed to use the program yet in electronic work orders yet. ector indicated there were 3 asistant were notified of eplacement work requested ne: f would keep notes on their	F 253			
	was his goal to put mainformation into the fainformation into the fainformatic director very familiar with the fit until coming to this fainformatic director the thoroughly trainformatic director the maintenance director ways he and or his assimatintenance repair/real and needing to be down 1) Housekeeping staff.	aintenance request acility's computer system but get anything in yet. The also indicated he was not program as he had not used facility and the staff had not ed to use the program yet in electronic work orders yet. ector indicated there were 3 ssistant were notified of eplacement work requested ne: f would keep notes on their				

If continuation sheet Page 15 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345391	B. WING			C 06/04/2014		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				1	1131 NORTH CHURCH STREET			
HEARILA	ND LIVING & REHABAI	THE MOSES H CONE MEM H		0	GREENSBORO, 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 253	Continued From page	9 15	F	253				
	and they would write concerning the neede 3) The maintenance of facility's staff having a computer system had program to electronic	or his assistant in hallway down the information ed repairs/replacements. director indicated the access to the facility's l access to the software ally place work order						
	observed, or were tole issue requiring repair were to enter the info program and this bec order. The maintenan	t when the facility's staff d about a maintenance or replacement etc. they rmation into the computer ame the electronic work nce director indicated he gram and see what needed						
	(in any fashion - elect The maintenance dire only one uncompleted work order softwarep work orders. A review orders indicated there uncompleted/deferred kitchen listed. There orders listed. There orders listed. The main requests or other door his staff had been not repair or replacement manager indicated he notebook for some ite produce any type of r documentation to sho	d work order for the facility's were four completed work aintenance director indicated intenance work order umentation to show he or tified of any items needing t. The Maintenance						

Facility ID: 943494

If continuation sheet Page 16 of 49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345391 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/04/2014 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 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X2)			ID HUMAN SERVICES					FORM	D: 04/05/2018 MAPPROVED D. 0938-0391
State of PROVIDER OR SUPPLIER Statest Statest Statest address, City, State, ZiP CODE HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H International control of the contof the control of the control of the control of the con	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,				(X3) DATE COMP	SURVEY
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H 1131 NORTH CHURCH STREET GREENSBORO, NC 22010 YOU ID PREEX TAG SUMMARY STREMENT OF DEFICIENCES (RECH DEFICIENCY MIST BE PRECIDED BY VILL REGULATORY OR LSC DENTIFYING INFORMATION) D PRETX TAG PROVIDERS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COME (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 253 Continued From page 16 replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written drown anywhere. F 253 On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders folund in the facility's maintenance manager. The regional maintenance manager. The regional maintenance manager pulled up the facility's work orders stwase program by his regional maintenance manager. The regional maintenance manager to hep ape indicating all work orders (compared to hep ace work orders. The maintenance director indicated there was no dured the the facility's maintenance director and his regional maintenance director indicated there was no dured the facility's maintenance director indicated there was no dured with the facility's maintenance director indicated there was no dured with the facility's maintenance director indicated there was no dured with the facility's maintenance director and his regional maintenance director indicated there was no dured with the facility's maintenance director indicated there was no dured with the facility's maintenance director and his regional maintenance director and his regional maintenance director between the dure backet in the secondent didentified above. The facility's maintenance director indicate			345391	B. WING					
IPEARLAND LIVING & REHAB AT THE MOSE'S H CONE MEM H GREENSBORO, NC 27401 IPAGE N SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG ID PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG IPAGE N (EACH OORECTICN MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG IPAGE N (EACH OORECTICN CATION BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OPAGE N (EACH OORECTICN CATION BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OPAGE N (EACH OORECTICN CATION BE COME DEFICIENCY) OPAGE N (EACH OORECTICN CATION BE COME DEFICIENCY CATENT AND	NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
CREENSBOR(N kC 27401 OW ID PREPX TXQ SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D PREPX TXQ PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OME F 253 Continued From page 16 replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere. F 253 F 253 On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. The regional maintenance manager to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility's maintenance manager. The tour observation identified above. The facility's maintenance director indicated the items previously identified and noted						1131 NORTH CHURCH STREET			
Precipitor TAG (EACH OERCIDEV MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COULD DEFICIENCY F 253 Continued From page 16 replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere. F 253 F 253 On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facility's maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance manager. The regional maintenance manager. The tour observation identified above was conducted with the facility's maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted	TEARILA		THE MOSES H CONE MEM H			GREENSBORO, NC 27401			
replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere. On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility's maintenance manager. The tour observation identified above was conducted with the facility's maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD B		(X5) COMPLETION DATE
he kept a lot of the information in his head but it was not written down anywhere. On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted	F 253			F	253	3			
conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager. The regional maintenance manager pulled up the facility's work orders offware program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance director		he kept a lot of the inf	ormation in his head but it						
 maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted 		conducted with the fa- and his regional main facility's maintenance were more work order order software progra maintenance manage work orders was cond maintenance director	cility's maintenance director tenance manager. The director indicated there rs found in the facilities work m by his regional er. A review of the electronic ducted with the facility's and his regional						
specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted		maintenance manage work order software p indicating all work ord uncompleted). There work orders. The ma there was no other pla information was store of any of the current it	er pulled up the facility's program to the page lers (completed and were no new uncompleted intenance director indicated ace any work order d to show they were aware tems identified that needed						
electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement. F) On 05/28/2014 at 9:07 a.m. an observation		specifically looking at identified above was of maintenance director maintenance manage identified of all of the and noted above. The director indicated the above were not docur electronic work order other place and he did documentation to sho identified as needing	the items noted and conducted with the facility's and his regional er. The tour observation items previously identified e facility's maintenance items observed/noted mented on the facility's software program or any d not have any other w the items had been repair or replacement.						

