		AND HUMAN SERVICES		-	D: 07/15/201 M APPROVE D. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DA	ATE SURVEY OMPLETED
		345391	B. WING	0	C 6/04/2014
NAME OF F	PROVIDER OR SUPPLIER	• •	S	STREET ADDRESS, CITY, STATE, ZIP CODE	
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM		131 NORTH CHURCH STREET GREENSBORO, NC 27401	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ſS	F 000		
F 253 SS=E	conducted a compl 05/27/2014 through interviews were cor Therefore, the surv 06/04/2014. 483.15(h)(2) HOUS MAINTENANCE SE The facility must pr maintenance service		F 253		7/2/14
	by: Based on observat and record reviews adequate maintenat to ensure a safe, or for 3 of 3 resident h findings included: A) On 05/27/2014 the facility was cont following areas wer repair: The resident comm nursing station - the mount and could be either direction side was placed on the f stall next to the toile operational and wo switch was turned of	NT is not met as evidenced tions, facility staff interviews, the facility failed to ensure ince services were preformed rderly, and comfortable interior halls (100, 200, and 300). The at 9:55 a.m. an initial tour of ducted. During the tour the re observed to be in need of non shower room by 200 hall to toilet was loose on floor to a side when light pressure toilet. The light in the shower et/sink area was not uld not come on when the on.		 A. The toilets in the 200 hall shower room was repaired at the time of survey. The light bulb in the 200 hall shower room was 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. C. The faucet in the 300 hall nourishmen room will be repaired by facility maintenance staff. D. The toilet in therapy ADL bathroom w be repaired by facility maintenance staff. The grab bar in the therapy ADL bathroom will be repaired by facility maintenance staff. 	s t

Electronically Signed

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.

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	Сом	E SURVEY PLETED
		345391	B. WING			C 04/2014
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
EARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н	1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 253	Continued From pa	ge 1	F 2	53		
	was made of the 20 shower room. The mount and could be the shower stall new	00 hall's resident common toilet was still loose on floor e easily moved and the light in kt to the toilet/sink area still when the switch was turned		E. The headboard and foot resident in room 306 will be facility maintenance staff. T behind the B bed in room 3 repaired by facility mainten F. The headboard in room	e repaired by The walls 306 will be ance staff.	
	 On 05/29/2014 at 10:40 a.m. a 3rd observation 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 on. On 05/29/2014 at 11:00 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's computer 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 or his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their 			repaired by facility mainten G. Facility maintenance sta drawer handles on the nigh 304B H. Facility maintenance sta	ance staff. aff will repair the ht stand in room aff will repair the	
				 drawer handle on the night 305A. Facility maintenance staff of full audit of all resident room resident care areas and ide toilets, headboards, faucet blinds, ceramic tiles, walls, and nightstands in need of All items identified to be in will be entered into the facility or work order system. Facility maintenance staff of identified repairs and sign for complete in the facility's elements or der system. Facility administrative and will be trained on identifying 	will conduct a ms and entify any lights, s, footboards, grab bars, repair. need of repair lities electronic with make them off as ectronic work	
	daily sheets and tur maintenance.2) By word of mouth	n them in daily to		footboards, faucets, blinds walls, toilets, lights, grab ba nightstands in need of repa enter work orders for need	, ceramic tile, ars and air and how to	

Facility ID: 943494

If continuation sheet Page 2 of 49

		AND HUMAN SERVICES & MEDICAID SERVICES	-		F	FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED C		
		345391	B. WING				04/2014
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	00/	
HEARTL	AND LIVING & REHAI	B AT THE MOSES H CONE MEM	н		31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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)		(X5) COMPLETION DATE
F 253	Continued From pa	ge 2	F 2	53			
	maintenance directer and they would write	or or his assistant in hallway e down the information			the facility's electronic work order sys as needed repairs are identified.	stem	
	 concerning the needed repairs/replacements. 3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order. 				Housekeeping staff will be trained in identifying head boards, footboards, faucets, blinds, ceramic tile, walls, lig toilets, grab bars and nightstands in r of repair and will continue to note the	ghts, need	
	requests in the syst director indicated th observed, or were t	ram to electronically place work order ests in the system. The maintenance tor indicated that when the facility's staff rved, or were told about a maintenance requiring repair or replacement etc. they to enter the information into the computer ram and this became the electronic work The maintenance director indicated he access the program and see what needed			Maintenance director will review the r	eets	
	were to enter the in program and this be order. The mainten could access the pr				from the housekeepers daily sheets ongoing, and enter any repairs noted the daily sheets in the facility's electro work order system.	l on	
	A request to review (in any fashion - ele The maintenance d only one uncomplet	placed on a daily basis. all outstanding work orders ectronic, notes etc.) was made. irector indicated there was red work order in the facility's e program and four completed			Facility maintenance staff with make identified repairs and sign them off as complete in the facility's electronic wo order system ongoing.	s	
	work orders. A revi orders indicated the uncompleted/deferr kitchen listed. Ther orders listed. The r he had no paper ma	ew of the electronic work ere was one red work order for the facility's re were four completed work maintenance director indicated aintenance work order			Administrative staff will complete rour audits three times weekly identifying a headboard, footboard, grab bar, toilet faucets, blinds, walls, lights, ceramic and nightstands in need of repair . A rounds tool will be utilized.	any ts, tile,	
	his staff had been n repair or replaceme manager indicated notebook for some produce any type of	ocumentation to show he or notified of any items needing ent. The Maintenance he had some notes in a items however he could not f notebook or other written how he had a list of focility			Maintenance director will review roun tools three times weeks to ensure any item identified on administrative round have been entered in the facility's electronic work order system.	ıy	
	maintenance issues replacement. The r	how he had a list of facility s/items needing repair or maintenance director indicated information in his head but it	1	Fagil	All rounds tools and a report of comp and open work orders will be reviewe the Quality Committee Monthly.		

Facility ID: 943494

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FEAN C		IDENTIFICATION NOWBER.	A. BUILDI	ING		00	C
		345391	B. WING			06	/04/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHAI	B AT THE MOSES H CONE MEM	н		GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 253	Continued From pa was not written dow On 05/30/2014 at 1 conducted with the and his regional ma facility's maintenance were more work or order software prog maintenance mana work orders was co maintenance direct maintenance mana work order software indicating all work of uncompleted). The work orders. The n there was no other information was sto of any of the curren repair or replaceme On 05/30/2014 at 1 specifically looking identified above wa maintenance direct maintenance direct maintenance direct maintenance direct maintenance direct maintenance direct maintenance direct maintenance mana identified of all of th and noted above. The director indicated th above were not doc electronic work orde other place and he documentation to sli identified as needin B) On 05/27/2014 at	ge 3 m anywhere. 1:50 a.m. an interview was facility's maintenance director intenance manager. The ce director indicated there ders found in the facilities work ram by his regional ger. A review of the electronic nducted with the facility's or and his regional ger. The regional ger pulled up the facility's e program to the page orders (completed and re were no new uncompleted haintenance director indicated place any work order red to show they were aware t items identified that needed int. 1:55 a.m. a tour of the facility, at the items noted and s conducted with the facility's or and his regional ger. The tour observation e items previously identified The facility's maintenance he items observed/noted sumented on the facility's er software program or any did not have any other how the items had been g repair or replacement. at 9:55 a.m. an initial tour of	F 2	253	DEFICIENCY)		
		ducted. During the tour the e observed to be in need of					

Facility ID: 943494

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUII -	TIDI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					IPLETED
						(С
		345391	B. WING			06/	04/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID			ID	_	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	< C	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETION DATE
					DEFICIENCY)		
F 253	Continued From pa	ne 4	F 2	53			
	repair:	90 1	1 2	00			
	The resident comm	on shower room by 100 hall					
		e toilet was loose on floor					
		e easily moved 1- 2 inches k and 1 - 2 inches side to side					
	in either direction w	hen light pressure was placed					
		6) ceramic tiles were observed					
		ng on the wall just above the hower stall and tub area.					
		tiles were observed to be					
		cent shower stall wall just					
	above the floor.						
		:20 p.m. a 2nd observation					
		00 hall's resident common toilet was loose on floor					
		eramic tiles were still missing					
	and the additional of	eramic tiles by the adjacent					
	shower stall were s	till broken.					
	On 05/29/2014 at 1	0:43 a.m. a 3rd observation					
		0 hall's resident common					
		toilet was loose on floor eramic tiles were still missing					
		eramic tiles by the adjacent					
	shower stall were s						
	On 05/29/2014 at 1	1:00 a.m. and interview and					
		conducted with the facility's					
	maintenance directed	or. The maintenance director					
		d not had a chance to fix Ily been at the facility for four					
		enance director indicated it					
	was his goal to put	maintenance request					
		facility's computer system but					
		to get anything in yet. The or also indicated he was not					
	very familiar with th	e program as he had not used					
	it until coming to thi	s facility and the staff had not					

