PRINTED: 03/09/2016 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE S	ETED	
		345391	B. WING		l l	, 25/2016	
	ROVIDER OR SUPPLIER ND 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	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	FO	For Residents Cited			
F 253 SS=E		e cited as a result of the on survey of 2/25/16. Event EKEEPING & RVICES	F 2	The floors in rooms and bathroo residents in rooms 311, 310, 203, 202, were thoroughly cleaned. The ceiling at the entrance to ropainted.	3, 217, 130,	3-24-16	
·	maintenance service sanitary, orderly, and	vide housekeeping and us necessary to maintain a dicomfortable interior. To is not met as evidenced		The hallway carpet outside of ro 104, and 105 was thoroughly cle carpet at the entrance to room 2 thoroughly cleaned.	eaned. The		
	by: Based on observation interviews the facility floors and carpet. To walls and floor tile in	ons, record review and staff r failed to maintain clean he facility failed to maintain good repair. This was dent units. (Unit 100, 200		The molding in room 107 was rewall behind 310 bed B was repa 229 the cracked tile was repaire molding in the bathroom was sewall. The cracked tile at the entra 206 was repaired.	ired. In room d and cove cured to the		
	an accumulation of a substance in the floor Room #311. B. Observation on brown colored staine # 310. The bathroom a brown and red color. Observation or Room #203 revealer colored bathroom floor floor and an accum colored substance work of the co	n 02/24/2016 at 8:58 AM in d heavily stained black por tile. The corners in the ulation of dust and brown under the cork board. 25/2016 9:33AM revealed the		For All Residents Sr. district manager for facility p operations and environmental s conducted a full audit of resident facility hallways to identify ceilin painting, walls in need of repair, repair, cove base in need of repair need of repair and resident roor resident bathroom floors and calleaning. Identified areas were repaired and painted. System Changes Facility housekeeping staff was regarding routine carpet cleaning.	ervices t rooms and gs in need of tile in need of air, molding in n floors, rpet in need of cleaned,	3-24-16	
_	PRECTOR'S OR PROVIDER	OSUPPLIER REPRESENTATIVE'S SIGNATU	RE	Executive	Director	(X6) DATE 3/18/16	

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.

Facility ID: 943494

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 " "		CONSTRUCTION	(X3) DATE S COMPL	ETED
		345391	B. WING			02/2	5/2016
		THE MOSES H CONE MEM H	3	11	REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
F 253	around the base of the E. Observation on a revealed in Room #1 was stained with a bit. The corners of the floaccumulation of a brown of E. Observation on revealed a heavy start #101.	m floor tile was stained to toilet bowl in Room #217. 02/24/2016 at 8:08 AM 30 the bathroom floor tile rown colored substance. For under the sink had an own colored substance. 02/24/2016 at 8:27AM lined carpet outside of Room	F	253	cleaning and detailed cleaning of res rooms. Facility housekeeping, administrative nursing staff was educated regarding process for entering repairs into the f work order system.	and the	3-24-16
	revealed the hallway accumulation of a brithe entrance to Room H. Observation on revealed the carpet of accumulation of a brientrance to Room #1. Observation on revealed the carpet of a brown colored s. J. Observation on revealed the floor compared by the floor co	02/24/2016 at 8:28 AM was soiled with an own colored substance at the 104. 02/24/2016 at 8:31AM at the entrance to Room #105 bstance with an accumulation ubstance. 02/24/2016 at 8:36 AM arriers under the sink in Room ulation of a brown colored 02/24/2016 at 8:47AM arriers was soiled with an own colored substance at the			District manager for plant operations environmental services or designee of conduct a detail audit of facility and reside is audited at least once monthly. The audit will address ceilings in nee painting, walls in need of repair, tile is repair, molding in need of repair, covered of repair, cracked tile in need of and resident room floors, resident base floors and carpet in need of cleaning Identified areas will be cleaned, repair painted. A QI tool will be utilized. Monitors Facility administrative staff will conducted resident room audits weekly fongoing ensure continued compliance. Audits will be submitted to the facility committee for review. Facility quality committed will review audits for concrevise plan as indicated.	will resident resident rent room ed of n need of re base in if repair, athroom hired and uct t to	3-24-16