If continuation sheet Page 17 of 49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C	FORM A OMB NO. (ID HUMAN SERVICES MEDICAID SERVICES	MENT OF HEALTH AN	
	(X2) MULTIPLE CONSTRUCTION (X3) DATE SL A. BUILDING COMPLE	. ,	(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT C
B. WING 06/04/2014		B. WING	345391		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STREET ADDRESS, CITY, STATE, ZIP CODE			ROVIDER OR SUPPLIER	NAME OF PF
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H 1131 NORTH CHURCH STREET GREENSBORO, NC 27401			THE MOSES H CONE MEM H	ND LIVING & REHAB AT	HEARTLA
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X2) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
F 253 Continued From page 17 was made of the headboard being loose on bed frame in room 228A. F 253 On 05/29/2014 at 4:33 p.m. a 2nd observation was made of the bed in 228A. The headboard was still loose on the bed frame. F 253 On 05/30/2014 at 10:25 a.m. a 2nd observation was made of the bed in 228A. The headboard was still loose on the bed frame. F 253 On 05/29/2014 at 11:20 a.m. a 2nd observation was made of the bed in 228A. The headboard was still loose on the bed frame. F 253 On 05/29/2014 at 11:20 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility somputer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and for his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance. 2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repair/seplacements.	F 253	F 2	dboard being loose on bed 3 p.m. a 2nd observation in 228A. The headboard bed frame. 25 a.m. a 2nd observation in 228A. The headboard bed frame. 20 a.m. and interview and nducted with the facility's . The maintenance director not had a chance to fix been at the facility for four ance director indicated it aintenance request acility's computer system but get anything in yet. The also indicated he was not program as he had not used facility and the staff had not ed to use the program yet in electronic work orders yet. ector indicated there were 3 ssistant were notified of eplacement work requested ne: f would keep notes on their them in daily to staff would stop the or his assistant in hallway down the information	 was made of the head frame in room 228A. On 05/29/2014 at 4:33 was made of the bed was still loose on the On 05/30/2014 at 10:3 was made of the bed was still loose on the On 05/29/2014 at 11:0 record review was commaintenance director. indicated he still had of things as he had only weeks. The maintenan was his goal to put maintenance director very familiar with the pit until coming to this fabeen thoroughly traine and were not putting in The maintenance director information into the fabeen thoroughly traine and were not putting in The maintenance director 1) Housekeeping staff daily sheets and turn maintenance. 2) By word of mouth, maintenance director 	F 253

Facility ID: 943494

If continuation sheet Page 18 of 49

		D HUMAN SERVICES MEDICAID SERVICES				F	ITED: 04/05/2018 ORM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) [DATE SURVEY COMPLETED
		345391	B. WING				C 06/04/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1131 NORTH CHURCH STREET		
HEARILA	ND LIVING & REHABAI	THE MOSES H CONE MEM H		0	GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 253	program to electronical requests in the system director indicated that observed, or were told issue requiring repair were to enter the infor program and this beca order. The maintenan could access the prog to be repaired or replat A request to review all (in any fashion - elect The maintenance dire only one uncompleted work order software p work orders. A review orders indicated there uncompleted/deferred kitchen listed. The main he had no paper main requests or other doc his staff had been not repair or replacement manager indicated he notebook for some ite produce any type of n documentation to sho maintenance issues/if replacement. The main	lirector indicated the loccess to the facility's access to the software ally place work order n. The maintenance when the facility's staff d about a maintenance or replacement etc. they mation into the computer ame the electronic work nee director indicated he gram and see what needed aced on a daily basis. I outstanding work orders ronic, notes etc.) was made. totor indicated there was d work order in the facility's rogram and four completed w of the electronic work e was one I work order for the facility's were four completed work intenance director indicated itenance work order umentation to show he or ified of any items needing . The Maintenance had some notes in a ms however he could not otebook or other written w he had a list of facility ems needing repair or intenance director indicated ormation in his head but it	F	253			
		50 a.m. an interview was cility's maintenance director					

If continuation sheet Page 19 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/05/2018 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345391	B. WING				C 04/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		1131 NORTH CHURCH ST GREENSBORO, NC 27			
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253			F 253	8			
	facility's maintenance	tenance manager. The director indicated there					
	order software progra						
	-	er. A review of the electronic ducted with the facility's and his regional					
	maintenance manage	-					
	work order software p						
	indicating all work ord	lers (completed and were no new uncompleted					
		intenance director indicated					
	there was no other pla	ace any work order to show they were aware					
		tems identified that needed					
	specifically looking at						
	maintenance director	conducted with the facility's and his regional er. The tour observation					
	identified of all of the	items previously identified e facility's maintenance					
	director indicated the	items observed/noted mented on the facility's					
		software program or any					
	documentation to sho	w the items had been repair or replacement.					
		9:39 a.m. an observation					
	was made in room 30						
	have two (2) missing	drawer handles on					
	-	handle without screws was e top of the nightstand.					
	1			1			1

If continuation sheet Page 20 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345391	B. WING				C 04/2014
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET BREENSBORO, 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 253	On 05/28/2014 at 3:3 was made of the nigh in room 304B. The di- missing and the hand on the night stand. On 05/29/2014 at 10: was made of the nigh in room 304B. The di- missing and the hand on the night stand. On 05/29/2014 at 11: record review was co- maintenance director indicated he still had things as he had only weeks. The maintena- was his goal to put m information into the fa- he hadn't had time to maintenance director very familiar with the it until coming to this been thoroughly train and were not putting The maintenance director ways he and or his as maintenance repair/re and needing to be do 1) Housekeeping staff daily sheets and turn maintenance. 2) By word of mouth, maintenance director and they would write	0 p.m. a 2nd observation tstand and hutch assembly rawer handles were still le with out screws was still 34 a.m. a 3rd observation tstand and hutch assembly rawer handles were still le with out screws was still 00 a.m. and interview and nducted with the facility's . The maintenance director not had a chance to fix been at the facility for four ance director indicated it aintenance request acility's computer system but get anything in yet. The also indicated he was not program as he had not used facility and the staff had not ed to use the program yet in electronic work orders yet. ector indicated there were 3 asistant were notified of eplacement work requested ne: f would keep notes on their them in daily to staff would stop the or his assistant in hallway	F	253			

If continuation sheet Page 21 of 49

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/05/2018 / APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345391	B. WING				C 04/2014
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HFARTI A	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		11	131 NORTH CHURCH STREET		
				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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page	21	F	253			
	3) The maintenance d	lirector indicated the					
	facility's staff having a						
		access to the software					
	program to electronica requests in the system						
	· · ·	when the facility's staff					
	observed, or were told	d about a maintenance					
		or replacement etc. they					
		rmation into the computer ame the electronic work					
		nce director indicated he					
		ram and see what needed					
	to be repaired or repla	aced on a daily basis.					
	A request to review al	l outstanding work orders					
	· ·	ronic, notes etc.) was made.					
		ector indicated there was					
		d work order in the facility's rogram and four completed					
		v of the electronic work					
	orders indicated there						
		work order for the facility's					
		were four completed work intenance director indicated					
	he had no paper main						
		umentation to show he or					
		ified of any items needing					
	repair or replacement manager indicated he						
	-	ms however he could not					
	produce any type of n	otebook or other written					
		w he had a list of facility					
		ems needing repair or aintenance director indicated					
		formation in his head but it					
	was not written down						
	On 05/30/2014 at 11:	50 a.m. an interview was					