Facility ID: 943494

If continuation sheet Page 5 of 49

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345391	B. WING _				C 04/2014
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	been thoroughly tra and were not putting The maintenance d ways he and or his maintenance repair and needing to be of 1) Housekeeping st daily sheets and tur maintenance. 2) By word of mouth maintenance directs and they would write concerning the nee 3) The maintenance facility's staff having computer system having were to enter the in program and this be order. The mainter could access the pr to be repaired or re A request to review (in any fashion - ele The maintenance d only one uncompleted work orders. A revi orders indicated the uncompleted/deferr	ined to use the program yet g in electronic work orders yet. lirector indicated there were 3 assistant were notified of /replacement work requested done: taff would keep notes on their rn them in daily to h, staff would stop the or or his assistant in hallway e down the information ded repairs/replacements. e director indicated the g access to the facility's ad access to the software hically place work order tem. The maintenance hat when the facility's staff cold about a maintenance air or replacement etc. they formation into the computer ecame the electronic work hance director indicated he rogram and see what needed placed on a daily basis.	F 25	53			

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		AND HUMAN SERVICES			PRINTED: 07/15/2 FORM APPRON OMB NO. 0938-03
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345391	B. WING		06/04/2014
	PROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM	н	STREET ADDRESS, CITY, STATE 1131 NORTH CHURCH STRE GREENSBORO, NC 2740	E, ZIP CODE ET
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ACTION SHOULD BE COMPLET
F 253	orders listed. The r he had no paper marequests or other de his staff had been r repair or replacement manager indicated notebook for some produce any type of documentation to s maintenance issues replacement. The r he kept a lot of the was not written dow On 05/30/2014 at 1 conducted with the and his regional mar facility's maintenance work orders was con- maintenance manar work orders was con- maintenance manar work order software indicating all work of uncompleted). The work orders. The r there was no other information was sto- of any of the current repair or replacement On 05/30/2014 at 1 specifically looking identified above war maintenance direct	maintenance director indicated aintenance work order ocumentation to show he or notified of any items needing ent. The Maintenance he had some notes in a items however he could not f notebook or other written how he had a list of facility s/items needing repair or maintenance director indicated information in his head but it on anywhere. 1:50 a.m. an interview was facility's maintenance director aintenance manager. The ce director indicated there ders found in the facilities work gram by his regional ger. A review of the electronic onducted with the facility's or and his regional ger pulled up the facility's e program to the page orders (completed and ere were no new uncompleted naintenance director indicated place any work order ored to show they were aware at items identified that needed ent. 1:55 a.m. a tour of the facility, at the items noted and s conducted with the facility's	F 2	253	

If continuation sheet Page 7 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES							: 07/15/2014 APPROVED
	CS FOR MEDICARE OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUT	וסו	E CONSTRUCTION		. 0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	• •		ECONSTRUCTION		IPLETED
				-			С
		345391	B. WING _			06/	04/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM		н		131 NORTH CHURCH STREET REENSBORO, NC 27401			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTI		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
			ļ		DEFICIENCY)		
F 253	Operations of From no						
F 200	Continued From pa	-	F 25	53			
		e items previously identified The facility's maintenance					
		ne items observed/noted					
		cumented on the facility's					
		er software program or any did not have any other					
		how the items had been					
	identified as needin	g repair or replacement.					
	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	at 9:55 a.m. an initial tour of					
		ducted. During the tour the					
	following areas wer	re observed to be in need of					
	repair:	the 200 hell					
		oom across from the 300 hall esink's faucet had water					
		ng/running from the faucet. An					
	attempt to turn off th	he water was made. The					
		out off the dripping/running					
	water.						
		:23 p.m. a 2nd observation					
		nk in the nourishment room					
		0 hall's nursing station. The bing/running from the faucet					
		Id not turn the water off.					
		0:48 a.m. a 3rd observation					
		nk in the nourishment room 0 hall's nursing station. The					
		bing/running from the faucet					
		ld not turn the water off.					
	On 05/20/2014 at 1	1:00 a.m. and interview and					
		conducted with the facility's					
	maintenance directe	or. The maintenance director					
		d not had a chance to fix					
		nly been at the facility for four enance director indicated it					
		maintenance request					

If continuation sheet Page 8 of 49

ATEMENT	OF DEFICIENCIES OF CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		345391			0	C 6/ 04/2014
AME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE,		
IEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н	1131 NORTH CHURCH STREET GREENSBORO, NC 27401	r	
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 253	Continued From pa	age 8	F 25	3		
	he hadn't had time maintenance direct very familiar with the it until coming to the been thoroughly tra- and were not putting. The maintenance of ways he and or his maintenance repair and needing to be 1) Housekeeping s daily sheets and tu maintenance. 2) By word of mout maintenance direct and they would write concerning the need 3) The maintenance facility's staff havin computer system he program to electron requests in the system of the system	taff would keep notes on their rn them in daily to h, staff would stop the tor or his assistant in hallway te down the information eded repairs/replacements. e director indicated the g access to the facility's had access to the software hically place work order tem. The maintenance				
	observed, or were issue requiring repayere were to enter the in program and this b order. The mainter could access the p	hat when the facility's staff told about a maintenance air or replacement etc. they formation into the computer ecame the electronic work nance director indicated he rogram and see what needed eplaced on a daily basis.				
	(in any fashion - ele The maintenance of	v all outstanding work orders ectronic, notes etc.) was made. lirector indicated there was ted work order in the facility's				

If continuation sheet Page 9 of 49

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
				3	С	
		345391				/04/2014
	PROVIDER OR SUPPLIER AND LIVING & REHA	B AT THE MOSES H CONE MEM	н	STREET ADDRESS, CITY, STATE, ZIP CO 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	DE	
(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) COMPLETIO DATE
F 253	Continued From pa	-	F 253	3		
	work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere.					
	conducted with the and his regional ma facility's maintenan were more work or order software prog maintenance mana work orders was co maintenance direct maintenance mana work order software indicating all work of uncompleted). The work orders. The r there was no other					

Facility ID: 943494

If continuation sheet Page 10 of 49

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	07/15/2014 APPROVED 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		DNSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	345391	B. WING				C 04/2014
NAME OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1	
HEARTLAND LIVING & REHAB	AT THE MOSES H CONE MEM	н		NORTH CHURCH STREET ENSBORO, NC 27401		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
 specifically looking at identified above was maintenance director maintenance manage identified of all of the and noted above. The director indicated the above were not docure electronic work order other place and he di documentation to sho identified as needing D) On 05/27/2014 at the facility was condure following areas were repair: The physical therapy training and activities bathroom used by resorcupational therapy floor mount and easil direction when light p toilet. The lower grate physical therapy depa observed to have the causing the grab bar mount and could eas and down. On 05/28/2014 at 4:4 was made of the physical therapy areas and the grab bar was On 05/29/2014 at 10: 	255 a.m. a tour of the facility, t the items noted and conducted with the facility's r and his regional er. The tour observation items previously identified he facility's maintenance e items observed/noted imented in the facility's r software program or any id not have any other ow the items had been repair or replacement. t 9:55 a.m. an initial tour of ucted. During the tour the observed to be in need of	F 2	53			

