PRINTED: 02/10/2012 FORM APPROVED FFR O 1 20 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345391	B. WING		01/2	27/2012
	ROVIDER OR SUPPLIER	THE MOSES H CONE MEM H	113	ET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401	=	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
F 441 SS=D	SPREAD, LINENS  The facility must estal Infection Control Prosafe, sanitary and co to help prevent the dof disease and infect  (a) Infection Control The facility must estal Program under which (1) Investigates, continuthe facility;  (2) Decides what proshould be applied to (3) Maintains a reconactions related to infection determines that a respreyent the spread of isolate the resident.  (2) The facility must promunicable disease from direct contact will train (3) The facility must promunicable disease from direct contact will train (3) The facility must professional practice.  (c) Linens  Personnel must hand	Program shish an Infection Control in it - irols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections.  d of Infection in Control Program sident needs isolation to f infection, the facility must conhibit employees with a se or infected skin lesions ith residents or their food, if insmit the disease. require staff to wash their ect resident contact for which cated by accepted	F 441	The facility will maintain Control program designed safe, sanitary, and comfor environment and to help development and transmit and infection  For the resident cited:  The blood glucose machinand sanitized for resident prior to his next blood glucose machinand sanitized for resident prior to his next blood glucose machinand sanitized for resident prior to his next blood glucose and control inservice all regarding the correct procedaning and disinfection the manufacturer's instructions are glucometer for cleaning and glucometer per the manufacture of glucometers per the manufacture of glucometers per the mainstructions as part of the mandatory orientation for facility will also address the disinfection control inservice CNA's.	I to provide a rtable prevent the ssion of disease seems of disease the was cleaned number 37 acose test.  I y at the time of the glucometer perfections.  I was and opriate disinfecting facturers  I d CNA's will ly in the disinfection anufacturer's a facility's a new hires. The he cleaning and in a biannual	1/25/2012 1/26/2012 2/24/2012
ARORATORY	DIRECTOR'S R PROVIDED	SUPPLIER REPRESENTATIVE'S SIGNATUR	F.	TITLE		(X6) DATE

LABORATORY DIRECTOR'S AR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any delicency statement lending 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.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/10/2012 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 345391 01/27/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H GREENSBORO, NC 27401 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 Continued From page 1 F 441 Monitors: Administrative nursing staff will observe 2/24/2012 This REQUIREMENT is not met as evidenced blood glucose checks five times a week for four weeks, then weekly ongoing. A by: skills checklist will be utilized. Education Based on observation, record review, and staff will be provided at the time the checklist interviews the facility failed to clean and disinfect is completed if needed. Results of skills a glucometer for 1 of 2 sampled resident checklists and will be reviewed in the (residents # 37 and #176) observed receiving facility's monthly Quality Improvement blood glucose monitoring. Meetings. Findings include: The Center for Disease Control (CDC) and Prevention Guidelines for Glucose Monitoring read in part: "Any time blood glucose monitoring equipment is shared between individuals there is a risk of transmitting viral hepatitis and other blood borne pathogens. Decontaminate environmental surfaces such as glucometers regularly and any time contamination with blood or body fluids occurs or is suspected. Glucose test meters approved for use with more than one person must be cleaned and disinfected following disinfection guidelines." Accu-check or fingerstick blood sugar (FSBS) tests involve sticking a resident's finger for a blood sample. which is then placed on a strip. The strip goes into a glucose meter that reads the blood sugar level. The facility's policy titled Infection Control-Standard Precautions dated 9/2005 read in part under the heading Resident-Care Equipment "Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned."

