

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MAR 0 5 2013
MAR 0 5 2013
MAR 0 5 2013

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS No deficiencies were cited for the complaint survey. Event ID #P4EH11.	F 000			
F 241 SS=D	The 2567 was amended on 2/20/2012. Two examples at F241 were deleted. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide an environment which preserved resident dignity by displaying signs above 3 of 3 sampled residents' beds identifying the residents as having care issues and the steps to follow for the identified care without first obtaining resident or family consents (residents #1, #39, and #46). Findings include: 1) A review of the most recent assessment dated 1/24/13 indicated Resident #1 had moderately impaired cognitive abilities. Review of the Therapy Note dated 2/6/13 documented that an orthotic device was fitted to Resident #1's left elbow joint. Also documented in this note was "Re-posted instructions of proper wearing schedule of splint/orthotic device". There was no documentation in the resident's record of	F 241	F 241 The facility will promote care for residents in an environment that promotes each resident's dignity For the resident cited: The signs in the rooms for residents # 1, #39, and #46 were all removed at the time of survey For all residents: Administrative Staff completed a walkthrough of the facility and removed any signs in resident rooms not approved by the resident or the resident's legal representative (excluding those required to be in compliance with infection control policies). Those signs that have been approved by the resident or legal representative will have documentation of such approval in the resident medical record. System Changes: Facility staff will be inserviced regarding the need to obtain approval form the resident or legal representative before posting signage in the resident rooms. Staff will be instructed to report any signs that have not been approved to the facility administrator or director of nursing. Monitors: Administrative staff will audit resident rooms for posting of unapproved signs three times a week for four weeks, then weekly ongoing to monitor for continued compliance. Any unapproved signs will be reported to the facility quality committee. A QI audit tool will be utilized.	3-3-13 3-7-13 3-7-13 3-7-13 3-7-13	

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

Shirley W. Ingram-Buss

TITLE

Administrator

(X6) DATE

2-25-13

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 1</p> <p>permission given by the resident or the resident 's family for the facility to post instructions in the resident's room.</p> <p>During an observation on 2/6/13 at 5:45pm, Resident #1 was sitting up in bed feeding herself the dinner meal. The resident was not receptive to conversation during this visit. The resident's left arm was encased in a blue brace/splint and supported on a pillow. A sign was posted on the wall next to the resident's bed with written instructions on how and when to apply the brace/splint.</p> <p>On 2/7/13 at 9:25am, the resident was observed reclining in bed, receiving her medications from a staff nurse. The resident was not wearing a splint/brace, but the instructions for the use of the device were posted on the wall next to the resident's bed.</p> <p>During an interview on 2/7/13 at 10:07am, NA#2 stated that the Therapy department posted the instructions on the wall, next to the resident's bed, on how to apply the splint/brace.</p> <p>During an interview on 2/7/13 at 11:15am, the Occupational Therapist (OTR/L) indicated he posted instructions on how/when to apply the brace on the wall, next to the resident's bed for any nursing assistants. The OTR/L indicated that he always obtained permission from a resident before posting a sign of instructions in a resident's room. He further stated that if a resident was not cognitively intact, he would obtain permission from the Rehabilitation/Therapy Manager who would inform the DON (Director of Nursing) about the posting of the instructions on</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 2 the wall.</p> <p>During an interview on 2/7/13 at 12:14pm, the DON stated she was not asked by anyone from the Rehabilitation department for permission to post therapy instructions on the walls in residents' rooms; and, she was not asked to obtain permission from residents' families.</p> <p>During an interview on 2/7/13 at 1:06pm, the Rehabilitation Manager indicated that he had no knowledge where permission to post instructions in residents' rooms for nursing assistants came from. He also revealed that the rehabilitation department did not have anything in writing from residents or their families giving permission.</p> <p>2) A review of the most recent assessment dated 1/05/13 indicated Resident #39 had moderately impaired cognitive abilities. The OT Notes dated 2/5/13 indicated the therapist printed out and posted instructions in the resident's room for the nursing assistant to follow regarding splint and wheelchair positioning. There was no documentation in the resident's record of permission given by the resident or the resident's family for the facility to post instructions in the resident's room.