Facility ID: 943494

If continuation sheet Page 22 of 49

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		345391	B. WING				04/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			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 PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 253	and his regional main facility's maintenance were more work order order software progra maintenance manage work orders was cond maintenance director maintenance director maintenance manage work order software p indicating all work ord uncompleted). There work orders. The ma there was no other pla information was store of any of the current if repair or replacement On 05/30/2014 at 11:3 specifically looking at identified above was of maintenance director maintenance director maintenance director maintenance director maintenance manage identified of all of the and noted above. Th director indicated the above were not docur electronic work order other place and he did documentation to sho identified as needing H) On 05/28/2014 at was made of resident	cility's maintenance director tenance manager. The director indicated there rs found in the facilities work im by his regional er. A review of the electronic ducted with the facility's and his regional er. The regional er pulled up the facility's program to the page lers (completed and were no new uncompleted intenance director indicated ace any work order d to show they were aware tems identified that needed to show they were aware tems identified that needed to show they were aware tems on the facility's and his regional er. The tour observation items previously identified e facility's maintenance items observed/noted mented on the facility's software program or any d not have any other we the items had been repair or replacement. 9:40 a.m. an observation froom 305A. The top resident's dresser was ing down 90 degrees. The to only have 1 screw	F	253			

Facility ID: 943494

If continuation sheet Page 23 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345391	B. WING				_ 04/2014	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET REENSBORO, 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 253	Continued From page On 05/28/2014 at 4:3 was made of resident drawer handle of the observed to still be ha still only having 1 scre drawer. On 05/29/2014 at 10: was made of resident drawer handle of the observed to still be ha still only having 1 scre drawer. On 05/29/2014 at 11: record review was co maintenance director indicated he still had things as he had only weeks. The maintenan was his goal to put m information into the fa he hadn't had time to maintenance director very familiar with the it until coming to this been thoroughly train and were not putting The maintenance dire ways he and or his as maintenance repair/re and needing to be do	5 p.m. a 2nd observation room 305A. The top resident's dresser was anging down 90 degrees and ew holding the handle to the 33 a.m. a 3rd observation room 305A. The top resident's dresser was anging down 90 degrees and ew holding the handle to the 00 a.m. and interview and nducted with the facility's . The maintenance director not had a chance to fix been at the facility for four ance director indicated it aintenance request acility's computer system but get anything in yet. The also indicated he was not program as he had not used facility and the staff had not ed to use the program yet in electronic work orders yet. ector indicated there were 3 asistant were notified of eplacement work requested ne:		253				
	1) Housekeeping stat daily sheets and turn maintenance.	f would keep notes on their them in daily to						

Facility ID: 943494

If continuation sheet Page 24 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345391	B. WING				C 04/2014
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 253	 By word of mouth, maintenance director and they would write concerning the needer The maintenance of facility's staff having a computer system had program to electronic requests in the syster director indicated that observed, or were tol- issue requiring repair were to enter the info program and this bec- order. The maintenance could access the prog- to be repaired or replated A request to review at (in any fashion - elect The maintenance direct only one uncompleted work order software p work orders. A review orders indicated there uncompleted/deferred kitchen listed. The maintenance requests or other door his staff had been not repair or replacement manager indicated here notebook for some ite produce any type of r documentation to sho maintenance issues/it 	staff would stop the or his assistant in hallway down the information ed repairs/replacements. director indicated the access to the facility's access to the software ally place work order m. The maintenance t when the facility's staff d about a maintenance or replacement etc. they rmation into the computer ame the electronic work nce director indicated he gram and see what needed aced on a daily basis. Il outstanding work orders tronic, notes etc.) was made. ector indicated there was d work order in the facility's program and four completed w of the electronic work e was one d work order for the facility's were four completed work aintenance director indicated neunance work order sumentation to show he or tified of any items needing t. The Maintenance	F	253			

Facility ID: 943494

If continuation sheet Page 25 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345391	B. WING				C 04/2014
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET REENSBORO, NC 27401		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 253	was not written down On 05/30/2014 at 11: conducted with the fa and his regional main facility's maintenance were more work orde order software progra maintenance manage work orders was conor maintenance director maintenance director maintenance manage work order software p indicating all work ord uncompleted). There work orders. The ma there was no other plainformation was store of any of the current if repair or replacement On 05/30/2014 at 11: specifically looking at identified above was maintenance director maintenance director maintenance director maintenance director maintenance manage identified of all of the and noted above. Th director indicated the above were not docur	formation in his head but it anywhere. 50 a.m. an interview was cility's maintenance director tenance manager. The director indicated there rs found in the facilities work im by his regional er. A review of the electronic ducted with the facility's and his regional er. The regional er. The regional er pulled up the facility's program to the page lers (completed and were no new uncompleted intenance director indicated ace any work order d to show they were aware terns identified that needed to show they mere aware terns identified that needed to show they mere aware terns identified that needed to show they mere aware terns identified that needed to show they mere aware terns identified that needed the facility's maintenance items observed/noted mented on the facility's	F 2	253			
F 278 SS=B	other place and he did documentation to sho identified as needing ASSESSMENT	software program or any d not have any other w the items had been repair or replacement. NATION/CERTIFIED	F 2	278			7/2/14

If continuation sheet Page 26 of 49

	-	ID HUMAN SERVICES				FORM	APPROVED
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			LETED
		345391	B. WING _			06/	C 04/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET		
	1			G	REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	26		278			
1 270	CFR(s): 483.20(g) - (j			210			
	011(0): 100:20(9) ()					
	The assessment mus resident's status.	t accurately reflect the					
	A registered nurse mu	ust conduct or coordinate					
	each assessment with						
	participation of health	professionals.					
	A registered nurse mu assessment is complete	ust sign and certify that the eted.					
		completes a portion of the n and certify the accuracy of sessment.					
	willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material and	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each					
	Clinical disagreement material and false sta	t does not constitute a tement.					
	by: Based on record revi facility failed to accura active diagnosis of Ps psychotropic medicat comprehensive asses	is not met as evidenced iew and staff interview the ately assess and include the sychosis for the use of ion identified in the facility sements tool the Minimum of 5 residents (Resident			The facility will ensure that any reside assessment accurately reflects the resident's status. Facility MDS nurse reviewed the most recent MDS for resident #152, residen		