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTI			MPLETED C
		345391	B. WING_			0	2/25/2016
	ROVIDER OR SUPPLIER ND LIVING & REHAI	3 AT THE MOSES H CONE MEM H	s.	1131 NOF	ADDRESS, CITY, STATE, ZIP CODE RTH CHURCH STREET SBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253	President reveale was held regarding procedure and sa made about what the response was would start. Interview on 02/2 administrator reveand maintenance on the 100 hall (Splace to strip all tistaff training. The clean was 11/16/administrator indisupervisor was respecific date provisor was respecific date provisor.	on with the Regional Vice d on 2/22/16 a training session ag the weekly housekeeping fety reminders. An inquiry was floors had been cleaned and the does not keep track but 5/2016 at 8:13 AM with the ealed on 10/19/15 housekeeping was identified with dirty floors couth). As a result a plan was in the floors on the 100 hall and the completion date for all floors 15. Additionally, the cated that the housekeeping eplaced in December 2015 (no crided) and the Regional vice onitoring in the facility twice a	F	253			
	administrator revihave clean reside 2. A. Observation revealed the mole bathroom was pain Room #107 B. Observation revealed rough at the wall near Room #200 complete the molding was part Room #229. Ob AM revealed the	on on 2/23/16 at 8:48 AM ding on the wall near the artially intact with metal exposed tion on 2/23/16 at 9:33 AM nd unfinished plaster repair on			· .		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD			,	c
		345391	B. WING			02/	25/2016
NAME OF P	ROVIDER OR SUPPLIER		:		TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H			131 NORTH CHURCH STREET		
,				٦	REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	of Room #229.	e 3 on 02/25/2016 at 9:35 AM	F	253			
F 278	Room #206. 483.20(g) - (j) ASSES		F	278	The facility will ensure the MDS assessment accurately reflects the resident's status.		
SS=D	The assessment mus	DINATION/CERTIFIED st accurately reflect the			For Residents Cited		3-24-16
	resident's status. A registered nurse m each assessment wit participation of health				The MDS assessment for resident #87 was corrected to reflect the resident's eating status.		
	assessment is compl	ust sign and certify that the leted.			The MDS assessment for resident #35 was corrected to reflect the resident's status for urinary incontinence.		
	assessment must sig that portion of the as Under Medicare and willfully and knowingl false statement in a r	n and certify the accuracy of			The MDS assessment for resident #85 was corrected to accurately reflect the resident problem with constipation. A correction sheet was		
	\$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				transmitted for each resident as indicated.		3-24-16
	penalty of not more t assessment.				For All Residents The MDS nurse conducted a full		
	material and false sta				audit of MDS assessments for all residents in the areas of ADL's, urinary incontinence and constipation. Correction sheets		
	This REQUIREMEN by:	T is not met as evidenced			will be completed for each resident as indicated.		

