STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/23/25 through 2/26/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #S9C311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/23/25 through 2/26/25. Event ID# S9C311. The following intakes were investigated NC00213186, NC00212129, NC00221215, NC00222011, and NC00222985. 12 of the 12 complaint allegations did not result in deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		3/19/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/19/2025

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to ensure walls in a resident's room did not have stains (room #116A) and failed to ensure a call light panel was securely attached to the wall behind a resident's bed (room 117B) for 2 of 4 rooms on 1 of 3 halls (100 hall) reviewed for a safe, clean and homelike environment. Findings included: 1. On 2/23/2025 at 10:39 am the wall beside the bed in room 116A had two 4-centimeters by 3-centimeters dried, dark brown stains. During observations on 2/24/2025 at 9:59 am and	F 584	1. TAG/CITATION: ____F-584 Clean/Safe/Homelike Environment A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 2/25/25, the Environmental Service Manager deep cleaned the room of Resident to include walls to ensure clean environment. On 2/26/25, the Maintenance Director repaired the call light outlet of Resident to ensure safe environment.	

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F 584	Continued From page 2 on 2/25/25 at 8:57 am the two 4-centimeters by 3-centimeters dried, dark brown stains remained on the wall beside the bed in room 116A. On 2/25/2025 at 9:18 am Nurse Aide #2 was interviewed, and she stated she was assigned to room 116A and housekeeping was responsible for cleaning the walls. Nurse #1 was interviewed on 2/25/2025 at 9:00 am and she stated room 116A was on her assignment but had not noticed the two dried, dark brown stains to his wall. Nurse #1 stated housekeeping was responsible for cleaning the walls in the room. During an interview with Housekeeper #1 on 2/25/2025 at 9:12 am she stated the two 4-centimeters by 3-centimeters dried, dark brown stains on the wall beside the bed in room 116A was dried stool. Housekeeper #1 stated she had the same assignment on 2/24/2025 and did not notice the stains on the wall beside the bed but housekeeping cleaned the walls twice a week in the residents' rooms. The Administrator was interviewed on 2/26/2025 at 9:15 am and she stated she was not aware of the two dried, dark brown stains on the wall beside his bed in room 116A. She stated the walls should be washed daily when housekeeping completed the daily room cleaning and as needed. 2. On 2/23/2025 at 10:44 am an observation of room 117B revealed the call light panel, which was above the head of the resident's bed, was detached from the wall and protruded 1 inch. The panel had a thick amount of caulk around the	F 584	B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 2/26/25, 100% audit of all resident rooms utilizing the "Resident Room audit tool" to include clean walls and safe outlets to include call lights by Environmental Service Manager or designee for clean and safe environment. Any issues identified immediately by Environmental Service Manager or designee were resolved. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 2/26/25, Executive Director implemented use of a new Resident Room audit tool to be completed daily by Interdisciplinary Team, to include Maintenance Director and Environmental Services Manager. On 2/26/25, Executive Director or designee will complete 100% education of the process enhancement of Resident Room audit tool with Interdisciplinary Team, to include Maintenance Director and Environmental Service Manager. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; As a monitoring mechanism, Executive Director will discuss any identified concerns from the new Resident Room	

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F 584	Continued From page 3 outer edges of the panel that was broken and the wiring to the panel was visible. On 2/25/2025 at 9:23 am an observation was made of room 117B and the call light panel at the head of the bed continued to protrude from the wall 1-inch and the thick caulk around the edges of the call light panel and the caulk had broken away in areas. The wiring to the panel was visible. The resident in room 117B stated she was afraid the panel would eventually fall out of the wall. During an interview with the Maintenance Director on 2/26/2025 at 8:59 am he stated he came to work at the facility about one month ago. He stated he had not been aware the call light panel in room 117B was protruding from the wall, and it looked like someone had tried to repair around the panel by filling the area between the wall and the panel with caulk instead of fixing the panel flush with the wall. The Maintenance Director stated the protruded call light panel was not a danger to the resident. The Administrator was present during the observation and interview with the Maintenance Director on 2/26/2025 at 8:59 am and was then interviewed on 2/26/2025 at 9:02 am and stated they had fixed a lot of maintenance issues since she came to the facility a month ago and she was not aware the call light panel in room 117B was protruding from the wall. The Administrator stated she was in room 117B on 2/22/2025 and the call light panel was not protruding from the wall that day. The Administrator stated the call light panel should be attached to the wall and they would get it fixed immediately.	F 584	Rounds audit during daily Interdisciplinary Team meeting on 2/27/25. 100% audit of resident room audit by Executive Director will be conducted during the daily morning meeting weekly x 4 weeks, monthly x 4 months, and quarterly thereafter for one year. Any noted concerns will be corrected immediately. The Executive Director will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly x 3 months. Any non compliance will be noted and corrective action until substantial compliance.	