</p> <p>During an observation on 2/4/13 at 2:00pm, Resident #39 was awake in bed. There was a sign on the wall near the foot of the bed consisting of instructions for range of motion exercises and how to apply the splinting device.</p> <p>During an interview on 2/7/13 at 11:15am, the Occupational Therapist (OTR/L) indicated that he</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 3</p> <p>always obtained permission from a resident before posting a sign of instructions in a resident's room. He further stated that if a resident was not cognitively intact, he would obtain permission from the Rehabilitation/Therapy Manager who would inform the DON (Director of Nursing) about the posting of the instructions on the wall.</p> <p>During an interview on 2/7/13 at 12:14pm, the DON stated she was not asked by anyone from the Rehabilitation department for permission to post therapy instructions on the walls in residents' rooms; and, she was not asked to obtain permission from residents' families.</p> <p>During an interview on 2/7/13 at 1:06pm, the Rehabilitation Manager indicated that he had no knowledge where permission to post instructions in residents' rooms for nursing assistants came from. He also revealed that the rehabilitation department did not have anything in writing from residents or their families giving permission.</p> <p>3) A review of the most recent assessment dated 1/1/13 indicated Resident #46 had short and long term memory problems with moderately impaired decision-making skills, and a swallowing disorder.</p> <p>The Speech Therapist (ST) Note dated 2/1/13 indicated the Therapist placed a sign in the resident's room consisting of instructions on when and how to feed Resident #46. There was no documentation in the resident's record of permission given by the resident or the resident's family for the facility to post instructions in the resident's room.</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 4 During an observation on 2/4/13 at 2:15pm, Resident #46 was asleep in his bed. There was a sign on the wall next to the resident's bed consisting of instructions on when and how to feed the resident. During an observation on 2/7/13 at 10:55am, the sign containing feeding instructions for Resident #46 was still on wall. Resident #46 was not in the room at the time of the observation. During an interview on 2/7/13 at 12:14pm, the Director of Nursing (DON) stated she was not asked by anyone from the Rehabilitation department for permission to post therapy instructions on the walls in residents' rooms; and, she was not asked to obtain permission from residents' families. During an interview on 2/7/13 at 1:06pm, the Rehabilitation Manager/ST indicated that he had no knowledge where permission to post instructions in residents' rooms for nursing assistants came from. He also revealed that the rehabilitation department did not have anything in writing from residents or their families giving permission.	F 241			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility record reviews the facility failed to maintain sanitary conditions in the kitchen and ensure proper food storage in 1 of 2 refrigerators and 1 of 1 freezers by: 1) allowing an employee to work around an active food service/serving line without a hairnet; 2) not ensuring equipment used in food processing was clean and free of debris; 3) ensuring all packaged food items opened and used then placed back in the refrigerator or freezer were dated; 4) ensure all food items boxed with inner freezer protection bags were closed/sealed to eliminate ice crystals and/or freezer burn to occur. The findings include: 1) A review of the facility's uniform policies and procedures entitled - Long Term Care Policies and Procedures, Subject: Uniform Policy: dated 2005 which was signed by the Dietary Manager on 09/17/2012 (page 1 of 1) read in part in sub-paragraph #3. Hairnets or hats are required to be worn at all times when preparing and serving food. On 02/06/2013 a continuous observation was made between 7:00 a.m. - 7:10 a.m. of the facility's kitchen/dinning area. During the observation staff member #3 was observed working around the food service line without a hair net on. The food service line was observed	F 371	For Residents Cited The employee failing to wear a hairnet was instructed to place a hairnet in during the survey. All items in the freezer noted not to be labeled or dated were discarded at the time they were noted during the survey. The slicer noted to be dirty was cleaned at the time of the survey. The items in the freezer not properly sealed were discarded at the time of survey. For all residents: The employee failing to wear a hairnet was instructed to place a hairnet in during the survey. All items in the freezer noted not to be labeled or dated were discarded at the time they were noted during the survey. The slicer noted to be dirty was cleaned at the time of the survey. The items in the freezer not properly sealed were discarded at the time of survey. System Changes Dietary staff will be inserviced regarding the facility uniform policy, specifically the requirement to wear a hairnet in the kitchen while food is being prepared or served. Signs will be posted at entrances to the kitchen regarding the requirement to wear a hairnet. In addition hairnets will be made available at each kitchen entry point. Dietary staff will be inserviced on the procedures for properly storing, labeling and dating stored items in the refrigerator and freezer. Dietary staff will be inserviced on the proper cleaning and frequency for cleaning kitchen equipment.	