The Manufacturer's recommendation titled "Recommended (brand name glucometer)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		345391	B. WIN	G		01/27	7/2012
NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				11	EET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Cleaning and Disinfer "Cleaning and disinfer using a commercially (Environmental Proted detergent or germicid remove from contained label instructions to product instructions for registered germicidal read in part "Some of the surface by thorouthe wipe. Most remain within two (2) minutes wipe."  Resident #37 was add 10/13/2011 with diagon mellitus (DM). Review record found orders included blood sugar bedtime.  In an observation on Nurse #1 prepared to sugar for Resident #3 glucometer from its control strip from its bottle. Shand sanitizer and put the test strip into the #37's finger with an assample using a disponder of blood to the test results, Nurse #1 strip, alcohol pad, an placed the glucometer removed her gloves a recording the blood strips.	cting Guidelines" read in part cting can be completed by available EPA-registered ction Agency) disinfectant le wipe. To use a wipe er and follow the product isinfect the meter." The or an acceptable EPA wipe used by the facility organisms are removed from ghly wiping the surface with ning organisms are killed is by exposure to the liquid mitted to the facility on noses that included diabetes of Resident #37's medical dated 10/13/2011 that checks before meals and at 1/25/2012 at 11:35 am obtain a finger stick blood	F	441			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345391		B. WNG	·		01/27/2012	
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				1131 N	ADDRESS, CITY, STATE, ZIP CODE NORTH CHURCH STREET ENSBORO, NC 27401		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	how often the glucom responded that it was calibrated. Asked if the cleaned, Nurse #1 station is visible blood on the gright away with a san stated that the Nursin Nursing Technicians sugars so they regula She indicated that she #37's blood sugar be felt like it was low.  During an interview of #2 when asked who cresponded that anyon after each used with manufacturer's recondensidered an accept At 12:40 pm on 1/25/interviewed together, they cleaned the glucometer after each cleaned the glucometer after each cleaned the glucometer.  On 1/25/2012 at 12:5 interview that the glucometer storing. She indicated to the glucometer stores.	seter was cleaned she cleaned each night when hat was the only time it was lated that if there was any lucometer it was cleaned litizer wipe. Nurse #1 also lig Assistants (NA) and (NT) usually took the blood larly cleaned the glucometers. It was only taking Resident cause the resident said she  In 1/25/12 at 12:35 pm Nurse cleaned the glucometers he who used it cleaned it an alcohol swab. Per hammendations, alcohol is not	F4	41			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345391	B. WIN	G		01/27	7/2012
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			11:	ET ADDRESS, CITY, STATE, ZIP CODE 31 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		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LÐ BE	(X5) COMPLETION DATE
F 441	glucometer storage b registered germicidal manufacturer.  In an interview on 1/2 indicated that the glucand after each use wistated that it was wipfor two minutes. She wipe container on the storage.  During an interview a he cleaned the glucorused alcohol preps in Resident #176 was a 1/17/12 with diagnose of physician's orders order to check blood and at bedtime.  On 1/25/2011 at 4 pm sugar on Resident # and used gloves to ta disposed of the lance NT #1 took the glucorcleaned it with disinfet that she cleaned the She indicated the wip basket attached to the machine. They were so NT#1 obtained the on the wall in front of disposed of her gloves.	ox. They were the EPA wipes recommended by the  5/2012 at 12:55 pm NA #3 cometer was cleaned before th a sanitizing wipe. She ed down and allowed to dry pointed out the sanitizer wall next to the glucometer  t 1:00 pm NA #4 stated that meter after every use, but stead of sanitizer wipes.  dmitted to the facility on es that included DM. Review dated 1/17/12 found an sugars before each meal  NT # 1 checked the blood 176. She washed her hands ke the blood sugar. She t and alcohol wipes. Then meter out of room and cotant wipes. NT #1 stated glucometer after every use. les were usually in the e wheeled blood pressure not in the basket at that time e wipes from the dispenser the nurses' station. She is and washed her hands.	F	441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345391	B. WNG		01	/27/2012
	ROVIDER OR SUPPLIER	T THE MOSES H CONE MEM H	S	STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION OF THE CORRECTIVE ACTION OF	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	sanitizer and gloves cleaned with a sanit by the glucometer s alcohol wipes were glucometer to take the wipes would be test strip and lancet sharps safe contain back to the storage sanitizer wipe and p to air dry. The glove washed. When aske should be cleaned for every use before put that she had receive in-service when hire. The Administrator si 1/25/2012 at 5:30 provided in Septe glucometers. The fa glucometer in 9/201 representative gave the use and care of Administrator indica not all the nurses reof the glucometers. On 1/26/2012 at 12: provided a copy of the 9/13/2011 in-ser of the glucometers. of an EPA registered that was approved for Sanitizer wipes used the handout to act as size of the service wipes used the handout to act as size of the glucometers.	were cleaned with hand put on. The glucometer was izer wipe located on the wall torage. The test strip and gathered along with the o a resident's room. After use disposed of in the trash. The would be disposed of in a er. The glucometer was taken area, cleaned with another flaced in its open storage bag is were removed and hands and how often the glucometer atting it away. She indicated and this training during an ind.  atted in an interview on in that the NAs and NTs were od sugars and had been imber 2011 about cleaning cility started using a new 1 and the manufacturer's an in-service at the facility on the glucometers. The ted that it was possible that ceived that training.  On noon the Administrator ine manufacturer's handout for vice on the care and cleaning The handout included the use of disinfectant or germicide or healthcare settings. The the by the facility were noted in	F 44	11		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345391	B. WING	<u></u>	01/	27/2012
NAME OF PROVIDER OR SUPPLIER  HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			113	ET ADDRESS, CITY, STATE, ZIP COD 31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	provided. Nurse #1, I names were not on the #2, NA #3, and NA#4  In a joint interview or Nurses and the Admit expected all staff to formal interview.	this in-service was also NA #1, NA #2, and NT #5's he list. Nurse #2, NT #1, NA t's names were on the list.  1/27/2012 the Director of inistrator indicated they follow the proper procedures affecting glucometers before	F 441			