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ripi	E CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
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		345391	B. WING			06/	04/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401		
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					DEFICIENCY)		
F 253	Continued From paresident training ambathroom. The toils and the grab bar way On 05/29/2014 at 1 record review was of maintenance direct indicated he still has things as he had or weeks. The maintenance direct was his goal to put information into the he hadn't had time maintenance direct very familiar with th it until coming to thi been thoroughly tra and were not putting. The maintenance repair and needing to be of 1) Housekeeping st daily sheets and tur maintenance direct and they would writ concerning the need 3) The maintenance and they work favore fav	ge 11 d activities of daily living (ADL) et was still loose on the floor as still loose on the wall. 1:00 a.m. and interview and conducted with the facility's or. The maintenance director d not had a chance to fix ly been at the facility for four mance director indicated it maintenance request facility's computer system but to get anything in yet. The or also indicated he was not e program as he had not used s facility and the staff had not ined to use the program yet g in electronic work orders yet. irector indicated there were 3 assistant were notified of /replacement work requested done: aff would keep notes on their n them in daily to h, staff would stop the or or his assistant in hallway e down the information ded repairs/replacements.	F 2	53			
	program to electron requests in the syst director indicated th	ad access to the software lically place work order em. The maintenance lat when the facility's staff					
	observed, or were t	old about a maintenance					

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATI	E SURVEY
		345391	B. WING	NG	(C 04/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	04/2014
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н	1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
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F 253	issue requiring repar were to enter the in program and this be order. The mainter could access the pr to be repaired or re A request to review (in any fashion - ele The maintenance d only one uncomplet work order software work orders. A revi orders indicated the uncompleted/deferr kitchen listed. The orders listed. The orders listed. The requests or other de his staff had been r repair or replacemen manager indicated notebook for some produce any type or documentation to s maintenance issues replacement. The he kept a lot of the was not written dow On 05/30/2014 at 1 conducted with the and his regional ma facility's maintenance were more work or order software prog maintenance mana	air or replacement etc. they formation into the computer ecame the electronic work hance director indicated he rogram and see what needed placed on a daily basis. all outstanding work orders ectronic, notes etc.) was made. lirector indicated there was ted work order in the facility's e program and four completed ew of the electronic work ere was one red work order for the facility's re were four completed work maintenance director indicated aintenance work order occumentation to show he or notified of any items needing ent. The Maintenance he had some notes in a items however he could not f notebook or other written how he had a list of facility s/items needing repair or maintenance director indicated information in his head but it vn anywhere. 1:50 a.m. an interview was facility's maintenance director aintenance manager. The ce director indicated there ders found in the facilities work gram by his regional ger. A review of the electronic onducted with the facility's	F 25	53		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
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		345391	B. WING				04/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHAI	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET GREENSBORO, NC 27401		
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F 253	work order software indicating all work of uncompleted). The work orders. The n there was no other information was sto of any of the curren repair or replaceme On 05/30/2014 at 1 specifically looking identified above was maintenance director maintenance director maintenance director maintenance director and noted above. The director indicated the above were not door electronic work order other place and he documentation to sti identified as needin E) On 05/27/2014 at the headboard and bed in room 306B w the bed frame and of and forth 5-6 inches was observed to ha broken off the wall i window blinds in roo broken/bent and wo access from the str	ger. The regional ger pulled up the facility's program to the page orders (completed and re were no new uncompleted naintenance director indicated place any work order red to show they were aware t items identified that needed ent. 1:55 a.m. a tour of the facility, at the items noted and s conducted with the facility's	F 2	253			

Facility ID: 943494

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/15/2014 APPROVED 0938-0391
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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X) IDENTIFICATION NUMBER (X) MULTIPLE CONSTRUCTION AB ULDING 345391 B. WING MAME OF PROVIDER OR SUPPLIER 345391 STREET ADDRESS, CITY, STATE, ZIP CODE HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H STREET ADDRESS, CITY, STATE, ZIP CODE (X) IDENTIFICATION STREP RECEDED BY FULL TAG (X) IDENTIFICATION STREP RECEDED BY FULL D (X) IDENTIFICATION STREP RECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OF DESCENTER ACTION SHOULD BE CORESTING ACTION OF OR PRAVE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OF DESCENTER ACTION SHOULD BE CORESTING ACTION OF OR PRAVE (EACH DEFICIENCY) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES PROVIDERS PLAN OF CORRECTION OF OR PRAVE (EACH DEFICIENCY) DEFICIENCY CORESTING ACTION OF OR PRAVE (AT DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCES PROVIDERS PLAN OF CORRECTION OF OR PRAVE (X) BY OR OF OROUTH, Staff would stop the maintenance director indicated the facility's staff observed, or were			AND HUMAN SERVICES				FORM	APPROVED
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program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed								
order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed								
could access the program and see what needed to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed								
to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed								
A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed								
(in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed		to be repaired of re	placed off a daily basis.					
(in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed		A request to review	all outstanding work orders					
only one uncompleted work order in the facility's work order softwareprogram and four completed								
work order softwareprogram and four completed		The maintenance d	irector indicated there was					
work orders. A review of the electronic work								
orders indicated there was one uncompleted/deferred work order for the facility's								
kitchen listed. There were four completed work								
orders listed. The maintenance director indicated								
he had no paper maintenance work order								
requests or other documentation to show he or								
his staff had been notified of any items needing		his staff had been r	notified of any items needing					
repair or replacement. The Maintenance								
manager indicated he had some notes in a								
notebook for some items however he could not								
produce any type of notebook or other written documentation to show he had a list of facility								
maintenance issues/items needing repair or								

Facility ID: 943494

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		345391	B. WING				C 04/2014
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM			н		131 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	replacement. The r he kept a lot of the was not written dow On 05/30/2014 at 1 conducted with the and his regional ma facility's maintenance were more work or order software prog maintenance mana work orders was co maintenance mana work orders was co maintenance mana work orders software indicating all work or uncompleted). The work orders. The n there was no other information was sto of any of the curren repair or replaceme On 05/30/2014 at 1 specifically looking identified above wa maintenance direct maintenance direct maintenance direct maintenance direct maintenance mana identified of all of th and noted above. T director indicated th above were not doo electronic work orde other place and he documentation to st identified as needin	maintenance director indicated information in his head but it in anywhere. 1:50 a.m. an interview was facility's maintenance director intenance manager. The ce director indicated there ders found in the facilities work fram by his regional ger. A review of the electronic inducted with the facility's or and his regional ger. The regional ger pulled up the facility's or program to the page orders (completed and the were no new uncompleted naintenance director indicated place any work order red to show they were aware t items identified that needed ent. 1:55 a.m. a tour of the facility, at the items noted and s conducted with the facility's	F 2	53			

Facility ID: 943494

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		AND HUMAN SERVICES				l	FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		X3) DATE	E SURVEY PLETED
		345391	B. WING _					C 04/2014
					REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET			
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н	GI	REENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD B		(X5) COMPLETION DATE
F 253	was made of the he frame in room 228A On 05/29/2014 at 4 was made of the be was still loose on th On 05/30/2014 at 1 was made of the be was still loose on th On 05/29/2014 at 1 record review was of maintenance director indicated he still had things as he had on weeks. The mainter was his goal to put information into the he hadn't had time to maintenance director very familiar with the it until coming to thi been thoroughly tra and were not putting. The maintenance d ways he and or his maintenance repair and needing to be of 1) Housekeeping st daily sheets and tur maintenance director and they would write	 adboard being loose on bed adboard been and the loose of the loo	F 25	53	DEFICIENCY			
		ded repairs/replacements.						

