STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 12/02/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted 12/02/2016. Event ID #7KK11	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g) - (j) The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		12/30/16

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

Electronically Signed | 12/21/2016

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F 278	Continued From page 1 by: Based on record review and staff interviews, the facility failed to accurately code on the Minimum Data Set (MDS) assessment to reflect PASRR (Preadmission Screening and Resident Review) level 2 (two) for 1 of 1 resident in the sample reviewed for PASRR. (Resident #65) Finding include: Resident #65 was admitted on 9/30/2016 with cumulative diagnoses which included disorder of psychological development, cerebral palsy and bipolar disorder. Review of PASRR Determination notification form revealed that Resident #11 was determined to be a PASRR level 11 with an expiration date 12/16/2016. Review of the MDS assessment dated 10/26/2016 revealed Section A of the MDS was not coded to reflect PASRR determination. During an interview with MDS Coordinator on 12/1/2016 at 12 PM revealed she missing coding of the PASRR coding. section A with yes. During an interview with Administrator on 12/1/2016 at 1 PM revealed her expectation that MDS assessment are coded to accurately reflect the resident's status.	F 278	The MDS for resident 11 was corrected to accurately reflect the resident's status in regards to PASRR determination. A correction sheet was submitted 12/28/16. Facility MDS staff conducted a full audit for all residents in the area of PASRR determination on 12/28/16. No other corrections were required. Facility MDS staff will be educated regarding correctly coding the MDS for PASRR determination before 12/30/16. All disciplines involved in coding of the MDS will be trained in coding each section of the MDS according to RAI guidelines before 12/30/16. All disciplines involved in coding of the MDS will collectively audit five MDS's weekly for accuracy for 12 months. A QI audit tool will be utilized. Results of the audit tools will be submitted to the quality committee for review monthly for 12 months.	
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.35(i) 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		12/30/16

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F 371	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure dish ware were allowed to air dry and were free from stains and food particles, ceiling vents were clean and hair restraints were worn by the staff while working in the kitchen. This had the potential to affect 94 of the 96 residents who resided in the facility. Findings Included: An observation of the kitchen on 11/20/16 at 11:30 am revealed: · 20 of 20 meal trays were stacked together wet on a storage rack and were ready for lunch service · 8 of 16 divided plates had heavy food stains and food particles on them and were stored on a shelf under the steam table ready for lunch service · 7 of 26 coffee mugs had heavy beverage stains and food particles on them and were stored in a clean dish rack ready for lunch service · 2 of 2 ceiling vents had a heavy build-up of dust and dirt · 1 of 2 male employees with facial hair did not have on a beard guard and was preparing the lunch meal An interview on 12/02/2016 at 11:54 am with the Dietary Manager revealed that his expectation was that all dish ware should be clean, free from	F 371	Facility will ensure food is stored, prepared, distributed and served under sanitary conditions. Dietary staff will ensure dishes are allowed to air dry, dishes are free of stains and debris and hair restraints are worn by staff serving and preparing food. Dietary staff will be educated regarding requirement to allow dishes to air dry 12/26/16. Dietary staff will be educated regarding requirement for hair restraints to be worn in the kitchen 12/26/16. The coffee mugs and plates identified at the time of survey will be distained or discarded. The ceiling vents identified at the time of the survey was cleaned 12/5/16. Dietary Manager will complete sanitation rounds five times weekly for twelve months to monitor for compliance with clean dishes, stained dishes clean ceiling vents and use of proper hair restraints. A QI Audit tool will be utilized. Executive Director or designee will	

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F 371	Continued From page 3 food stains and air dried. He stated that male employees with facial hair should put on a beard guard at the beginning of their shift and wear through-out the day. He stated that the ceiling vents were cleaned by the maintenance department and that he had submitted a maintenance request for them to be cleaned. An interview on 12/02/2016 at 12:20 pm with the facility administrator revealed that her expectation was that dishes were allowed to air dry and that cups and plates were clean and free from stains. She stated that male employees with facial hair should wear a beard guard when they are working in the kitchen and that maintenance was responsible for the kitchen ceiling vents and she expected them to be clean.	F 371	conduct a sanitation round weekly for four weeks to monitor for compliance with clean dishes, stained dishes clean ceiling vents and use of proper hair restraints. A QI tool will be utilized. Results of completed audits will be submitted to facility quality committee monthly for 12 months for review.	
F 520 SS=F	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(o)(1) A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520		12/30/16