record review the facility failed to accurately assess the eating status of 1 of 3 resident's reviewed for activities of daily living. (Resident #87) 2. The facility failed to accurately assess the urinary incontinence of 1 of 3 residents in the sample reviewed for urinary incontinence (Resident #35). 3. The facility failed to code the assessment for constipation for 1 of 1 resident reviewed for constipation. (Resident #85) Facility MDS staff were educated regarding RAI guidelines for coding of ADL's, urinary incontinence and constipation. CNA staff were educated regarding accurate documentation of resident ADL's and resident voiding.	=12046
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 Continued From page 4 Based on observation, interview with staff and record review the facility failed to accurately assess the eating status of 1 of 3 resident's reviewed for activities of daily living. (Resident #87) 2. The facility failed to accurately assess the urinary incontinence of 1 of 3 residents in the sample reviewed for urinary incontinence (Resident #35). 3. The facility failed to code the assessment for constipation for 1 of 1 resident reviewed for constipation. (Resident #85) Findings included: 10 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 278 System Changes Facility MDS staff were educated regarding RAI guidelines for coding of ADL's, urinary incontinence and constipation. CNA staff were educated regarding accurate documentation of resident ADL's and resident voiding. Findings included: Monitors	3/2070
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 278	
Summary Statement of Deficiencies (EACH Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) PREFIX TAG TAG F 278 Continued From page 4 Based on observation, interview with staff and record review the facility failed to accurately assess the eating status of 1 of 3 resident's reviewed for activities of daily living. (Resident #87) 2. The facility failed to accurately assess the urinary incontinence of 1 of 3 residents in the sample reviewed for urinary incontinence (Resident #35). 3. The facility failed to code the assessment for constipation of 1 of 1 resident reviewed for constipation. (Resident #85) Findings included: F 278 F 278 System Changes F acility MDS staff were educated regarding RAI guidelines for coding of ADL's, urinary incontinence and constipation. CNA staff were educated regarding accurate documentation of resident ADL's and resident voiding.	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 Continued From page 4 Based on observation, interview with staff and record review the facility failed to accurately assess the eating status of 1 of 3 resident's reviewed for activities of daily living. (Resident #87) 2. The facility failed to accurately assess the urinary incontinence of 1 of 3 residents in the sample reviewed for urinary incontinence (Resident #35). 3. The facility failed to code the assessment for constipation for 1 of 1 resident reviewed for constipation. (Resident #85) Findings included: PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE System Changes Facility MDS staff were educated regarding RAI guidelines for coding of ADL's, urinary incontinence and constipation. CNA staff were educated regarding accurate documentation of resident ADL's and resident voiding. Findings included: Monitors	
Based on observation, interview with staff and record review the facility failed to accurately assess the eating status of 1 of 3 resident's reviewed for activities of daily living. (Resident #87) 2. The facility failed to accurately assess the urinary incontinence of 1 of 3 residents in the sample reviewed for urinary incontinence (Resident #35). 3. The facility failed to code the assessment for constipation for 1 of 1 resident reviewed for constipation. (Resident #85) Findings included: System Changes Facility MDS staff were educated regarding RAI guidelines for coding of ADL's, urinary incontinence and constipation. CNA staff were educated regarding accurate documentation of resident ADL's and resident voiding. Monitors	(X5) COMPLETION DATE
Data Set (MDS) assessment tools dated 10/21/16 and 1/15/16 quarterly revealed Resident #87 had a decline in eating from being independent to requiring supervision from staff. Interview on 02/24/2016 at 12:54 PM with the MDS nurse #2 evealed the coding on the activities of daily living (ADL) form documented by the nursing assistant (NA) maybe inaccurate. They (referring to NA) are documenting so fast or maybe he needed assistance that day. MDS nurse #2 also indicated Resident #87 was independent in eating as of this survey. Observation on 02/24/2016 at 1:49 PM revealed Resident #87 had his lunch tray in front of him and eating without staff assistance. Interview on 02/24/2016 at 3:19 PM with NA #14 revealed it was an error in documentation and coding on the ADL form. NA #14 indicated Resident #87 can fed himself and does not need cueing during meals.	3-24-16

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTIOŇ		TE SURVEY MPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NONDER.	A. BUILDIN	IG		
		345391	B. WING_			C)2/25/2016
VIVING OF B	ROVIDER OR SUPPLIER	VT0001		STREET ADDRESS, CITY, STATE, ZIP COD		
	er .			1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB	AT THE MOSES H CONE MEM H		GREENSBORO, NC 27401		
(YA) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
F 278	Continued From pa	ge 5	F2	778		
	the diagnosis in parmost recent minimus severe impairment bowel and bladder, assessment dated frequently incontine urinary incontinent continent voiding). Assessment: dated incontinent (no epis Review of the bowed data form for the as 8/28/15 at 1:55 PM of urine. During an interview MDS Nurse #2 individed been incontinent. Serror. The C.N.A #2 She indicated she bladder data form a obtain an assessment any errors made by the MDS assessment. During interview or C.N.A. #1 indicated and change prograevery two hours. Secommunicate her reincontinent. During an interview C.N.A #1 indicated when she had first documented Resident.	as admitted on 08/27/15, with rt of vascular dementia. The am data set (MDS) revealed and always incontinent of Review of - Admission 09/03/2015 revealed, ent (7 or more episodes of e, but at least one episode of Compared To: 90-Day MDS d 11/22/2015, always sodes of continent voiding). el and bladder data collection assessment period revealed on Resident #35 was continent on 02/24/2016 1:39:38PM, cated Resident#35 had always the indicated it was a coding 2 documentation was wrong. The reviewed the bowel and and interviewed the staff to ent. MDS Nurse #2 indicated by the aides were corrected on ent. The o2/24/2016 2:41:45PM, desident #35 was on a check am for incontinence at least the was never able to needs and was always or on 02/25/2016 11:57:46 AM, she remembered Resident#35 arrived. She indicted she had tent#35 as incontinent. If she er as continent it was an error.				
	During an interview	v on 02/25/2016 1:58:09 PM,				