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F 690	Continued From page 4	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		3/19/25

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F 690	Continued From page 5 Based on observations, staff interviews, and record review, the facility failed to keep a urinary catheter bag and its tubing from touching the floor to reduce the risk of infection for 1 of 3 residents (Resident #55) reviewed with a urinary catheter. The findings included: Resident #55 was admitted to the facility on 2/6/25. Her cumulative diagnoses included obstructive uropathy (a condition where the flow of urine is blocked, leading to a buildup of urine in the urinary tract). Resident #55's care plan included an area of focus related to the resident having an indwelling urinary catheter in place (Initiated on 2/6/25). An admission Minimum Data Set (MDS) assessment dated 2/12/25 revealed Resident #55 had moderately impaired cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #55 required supervision or touching assistance for eating and personal hygiene; partial to moderate assistance for sit to stand and chair/bed to chair transfers; and substantial to maximum assistance for toileting, bathing, dressing and bed mobility. The MDS reported Resident #55 had an indwelling urinary catheter. An observation was conducted on 2/24/25 at 10:20 AM as Resident #55 was sitting in her wheelchair with a urinary catheter collection bag hanging from her wheelchair. At the time of this observation, 1 inch of the bottom of Resident #55's urinary catheter bag and approximately 2 inches of the catheter tubing were lying on the floor. The resident appeared confused at the	F 690	TAG/CITATION: ___F660 Bowel/Bladder Incontinence_____ A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 2/24/25, Clinical Care Coordinator relocated the placement of the catheter bag and catheter tubing to be hung on the top of the wheelchair to ensure catheter bag and tubing were properly placed and not touching the floor. On 2/26/25, Clinical Care Coordinator placed Basin under catheter bag and tubing to provide barrier between catheter bag and the floor. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 2/26/25, Director of Nursing or designee completed 100% audit titled Catheter Audit Form completed for all resident with a catheter to ensure the catheter bags and tubing were placed properly, and not touching the floor. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 2/26/25, Clinical Nurse Liaison completed 100% education for all clinical staff regarding placing catheter bag and tubing on wheelchair so that they do not	

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F 690	Continued From page 6 time of the observation and could not provide any information regarding her urinary catheter. Another observation was conducted of Resident #55 on 2/26/25 at 8:20 AM as she laid in her bed with the head of the bed raised and her breakfast meal placed on the bedside tray table in front of her. One-half (1/2) of the resident's urinary catheter bag and approximately four (4) inches of the catheter tubing was observed to be lying on the floor. On 2/26/25 at 8:25 AM, Nurse Aide (NA) #1 was identified as the NA who was assigned to care for Resident #55. Accompanied by the NA to Resident #55's room, another observation was made of the resident's catheter bag and tubing lying on the floor. When NA #1 was asked what her thoughts were with regards to the position of the catheter bag and tubing, the NA stated, "It shouldn't be on the floor." The NA was observed to wash her hands and don gloves as she prepared to address the positioning of the catheter bag and tubing. Upon her request, an interview was conducted on 2/26/25 at 8:53 AM with the facility's Director of Nursing (DON). The DON stated she was made aware of the concerns related to Resident #55's urinary catheter bag and tubing having been on the floor. She reported that the entire catheter bag and tubing system was replaced this morning since they had been observed to be lying on the floor. An interview was conducted on 2/26/25 at 2:45 PM with the facility's Infection Preventionist. During the interview, the Infection Preventionist reported NA #1 told her about Resident #55's	F 690	touch the floor and placement of a barrier between floor and catheter bag when the resident is in a (low) bed. Any staff member that has not completed education prior to the due date will complete the education prior to next scheduled shift. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Director of Nursing Services or Designee will Audit all resident with a foley catheter using the Catheter Audit Form and proper placement of catheter bag and tubing to include while resident in wheelchair or low bed 3 x weekly x 4 weeks, twice weekly x 4 weeks, weekly x 4 weeks. Auditing times may be extended to achieve substantial compliance. Any issues identified will be discussed in AM meeting as members of the QAPI team routinely attend this meeting. Plan will be revised as needed. Executive Director will review results of monitoring audits during QAPI for 3 months or until substantial compliance achieved.	