Facility ID: 943494

If continuation sheet Page 27 of 49

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345391	B. WING		C 06/04/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
F 278	unnecessary medicat Findings Included: 1) Resident #40 was 6/14/2013. A record review of the for Resident #40 code [comprehensive] assed did not include the act or Anxiety in Section for medications receiv Antipsychotic, Antian 7 days of the 7 day lo Physician Orders for of May 2014 included at 1:00 PM for psycho mouth at 9:00 PM for at hour of sleep for an tab in the AM and 1/2 and Cymbalta 60mg lo depression. An interview on 5/29/ MDS nurse revealed psychosis was not into MDS because the first	Resident #21) reviewed for tion usage. admitted to the facility on e facility most recent MDS ed an annual essment dated 5/23/2014 tive diagnosis of Psychosis I Active Diagnosis. Section N ved included the use of an xiety, and Antidepressant for	F 27	 #40, and resident #21. Facility M made corrections to the residents recent MDS's and submitted cor assessments as indicated. Facility MDS staff and administra nursing staff will be educated on manual and the guidelines for co active diagnoses in section I of th Facility MDS nurse and administra nursing staff will review section I residents and ensure all active di were accurately coded on the res most recent MDS. Facility MDS r complete a corrections sheet as Facility QI nurse will audit MDS assessments randomly five times to ensure accurate coding of assessments ongoing. A QI audi be utilized. The facility Quality committee will the results of the audit monthly. 	s' most rection tive RAI ding ne MDS. rative for all agnoses sident's nurse will indicated. s weekly t tool will
	Administrator reveale should have been in s An interview on 5/30/	2014 at 3:00 PM with the ed the diagnosis of psychosis section I of the MDS. 2014 at 10:00 AM with the ed she considered			

If continuation sheet Page 28 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345391	B. WING				04/2014
NAME OF PI	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 278	and that if a resident is psychotropic medicated active diagnosis should section I of the comptementation of the comptementation of the comptementation of the comptementation of the section I of the comptementation of the section o	treatment for resident care was being treated with a ion then an appropriate lid have been coded in rehensive MDS. a admitted to the facility on ission diagnoses included osis. a facility MDS for Resident ost recent MDS dated lude the active diagnosis of I Active Diagnosis. Section eived included the use of an ays of the 7 day look back ensive MDS dated clude the active diagnosis of I Active Diagnosis. Section eived included the use of an ays of the 7 day look back ensive MDS dated clude the active diagnosis of I Active Diagnosis. Section eived included the use of an ays of the 7 day look back ensite MDS dated clude the active diagnosis of I Active Diagnosis Section eived included the use of an ays of the 7 day look back ensite MDS dated clude the active diagnosis of I Active Diagnosis Section eived included the use of an ays of the 7 day look back ensite MDS dated isperdal [antipsychotic] 0.25 outh at hour of sleep for 3/2/2014 Risperdal 0.25 mg 2014 at 3:00 PM with the the active diagnosis of cluded in section I of the at 9 diagnosis [coded] for were populated into the MDS	F	278			
		2014 at 3:00 PM with the d the diagnosis of psychosis					

If continuation sheet Page 29 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/05/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED C
		345391	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	should have been in s An interview on 5/30/2 Administrator reveale medication a form of and that if a resident psychotropic medicat active diagnosis shou section I of the compr 3) Resident #21 was 9/13/2013. Her admis Anxiety and Schizoph A record review of the #21 revealed MDS da Section I Active Diagr Diabetes Mellitus, Hy disorder, and Asthma	section I of the MDS. 2014 at 10:00 AM with the d she considered treatment for resident care was being treated with a ion then an appropriate and have been coded in rehensive MDS. admitted to the facility on asion diagnosis included arenia. e facility MDS for Resident ated 4/16/2014 included hosis checked Hypertension, perlipidemia, Anxiety . Additional diagnoses were	F	278	DEFICIENCY)		
	Antidepressants for 7 period. Physician Order for P 2/12/2014. Physician Order for R twice a day dated 3/2 Physician Order for R mouth daily dated 3/1 An interview on 5/29/2 MDS nurse revealed psychosis was not inc MDS because the firs	included the use of hys, Diuretic for 7 days and days of the 7 day look back sychiatric Service dated tisperdal 1mg by mouth /2014.					

Facility ID: 943494

If continuation sheet Page 30 of 49

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345391	B. WING _				C 04/2014
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278		e 30 2014 at 3:00 PM with the d the diagnosis of psychosis	F 2	278			
F 309 SS=G	should have been in s An interview on 5/30/2 Administrator reveale medication a form of f and that if a resident psychotropic medicat active diagnosis shou section I of the compr PROVIDE CARE/SEF WELL BEING CFR(s): 483.25 Each resident must re provide the necessary or maintain the higher mental, and psychoso	section I of the MDS. 2014 at 10:00 AM with the d she considered treatment for resident care was being treated with a ion then an appropriate Id have been coded in rehensive MDS. RVICES FOR HIGHEST eceive and the facility must y care and services to attain st practicable physical,	F 3	809			
	by: Based on observatio interviews, and record report a transfer incid assess a resident afte and reported being dr 1 of 1 residents (Resi assessment.	is not met as evidenced ns, resident and facility staff d reviews the facility failed to ent to nursing and failed to er she complained of pain ropped during a transfer for dent #46) reviewed for			Past noncompliance: no plan of correction required.		
		started on 4/22/14. The eficient practice and started					