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NO	: 07/15/2014 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345391	B. WING				04/2014	
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 253	facility's staff having computer system h program to electror requests in the syst director indicated th observed, or were to issue requiring repa- were to enter the in program and this be order. The mainter could access the pr to be repaired or re A request to review (in any fashion - ele The maintenance do only one uncompleted work order software work orders. A revi- orders indicated the uncompleted/deferred kitchen listed. The re- he had no paper ma- requests or other do his staff had been r repair or replaceme manager indicated notebook for some produce any type o	e director indicated the g access to the facility's ad access to the software nically place work order tem. The maintenance nat when the facility's staff cold about a maintenance air or replacement etc. they formation into the computer ecame the electronic work nance director indicated he rogram and see what needed placed on a daily basis. all outstanding work orders ectronic, notes etc.) was made. lirector indicated there was ted work order in the facility's e program and four completed ew of the electronic work	F 2	53				
	replacement. The he kept a lot of the was not written dow On 05/30/2014 at 1	s/items needing repair or maintenance director indicated information in his head but it vn anywhere. 1:50 a.m. an interview was facility's maintenance director						

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		AND HUMAN SERVICES				FORM	: 07/15/2014 APPROVED . 0938-0392
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	CON	e survey Ipleted C
	345391						04/2014
NAME OF PROVIDER OR SUPPLIER			н	1131	ET ADDRESS, CITY, STATE, ZIP CODE NORTH CHURCH STREET ENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 253	facility's maintenan- were more work or order software prog maintenance mana work orders was co maintenance direct maintenance mana work order software indicating all work or uncompleted). The work orders. The m there was no other information was sto of any of the curren repair or replaceme On 05/30/2014 at 1 specifically looking identified above wa maintenance direct maintenance mana identified of all of th and noted above. director indicated th above were not doo electronic work ord other place and he documentation to s identified as needin G) On 05/28/2014 was made in room nightstand and huto have two (2) missin nightstand. A draw	aintenance manager. The ce director indicated there ders found in the facilities work gram by his regional ger. A review of the electronic onducted with the facility's or and his regional ger. The regional ger pulled up the facility's e program to the page orders (completed and ere were no new uncompleted naintenance director indicated place any work order ored to show they were aware at items identified that needed ent. 1:55 a.m. a tour of the facility, at the items noted and s conducted with the facility's	F 2	53			

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		AND HUMAN SERVICES				FORM): 07/15/2014 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DA	TE SURVEY MPLETED C
	345391					06	/04/2014
_	PROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM	н	1131	ET ADDRESS, CITY, STATE, ZIP COD NORTH CHURCH STREET ENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 253	On 05/28/2014 at 3 was made of the ni in room 304B. The missing and the ha on the night stand. On 05/29/2014 at 1 was made of the ni in room 304B. The missing and the ha on the night stand. On 05/29/2014 at 1 record review was maintenance direct indicated he still ha things as he had or weeks. The mainte was his goal to put information into the he hadn't had time maintenance direct very familiar with th it until coming to th been thoroughly tra and were not puttin The maintenance co ways he and or his maintenance repain and needing to be of 1) Housekeeping si daily sheets and tu maintenance. 2) By word of mout maintenance direct and they would writ	 30 p.m. a 2nd observation ghtstand and hutch assembly a drawer handles were still ndle with out screws was still 0:34 a.m. a 3rd observation ghtstand and hutch assembly a drawer handles were still ndle with out screws was still 1:00 a.m. and interview and conducted with the facility's or. The maintenance director d not had a chance to fix hy been at the facility for four enance director indicated it maintenance request facility's computer system but to get anything in yet. The or also indicated he was not be program as he had not used is facility and the staff had not ined to use the program yet g in electronic work orders yet. Ilirector indicated there were 3 assistant were notified of the director indicated there were a director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated there were a substant were notified of the director indicated th			2.943494 If cont		t Page 21 of 49

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		AND HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						<u> 2MB NO. 0938-0391</u>		
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
			A. DOILD			с		
		345391	B. WING				04/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
HEARTL	AND LIVING & REHAI	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET GREENSBORO, NC 27401			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE	
170			1/10		DEFICIENCY)			
			1					
F 253	Continued From pa	ge 21	F 2	253				
	2) The maintenance	director indicated the						
		e director indicated the g access to the facility's						
	computer system h	ad access to the software						
		ically place work order						
	director indicated th	em. The maintenance at when the facility's staff						
		old about a maintenance						
		ir or replacement etc. they						
		formation into the computer ecame the electronic work						
		ance director indicated he						
	could access the pr	ogram and see what needed						
	to be repaired or re	placed on a daily basis.						
	A request to review	all outstanding work orders						
		ectronic, notes etc.) was made.						
		irector indicated there was						
		ed work order in the facility's program and four completed						
		ew of the electronic work						
	orders indicated the	ere was one						
		red work order for the facility's						
		e were four completed work maintenance director indicated						
	he had no paper ma	aintenance work order						
	•	ocumentation to show he or						
		notified of any items needing ent. The Maintenance						
		he had some notes in a						
	notebook for some	items however he could not						
		f notebook or other written						
		how he had a list of facility s/items needing repair or						
		maintenance director indicated						
	he kept a lot of the	information in his head but it						
	was not written dow	in anywhere.						
	On 05/30/2014 at 1	1:50 a.m. an interview was						

Facility ID: 943494

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY IPLETED C
		345391	B. WING				04/2014
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				11	IREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 253	and his regional ma facility's maintenan were more work or order software prog maintenance mana work orders was co maintenance direct maintenance mana work order software indicating all work of uncompleted). The work orders. The r there was no other information was sto of any of the curren repair or replaceme On 05/30/2014 at 1 specifically looking identified above wa maintenance direct maintenance mana identified of all of th and noted above. director indicated th above were not doo electronic work ord other place and he documentation to s identified as needin H) On 05/28/2014 was made of reside drawer handle of th observed to be han handle was observe	facility's maintenance director aintenance manager. The ce director indicated there ders found in the facilities work gram by his regional ager. A review of the electronic onducted with the facility's or and his regional ager. The regional ager pulled up the facility's e program to the page orders (completed and ere were no new uncompleted naintenance director indicated place any work order ored to show they were aware at items identified that needed ent. 1:55 a.m. a tour of the facility, at the items noted and is conducted with the facility's	F 2	53			

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391	
				TIPLE CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED		
	SI CORRECTION	IDENTIFICATION NONDER.	A. BUILDING			C		
		345391	B. WING			06/	04/2014	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C 1131 NORTH CHURCH STREET	CODE			
HEARTL	HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEN			GREENSBORO, NC 27401				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE	
F 253	Continued From pa	ge 23	F 25	53				
	On 05/28/2014 at 4 was made of reside drawer handle of th observed to still be still only having 1 so drawer. On 05/29/2014 at 1 was made of reside drawer handle of th observed to still be still only having 1 so drawer. On 05/29/2014 at 1 record review was of maintenance direct indicated he still have things as he had or weeks. The mainte was his goal to put information into the he hadn't had time maintenance direct very familiar with th it until coming to thi been thoroughly tra and were not putting The maintenance repair and needing to be of	 :35 p.m. a 2nd observation ent room 305A. The top e resident's dresser was hanging down 90 degrees and crew holding the handle to the 0:33 a.m. a 3rd observation ent room 305A. The top e resident's dresser was hanging down 90 degrees and crew holding the handle to the 1:00 a.m. and interview and conducted with the facility's or. The maintenance director d not had a chance to fix hy been at the facility for four enance director indicated it maintenance request facility's computer system but to get anything in yet. The or also indicated he was not e program as he had not used s facility and the staff had not ined to use the program yet g in electronic work orders yet. irector indicated there were 3 assistant were notified of /replacement work requested done: 						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							D: 07/15/2014 M APPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION		ATE SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		CC	MPLETED
		345391	B. WING _			0	C 6/ 04/2014
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	•	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
5 050		- /					
F 253	p	-	F 2	53			
		h, staff would stop the or or his assistant in hallway					
		e down the information					
		ded repairs/replacements.					
	3) The maintenance	e director indicated the					
		g access to the facility's					
		ad access to the software					
		hically place work order					
		tem. The maintenance nat when the facility's staff					
		old about a maintenance					
	issue requiring repa	air or replacement etc. they					
		formation into the computer					
		ecame the electronic work nance director indicated he					
		rogram and see what needed		ĺ			
		placed on a daily basis.					
		all outstanding work orders					
		ectronic, notes etc.) was made.					
		lirector indicated there was ted work order in the facility's		ĺ			
		e program and four completed					
		iew of the electronic work					
	orders indicated the						
		red work order for the facility's					
		re were four completed work maintenance director indicated					
		aintenance work order					
		ocumentation to show he or					
	his staff had been r	notified of any items needing					
		ent. The Maintenance					
		he had some notes in a items however he could not					
		f notebook or other written					
		how he had a list of facility					
		s/items needing repair or					
	replacement. The	maintenance director indicated					