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F 690	Continued From page 7 catheter bag and tubing found lying on the floor earlier that morning. The Infection Preventionist stated that because of this observation, she went ahead and "changed the whole system." She stated that changing the system, "brought it [the catheter bag] up" and off the floor. When asked if the catheter bag and tubing should be on the floor, she reported they should not.	F 690		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 9 of 91 days reviewed for sufficient nurse staffing (September 2024, October 2024, November 2024). Findings included: Review of the facility's Posted Nurse Staffing for September of 2024 revealed there was not a	F 727	TAG/CITATION: ___F727 RN 8 Hours/7 days Wk, FT DON_____ A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Nursing (DON) and Executive Director (ED) reviewed Posted	3/19/25

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F 727	Continued From page 8 Registered Nurse scheduled for at least 8 hours a day on September 6, 2024, September 7, 2024, September 21, 2024, and September 22, 2024. The Posted Nurse Staffing for October 2024 was reviewed and there was not a Registered Nurse scheduled for at least 8 hours a day on October 6, 2024 and October 20, 2024. The November Posted Nurse Staffing was also reviewed and there was not a Registered Nurse scheduled for at least 8 hours daily for November 3, 2024, November 16, 2024, and November 17, 2024. During an interview with the Director of Nursing on 2/25/2025 at 1:19 pm she stated she was responsible for the nurse staffing schedule in September 2024, October 2024, and November 2024. The Director of Nursing stated there was a staffing issue during those months and she was aware there was not a Registered Nurse in the facility for 8 hours on the dates in September 2024, October 2024, and November 2024. The Director of Nursing stated they had initiated a plan of correction for the scheduling of a Registered Nurse for 8 hours daily. The Administrator was interviewed on 2/26/2025 at 3:19 pm and she stated she expected nursing to have a Registered Nurse in the building 8 hours a day every day. The Administrator stated she was not the Administrator during September 2024, October 2024, and November 2024 but had reviewed the Plan of Correction initiated during that time.	F 727	Nursing hours, Nursing Assignment sheet and Payroll Based Journal (PBJ) report for dates of 9/6/24, 9/7/24,9/21/24, 9/22/24, 10/6/24, 10/20/24, 11/3/24, 11/16/24, 11/17/24. The PBJ report reflected 8 or more Registered Nurse (RN) hours for dates of 9/7/24, 9/21/24, 9/22/24 and11/03/24. On dates 10/20/24 and 11/16/24, the PBJ report reflected 7.5 and 7.75 RN hours, due to the program automatically subtracting 30 minutes from submitted hours for breaks. Dates of 9/6/24, 10/6/24 and 11/17/24 did not have documented 8 hours of RN coverage due to error or omission. On 3/18/25, The Director of Nursing reviewed 24 hour shift reports for the dates of 9/6/24, 10/6/24 and 11/17/24, to identify residents with change of condition, and validated that there were no negative outcomes related to the facility not staffing an Registered Nurse (RN) for 8 hours on those dates. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/17/25, The Director of Nursing completed audits of Registered Nurse (RN) coverage from 11/22/24-3/17/25, with no other dates identified with less than 8 hours of RN coverage. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 727	Continued From page 9	F 727	On 3/18/25, Director of Operations provided education for the Executive Director (ED), Director of Nursing (DON) and Staffing Coordinator regarding requirement for an Registered Nurse (RN) 8 consecutive hours a day/ 7 days a week. The DON provided education for the RN staff regarding working 8 consecutive hours, to include notifying the DON if the RN must leave prior to completion of the 8 hours. If the RN calls out for a shift or is not able to complete the shift, the DON must be notified and will assure RN coverage is provided. On 3/18/25, The Director of Nursing implemented the Staffing Coordinator to complete the Daily Posted hours form and to notify the Director of Nursing daily if Registered Nurse (RN) coverage does not meet or exceed 8 consecutive hours. Staffing Coordinator will meet with Executive Director (ED) and/or DON weekly to discuss RN coverage for the upcoming week and will staff accordingly. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; On 3/17/25, Director of Nursing will audit daily staffing sheets, Daily Posted hours and payroll sheets (PBJ reports) weekly x4 then monthly x2 to ensure Registered Nurse (RN) hours meet or exceed 8 hours per day. Executive Director will review the Results of the audits in QAPI monthly x 4 or until substantial compliance is met.	

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