				MAR 1 10 2011/2. FOR	RM APPROVED
DEPART	MENT OF HEALTH	AND HUMAN SERVICES  A MEDICAID SERVICES		4 BMO	IO. 0938-0391 E SURVEY
SYATEMENT	OF DEPICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTII A. BUILDIN	COM	PLETED
	•	345391	B. WING		2/29/2012
NAME OF P	NOVIDER OR SUPPLIER	<u></u>	SYR	REET ADDRESS, CITY, STATE, ZIP CODE	
UEARTI	AND LIVING & REHA	B AT THE MOSES H CONE MEM	H G	CREENSBORO, NC 27481	
ДЕМКТЕ		AYEMENT OF DEFICIENCIES	l ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
(X4) ID PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	217A((
K 000	an advadad on por	ode(LSC) survey was The Code of Federal Register	K 000	Penetration was filled with fire rated sealant.	
,	at 42CFR 483.70(a Care section of the publications. This to construction, one security automatic sprinkles	a); using the existing health be LSC and its referenced building is Type III(211) story, with a complete r system.		2. Corrective Action ! Inspection was made of all mechanical rooms to ensure other possible penetrations were sealed.	
K 012 SS=E	are as follows: NFPA 101 LIFE SA	etermined during the survey  AFETY CODE STANDARD  on type and height meets one 9.1.6.2, 19.1.6.3, 19.1.6.4,	K 012	3. Systemic Changes - A contractor "Statement of Responsibility" was established to ensure sealing of penetration after work is completed and will be monitored by the	414 12
	Surveyor: 27871 Based on observations approximately 8:30 Items were noncortinglude: mechanic	is not met as evidenced by:  tions and staff interview at ) am onward, the following npliant, specific findings al room #3 has un-sealed are not seal to maintain the 1 reting of the facility.		maintenance department.  4. Monitoring - The inspection of all mechanical rooms for penetrations was included on the daily rounds report.	41412
K 018 SS=E	Doors protecting of required enclosure hazardous areas a those constructed wood, or capable to the second or capable to t	orridor openings in other than es of vertical openings, exits, or the substantial doors, such as of 1% inch solid-bonded core of resisting fire for at least 20	K 018		(X6) DAYF
LABORATOR	Y DIRECTOR OR PROV	DERIGUEPLIER REPRESENTATIVE'S SIC	INATURE	A description 3	110 lis

Arry beficiency statement enting with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that often 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.

