DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVI
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391		B. WING		C 12/02/2016
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		THE MOSES H CONE MEM H		1131 NORTH CHURCH STREET	
HEARILA		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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIO
F 000	INITIAL COMMENTS	3	F 00	00	
5 070	complaint investigation Event ID #7KK11	e cited as a result of the on conducted 12/02/2016.			10/00/40
F 278 SS=D		DINATION/CERTIFIED j)	F 27	78	12/30/16
	The assessment mus resident's status.	st accurately reflect the			
	A registered nurse m each assessment wit participation of health				
	A registered nurse m assessment is compl	ust sign and certify that the eted.			
		completes a portion of the n and certify the accuracy of sessment.			
	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a	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 disagreemen material and false sta	t does not constitute a atement.			
	This REQUIREMEN	is not met as evidenced			
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				12/21/201

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.

		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 04/05/2018 RM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345391	B. WING		1	C 2/02/2016	
	ROVIDER OR SUPPLIER	THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STAT 1131 NORTH CHURCH STRE GREENSBORO, NC 2740	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 278 F 371 SS=F	facility failed to accur Data Set (MDS) asse (Preadmission Screen level 2 (two) for 1 of 1 reviewed for PASRR. Finding include: Resident #65 was ad cumulative diagnoses psychological develop bipolar disorder. Review of PASRR De- revealed that Resider a PASRR level 11 wit 12/16/2016. Review of the MDS a 10/26/2016 revealed not coded to reflect P During an interview w 12/1/2016 at 12 PM r of the PASRR coding During an interview w 12/1/2016 at 1 PM re MDS assessment are the resident's status. FOOD PROCURE, S SANITARY CFR(s): 483.35(i) The facility must - (1) Procure food from considered satisfacto authorities; and	iew and staff interviews, the ately code on the Minimum ssment to reflect PASRR ning and Resident Review) resident in the sample (Resident #65) mitted on 9/30/2016 with which included disorder of oment, cerebral palsy and etermination notification form at #11 was determined to be h an expiration date ssessment dated Section A of the MDS was ASRR determination. with MDS Coordinator on evealed she missing coding . section A with yes. with Administrator on vealed her expectation that e coded to accurately reflect TORE/PREPARE/SERVE -	F 2	The MDS for resider accurately reflect the regards to PASRR de correction sheet was Facility MDS staff co for all residents in the determination on 12/ corrections were req Facility MDS staff will regarding correctly co PASRR determination All disciplines involve MDS will be trained i of the MDS according before 12/30/16. All disciplines involve MDS will collectively weekly for accuracy to audit tool will be utiliz Results of the audit to to the quality commit monthly for 12 month	etermination. A s submitted 12/28/16. Inducted a full audit e area of PASRR (28/16. No other uired. Il be educated oding the MDS for on before 12/30/16. ed in coding of the in coding each section g to RAI guidelines ed in coding of the audit five MDS's for 12 months. A QI zed. tools will be submitted ttee for review	12/30/16	

Facility ID: 943494

If continuation sheet Page 2 of 7

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/05/2018 MAPPROVED D: 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345391			B. WING			C 12/02/2016	
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				11	131 NORTH CHURCH STREET		
HEARILA	ND LIVING & REHAB AI	THE MOSES H CONE MEM H		G	REENSBORO, NC 27401		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
			-				
F 371	Continued From page	2		074			
F 3/ I	Continued From page	32	F	371			
	This REQUIREMENT	is not met as evidenced					
	by:						
	Based on observatio			Facility will ensure food is stored,			
	facility failed to ensure			prepared, distributed and served unde	r		
	air dry and were free			sanitary conditions.			
	particles, ceiling vent						
	restraints were worn l			Dietary staff will ensure dishes are	-i		
	the 96 residents who	the potential to affect 94 of			allowed to air dry, dishes are free of sta and debris and hair restraints are worn		
	the so residents who	resided in the facility.			staff serving and preparing food.	Бу	
	Findings Included:						
	Ū				Dietary staff will be educated regarding	1	
	An observation of the	kitchen on 11/20/16 at			requirement to allow dishes to air dry		
	11:30 am revealed:				12/26/16.		
	00 (00 11						
		ys were stacked together			Dietary staff will be educated regarding		
	service	and were ready for lunch			requirement for hair restraints to be wo in the kitchen 12/26/16.	111	
		lates had heavy food stains					
		them and were stored on a			The coffee mugs and plates identified a	at	
	•	table ready for lunch			the time of survey will be distained or		
	service				discarded.		
		lgs had heavy beverage					
		les on them and were			The ceiling vents identified at the time	of	
		rack ready for lunch service			the survey was cleaned 12/5/16.		
	 2 of 2 ceiling ven dust and dirt 	ts had a heavy build-up of			Diotan Managor will complete conitati	n	
		oyees with facial hair did not			Dietary Manager will complete sanitation rounds five times weekly for twelve		
		d and was preparing the			months to monitor for compliance with		
	lunch meal	Freedoming and			clean dishes, stained dishes clean ceil	ng	
					vents and use of proper hair restraints.	-	
	An interview on 12/02	2/2016 at 11:54 am with the			QI Audit tool will be utilized.		
		aled that his expectation					
	was that all dish ware should be clean, free from				Executive Director or designee will		