Facility ID: 943494

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		E & MEDICAID SERVICES	T			0.0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345391	B. WING		C 06/04/2014		
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
HEARTL	AND LIVING & REHA	AB AT THE MOSES H CONE MEM	ин	1131 NORTH CHURCH STREET GREENSBORO, NC 27401			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETIC	
F 253	Continued From pa	age 25	F 25	3			
	he kept a lot of the was not written do	information in his head but it wn anywhere.					
c a fa w o m w		11:50 a.m. an interview was facility's maintenance director					
	and his regional m facility's maintenar	aintenance manager. The need there					
	order software pro	ders found in the facilities work gram by his regional ager. A review of the electronic					
	work orders was commaintenance direct	onducted with the facility's tor and his regional					
		ager. The regional ager pulled up the facility's e program to the page					
	indicating all work	orders (completed and ere were no new uncompleted					
	there was no other	maintenance director indicated place any work order					
		ored to show they were aware nt items identified that needed ent.					
	specifically looking identified above wa	11:55 a.m. a tour of the facility, at the items noted and as conducted with the facility's tor and his regional					
	maintenance mana identified of all of the and noted above.	ager. The tour observation he items previously identified The facility's maintenance					
	above were not do electronic work ord	he items observed/noted cumented on the facility's ler software program or any did not have any other					
	documentation to s	show the items had been ng repair or replacement.					
F 278 SS=B	483.20(g) - (j) ASS	•	F 27	8		7/2/14	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		345391	B. WING			-	,)4/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 26	F 2	278			
	The assessment m resident's status.	ust accurately reflect the					
	A registered nurse in each assessment with participation of heal						
	A registered nurse i assessment is com	must sign and certify that the pleted.					
		o completes a portion of the ign and certify the accuracy of ssessment.					
	willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessment	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each					
	Clinical disagreeme material and false s	ent does not constitute a statement.					
	by: Based on record refacility failed to accurative diagnosis of psychotropic medic comprehensive ass Data Set (MDS) for	NT is not met as evidenced eview and staff interview the urately assess and include the Psychosis for the use of ation identified in the facility sessments tool the Minimum 3 of 5 residents (Resident 2, Resident #21) reviewed for			The facility will ensure that any resid assessment accurately reflects the resident's status. Facility MDS nurse reviewed the mo recent MDS for resident #152, resid #40, and resident #21. Facility MDS	ost ent	

Facility ID: 943494

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		AND HUMAN SERVICES			FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	_ COM	E SURVEY PLETED C
		345391	B. WING			_ 04/2014
	PROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM	н	STREET ADDRESS, CITY, ST. 1131 NORTH CHURCH STI GREENSBORO, NC 27	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 278	unnecessary media Findings Included: 1) Resident #40 wa 6/14/2013. A record review of f for Resident #40 co [comprehensive] as did not include the or Anxiety in Sectio for medications rec Antipsychotic, Antia 7 days of the 7 day Physician Orders for of May 2014 includ at 1:00 PM for psyc mouth at 9:00 PM for tab in the AM and 1 and Cymbalta 60m depression. An interview on 5/2 MDS nurse revealed psychosis was not MDS because the f skilled nursing care and she used those An interview on 5/2 Administrator reveal should have been i An interview on 5/3 Administrator reveal	as admitted to the facility on the facility most recent MDS oded an annual ssessment dated 5/23/2014 active diagnosis of Psychosis on I Active Diagnosis. Section N ceived included the use of an anxiety, and Antidepressant for look back period. For Resident #40 for the Month ed Seroquel 12.5 mg by mouth chosis, Seroquel 12.5 mg by for psychosis, Xanax 0.25 mg anxiety, Xanax 0.25 mg 1/2 1/2 tab at 4:00 PM for anxiety, g by mouth at hour of sleep for 19/2014 at 3:00 PM with the ed the active diagnosis of included in section I of the first 9 diagnosis [coded] for a were populated into the MDS		 made corrections to recent MDS's and s assessments as ind Facility MDS staff at nursing staff will be manual and the guid active diagnoses in Facility MDS nurse nursing staff will rev residents and ensur were accurately coor most recent MDS. F complete a correction Facility QI nurse wil assessments rando to ensure accurate o assessments ongoi be utilized. 	nd administrative educated on RAI delines for coding section I of the MDS. and administrative view section I for all re all active diagnoses ded on the resident's Facility MDS nurse will ons sheet as indicated. I audit MDS omly five times weekly coding of ng. A QI audit tool will	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES								07/15/2014 APPROVED
	COF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION			0938-0391
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:				,	COM	PLETED
		345391	B. WING _) 06/0	C 04/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		31 NORTH CHURCH STREET REENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 278	 psychotropic medic active diagnosis sha section I of the com 2) Resident #152 w 10/12/2013. Her ad Dementia and Psych A record review of t #152 revealed her r 3/25/2014 did not in Psychosis in Section N for medications reactions of Antipsychotic for 7 of period. The compresent 10/19/2013 did not Psychosis in Section N for medications reactions of Antipsychotic for 5 of period. A record review of F 2/14/2014 included mg (milligrams) by Psychosis and date by mouth twice a data An interview on 5/20 MDS nurse revealed psychosis was not in MDS because the f skilled nursing care and she used those 	 A twas being treated with a ation then an appropriate ould have been coded in aprehensive MDS. A ation then an appropriate ould have been coded in aprehensive MDS. A ation the facility on mission diagnoses included chosis. A facility MDS for Resident most recent MDS dated active diagnosis of a l Active Diagnosis. Section eceived include the active diagnosis of a l Active Diagnosis. Section eceived include the use of an days of the 7 day look back enersive MDS dated include the active diagnosis of a l Active Diagnosis. Section eceived included the use of an days of the 7 day look back enersite MDS dated include the active diagnosis. Section eceived included the use of an days of the 7 day look back Physician Orders dated Risperdal [antipsychotic] 0.25 mouth at hour of sleep for ad 3/2/2014 Risperdal 0.25 mg ay. 9/2014 at 3:00 PM with the d the active diagnosis of an cluded in section I of the irst 9 diagnosis [coded] for were populated into the MDS action and the active diagnosis of an cluded in the most of the most of the irst 9 diagnosis [coded] for were populated into the MDS action at 3:00 PM with the d the active diagnosis [coded] for were populated into the MDS action at 3:00 PM with the 3:00 PM w	F 27	78	DEFICIENCY)			
	Administrator revea	led the diagnosis of psychosis n section I of the MDS.						

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		AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES						0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
				-			(2
		345391	B. WING				06/0	04/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		I31 NORTH CHURCH STREET REENSBORO, NC 27401			
(X4) ID			ID					(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)			COMPLETION DATE
F 278	Continued From pa	ge 29	F 2	78				
	An interview on 5/3	0/2014 at 10:00 AM with the						
	Administrator revea							
		of treatment for resident care						
		nt was being treated with a ation then an appropriate						
	active diagnosis she	ould have been coded in						
	section I of the com	prehensive MDS.						
		s admitted to the facility on						
	9/13/2013. Her adm Anxiety and Schizo	nission diagnosis included phrenia.						
		he facility MDS for Resident dated 4/16/2014 included						
	Diabetes Mellitus, H disorder, and Asthm	gnosis checked Hypertension, Hyperlipidemia, Anxiety na. Additional diagnoses were						
	Medications receive Antipsychotic for 7	Section I Section N for ed included the use of days, Diuretic for 7 days and 7 days of the 7 day look back						
	period.	r days of the r day look back						
	Physician Order for 2/12/2014.	Psychiatric Service dated						
	Physician Order for twice a day dated 3	Risperdal 1mg by mouth /2/2014.						
	Physician Order for mouth daily dated 3	Risperdal 1 mg tablet by 8/19/2014.						
	MDS nurse reveale	9/2014 at 3:00 PM with the diagnosis of						
	MDS because the f	included in section I of the irst 9 diagnosis [coded] for were populated into the MDS						
	and she used those							

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>CENTERS FOR MEDICARE & MEDICAID SERVICES</u>							
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345391	B. WING			C 04/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HEARTL	AND LIVING & REHAI	B AT THE MOSES H CONE MEM	н Г	1131 NORTH CHURCH STREET GREENSBORO, NC 27401				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 278	Continued From pa	ge 30	F 278	3				
	An interview on 5/29/2014 at 3:00 PM with the Administrator revealed the diagnosis of psychosis should have been in section I of the MDS. An interview on 5/30/2014 at 10:00 AM with the							
F 309	Administrator revea medication a form of and that if a residen psychotropic medic active diagnosis sho section I of the com	led she considered of treatment for resident care it was being treated with a ation then an appropriate ould have been coded in	F 309	9				
SS=G	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain test practicable physical,						
	by: Based on observat interviews, and reco report a transfer inc assess a resident a and reported being	NT is not met as evidenced ions, resident and facility staff ord reviews the facility failed to ident to nursing and failed to fter she complained of pain dropped during a transfer for esident #46) reviewed for		Past noncompliance: no plan of correction required.				
	facility identified the implementing a corr	ce started on 4/22/14. The deficient practice and started rective action plan on 4/26/14. ompliance as of 5/5/14.						