Event ID: OTWY21

Facility 10 943494

If continuation sheet Page 1 of 4

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES					FORM	; 03/05/2012 APPROVED . 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDEN'IFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		COMPLETED		
		345391	B. Wil	B. WING 02/29/20			9/2012	
	ROVIDER OR SUPPLIER AND LIVING & REHA	3 AT THE MOSES H CONE MEM	н	11	EET ADDRESS, CITY, STATE, ZIP CO 131 NORTH CHURCH STREET RÉENSBORO, NC 27401			
(X4) ID PREPIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	OHS V APPR	ULO BE	ACH THMUS FEAG 11AG
К 018	Continued From parinules. Opers in strequired to resist the no impediment to the street provided with a the door closed. During permitted. 19 Roller latches are printed in all health care factors. This STANDARD is Surveyor: 27871 Based on observational approximately 8:30 items were noncomfined to the continued of the continued	ge 1 sprinklered bulldings are only e passage of smoke. There is the closing of the doors. Doors means suitable for keeping stch doors meeting 19.3.6.3.6 .3.6.3 rohibited by CMS regulations silities.  In not met as evidenced by: ons and staff interview at am onward, the following pliant, specific findings	K	018	Immediate Response rubber wedges were from doors being hel Corrective Action - In staff was conducted the prohibited use of impeded the closure Systemic Changes - protection contractor contacted to install n on designated doors physical therapy) the release by fire alarm Monitoring - Inspectibeing impeded from was included on the rounds. Immediate c would be made durir when observed and the safety committee	e - A rem d op l-ser rega item of d Fire was lag l (i.e. two sys on o clos daily orreported to the contract of	oved en. vice of ording one that oors. slocks ould tem. of doors ing viction ounds orted at	4-14-12
SS≃Œ Î	devices or equipme NFPA 72, National effective warning of Activation of the cor manual fire alarm in	with approved components, on its installed according to Fire Alarm Code, to provide tire in any part of the building. Inplete fire alarm system is by ilitation, automatic detection or no peration. Pull stations in as may be omitted provided			,			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					. 0936-039
STATEMENT	of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	AULTIPI ILDING	LE CONSTRUCTION 01 - MAIN BUILDING 01	COMPLETED	
		345391	IW B	NG		02/	29/2012
	PROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM	н	113	ET ADORESS, CITY, SYAYE, ZIP CÓDE 31 NORYH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	TRYCH DODGCENC,	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	10UL0 BE	(X5) CONULLTION DATE
K 051	nurse's stations. P path of egress. Elst tests are available. power is provided. maintained in acco records of mainten. There is remote an	age 2 altons are within 200 feet of ull stations are focated in the ectronic or written records of A reliable second source of Fire alarm systems are rdance with NFPA 72 and ance are kept readily available. nunciation of the fire alarm yed central station. 19,3.4,	K	051	Immediate Action - Fire protection contractor wa contacted to make approrepairs/commodation to provide a visual/audib trouble signal at panel.  Corrective Action - Repaire made to FACP by Fire Protection contractors	opriate FACP ole airs T&S	4-14-12
The second secon	Surveyor: 27871 Based on observati approximately 8:30 items were noncom include: there was signal at the Fire Al	s not met as evidenced by:  ons and staff Interview at am onward, the following pliant, specific findings not a visual/audible trouble arm Control Panel (FACP) ne line connection and loss of er.			Systemic Changes/Moni Annually the fire protectic contractor will ensure the FACP's provide a working visual/audible trouble signification of facilities during inspection process to encompliance.	ion at all ng gnal. y the ng the	
K 147 SS≃€	Electrical Wiring 800	FETY CODE STANDARD I equipment is in accordance onal Electrical Code, 9,1,2	К 1	47			4-14-12
· · · · · · · · · · · · · · · · · · ·		Overly Evan) IQ: OTWT21		Exclin	1D: 943494 If co	ntinuation she	el Page 3 of

!

PRINTED: 03/05/2012

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER. AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B, WING 02/29/2012 345391 SYREET ADDRESS, CITY, SYATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1131 NORTH CHURCH STREET HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H GREENSBORO, NC 27401 PROVIDER'S PLAN OF CORRECTION CCWLTTION SUMMARY STATEMENT OF DEFICIENCIES (X4) 10 PREFIX (EACH CORRECTIVE ACTION SHOULD BE LEACH DEPICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Immediate Response -4-14-12 K 147 K 147 Continued From page 3 1. Protected covers were This STANDARD is not mel as evidenced by: installed on identified exposed Surveyor: 27871 light tubes. Based on observations and staff interview at 2. Multi-plug outlets were approximately 8;30 am onward, the following removed from identified resident items were noncompliant, specific findings include: 1.facility has exposed light lubes with out protect covers at nurse station on South Hall. 2. 3.GFCI cover was installed on residents bedroom #126 is using multi plug outlet for permanent power source for TV, 3. GFCI at identied outlet. South Courtyard(out side) is missing cover. 4. 4. Fire protection contractor was staff could not locate breaker for Fire Alarm contacted and facility staff Control Panel for loss of AC power test. located breaker for FACP and tested for loss of AC power. 42 CR 483,70(a) Corrective Action -1. Inspection was made on all exposed light tubes and protective covers were installed. 2. Inspection of all resident rooms were made to ensure that other multi-plug outlets were not lin use or removed. 3. Inspection of other outside GFCI outlets was made for missing plate covers. See above response. Systemic Changes -1. Inspection of exposed light tubes was added to the weekly light inspection form. If continuation sheet Page 4 of 4 Event ID: OTWY21 Facility ID: 949494 FORM CMS-2667(02-99) Frevious Versions Obsolate