If continuation sheet Page 31 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FC	ED: 04/05/2018 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCT		(X3) DA	ATE SURVEY MPLETED
		345391	B. WING _				C 06/04/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE	•	
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			CHURCH STREET RO, 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 CORR ACH CORRECTIVE ACTION SH DSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	The facility was in con The findings included Resident #46 was ad 8/9/2011 Diagnosis in Failure to Thrive and The Minimum Data S revealed Resident #4 cognitively impaired a with two staff member mobility and transfers The Care Plan for Re- revealed a plan of ca- to impaired mobility, of joint disease, and poor included transfer with of care for; potential f mobility, poor vision a revealed an approach transfers and low bed A record review of Nu 4/23/2014 at 7:16 AM stated the Nurse Aided dropped her while as Resident #46 stated to the bed and the floor. Director of Nursing (D An interview on 6/4/2 #7 who was the prima	ctive action plan on 4/26/14. mpliance as of 5/5/14. : mitted to the facility on heluded Muscle Weakness, Osteoporosis. et (MDS) dated 2/1/2014 6 was moderately and required extensive assist r physical assistance for bed 5. sident #46 dated 2/14/2014 re for; self care deficits due Osteoarthritis, degenerative or vision. The approach stand-up lift. A second plan for falls due to impaired and past history of falls n for stand up lift for safe f. urse #7 ' s nurse note on I revealed Resident #46 e (NA) on the 3-11 shift sisting her back to bed. that her body was partly on Incident reported to the DON). 014 at 4:34 PM with Nurse ary nurse for Resident #46 d she was on duty from 11	F 3	09			
	Resident #46 stated t the bed and the floor. Director of Nursing (E An interview on 6/4/2 #7 who was the prima on 4/22/2014 reveale PM to 7 AM and Resi anything all night. It w	that her body was partly on Incident reported to the DON). 014 at 4:34 PM with Nurse ary nurse for Resident # 46 d she was on duty from 11					

Facility ID: 943494

If continuation sheet Page 32 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345391	B. WING				C 1 04/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 309	Resident #46 ' s room that the NA [3-11 shift assisting her back to she asked Resident # or the floor and Resid back on the bed and #7 stated she did not reported it to the DON A record review of Nu 4/23/2014 at 8:17 AM was asymptomatic to no signs of disorienta confusion. Staff will co pain and assess her f increased confusion a The nurse notes docu 4/23/2014 note and 4 did not include assess The nurse notes on 4/2 Medication Administra The nurse note on 4/2 Medication Administra A record review of Nu documented on 4/26/ during AM care on 4/2 Nurse #9 to Resident the resident complain and foot. Nurse #9 no Resident #46 reporter and that it was very s	 h. Resident #46 reported [c] dropped her while bed. Nurse #7 reported that t46 if she landed on the bed lent #46 reported she fell partially on the floor. Nurse do an assessment but N. Irse #8 's nurse note on l documented the resident fall yesterday. She shows tion nor did she have any ontinue to assess her for for any behaviors such as and or disorientation. Imented from the above /46/2014 note at 4:32 PM sments and read as below. /25/2014 at 7:52 AM read ation Tylenol. 26/2014 at 1:34 PM read ation Tylenol. 	F	309	9		

Facility ID: 943494

If continuation sheet Page 33 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345391	B. WING				C 04/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	[broken bone]. Nurse Nursing further asses and Resident #46 wa for further examinatio An observation and in AM with Resident #46 with her lower extrem leg splint boots. Resid hurt but she did recein An interview on 5/30/2 Resident #46 reveale during the process of chair in her room. Re- ask to go to bed; this to bed. He said he wa He asked me to do a like sit in a certain pla me up and slammed you hurt me and he s tomorrow. He left and to bed I guess? I was and my memory is ba how I was put in the to An interview on 5/30/2 #9 revealed the event attention as an acute during AM care and N 4/26/2014 nurse note An interview on 6/4/2/ #10 who was Resident the 3-11 shift on 4/22, assessed Resident #4	 ded a positive ankle fracture #9 reported the Director of sed bruising to the left ankle s transferred to the hospital n. hterview on 5/29/2014 10:00 b revealed she was in bed ities elevated, bilateral lower dent #46 reported her feet ve pain medication. 2014 at 2:42 PM with d she sustained injury being put to bed from the sident #46 stated " I did not fellow came in and put me as putting everyone to bed. few things I could not do ice and position. He picked me down on the table. I said aid I would be alright I then someone else put me hurting. It was so sudden id and I can ' t remember oed " . 2014 at 2:30 PM with Nurse t was brought to her episode of pain from the NA lurse #9 agreed to her as accurate documentation. 014 at 4:41 PM with Nurse nt #46 ' s primary nurse on /2014 revealed she 46 who was in bed around it #46 stated her arthritis 	F	309			

If continuation sheet Page 34 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345391	B. WING				C 104/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Nurse #10 returned to discussed the pain m revealed her arthritis and shoulder it was in told Nurse #10 she w Nurse #10 the descrip chair to bed was not of Nurse #10 reported s in the transfer and he unusual or anything th #46. Nurse #10 report returned to Resident is was pain free. Nurse an assessment on Res The Nurse Aide involve available for an interv A record review of the completed by the DO 4/22/2014 but complet Resident #46 stated is transferred to bed. Bill both ankles on 4/26/2 documented the immu a complete skin asses evaluation and a trans A record review of the 4/26/2014 of the right di lower leg bones that is medial malleolus [bor side of the ankle] with A record review of ho 4/26/2014 for residen	t due for pain medication. D Resident #46 and anagement. Resident #46 pain was not in her back h her foot. Resident #46 then as " manhandled " but to botion of the transfer from described in an unusual way. he spoke to the NA involved answered no to anything hat may have hurt Resident ted with in the hour she #46 a third time and she #10 reported she did not do esident #46 ' s foot. wed in the event was not iew. e Resident Incident Report N and back dated to eted on 4/26/2014 revealed she was dropped while being lateral bruising noted on 1014. The report ediate action taken included ssment, a physician	F	309			

Facility ID: 943494

If continuation sheet Page 35 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 04/05/2018 RM APPROVED NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345391	B. WING			0	C 6/04/2014
NAME OF PI	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		THE MOSES H CONE MEM H		1	1131 NORTH CHURCH STREET		
				•	GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	fibular fracture and tra fracture. A record review of the note from the emerge	e 35 nd an oblique distal right ansverse medial malleolar e hospital Physician progress ency department revealed aced in bilateral posterior	F	309	9		
	splints, no surgery re Orthopedic consult fo The facility Action Pla	quired and had an r follow up. in dated 4/26/2014 was					
	grievance log and inc Problem Description: lift resulting in a fall for Fracture to resident a	Employee failed to use the or 1 resident [Resident #46]. Inkle not identified until four					
	another to be a fall. S	I not identify the ent from one surface to staff member completing poming during investigation.					
	Resident #46 was se	for the resident included: nt to the ED on 4/26/2014 to es. On 4/30/2014 Resident					
	in status. On 5/1/2014 was changed on the (healthcare information	-					
	potential risk included completed the incorre suspended pending in	o for all other residents at d: On 4/26/2014 the NA that ect transfer technique was nvestigation and then loyment. On 4/28/2014 all					
	staff was in-serviced no new residents wer through the communi	on the definition of fall and re identified to have fallen					