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		pleted C
		345391	B. WING			04/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHAI	B AT THE MOSES H CONE MEM	H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 31	F 309)		
	The findings include	ed:				
		admitted to the facility on included Muscle Weakness, d Osteoporosis.				
	revealed Resident # cognitively impaired	I and required extensive assist per physical assistance for bed				
	revealed a plan of c to impaired mobility joint disease, and p included transfer wi of care for; potentia mobility, poor vision	Resident #46 dated 2/14/2014 care for; self care deficits due of, Osteoarthritis, degenerative oor vision. The approach th stand-up lift. A second plan I for falls due to impaired and past history of falls ch for stand up lift for safe ed.				
	4/23/2014 at 7:16 A stated the Nurse Aid dropped her while a Resident #46 stated	Nurse #7 ' s nurse note on M revealed Resident #46 de (NA) on the 3-11 shift assisting her back to bed. d that her body was partly on or. Incident reported to the (DON).				
	#7 who was the prir on 4/22/2014 revea PM to 7 AM and Re anything all night. It in the morning that Resident #46 ' s roo	/2014 at 4:34 PM with Nurse mary nurse for Resident # 46 led she was on duty from 11 esident #46 did not say was after the change of shift the 7AM NA called me to om. Resident #46 reported hift] dropped her while				

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345391	B. WING				C 04/2014
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	she asked Residen or the floor and Res back on the bed an #7 stated she did nor reported it to the DO A record review of N 4/23/2014 at 8:17 A was asymptomatic no signs of disorien confusion. Staff will pain and assess he increased confusion The nurse notes do 4/23/2014 note and did not include asse The nurse notes on Medication Adminis The nurse note on A Medication Adminis The nurse note on A Medication Adminis The nurse note on A Medication Adminis A record review of N documented on 4/2 during AM care on A Nurse #9 to Reside the resident compla and foot. Nurse #9 Resident #46 repor and that it was very nurse touched it. A	 ab bed. Nurse #7 reported that t #46 if she landed on the bed sident #46 reported she fell d partially on the floor. Nurse ot do an assessment but DN. Nurse #8 's nurse note on M documented the resident to fall yesterday. She shows tation nor did she have any continue to assess her for er for any behaviors such as n and or disorientation. Decumented from the above 14/46/2014 note at 4:32 PM essments and read as below. 4/25/2014 at 7:52 AM read tration Tylenol. 4/26/2014 at 7:15 AM read tration Tylenol. 4/26/2014 at 1:34 PM read tration Tylenol. Nurse #9 's nurse note 6/2014 at 4:32 PM revealed 4/26/2014 a staff NA called nt #46 's room and indicated ained of pain to her right ankle noted bruising and swelling. ted yes to her ankle hurting 's ore and tender when the radiology film was taken of the 	F3	609			
	nurse touched it. A right ankle and reve						

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPLIE	SURVEY
345391 B. WING 06/04	4/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H GREENSBORO, NC 27401	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)ID CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 F 309 Continued From page 33 Nursing further assessed bruising to the left ankle and Resident #46 was transferred to the hospital for further examination. An observation and interview on 5/29/2014 10:00 AM with Resident #46 revealed she was in bed with her lower extremities elevated, bilateral lower leg splint boots. Resident #46 reported her feet hurt but she did receive pain medication. An interview on 5/30/2014 at 2:42 PM with Resident #46 revealed she sustained injury during the process of being put to bed from the chair in her room. Resident #46 stated '1 lid not ask to go to bed; this fellow came in and put me 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 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 4:41 PM with Nurse #10 who was Resident #46 's primary nurse on the 3-11 shift no 4/22/2014 revealed she assessed Resident #46 was not due for a farmined me down and put prevention as an acute place and Rurse #0 agreed to her Al-4/26/2014 nurse note as accurate documentation. An interview on 6/4/2014 at 4:41 PM with Nurse #10 who was Resident #46 's primary nurse on the 3-11 shift no 4/22/2014 revealed she assessed Resident #46 was not due for pain medication. Nurse #10 retweet to the for ant medication. 	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				-			С
		345391	B. WING			06/	04/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	discussed the pain revealed her arthriti and shoulder it was told Nurse #10 she Nurse #10 the desc chair to bed was no Nurse #10 reported in the transfer and H unusual or anything #46. Nurse #10 rep returned to Resider was pain free. Nurs an assessment on H The Nurse Aide inve available for an inter A record review of t completed by the D 4/22/2014 but comp Resident #46 stated transferred to bed. both ankles on 4/26 documented the im a complete skin ass evaluation and a tra A record review of t 4/26/2014 of the rig fracture of the right lower leg bones that medial malleolus [b side of the ankle] w A record review of t 4/26/2014 for reside distal left fibular frac malleolar fracture.	management. Resident #46 is pain was not in her back in her foot. Resident #46 then was " manhandled " but to cription of the transfer from at described in an unusual way. I she spoke to the NA involved he answered no to anything that may have hurt Resident orted with in the hour she at #46 a third time and she is #10 reported she did not do Resident #46 ' s foot. olved in the event was not erview. he Resident Incident Report ON and back dated to oleted on 4/26/2014 revealed d she was dropped while being Bilateral bruising noted on	F 3	09			

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		AND HUMAN SERVICES				FORI	D: 07/15/2014 MAPPROVED D: 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED C
		345391	B. WING	;		06	5/04/2014
NAME OF	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP COI	DE	
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	note from the emer Resident #46 was p splints, no surgery in Orthopedic consult The facility Action F presented immedia grievance log and in Problem Descriptio lift resulting in a fall Fracture to resident days after resident Root Cause: Staff of unintentional movel another to be a fall. action was not forth Staff member disret transfer technique f Implementation ste Resident #46 was s address ankle fract #46 was assessed designated to be a in status. On 5/1/20 was changed on the (healthcare information Implementation ste potential risk includ completed the inco suspended pending discharged from en staff was in-service no new residents w through the commu- reported to have fat assessed for unkno	the hospital Physician progress gency department revealed blaced in bilateral posterior required and had an for follow up. Plan dated 4/26/2014 was tely upon request with the ncluded: n: Employee failed to use the for 1 resident [Resident #46]. t ankle not identified until four alleged to have fallen. did not identify the ment from one surface to Staff member completing nooming during investigation. garded the designated for resident. ps for the resident included: sent to the ED on 4/26/2014 to ures. On 4/30/2014 Resident upon readmission and total lift related to her change 014 Resident #46 ' s lift status e care plan and KARDEX		309			

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345391	B. WING			06/04/2014		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		31 NORTH CHURCH STREET REENSBORO, NC 27401			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE	
F 309	Continued From pa	ge 36	F 3	09				
		ing pain were assessed for						
		All residents were reviewed for rechnique and any questions						
	regarding transfer t	echnique of a resident was						
		for review. On 5/5/2014 skin completed on all residents to						
	identify residents w	ith unidentified injury.						
		: On 4/28/2014 the nursing d regarding transfer of						
	residents according	to the resident care plan and						
		2014 the nursing staff was sment after alleged fall. On						
		sed staff was in-serviced on						
		concern regarding resident						
		ssment for pain. On 5/1/2014 as in-serviced on the new						
	implementation of t	he Stop and Watch form and						
	return demonstration	14 the NA staff preformed ons to the nursing						
	administration team	n of a transfer using the						
	mechanical lift.	The administrative nursing						
	staff cross referenc	ed nursing notes, incidents,						
		ms, and the facility 24 hour lentify residents with alleged						
		nt for pain. The cross						
		ngoing assessment tool for						
		ation and identification of falls inistrative nursing staff						
	watched return dem	nonstration of resident						
		a week ongoing to ensure KARDEX for resident						
	transfer.							
	A record review rev	ealed the completed						
	in-services listed in	the Action Plan; the						
		competency check list for ; the Stop and Watch form for						
		eted skin assessments and						