2. Notification was sent to resident family members about prohibited use of multi-plug outlets in resident rooms. 3. Inspection of GFCI outlets for missing covers/repairs was included in daily rounds form. 4. Fire protection contractor was informed to include testing of power loss and visual/audible trouble signal on FACP.

Monitoring - 1&3. Daily rounds will be monitored by director of facilities for compliance. 2. Monitoring of use of multi-plug outlets will be included in resident room PM inspection and reported on in safety committee meeting. 4. Director of Facilities will monitor fire protection contractor for compliance.

DEPARTMENT OF HEALTI	H AND HUMAN SERVICES		MAR 1 6201	FORM OMB NO	): 03/05/20 1 APPROVI ): 0938-03
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
	345391	B. WING		02/2	9/2012
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHA	AB AT THE MOSES H CONE MEM	() 11	EET AODRESS, CITY, STATE, ZIP CO 31 NORTH CHURCH SYREET REENSHORO, NC 27401	DDE	
MACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDEN'S PLAN OF CO (EACH CORRECYNE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	( SHOULD BE	COMPLETE DATE
K 000 INITIAL COMMEN	TS	K ann	llate Respons		
conducted as per T at 42CFR 483.70(a Care section of the publications, This b	t); using the existing flee LSC and its referenced building is Type III(211) tory, with a complete	Copy	lant.  ive Action i was made al rooms to jible penetra	of all ensure	
are as follows:  K 012 NFPA 101 LIFE SA  SS=E  Building construction	etermined during the survey  SETY CODE STANDARD  on type and height meets one  1.1.6.2, 19.1.6.3, 19.1.6.4,	K 012	3. Systemic Changes contractor "Statement Responsibility" was established to ensure of penetration after we completed and will be monitored by the	of sealing	
Surveyor: 27871 Based on observative approximately 8:30 Items were noncominclude: mechanical penetrations that are hour construction reservations.	ons and staff interview at am onward, the following plant, specific findings troom #3 has un-sealed a not seal to maintain the 1 ating of the facility.		maintenance departm  4. Monitoring - The insof all mechanical room penetrations was incluthe daily rounds report	spection ns for ided on	
SS=E  Doors protecting co- required enclosures hazardous areas are those constructed o	rridor openings in other than of vertical openings, exits, or e substantial doors, such as f 1% inch solid-bonded core resisting fire for at least 20	K 018			
	ERJOUPPLIER REPRESENTATIVE'S SIGN	AYURE	Administrator		χο ηλιά Γων

program panicipation.