Facility ID: 943494

If continuation sheet Page 36 of 49

	S FOR MEDICARE &				OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					с
		345391	B. WING		06/04/2014
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE
		T THE MOSES H CONE MEM H		1131 NORTH CHURCH STREET	
HEARILA	IND LIVING & REHAD A	THE MOSES HOONE 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLET HE APPROPRIATE DATE
F 309	Continued From pag	e 36	F 3	09	
	10	vn injury. On 4/30/2014 all	1.0		
		wed for current report of pain.			
		g pain were assessed for			
	unidentified injury. Al	Il residents were reviewed for			
		technique and any questions			
	regarding transfer technique of a resident was referred to therapy for review. On 5/5/2014 skin				
	identify residents with	ompleted on all residents to			
		On 4/28/2014 the nursing			
		regarding transfer of			
		to the resident care plan and			
	KARDEX. On 4/29/20	014 the nursing staff was			
		nent after alleged fall. On			
		ed staff was in-serviced on			
		oncern regarding resident sment for pain. On 5/1/2014			
		in-serviced on the new			
		e Stop and Watch form and			
		4 the NA staff preformed			
	return demonstration	-			
	administration team	of a transfer using the			
	mechanical lift.				
		he administrative nursing			
		d nursing notes, incidents,			
		ns, and the facility 24 hour entify residents with alleged			
	falls and assessment				
		going assessment tool for			
		tion and identification of falls			
	and pain. The admin	-			
	watched return demo				
		week ongoing to ensure			
	staff adhered to the k transfer.	VARUEX TOF RESIDENT			
	A record review revealed the completed				1
	A record review rever in-services listed in the	-			

Facility ID: 943494

If continuation sheet Page 37 of 49

		ID HUMAN SERVICES MEDICAID SERVICES		FORM APPF OMB NO. 0938				
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMP		
		345391	B. WING _				_ 04/2014	
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 131 NORTH CHURCH STREET			
HEARILA	ND LIVING & REHAB AI	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	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 309 F 323 SS=G	NA use; the complete pain assessments on medical records used or complaint of pain. On 05/29/2014 at 10:1 her knowledge of safe Watch form and resou Care Plan and KARD On 5/29/2014 at 10:2 knowledge of Resider transfers, in-services Stop and Watch tool. On 05/29/2014 at 10:1 her knowledge of the assessments, change hour report. On 5/29/2014 at 11:14 knowledge of the Stop transfer in-service. On 6/4/2014 at 4:30 F Assurance (QA) team meeting was in Febru incident and the follow held the last week in I due to the federal sur May 2014 included re tools. FREE OF ACCIDENT	he Stop and Watch form for d skin assessments and all residents; the reviewed for cross reference of a fall 08:15 AM NA #1 revealed ety checks, the Stop and urces for resident care i.e. EX. 8 AM Nurse #9 revealed her nt #46 ' s status change for on assessments, and the 56 AM Nurse #11 revealed Stop and Watch tool, e of condition and the 24 4 AM NA #2 revealed her p and Watch tool and the PM the facility Quality neets quarterly. The last tary 2014 prior to the wing QA meeting was to be May 2014 but put on hold vey. The QA agenda for eview of all active monitoring - SION/DEVICES		309				
	HAZARDS/SUPERVI CFR(s): 483.25(h)	SION/DEVICES	F:	323				

Facility ID: 943494

If continuation sheet Page 38 of 49

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/05/2018 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345391	B. WING _				C 04/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET		
				G	REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 323	environment remains as is possible; and ea	as free of accident hazards	FS	323			
	by: Based on observation interviews, and record use the mechanical life assist to transfer a rest ankles for 1 of 3 reside reviewed for accident The deficient practice facility identified the d implementing a correct The facility was in corr The findings included Resident #46 was add 8/9/2011. Diagnosis in Failure to Thrive and The Minimum Data Sov revealed Resident #4 cognitively impaired a with two staff member mobility and transfers	s. started on 4/22/14. The eficient practice and started ctive action plan on 4/26/14. npliance as of 5/5/14. mitted to the facility on ncluded Muscle Weakness, Osteoporosis. et (MDS) dated 2/1/2014 6 was moderately nd required extensive assist physical assistance for bed			Past noncompliance: no plan of correction required.		
	revealed a plan of car to impaired mobility, (joint disease, and poo	re for; self care deficits due Osteoarthritis, degenerative or vision. The approach stand-up lift. A second plan					

Facility ID: 943494

If continuation sheet Page 39 of 49

	-	ID HUMAN SERVICES				FORM	/ APPROVED		
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMP	LETED		
		345391	B. WING				C 04/2014		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
ΗΕΔΡΤΙ Δ	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		1131 NORTH CHURCH STREET					
	ND EIVING & REHAD AT			(GREENSBORO, NC 27401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 323	Continued From page	e 39	F	323	3				
	of care for; potential f	or falls due to impaired							
	mobility, poor vision and past history of falls revealed an approach for stand up lift for safe transfers and low bed. A record review of Nurse #7 's nurse note on 4/23/2014 at 7:16 AM revealed Resident #46								
		e (NA) on the 3-11 shift sisting her back to bed.							
		hat her body was partly on							
		Incident reported to the							
	A record review of Nu								
		2014 at 4:32 PM revealed f NA called Nurse #9 to							
	•	n and indicated the resident							
		her right ankle and foot.							
		ing and swelling. Resident er ankle hurting and that it							
	was very sore and ter	•							
		y film was taken of the right							
		positive ankle fracture #9 reported the Director of							
		sed bruising to the left ankle							
	and Resident #46 wa	s transferred to the hospital							
	for further examinatio	n.							
	An observation and ir	nterview on 5/29/2014 10:00							
	AM with Resident #46	6 revealed she was in bed							
		ities elevated, bilateral lower							
	hurt but she did recei	dent #46 reported her feet ve pain medication.							
	An interview on 5/30/								
		d she sustained injury being put to bed from the							
		sident #46 stated "I did not							
	ask to go to bed; this	fellow came in and put me							