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F 520	Continued From page 4 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and resident interviews, the facility ' s Quality Assurance and Assessment (QAA) Committee failed to maintain procedures and monitor the interventions that the committee put into place following the February 25, 2016 recertification and complaint survey in the areas of Assessment Accuracy (F 278) and Food Procure (F 371). These deficiencies F 278 and F 371 were cited the recertification survey of December 2, 2016. The continued failure of the facility during two consecutive federal survey of record (F 278 and F 371) showed a pattern of the facility inability to sustain an effective Quality Assurance (QAA) program. The finding included: This citation was cross referenced to: F 278 Based on record review and staff interviews, the facility failed to accurately code on the Minimum Data Set (MDS) assessment to reflect PASRR (Preadmission Screening and Resident Review) level 2 (two) for 1 of 1 resident in the sample reviewed for PASRR. (Resident #65) During the recertification and complaint survey conducted February 25, 2016 the facility failed to	F 520	Facility will ensure food is stored, prepared, distributed and served under sanitary conditions. Dietary staff will ensure dishes are allowed to air dry, dishes are free of stains and debris and hair restraints are worn by staff serving and preparing food. Dietary staff will be educated regarding requirement to allow dishes to air dry. Dietary staff will be educated regarding requirement for hair restraints to be worn in the kitchen. The coffee mugs and plates identified at the time of survey will be distained or discarded. The ceiling vents identified at the time of the survey was cleaned. Dietary Manager will complete sanitation rounds five times weekly to monitor for compliance. A QI Audit tool will be utilized. Executive Director or designee will conduct a sanitation round weekly to	

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F 520	Continued From page 5 accurately assess the eating status of 1 of 3 residents reviewed for activities of daily living. The facility failed to accurately assess the urinary incontinence of 1 of 3 residents in the sample reviewed for urinary incontinence. The facility failed to code the assessment for constipation for 1 of 1 resident reviewed for constipation. 2. F371 Based on observation and staff interviews the facility failed to ensure dish ware were allowed to air dry and were free from stains and food particles, ceiling vents were clean and hair restrains were used by staff while working in the kitchen. This had the potential to effect 94 of the 96 residents who resided in the facility. During the recertification and the complaint survey conducted February 25, 2916, the facility failed to label and date food items. The facility failed to store food items off the floor. The facility failed to have floors, carpets and walls in the kitchen, dining room and dry storage area that were clean, free from cracks and free from an accumulation of dark brown colored substance. Interview on 12/02/2016 at 1 PM with the Administrator she indicated that her expectation for QAA program was to addressed past deficiencies each meeting for the last year. Further interview with the Administrator revealed the areas of kitchen sanitation and MDS accuracy had not been effective.	F 520	monitor for compliance. A QI tool will be utilized. Results of audits will be submitted to facility quality committee monthly for review for 12 months The MDS for resident 11 was corrected to accurately reflect the resident's status in regards to PASRR determination. A correction sheet was submitted. Facility MDS staff conducted a full audit for all residents in the area of PASRR determination. Correction sheets will be completed and submitted as indicated. Facility MDS staff will be educated regarding correctly coding the MDS for PASRR determination. All disciplines involved in coding of the MDS will be trained in coding each section of the MDS according to RAI guidelines. All disciplines involved in coding of the MDS will collectively audit five MDS's weekly for accuracy. A QI audit tool will be utilized. Results of the audit tools will be submitted to the quality committee for review monthly for 12 months. Facility quality committee will review the results of audits in the area of F 278 and F 371 for 12 months. Based on audits, Facility Quality Assurance committee will revise plans of corrections as indicated.	

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