Facility ID: 943494

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345391	B. WING			C 06/04/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	medical records us or complaint of pair On 05/29/2014 at 1 her knowledge of s Watch form and res	on all residents; the reviewed ed for cross reference of a fall n. 0:08:15 AM NA #1 revealed afety checks, the Stop and sources for resident care i.e.	F 3	09			
	knowledge of Resid transfers, in-service Stop and Watch too On 05/29/2014 at 1 her knowledge of th	:28 AM Nurse #9 revealed her lent #46 ' s status change for es on assessments, and the					
		:14 AM NA #2 revealed her top and Watch tool and the					
F 323 SS=G	Assurance (QA) tea meeting was in Feb incident and the foll held the last week i due to the federal s		F 3	23			
	environment remain as is possible; and	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to					

Facility ID: 943494

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED				
		345391	B. WING			C 04/2014			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEN			н	1131 NORTH CHURCH STREET GREENSBORO, NC 27401					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 323	Continued From pa prevent accidents.	ge 38	F 32:	3					
	by: Based on observation interviews, and reco use the mechanical assist to transfer and ankles for 1 of 3 res reviewed for accide The deficient practic facility identified the implementing a com The facility was in com The facility was in com The findings include Resident #46 was a 8/9/2011. Diagnosis Failure to Thrive an The Minimum Data revealed Resident # cognitively impaired with two staff memb mobility and transfe The Care Plan for F revealed a plan of co to impaired mobility joint disease, and p included transfer wi of care for; potentia	ce started on 4/22/14. The e deficient practice and started rective action plan on 4/26/14. compliance as of 5/5/14. ed: admitted to the facility on a included Muscle Weakness, d Osteoporosis. Set (MDS) dated 2/1/2014 #46 was moderately and required extensive assist per physical assistance for bed		Past noncompliance: no plan of correction required.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG _			IPLETED
		345391	B. WING _				C / 04/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 323	Continued From pa	ge 39	F 32	23			
	transfers and low b	-	_				
		Nurse #7 ' s nurse note on M revealed Resident #46					
	stated the Nurse Ai	de (NA) on the 3-11 shift					
		assisting her back to bed. I that her body was partly on					
	the bed and the floo	or. Incident reported to the					
	Director of Nursing	(DON).					
		Nurse #9 ' s nurse note					
		6/2014 at 4:32 PM revealed aff NA called Nurse #9 to					
	Resident #46 ' s roo	om and indicated the resident					
		to her right ankle and foot. ising and swelling. Resident					
	#46 reported yes to	her ankle hurting and that it					
		ender when the nurse					
	ankle and revealed	a positive ankle fracture					
		se #9 reported the Director of essed bruising to the left ankle					
	and Resident #46 w	vas transferred to the hospital					
	for further examinat	tion.					
		interview on 5/29/2014 10:00					
		46 revealed she was in bed mities elevated, bilateral lower					
	leg splint boots. Re	sident #46 reported her feet					
	nurt but she did rec	eive pain medication.					
		0/2014 at 2:42 PM with					
		led she sustained injury of being put to bed from the					
	chair in her room. F	Resident #46 stated " I did not					
		is fellow came in and put me was putting everyone to bed.					
	He asked me to do	a few things I could not do					
	like sit in a certain p	place and position. He picked					

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						<u>). 0938-039</u> TE SUDVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
			AL BOILDIN			С
		345391	B. WING _		06	6/04/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEN	н	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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 323	Continued From pa	age 40	F 32	23		
	me up and slamme you hurt me and he tomorrow. He left a to bed I guess? I w	ed me down on the table. I said e said I would be alright and then someone else put me ras hurting. It was so sudden bad and I can ' t remember				
	#9 revealed the even attention as an acu during AM care and	0/2014 at 2:30 PM with Nurse ent was brought to her ite episode of pain from the NA d Nurse #9 agreed to her ote as accurate documentation.				
	#7 revealed she wa and Resident #46 of was after the change the 7AM NA called Resident #46 report dropped her while a Nurse #7 reported she landed on the #46 reported she for partially on the floor	A/2014 at 4:34 PM with Nurse as on duty from 11 PM to 7 AM did not say anything all night. It ge of shift in the morning that me to Resident #46 ' s room. rted that the NA [3-11 shift] assisting her back to bed. that she asked Resident #46 if bed or the floor and Resident ell back on the bed and r. Nurse #7 stated she did not but reported it to the DON.				
	#10 who was Resid the 3-11 shift on 4/2 assessed Resident 9:30 PM and Resid was bothering her. Resident #46 was Nurse #10 returned discussed the pain revealed her arthrit and shoulder it was	22014 at 4:41 PM with Nurse dent #46 ' s primary nurse on 22/2014 revealed she t #46 who was in bed around lent #46 stated her arthritis Nurse #10 determined not due for pain medication. d to Resident #46 and management. Resident #46 is pain was not in her back s in her foot. Resident #46 then was " manhandled " but to				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345391	B. WING _			C 04/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н	1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	chair to bed was no Nurse #10 reported in the transfer and H unusual or anything #46. Nurse #10 rep returned to Resider was pain free. Nurs an assessment on H The Nurse Aid invol unavailable for an in A record review of t completed by the D 4/22/2014 but comp Resident #46 stated transferred to bed. both ankles on 4/26 documented the im a complete skin ass evaluation and a tra A record review of t 4/26/2014 of the rig fracture of the right lower leg bones tha medial malleolus [b side of the ankle] w A record review of t 4/26/2014 for reside distal left fibular fracture. A record review of t analleolar fracture. A record review of t 4/26/2014 for reside distal left fibular fracture. A record review of t analleolar fracture and fracture.	t described in an unusual way. she spoke to the NA involved he answered no to anything that may have hurt Resident orted with in the hour she at #46 a third time and she the #10 reported she did not do Resident #46 ' s foot. Wed in the event was he Resident Incident Report ON and back dated to bleted on 4/26/2014 revealed d she was dropped while being Bilateral bruising noted on	F 32	23		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FC	ORM A	APPROVED 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345391	B. WING _				C 06/0	; 4/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET REENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	E	(X5) COMPLETION DATE
F 323	Orthopedic consult An interview on 6/4, Administrator reveal incident was by him had been trained in checks were dated was in-serviced on KARDEX for reside involved in the incid Administrator that h for incontinent care and her legs buckle The facility Action P presented immedia grievance log and in Problem Description lift resulting in a fall Fracture to resident days after resident Root Cause: Staff of unintentional mover another to be a fall. action was not forth Staff member disre transfer technique f Implementation ste Resident #46 was s address ankle fract #46 was assessed designated to be a in status. On 5/1/20 was changed on the (healthcare informa Implementation ste potential risk includ completed the incom	for follow up. for follow up. /2014 at 4:30 PM with the led the NA involved in the uself during the transfer and proper transfers. His skills 8/23/2012 and 8/8/2013. He 12/2/2013 for referring to the nt lift technique. The NA lent reported to the the was standing the resident and a stand and pivot transfer ed so he pushed her to bed. Plan dated 4/26/2014 was tely upon request with the ncluded: n: Employee failed to use the for 1 resident [Resident #46]. t ankle not identified until four alleged to have fallen. Id not identify the ment from one surface to Staff member completing icoming during investigation. garded the designated for resident. ps for the resident included: sent to the ED on 4/26/2014 to ures. On 4/30/2014 Resident upon readmission and total lift related to her change 14 Resident #46 's lift status e care plan and KARDEX	F 32	23				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/15/2014 APPROVED 0938-0391	
STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	СОМ	TE SURVEY MPLETED	
		345391	B. WING			06/04/2014		
NAME OF PRO	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HEARTLANI	D LIVING & REHAI	B AT THE MOSES H CONE MEM	н		131 NORTH CHURCH STREET GREENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
dis sta no thr rej as res All un ap res res as ide Sy sta co the im pre ref as s ide Sy sta res res fal s s s s ta s res res res res res res res res res r	aff was in-serviced o new residents we rough the commu ported to have fall assessed for unknow sidents were revie I residents reporti- identified injury. A opropriate transfer garding transfer to ferred to therapy for sessments were entify residents wi vatemic Changes: aff was in-serviced sidents according ARDEX. On 4/29/2 lucated on assess assessments for a co- ondition and assess e nursing staff wa uplementation of the ocess. On 5/5/207 turn demonstration lechanical lift. vatem Monitored: aff cross reference op and Watch for port log daily to id lis and assessments ference was an op- curate document atched return dem	apployment. On 4/28/2014 all d on the definition of fall and ere identified to have fallen nication. All residents len in the past 30 days were own injury. On 4/30/2014 all ewed for current report of pain. Ing pain were assessed for All residents were reviewed for technique and any questions echnique of a resident was for review. On 5/5/2014 skin completed on all residents to ith unidentified injury. On 4/28/2014 the nursing d regarding transfer of to the resident care plan and 2014 the nursing staff was sment after alleged fall. On sed staff was in-serviced on concern regarding resident assment for pain. On 5/1/2014 s in-serviced on the new he Stop and Watch form and 14 the NA staff preformed	F3	23				

