CENTERSTON	MEDICARE & MEDICAID SERVICES			A FURWI	
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY	
NO HARM WITH	ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:	
FOR SNFs AND N	Fs	345391	B. WING	6/4/2014	
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC			
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES				
F 514	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.75()(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with physician and staff, the facility failed to maintain clinical records that were complete and accurately documented for 1 of 16 residents (Resident #85). Findings included: Resident #85 was admitted to the facility on 10/30/12 and had diagnoses that included hypertension, cardiovascular disease, and history of transient ischemic attack/stroke. The physician order dated 1/16/13 indicated Resident #85 was to have her vital signs taken every Monday, Wednesday, and Friday. Review of physician orders for April and May 2014 indicated vital signs were to be taken "per facility protocol unless otherwise ordered by physician." Record review of the Medication Administration Record (MAR) for April and May 2014 revealed the following orders: Hydrochlorothiazide 12.5 milligrams (mg) by mouth daily for hypertension Losartan 50 mg by mouth daily for hypertension Vital signs every Monday, Wednesday, Friday.] The MARs revealed nurses every Monday, Wednesday, and Friday had signed that vitals signs were taken as ordered on the MAR. Review of the nurse aide vital sign sheets for April and May 2014 revealed: No vital signs for Resident #85 for the month of April. Vital signs taken on 5/10, 5/17, and 5/24 for the month of May.				

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

The above isolated deficiencies pose no actual harm to the residents

Event ID: 7QVY11 If continuation sheet 1 of 2

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FOR SNFs AND	NFs	345391	B. WING	6/4/2014		
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC				
	SUMMARY STATEMENT OF DEFICIENCIES					
PREFIX TAG F 514	Continued From Page 1 the nurse's notes, the nurse aide vital sign sheet, and the electronic medical record. She indicated there was an order for vitals to be taken every Monday, Wednesday, and Friday and that staff had signed off on the MARs that vitals were done. She further indicated, other than the 4 sets of vital signs taken in May, she was unable to locate any other vitals in the medical record and that the physician order was for there to be 3 sets of vitals taken weekly. During a phone interview on 5/30/14 at 12:16pm Physician #1 stated, "I think we can change [Resident #85] back to weekly vitals. I don't know why she was on vitals three times a week. I would expect her to be getting weekly vitals. She has been very stable lately." During an interview on 5/30/14 at 12:33 pm Nurse #4 indicated [Resident #85's] physician order indicated vital signs on Monday, Wednesday, and Friday and that the checkmark and nurse's initials (on the MAR) indicated vitals were taken. She indicated there was a checkmark with her initials on 5/30/14, was not aware of Resident #85 having vitals done on 5/30/14, and she did not know why she signed off on the vitals for 5/30/14 when she was not aware they had been done. She further stated, "I think everyone just gets used to signing them off without checking." During an interview on 5/30/14 at 12:54 pm the DON stated, "We should be following the physician order. We could have contacted the doctor to get the order changed, but until then [nurses] should be following the order. [Nurses] should be getting [vitals] themselves or review what the aide took. They should not sign off without the vitals being done." During an interview on 5/30/14 at 1:13 pm Nurse #5 reviewed Resident #85's orders and indicated the resident should have vitals taken on Monday, Wednesday, and Friday. Nurse #5 further indicated she was assigned to Resident #85 on Friday May 9, Monday May 12, Wednesday May 14, and Friday May 16. She stated. "There were no vitals on here (indicating the nurse aide vital si					