Event ID: OTWY21

Facility ID 943494

If conlinuation sheet Page 1 014

PRINTED: 03/05/2012

DEPAR	FORM APPROVED OMB NO. 0938-0391					
STATEMEN	RS FOR MEDICARE T OF BEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA DENTIFICATION NUMBER:	1 '	IULTIPLE CONSTRUCTION ILDING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
345391			B. WI	16	02/29/2012	
ł	SUMMARY STA	B <sub>.</sub> AT THE MOSES H CONE MEM TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	H ID PREFI YAG		RECTION IX9;	
K 018	required to resist the no impediment to the are provided with a the door closed. On are permitted. 19 Roller latches are p in all health care factors.	sprinklered buildings are only e passage of smoke. There is see closing of the doors. Doors means suitable for keeping atch doors meeting 19.3.6.3.6 a.3.6.3 rohibited by CMS regulations	Ķ¢	Immediate Response rubber wedges were from doors being held Corrective Action - In staff was conducted the prohibited use of impeded the closure protection contractor contacted to install mon designated doors physical therapy) that release by fire alarm	removed I openservice of egarding litems that of doorsfire was ag locks (i.e. would system.	
K 051 S5≂€	Based on observation approximately 8;30 items were noncomplicated include; doors to Phasa, Director of Number wedge.  42 CFR 483,70(a) NFPA 101 LIFE SAME of the alarm system devices or equipment of the confidence of the confidence in the confidence in the confidence of the confidence in the confidence of the confidence of the confidence in the confidence of the confidence in the confidence of the confiden	am onward, the following pliant, specific findings ysical Therapy and raing were being held open with approved components, at its installed according to fire Alarm Code, to provide fire in any part of the building, aplete fire alarm system is by liation, automatic detection or a operation. Pull stations in as may be omitted provided	K 09	Monitoring - Inspection being impeded from a was included on the condition of the condition would be made during when observed and retained the safety committee	losing laily	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If confinuation sheet Page 3 of 4

PRINTED: 03/05/2012

FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 D WING 345391 02/29/2012 SYREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1131 NORTH CHURCH SYREET HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H GREENSBORO, NC 27401 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (AA) NCITY,IHAOD 10 (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE YAG TAG DEFICIENCY) Continued From page 2 K 051 K 051 Immediate Action - Fire that manual pull stations are within 200 feet of protection contractor was nurse's stations. Pull stations are located in the contacted to make appropriate path of egress. Electronic or written records of tests are available. A reliable second source of repairs/commodation to FACP power is provided. Fire alarm systems are to provide a visual/audible maintained in accordance with NFPA 72 and trouble signal at panel. records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. Corrective Action - Repairs 9.6 were made to FACP by T&S Fire Protection contractor. Systemic Changes/Monitoring ~ Annually the fire protection contractor will ensure that all FACP's provide a working visual/audible trouble signal. This STANDARD is not met as evidenced by: This will be monitored by the Surveyor: 27871 Based on observations and staff interview at director of facilities during the approximately 8:30 am onward, the following inspection process to ensure items were noncompliant, specific findings compliance. include: there was not a visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of telephone line connection and loss of battery and AC power. 42 CFR 483,70(a) K 147 K 147 NFPA 101 LIFE SAFETY CODE STANDARD SS⋍E Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2

Event (D; OTWT21

FORM CMS-2587(02-99) Previous Versions Obsolele

Facility ID: 943494

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/05/2012

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B, WING 345391 02/29/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H GREENSBORD, NG 27401 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XS) COMPLITION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX IBACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DAH. HEGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Immediate Response -K 147 K 147 Continued From page 3 Protected covers were This STANDARO is not met as evidenced by: installed on identified exposed Surveyor: 27871 light tubes. Based on observations and staff interview at 2, Multi-plug outlets were approximately 8:30 am onward, the following items were noncompliant, specific findings removed from identified resident include: 1,facility has exposed light tubes with out rooms. protect covers at nurse station on South Hall. 2. 3.GFCI cover was installed on residents bedroom #126 is using multi plug bullet identied outlet. for permanent power source for TV. 3. GFCI at South Courtyard(out side) is missing cover, 4. 4. Fire protection contractor was staff could not locate breaker for Fire Alarm contacted and facility staff Control Panel for loss of AC power test. located breaker for FACP and 42 CR 483.70(a) tested for loss of AC bower. Corrective Action - Inspection was made on all exposed light tubes and protective covers were installed. 2. Inspection of all resident rooms were made to ensure that other multi-plug outlets were not in use or removed. 3. Inspection of other outside GFCI outlets was made for missing plate covers. 4. See above response, Systemic Changes -1. Inspection of exposed light tubes was added to the weekly light inspection form.

2. Notification was sent to resident family members about prohibited use of multi-plug outlets in resident rooms. 3. Inspection of GFCI outlets for missing covers/repairs was included in daily rounds form. 4. Fire protection contractor was informed to include testing of power loss and visual/audible trouble signal on FACP.

Monitoring - 1&3. Daily rounds will be monitored by director of facilities for compliance, 2. Monitoring of use of multi-plug outlets will be included in resident room PM inspection and reported on in safety committee meeting, 4. Director of Facilities will monitor fire protection contractor for compliance.