Facility ID: 943494

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
			(X2) MUI	TIPI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED		
							C	
		345391	B. WING			06/	04/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 131 NORTH CHURCH STREET			
HEARTL	AND LIVING & REHA	B AT THE MOSES H CONE MEM	н		REENSBORO, NC 27401			
(X4) ID			ID				(X5) COMPLETION	
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE	
					DEFICIENCY)			
E 222	Continued Frame	44						
F 323	Continued From pa transfer.	ge 44	F 3	323				
	liansier.							
		ealed the completed						
		the Action Plan; the						
		competency check list for the Stop and Watch form for						
		ted skin assessments and						
		on all residents; the reviewed						
	or complaint of pair	ed for cross reference of a fall						
		1.						
		15 AM a transfer with a						
		observed on Resident #47 sident care plan and proper						
	transfer technique.	sident care plan and proper						
		0:08:15 AM NA #1 revealed after the stop and						
		sources for resident care i.e.						
	Care Plan and KAR	DEX.						
	On 5/20/2014 at 10	:28 AM Nurse #9 revealed her						
		lent #46 's status change for						
	-	es on assessments, and the						
	Stop and Watch too	ol.						
	On 05/29/2014 at 1	0:56 AM Nurse #11 revealed						
		ne Stop and Watch tool,						
		ge of condition and the 24						
	hour report.							
		:14 AM NA #2 revealed her						
	5	top and Watch tool and the						
	transfer in-service.							
) PM the facility Quality						
		am meets quarterly. The last						
		oruary 2014 prior to the owing QA meeting was to be						
		sming was to be						

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 07/15/2014 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED
		345391	B. WING		0	6/04/2014
	ROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM	н	11	REET ADDRESS, CITY, STATE, ZIP CODE I31 NORTH CHURCH STREET REENSBORO, NC 27401	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 F 460 SS=D	due to the survey. T included review of a 483.70(d)(1)(iv)-(v) VISUAL PRIVACY Bedrooms must be assure full visual pr In facilities initially of except in private ro- ceiling suspended of the bed to provide t combination with ac This REQUIREMEN by: Based on observat	n May 2014 but put on hold The QA agenda for May 2014 all active monitoring tools. BEDROOMS ASSURE FULL designed or equipped to ivacy for each resident. certified after March 31, 1992, oms, each bed must have curtains, which extend around otal visual privacy in djacent walls and curtains.		460	The broken blinds in room 306 will be	7/2/14
	window blinds were provide bedroom pr rooms (# 306). The On 05/27/2014 at 4	:30 p.m. an observation was			replaced by facility maintenance staff. Facility maintenance staff will conduct a full audit of all resident rooms and resident care areas and identify any blind in need of repair	
	observed to be occ window blinds were broken and would r access into the resi walking by and cars	oom 306. The room was upied by 2 residents. The observed to be bent and not fully close allowing viewing dent's room from persons passing the building.			All items identified to be in need of repair will be entered into the facilities electroni- work order system. Facility maintenance staff with make identified repairs and sign them off as complete in the facility's electronic work	
	was made of the wi window blinds were would not fully close	:30 p.m. a 2nd observation ndow blinds in room 306. The still bent and broken and e to ensure privacy by allowing ne resident's room from			order system. Facility administrative and nursing staff will be trained on identifying blinds in nee of repair and how to enter work orders for	

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		AND HUMAN SERVICES			FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED
		345391	B. WING _			<i>.</i> 04/2014
	PROVIDER OR SUPPLIER AND LIVING & REHA	B AT THE MOSES H CONE MEM	н	STREET ADDRESS, CITY, STATE, ZIP (1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 460	persons walking an On 05/29/2014 at 1 was made of the wi window blinds were would not fully close viewing access in th persons walking an On 05/29/2014 at 1 record review was of maintenance direct indicated he still hat things as he had or weeks. The mainten was his goal to put information into the he hadn't had time maintenance direct very familiar with th it until coming to thi been thoroughly tra and were not puttin The maintenance d ways he and or his maintenance repair and needing to be of 1) Housekeeping st daily sheets and tur maintenance direct 2) By word of mouth maintenance direct and they would write concerning the nee 3) The maintenance	d cars passing the building. 0:30 a.m. a 3rd observation indow blinds in room 306. The estill bent and broken and e to ensure privacy by allowing ne resident's room from d cars passing the building. 1:00 a.m. and interview and conducted with the facility's or. The maintenance director d not had a chance to fix hy been at the facility for four enance director indicated it maintenance request facility's computer system but to get anything in yet. The or also indicated he was not e program as he had not used s facility and the staff had not ined to use the program yet g in electronic work orders yet. irector indicated there were 3 assistant were notified of /replacement work requested done:	F 46	 needed repairs into the fact work order system as need identified. Housekeeping staff will be identifying blinds in need of continue to note the need for their daily sheets Maintenance director will refrom the housekeepers dai ongoing, and enter any rep the daily sheets in the facilit work order system. Facility maintenance staff wildentified repairs and sign the complete in the facility's electronic system ongoing. Administrative staff will com audits three times weekly identified of repairs. A will be utilized. Maintenance director will refrom the tools three times weeks to item identified on administrative staff and open work order system. 	led repairs are trained in f repair and will or any repairs eview the notes ly sheets airs noted on ty's electronic with make them off as ectronic work nplete rounds dentifying QI rounds tool eview rounds ensure any ative rounds acility's m.	

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		345391	B. WING			C 06/04/2014		
	PROVIDER OR SUPPLIER	B AT THE MOSES H CONE MEM	н	11	TREET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 460	computer system h program to electror requests in the syst director indicated th observed, or were to issue requiring repay were to enter the in program and this bu- order. The mainter could access the pu- to be repaired or re A request to review (in any fashion - electron The maintenance do only one uncompleted work orders. A revi- orders indicated the uncompleted/defer kitchen listed. The orders listed. The orders listed. The orders listed. The orders listed. The orders listed free he had no paper m requests or other d his staff had been r being in need of rep Maintenance direct notes in a notebool could not produce a written documentat facility maintenance or replacement. Th indicated he kept a head but it was not On 05/30/2014 at 1 conducted with the and his regional mate	ad access to the software nically place work order tem. The maintenance hat when the facility's staff cold about a maintenance air or replacement etc. they formation into the computer ecame the electronic work hance director indicated he rogram and see what needed placed on a daily basis. all outstanding work orders ectronic, notes etc.) was made. lirector indicated there were ted work order in the facility's e program and four completed iew of the electronic work ere was one red work order for the facility's re were four completed work maintenance director indicated aintenance work order ocumentation to show he or notified of the window blinds pair or replacement. The or indicated he had some k for some items however he any type of notebook or other ion to show he had a list of e issues/items needing repair ne maintenance director lot of the information in his written down anywhere. 1:50 a.m. an interview was facility's maintenance director aintenance manager. The ce director indicated there	F 4		ility ID: 943494	tion choot	Page 48 of 49	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES						07/15/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(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			STREET ADDRESS, CITY, STATE, ZIP CODE			
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM			H GREENSBORO, NC 27401			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N SHOULD BE COMPL E APPROPRIATE DA	
F 460	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 460			

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