Facility ID: 943494

If continuation sheet Page 40 of 49

	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 04/05/2018 ORM APPROVED NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) E	DATE SURVEY OMPLETED	
		345391	B. WING			C 06/04/2014		
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	•		
				113	1 NORTH CHURCH STREET			
HEARILA	ND LIVING & REHAB AI	THE MOSES H CONE MEM H		GR	EENSBORO, NC 27401			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	 F 323 Continued From page 40 to bed. He said he was putting everyone to bed. He asked me to do a few things I could not do like sit in a certain place and position. He picked me up and slammed me down on the table. I said you hurt me and he said I would be alright tomorrow. He left and then someone else put me to bed I guess? I was hurting. It was so sudden and my memory is bad and I can ' t remember how I was put in the bed ". An interview on 5/30/2014 at 2:30 PM with Nurse #9 revealed the event was brought to her attention as an acute episode of pain from the NA during AM care and Nurse #9 agreed to her 4/26/2014 nurse note as accurate documentation. An interview on 6/4/2014 at 4:34 PM with Nurse #7 revealed she was on duty from 11 PM to 7 AM and Resident #46 did not say anything all night. It was after the change of shift in the morning that the 7AM NA called me to Resident #46 ' s room. 		F	323				
	dropped her while as Nurse #7 reported that she landed on the be #46 reported she fell partially on the floor. do an assessment bu An interview on 6/4/2 #10 who was Resident the 3-11 shift on 4/22 assessed Resident # 9:30 PM and Resider was bothering her. No Resident #46 was no Nurse #10 returned to discussed the pain m	Nurse #7 stated she did not it reported it to the DON. 014 at 4:41 PM with Nurse nt #46 ' s primary nurse on /2014 revealed she 46 who was in bed around nt #46 stated her arthritis urse #10 determined t due for pain medication.						

If continuation sheet Page 41 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345391	B. WING _				C 104/2014		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET REENSBORO, NC 27401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE		
F 323	and shoulder it was in told Nurse #10 she w Nurse #10 the descrip chair to bed was not o Nurse #10 reported s in the transfer and he unusual or anything th #46. Nurse #10 report returned to Resident is was pain free. Nurse an assessment on Res The Nurse Aid involve unavailable for an inter A record review of the completed by the DO 4/22/2014 but comple Resident #46 stated s transferred to bed. Bill both ankles on 4/26/2 documented the imme a complete skin asses evaluation and a trans A record review of the 4/26/2014 of the right di lower leg bones that s medial malleolus [bor side of the ankle] with A record review of ho 4/26/2014 for residen distal left fibular fractur malleolar fracture and tra- fracture.	her foot. Resident #46 then as " manhandled " but to obtion of the transfer from described in an unusual way. he spoke to the NA involved answered no to anything hat may have hurt Resident ted with in the hour she #46 a third time and she #10 reported she did not do esident #46 ' s foot. ed in the event was erview. e Resident Incident Report N and back dated to eted on 4/26/2014 revealed she was dropped while being lateral bruising noted on 2014. The report ediate action taken included ssment, a physician	F3	323					

Facility ID: 943494

If continuation sheet Page 42 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/05/2018 M APPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE COM	E SURVEY PLETED		
		345391	B. WING _			C 06/04/2014		
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	-		
		THE MOSES H CONE MEM H		113	1 NORTH CHURCH STREET			
				GR	EENSBORO, NC 27401			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 323	Resident #46 was plat splints, no surgery rea Orthopedic consult for An interview on 6/4/2 Administrator revealed incident was by himse had been trained in p checks were dated 8/ was in-serviced on 12 KARDEX for resident involved in the incided Administrator that he for incontinent care a and her legs buckled The facility Action Plat presented immediate grievance log and inco Problem Description: lift resulting in a fall for Fracture to resident al days after resident all Root Cause: Staff did unintentional movement another to be a fall. S action was not forthoo Staff member disregat transfer technique for Implementation steps Resident #46 was set address ankle fractur #46 was assessed up designated to be a to	ency department revealed aced in bilateral posterior quired, and had an r follow up. 014 at 4:30 PM with the d the NA involved in the elf during the transfer and roper transfers. His skills (23/2012 and 8/8/2013. He 2/2/2013 for referring to the lift technique. The NA nt reported to the was standing the resident nd a stand and pivot transfer so he pushed her to bed. In dated 4/26/2014 was ly upon request with the studed: Employee failed to use the or 1 resident [Resident #46]. Inkle not identified until four leged to have fallen. I not identify the ent from one surface to staff member completing poing during investigation. arded the designated resident. 6 for the resident included: in to the ED on 4/26/2014 to es. On 4/30/2014 Resident	F 3	223	DEFICIENCY)			
	(healthcare information	care plan and KARDEX on tool). a for all other residents at						

Facility ID: 943494

If continuation sheet Page 43 of 49

	F DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	· · · ·	E SURVEY IPLETED
			A. BOILDING	J		С
		345391	B. WING		06/04/2014	
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		0/04/2014
				1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		GREENSBORO, NC 27401		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIO
F 323	Continued From page	e 43	F 32	23		
	potential risk included	d: On 4/26/2014 the NA that				
	•	ect transfer technique was				
		nvestigation and then				
	-	loyment. On 4/28/2014 all				
		on the definition of fall and				
		re identified to have fallen				
	through the communi	ication. All residents in in the past 30 days were				
	•	n injury. On 4/30/2014 all				
		ved for current report of pain.				
		g pain were assessed for				
		I residents were reviewed for				
	appropriate transfer t	echnique and any questions				
		chnique of a resident was				
		r review. On 5/5/2014 skin				
		ompleted on all residents to				
	identify residents with	Dn 4/28/2014 the nursing				
	staff was in-serviced	•				
		o the resident care plan and				
	•	014 the nursing staff was				
		nent after alleged fall. On				
		ed staff was in-serviced on				
	assessments for a co	oncern regarding resident				
		ment for pain. On 5/1/2014				
		in-serviced on the new				
	-	e Stop and Watch form and				
	return demonstration	the NA staff preformed				
		of a transfer using the				
	mechanical lift.					
		he administrative nursing				
		d nursing notes, incidents,				
		s, and the facility 24 hour				
		ntify residents with alleged				
	falls and assessment					
		going assessment tool for				
	accurate documentat	ion and identification of falls				1

Facility ID: 943494

If continuation sheet Page 44 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345391	B. WING				C 04/2014	
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 323	watched return demo transfers five times a staff adhered to the K transfer. A record review revea in-services listed in th completed clinical cor transfer monitoring; th NA use; the complete pain assessments on medical records used or complaint of pain. On 5/28/2014 at 8:15 mechanical lift was of and followed the resid transfer technique. On 05/29/2014 at 10: her knowledge of safe Watch form and resou Care Plan and KARD On 5/29/2014 at 10:2 knowledge of Residen transfers, in-services Stop and Watch tool. On 05/29/2014 at 10: her knowledge of the assessments, change hour report. On 5/29/2014 at 11:14	nstration of resident week ongoing to ensure ARDEX for resident aled the completed he Action Plan; the mpetency check list for he Stop and Watch form for ed skin assessments and all residents; the reviewed for cross reference of a fall AM a transfer with a oserved on Resident #47 dent care plan and proper 08:15 AM NA #1 revealed ety checks, the Stop and urces for resident care i.e. EX. 8 AM Nurse #9 revealed her nt #46 ' s status change for on assessments, and the 56 AM Nurse #11 revealed Stop and Watch tool, e of condition and the 24 4 AM NA #2 revealed her p and Watch tool and the	F	323				