3-7-13 3-7-13 3-7-13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 6</p> <p>to have the morning's breakfast meal on the service line and the cook, staff member #4, was previously observed to have removed several plastic wrap covers off of several food items getting ready to take the food temperatures. Staff member #3 was observed to leave the kitchen go to the dining room area then re-enter the kitchen and go to the food service line where she was assisting getting the food service line ready for serving. Staff member #3 was observed not wearing a hair net. Staff member #3 then left the kitchen again and went into the dry/paper goods storage room in the dining room area where she retrieved a stack of plastic cup lids and returned to the kitchen's food service line. Staff member # 3 was observed to still not have a hair net on.</p> <p>On 02/06/2013 at 7:12 a.m. an interview was conducted with staff member #3 at the food service line prior to her putting on a hair net. Staff member #3 acknowledged she did not have a hair net on then retrieved and put on a hair net. Staff member #3 was asked why she did not have a hair net on but declined to answer the question. Staff member #3 was asked what time she started working in the kitchen that morning and again staff member declined to answer. Staff member # 3 was asked how many times she had left the kitchen and then returned without wearing a hair net. Staff member again declined to answer. Staff member #3 was asked if she knew if she was supposed to be wearing a hair net while working around an active food service line. Staff member #3 indicated she knew she was supposed to have a hair net on when in the kitchen and around the food service line.</p> <p>On 02/06/2013 at 7:17 a.m. an interview was</p>	F 371	<p>Monitors:</p> <p>The facility dietary manager or designee will conduct walkthrough rounds of the kitchen twice daily five times a week for one week, then once daily five times a week ongoing to monitor for continued compliance. A QI audit tool will be utilized. The facility dietary manager or designee will conduct the unit sanitation audit and the food handling unit audit monthly. The dietary manager will develop plans of action based on the results of the monthly audit tools. The results of the monthly audit tools and the plans of action will be reviewed by the quarterly quality committee.</p>	3-7-13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 7</p> <p>conducted with the facility's Dietary Manager. The Dietary Manager was asked his expectations of staff working in and around the kitchen's food service line and the wearing of hair nets. The Dietary Manager indicated that all staff members working in the kitchen and around the food service line are required to wear hair nets. The Dietary Manager was asked how long staff member #3 had been working in and around the food service line this morning. The Dietary Manager initially indicated staff member #3 had started work at 7:00 a.m. as she had come into the building via the back door with him. A review of staff member #3's time card was conducted by the Dietary Manager. The Dietary Manager indicated staff member #3's time card documented staff member #3 had clocked in and started working at 6:30 a.m. The Dietary Manager then indicated staff member #3 must have been out at the garbage dumpster and come back into the facility with him at 7:00 a.m.</p> <p>An interview with the administrator was conducted on 02/06/2013 at 12:45 p.m. The Administrator was asked to explain item #3 of the facility's uniform policy (hair nets) in reference to a staff member not preparing or serving food but working in close proximity of the food service line while food service is underway. The Administrator indicated that any staff working around any food even though they may not be serving or preparing the food would still have to wear a hair net.</p> <p>2) On 02/04/2013 at 10:20 a.m. a tour of the kitchen was conducted with the facility's Dietary Manager. During the tour the kitchen's meat slicer was observed on a table under a plastic</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 8</p> <p>cover. There was food debris observed on the table under the meat slicer. The Dietary Manager removed the slicer's cover to make a closer observation. The observation revealed the meat slicer had a 1/2 inch food particle build up on the meat feeder bracket and additional food debris was observed on the slicer blade. An interview was conducted with the Dietary Manager who indicated the food slicer had not been used for 3 or more weeks. Also during the tour the kitchen/dining room's microwave oven was observed. The microwave's entire inside hood area surface was observed to have baked on food/dark substance debris. An interview with the Dietary Manager was conducted. The Dietary manager indicated he was not aware of the food/dark substance debris on the inside hood of the microwave until it was observed during the tour.