Facility ID: 943494

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DAT	<u>O. 0938-039</u> E SURVEY PLETED	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	A. BUILDING				
		345391	B. WING	B. WING			
NAME OF PROVIDER OR SUPPLIER		s					
HEARTLAND 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 371	Continued From page	e 3	F 371				
F 520 SS=F	employees with facial guard at the beginnin through-out the day. I vents were cleaned b department and that I maintenance request An interview on 12/02 facility administrator r was that dishes were cups and plates were She stated that male should wear a beard working in the kitcher responsible for the kit expected them to be QAA COMMITTEE-M	he had submitted a for them to be cleaned. 2/2016 at 12:20 pm with the revealed that her expectation allowed to air dry and that clean and free from stains. employees with facial hair guard when they are and that maintenance was tchen ceiling vents and she clean. EMBERS/MEET	F 520	conduct a sanitation round weekly for four weeks to monitor for compliance with clean dishes, stained dishes clean ceiling vents and use of proper hair restraints. A QI tool will be utilized. Results of completed audits will be submitted to facility quality committee monthly for 12 months for review.		12/30/16	
	assurance committee nursing services; a pl facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activit develops and implem action to correct ident A State or the Secret	east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/05/2018 RM APPROVED IO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345391	B. WING			1	2/02/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET IREENSBORO, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 520	 F 520 Continued From page 4 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and resident interviews, the facility 's Quality Assurance and Assessment (QAA) Committee failed to maintain procedures and monitor the interventions that the committee put into place following the February 25, 2016 recertification and complaint survey in the areas of Assessment Accuracy (F 278) and Food Procure (F 371). These deficiencies F 278 and F 371 were cited the recertification survey of December 2, 2016. The continued failure of the facility during two consecutive federal survey of record (F 278 and F 371) showed a pattern of the facility inability to sustain an effective Quality Assurance (QAA) program. The finding included: This citation was cross referenced to: 		F	520	Facility will ensure food is stored, prepared, distributed and served under sanitary conditions. Dietary staff will ensure dishes are allowed to air dry, dishes are free of st and debris and hair restraints are worr staff serving and preparing food.	tains	
					Dietary staff will be educated regarding requirement to allow dishes to air dry. Dietary staff will be educated regarding requirement for hair restraints to be we in the kitchen. The coffee mugs and plates identified the time of survey will be distained or discarded.	g orn	
	the Minimum Data Ser reflect PASRR (Pread Resident Review) lev in the sample reviewe #65) During the recertificat	rd review and staff failed to accurately code on et (MDS) assessment to finission Screening and el 2 (two) for 1 of 1 resident ed for PASRR. (Resident ion and complaint survey 25, 2016 the facility failed to			The ceiling vents identified at the time the survey was cleaned. Dietary Manager will complete sanitati rounds five times weekly to monitor fo compliance. A QI Audit tool will be utili Executive Director or designee will conduct a sanitation round weekly to	ion r	

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STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION				X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345391		B. WING _		1	C 12/02/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		2/02/2010	
				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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page	e 5	F 5	20			
	accurately assess the residents reviewed for	e eating status of 1 of 3 or activities of daily living. accurately assess the urinary		monitor for compliance. A C utilized.	N tool will be		
	incontinence of 1 of 3 reviewed for urinary i	B residents in the sample incontinence. The facility sessment for constipation for		Results of audits will be sub facility quality committee mo review for 12 months			
	2. F371 Based on ob interviews the facility were allowed to air d	-		The MDS for resident 11 wa accurately reflect the reside regards to PASRR determin correction sheet was submin	nt's status in ation. A		
	hair restrains were us the kitchen. This had the 96 residents who	sed by staff while working in the potential to effect 94 of resided in the facility.		Facility MDS staff conducted for all residents in the area of determination. Correction sh completed and submitted as	of PASRR neets will be		
	During the recertification and the complaint survey conducted February 25, 2916, the facility failed to label and date food items. The facility failed to store food items off the floor. The facility failed to have floors, carpets and walls in the			Facility MDS staff will be ed regarding correctly coding the PASRR determination.	he MDS for		
	were clean, free from	and dry storage area that cracks and free from an brown colored substance.		All disciplines involved in co MDS will be trained in codin of the MDS according to RA	ig each section		
	for QAA program was deficiencies each me	licated that her expectation		All disciplines involved in cc MDS will collectively audit fi weekly for accuracy. A QI a utilized.	ve MDS's		
	the areas of kitchen s had not been effectiv	sanitation and MDS accuracy e.		Results of the audit tools wi to the quality committee for monthly for 12 months.			
				Facility quality committee w results of audits in the area F 371 for 12 months. Based Facility Quality Assurance c	of F 278 and I on audits,		

Event ID: 7KK011

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>IO. 0938-0391</u>	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		TE SURVEY MPLETED		
		A. B		NG			
	345391 B. WING				C 2/02/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		2/02/2016	
				1131 NORTH CHURCH STREET			
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		GREENSBORO, NC 27401			
(X4) ID PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				ACTION SHOULD BE COMPLETION		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO 1 DEFICIENC	DATE		

Facility ID: 943494

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