If continuation sheet Page 45 of 49

	S FOR MEDICARE &	MEDICAID SERVICES		CONSTRUCTION	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:			C		
		345391	B. WING		06/04/2014		
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		131 NORTH CHURCH STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 323	meeting was in Febru incident and the follow held the last week in due to the survey. Th	n meets quarterly. The last	F 323				
F 460 SS=D	CFR(s): 483.70(d)(1) Bedrooms must be de	RE FULL VISUAL PRIVACY (iv)-(v) esigned or equipped to acy for each resident.	F 460		7/2/14		
	except in private roor ceiling suspended cu the bed to provide tot	rtified after March 31, 1992, ns, each bed must have rtains, which extend around al visual privacy in acent walls and curtains.					
	by: Based on observatio and record reviews th window blinds were re	is not met as evidenced ins, facility staff interviews, ne facility failed to ensure epaired or replaced to acy for 1 of 82 resident indings included:		The broken blinds in room 306 will be replaced by facility maintenance staff. Facility maintenance staff will conduct full audit of all resident rooms and resident care areas and identify any bl in need of repair	a		
	made of resident room observed to be occup window blinds were of broken and would no access into the reside walking by and cars p On 05/28/2014 at 4:3	0 p.m. an observation was m 306. The room was bied by 2 residents. The observed to be bent and t fully close allowing viewing ent's room from persons bassing the building. 0 p.m. a 2nd observation dow blinds in room 306. The		All items identified to be in need of rep will be entered into the facilities electro work order system. Facility maintenance staff with make identified repairs and sign them off as complete in the facility's electronic wor order system.	onic		

Facility ID: 943494

If continuation sheet Page 46 of 49

						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	ATE SURVEY OMPLETED
			A. BUILDING	;		С
		345391	B. WING			06/04/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (06/04/2014
				1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		GREENSBORO, NC 27401		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
F 460	Continued From page	e 46	F 46	0		
	window blinds were s	till bent and broken and		Facility administrative and	nursing staff	
		to ensure privacy by allowing		will be trained on identifyin		
		resident's room from		of repair and how to enter		
	persons walking and	cars passing the building.		needed repairs into the fac		
	On 05/20/2014 at 10:	30 a.m. a 3rd observation		work order system as need identified.	ded repairs are	
		dow blinds in room 306. The				
		still bent and broken and		Housekeeping staff will be	trained in	
		to ensure privacy by allowing		identifying blinds in need of		
		resident's room from		continue to note the need	for any repairs	
	persons walking and	cars passing the building.		on their daily sheets		
	On 05/29/2014 at 11:	00 a.m. and interview and				
		nducted with the facility's		Maintenance director will r		
		. The maintenance director		from the housekeepers da	•	
		not had a chance to fix		ongoing, and enter any rep		
		been at the facility for four ance director indicated it		the daily sheets in the faci work order system.	ity's electronic	
	was his goal to put m			work order system.		
		acility's computer system but		Facility maintenance staff	with make	
		get anything in yet. The		identified repairs and sign		
	maintenance director	also indicated he was not		complete in the facility's el	ectronic work	
		program as he had not used		order system ongoing.		
		facility and the staff had not				
		ed to use the program yet				
		in electronic work orders yet. ector indicated there were 3		Administrative staff will con audits three times weekly	•	
		ssistant were notified of		blinds in need of repair . A		
		eplacement work requested		will be utilized.		
	and needing to be do					
		for a state of the		Maintenance director will r		
		ff would keep notes on their		tools three times weeks to item identified on administ	-	
	daily sheets and turn maintenance director	-		have been entered in the f		
				electronic work order syste	-	
	2) By word of mouth -					
		or his assistant in hallway		All rounds tools and a repo		
	and they would write			and open work orders will		
	concerning the neede	ed repairs/replacements.		the Quality Committee Mo	nthly.	

Facility ID: 943494

If continuation sheet Page 47 of 49

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/05/2018 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345391	B. WING _				C 04/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
		THE MOSES H CONE MEM H		11	31 NORTH CHURCH STREET		
TEARILA	ND LIVING & REHAD AT			G	REENSBORO, NC 27401		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 460	Continued From page	47	F 4	60			
	3) The maintenance of	lirector indicated the					
	facility's staff having a						
		access to the software					
	program to electronica						
	requests in the system	n. The maintenance when the facility's staff					
		d about a maintenance					
		or replacement etc. they					
		mation into the computer					
		ame the electronic work					
		nce director indicated he Iram and see what needed					
	to be repaired or repla						
	A request to review al	l outstanding work orders					
	•	ronic, notes etc.) was made.					
		ctor indicated there were					
		I work order in the facility's					
	-	rogram and four completed					
	orders indicated there						
		I work order for the facility's					
		were four completed work					
	he had no paper main	intenance director indicated					
		umentation to show he or					
	-	ified of the window blinds					
		r or replacement. The					
		indicated he had some					
		or some items however he / type of notebook or other					
		to show he had a list of					
		ssues/items needing repair					
	or replacement. The	C .					
	-	t of the information in his					
	head but it was not wi	ritten down anywhere.					
	On 05/30/2014 at 11:5	50 a.m. an interview was					

If continuation sheet Page 48 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								PRINTED: 04/05/2018 FORM APPROVED OMB NO. 0938-0391	
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 06/04/2014		
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP (CODE			
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				1131 NORTH CHURCH STREET GREENSBORO, NC 27401					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		PROVIDER'S PLAN OF			(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECT TAG CROSS-REFERENC		(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE			
F 460	 F 460 Continued From page 48 conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The facility's maintenance director indicated there was no other place any work order information was stored to show they were aware of the bent/broken blinds in room 306 needing repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility 			460					
	was conducted with th director and his region The tour observation window blinds in roon maintenance director were not documented work order software p and he did not have a show the window blin	ne facility's maintenance nal maintenance manager. identified the bent/broken							

Facility ID: 943494

If continuation sheet Page 49 of 49