</p> <p>3) On 02/04/2013 at 10:30 a.m. a tour of the kitchen was conducted with the facility's Dietary Manager. During the observation the following was observed in the facility's refrigerator:</p> <p>Refrigerator - 1 rewrapped bag of diced potatoes that was not labeled to indicate the bag's contents and was not dated to indicate when the item was initially opened, rewrapped, and/or returned to the refrigerator; 2 cucumber pieces (1/4 and 1/2) with plastic wrap on them. There was no date on either cucumber's plastic wrap or cucumber skin to indicate when either cucumber was first used, rewrapped and/or replaced back in refrigerator; 1/4 block of cheese slices that had been rewrapped in plastic wrap and had no date as to when the cheese was initially opened, rewrapped and/or the manufacturer's original expiration date</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 9 to indicate when the cheese was no longer good for service. 4) On 02/04/2013 at 10:35 a.m. a tour of the kitchen was conducted with the facility's Dietary Manager. During the observation the following was observed in the facility's freezer: 1 bag of stuffed pasta shells inside another bag. Both bags were observed to be open to the air and ice crystals/freezer burn was observed on the pasta shells. There was no date to indicate when the bag of pasta shells was initially opened or returned to the freezer; 1 box of cobbler crust pastry shells in a bag. The bag was open to the air and was undated and unlabeled. Ice crystals/freezer burn was observed on the pastry shells; 1 round angel food cake without icing, having a slice removed in a plastic bag. There was no date on the bag to indicate when the cake was initially opened, returned to the freezer, or when the manufacturer's expiration date was; 1 box of bread dough sticks in a plastic bag which was open to air. Ice crystals/freezer burn was observed on the frozen dough; 1 box of round bread dough balls in box with the bag open to air. Ice crystals/freezer burn was observed on the frozen dough.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F 441 The facility will maintain an infection control program that is designed to help prevent the development and transmission of disease and infection For the resident cited: Contact isolation obtained from the SPICE website were place on the doors for resident	3-7-13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 10</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, and the facility failed to adhere to current infection control standards of practice by: 1) Not appropriately identifying 2 of 2 facility residents on contact isolation precautions per physician's orders (residents #198 and #200); 2)</p>	F 441	<p>#198 and resident #200. On those signs are directions for staff as to what is required to be worn for residents who are on contact isolation.</p> <p>For all residents</p> <p>Facility staff was inserviced in the required signage for residents as well as the required attire to be worn for residents who are on contact isolation, and how to determine the proper protective equipment to be worn when a resident is on any type of isolation.</p> <p>System Changes:</p> <p>Facility staff will initiate the appropriate isolation sign for residents and place on the resident's door per the facility infection control policy. Approved isolation signs will be made available on the isolation carts. All newly hired facility staff will be inserviced on isolation precautions, signage requirements, and how to determine the proper protective equipment to be worn when caring for a resident on any isolation precaution</p> <p>Monitors:</p> <p>DON or designee will conduct infection control rounds five times a week for four weeks and weekly ongoing. Rounds will include inspection of proper isolation signage, inspection of isolation carts, observation of care for a resident requiring isolation if present in facility. A QI audit tool will be utilized. Results of audits will be submitted to the facility quarterly quality committee and plans of action implemented if indicated.</p>	<p>3-7-13</p> <p>3-7-13</p> <p>3-7-13</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 11</p> <p>Not ensuring facility staff followed the facility's infection control policies and procedures and current standards of practice for caring for residents on contact isolation.</p> <p>Findings Include:</p> <p>1) On 02/04/2013 at 10:15 a.m. a tour of the facility was conducted. During the tour two plastic contact isolation personal protective equipment (PPE) storage boxes were observed on the 100 hall. Each storage box contained a box of protective gloves, four gowns, and a box of masks. Each of the two PPE storage boxes was located near four resident rooms in two separate alcoves of the 100 hall. There was no signage to indicate which resident of the four residents in each of the alcove was on some type of isolation. An interview with staff member #6 revealed residents #198 and #200 were on contact isolation. A review of resident #198's medical record indicated the resident was positive for C-Diff and had a physician's order for contact isolation. A review of resident #200's medical record indicated the resident was positive for open Herpes lesions and had a physician's order for contact isolation.</p> <p>On 02/05/2013 at 11:00 a.m. an observation was made of resident #198's and #200's room doors/entry areas. There was no signage to identify the resident's were on isolation precautions.</p> <p>On 02/06/2013 at 9:10 a.m. an observation was made of resident #198's and #200's room doors/entry areas. There was no signage to identify the resident's were on isolation</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 12 precautions.</p> <p>A review of the facility's infection control policies and procedures entitled: Isolation-Categories of Transmission-Based Precautions, dated 2001 and revised September 2005 (MED-PASS, INC.) was conducted with the facility's DON. The policies and procedures read in part on page 46 paragraph g - Signs - Use color coded signs to alert staff of the implementation of Transmission-Based Precautions. In sub paragraph g (1) the policy read in part - Place an orange sign at the doorway instructing visitors to report to the nurse's station before entering the room.</p> <p>On 02/06/2013 at 11:20 a.m. an observation was conducted with the facility DON of resident #198's and resident 200's doors/entry that were previously identified as not having isolation precaution signage. There was no signage on either resident's doors/entry way to indicate the residents were on isolation precautions. An interview with the facility's DON was conducted. The DON could not explain why the facility had no signs identifying which facility residents were on isolation precautions or why the facility was not following their infection control policies and procedures.</p> <p>2) On 02/04/2013 at 10:15 a.m. a tour of the facility was conducted. During the tour two plastic contact isolation personal protective equipment (PPE) storage boxes were observed on the 100 hall. Each storage box contained a box of protective gloves, four gowns, and a box of .</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 13</p> <p>masks. Each of two PPE storage boxes was located near four resident rooms in two separate alcoves of the 100 hall. There was no signage to indicate which resident of the four resident rooms in each of the alcoves was on some type of isolation. An interview with staff member #6 revealed residents #198 and #200 were on contact isolation. An attempt to open the PPE storage box drawer containing the gowns was unsuccessful. The drawer was caught on the plastic interior of the box. Four gowns could be easily seen through the plastic drawer front.</p> <p>A review of resident #198's medical record was conducted. The record indicated the resident was positive for C-Diff and had a physician's order for contact isolation. A review of resident #200's medical record was also conducted. Resident #200's record indicated the resident was positive for open Herpes lesions and had a physician's order for contact isolation.</p> <p>On 02/04/2013 at 2:30 p.m. staff member #5 was observed to enter resident #198's room without donning a mask, gown, or gloves. Staff member #5 was observed to reposition resident 198 in her wheelchair. The therapist's clothes were observed making contact with the resident's clothes while she repositioned the resident. Staff member #5 then rolled resident in a wheel chair out of the room. An interview was conducted with staff member #5 who indicated she was taking resident #198 to the therapy department. Staff member #5 was asked if the resident was on isolation precautions. Staff member #5 stated, "I have no clue," indicating she was unaware the resident was on isolation precautions. Staff member #6 passing medications in the alcove</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 14</p> <p>area informed staff member #5 the resident was on isolation precautions and she should gown, glove and/or mask prior to entering the room and making physical contact with the resident. Again staff member #5 indicated she was unaware the resident was on isolation precautions.</p> <p>3) On 02/04/2013 at 10:15 a.m. a tour of the facility was conducted. During the tour two plastic contact isolation personal protective equipment (PPE) storage boxes were observed on the 100 hall. Each storage box contained a box of protective gloves, four gowns, and a box of masks. Each of two PPE storage boxes was located near four resident rooms in two separate alcoves of the 100 hall. There was no signage to indicate which resident of the four resident rooms in each of the alcoves was on some type of isolation. An interview with staff member #6 revealed residents #198 and #200 were on contact isolation. An attempt to open the PPE storage box drawer containing the gowns was unsuccessful. The drawer was caught on the plastic interior of the box. Four gowns could be easily seen through the plastic drawer front.</p> <p>A review of resident #198's medical record was conducted. The record indicated the resident was positive for C-Diff and had a physician's order for contact isolation.</p> <p>On 02/06/2013 from 10:10 a.m. to 10:20 a.m. a continuous observation was made from resident #198's room entry area prior to wound care being conducted. Staff member #7, the wound care nurse, was observed to enter resident #198's room without masking, gowning, or gloving. Staff</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 15</p> <p>member #7 was observed to remove resident #198's personal items on the bed side table and then move the resident's used bed covers/linens back so the resident could be placed in the bed for the wound care. Staff member #8 was observed to enter resident # 198's room wearing only gloves. After staff member #8 entered the room staff member #7 put on a pair of gloves to assist staff member #8 transfer the resident from a wheelchair to the bed using a stand lift. Both staff members #7 and #8 were observed to be wearing scrubs and were observed to come in contact with resident #198's hands, clothes and bed linens during the transfer. Staff member #8 was observed to use a stand lift to transfer the resident from her wheelchair to her bed (belts, straps, handle bars, foot rests were in contact with the resident). After transferring resident #198 to the bed Staff member #8 was asked if the lift was a community use lift or designated specifically for resident #198's use. Staff member #8 indicated the list was a community use lift.</p> <p>On 02/06/2013 at 10:20 a.m. an interview was conducted prior to the wound care with both staff member #7 and staff member #8. Both staff members were asked if resident #198 was on isolation precautions as they were observed to not be wearing full PPE (masks, gloves and gowns). Both staff member #7 and #8 indicated they were aware the resident was on contact isolation precautions and were supposed to be wearing gloves, gowns and masks due to the resident's isolation diagnoses. Both staff member #7 and #8 then gowned, re-gloved and masked prior to performing the resident's wound care. Prior to initiating the wound care staff member #7 asked staff member #8 if the resident had been</p>	F 441		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 16</p> <p>taken to the shower this morning relating it to the wound care. Staff member #8 indicated the resident was on isolation precautions and was not supposed to be taken to the shower room.</p> <p>02/06/2013 at 11:20 a.m. interview with the facility's DON was conducted. The DON was asked what her expectations were for the facility staff to follow professional standards of practice and the facility's isolation precautions policies and procedures. The DON indicated facility's staff were to follow professional standards of practice and the facility's policies and procedures for isolation precautions by gowning, gloving, and or masking prior to entering an identified resident's room who was on contact isolation.</p> <p>4) On 02/04/2013 at 10:15 a.m. a tour of the facility was conducted. During the tour two plastic contact isolation personal protective equipment (PPE) storage boxes were observed on the 100 hall. Each storage box contained a box of protective gloves, four gowns, and a box of masks. Each of two PPE storage boxes was located near four resident rooms in two separate alcoves of the 100 hall. There was no signage to indicate which resident of the four resident rooms in each of the alcoves was on some type of isolation. An interview with staff member #6 revealed residents #198 and #200 were on contact isolation. An attempt to open the PPE storage box drawer containing the gowns was unsuccessful. The drawer was caught on the plastic interior of the box. Four gowns could be easily seen through the plastic drawer front.</p> <p>A review of resident #198's medical record was</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 17</p> <p>conducted. The record indicated the resident was positive for C-Diff and had a physician's order for contact isolation.</p> <p>On 02/07/2013 at 2:37 p.m. an observations was made of staff member #6 entering resident #198's room to administer medications to the resident. Staff member #6 was not wearing gloves, mask, or a gown. Upon entry to the room staff member #6 moved the resident's bed side table with her hands, placed several medication cups with medications, water and a liquid supplement on the table. The resident was then observed to reach out and touch staff member #6's hand while reaching for the plastic cup of water. Staff member #6 then repositioned the resident in the wheelchair and administered the medications and supplement.</p> <p>An interview was conducted with staff member #6 upon her exit from resident #198's room. Staff member #6 acknowledged she was not wearing gloves, a gown, or a mask when administering medications to resident #198. Staff member #6 indicated she knew she was supposed to have on a gown, gloves, and mask prior to entering the resident's room as she had instructed staff member #5 on 02/04/2013 (see example # 1 above).</p> <p>An interview was conducted with the facility's DON on 02/07/2013 at 3:40 p.m. The DON indicated the facility's staff members were in-serviced on 02/06/2013 concerning professional standards of practice and the facility's policies and procedures concerning infection control, isolation precautions, and the use of PPE. The DON stated staff member #6</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345391	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 18 had attended the in-service training on 02/06/2013, signed the in-service training roster and could not explain why staff member #6 was not following professional standards of practice and/or the facility's policies and procedures for contact isolation.	F 441			