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NOWIDER.	A. BUILD	ING		C	
		345391	B. WING			02/2	5/2016
	OVIDER OR SUPPLIER ND LIVING & REHAB A	THE MOSES H CONE MEM H		11:	REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 278	incorrectly document it was accurate. Once	e 6 ated when the C.N.A sed. The C.N.A. was asked if e it is documented it cannot as coded accurately on the	F	278			
	4/30/15. The medical was prescribed, Am mouth twice daily on 1 by mouth daily on mouth daily on 1/22/by mouth twice daily medications are use bowel irrgularities, a	a admitted to the facility on all record revealed that she itiza 24 mcg (micrograms) by 7/3/15, Senokot with Senna 12/31/15, Lactulose 15 ml by 16, and Miralax 17 g (grams) on 1/30/16. All of these d to treat constipation and/or and all used together indicated a severe issue with bowel					
	were reviewed and r	Sets (MDS) since 7/2015 none indicated that Resident with constipation or any sort s.					
	PM and confirmed the standing issue with the MDS #1 nurse with the	erviewed on 2/25/16 at 12:30 hat she has had a long her bowel movements.					
	bowel irregularities of replied "It isn't on the Milk of Magnesia was look back period. The medications."	ng for constipation and/or on Resident #85's MDS. She he MDS because 'as needed' his only used once during the did not look at the scheduled	F	332			
F 332 SS=D	RATES OF 5% OR			- 332			
	The facility must en	sure that it is free of					

T		WEDIO/ (ID OCI (VIOLO)	(X3) MHI.	TIDI E	CONSTRUCTION	(X3) DATE S	SURVEY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COMPLETED	
,			A. BUILDI	_			,
		245204	B. WING			ł	
		345391	D. WING.		TOTAL ADDRESS OF STATE TIP CODE	UZIZ	25/2016
NAME OF P	ROVIDER OR SUPPLIER			`	TREET ADDRESS, CITY, STATE, ZIP CODE		
LICADTIA	ND I MING & DEHAR A	T THE MOSES H CONE MEM H			131 NORTH CHURCH STREET		
HEARILA	NO CIVING & RELIAD A	THE MODES IT SOME MENT		G	REENSBORO, NC 27401		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	\\L	
					The facility will maintain a medication	error	
					rate of less than five percent.		
F 332	Continued From pag	e 7	F	332	Tate of 1656 than the percent		7
	medication error rate	es of five percent or greater.		For Residents Cited		3-24-	
		,			TOT Residents Offed		
					Medications for residents #41, #145 a	nd #193	
					will be administered as ordered and a		
	This REQUIREMEN	T is not met as evidenced			to standards of practice.	ocoranig	
	by:				lo standards of practice.		
	Based on observation	ons, medical record review,			For all Residents		3-24-16
	and staff interview, t	he facility failed to maintain a					
		ration rate below 5% (error			Medications for all residents will be		
		ut of 25 opportunities,			administered as ordered and according	a to	
	Residents #41, 145,	and 193). Findings included:			standards of practice.	g to	
		admitted to the facility on			standards of practice.		
		n/Vitamin D deficiency. The			Facility nurses and medication aides v	were	
		aled that the physician had			educated on the six rights of medication		
		ng (milligram) with Vitamin D,			administration. Facility medication aid		
	Give 1 tablet daily as	s a supplement, on 3/23/15.			nurses were educated regarding med		
					that cannot be crushed.	loations	
		ration observations was			that cannot be crushed.		_
	ł	6 at 8:00 AM. Medication			System Changes		3-24-16
	i e	ed administering 1 tablet of			System Changes		
	Calcium 500 mg to F	Resident #41.			Facility nurses and medications aides	were	
	No an interview on O	124/16 of 11:20 AM			educated in regards to order entry and		
	Upon interview on 2. Medication Aide #1				documentation policy and practices. F		
		m only to Resident #41 and			nurses and mediation aides were edu	cated on	
		bottles of Calcium only in my			interface between pharmacy and the		
		don't have stock bottles of			EMAR system used to identify and co		
		n D tablets in my cart. I will			order discrepancies.		
	notify administration				order discrepansion.		3-24-16
		•			Monitors '.		3-2-16
	The Director of Nurs	sing was interviewed on					
		She stated "My expectation			Facility DON or designee will conduct		
		ns are given according to the			medication pass audits five times eac		
		on administration; the right			with nurses and medication aides ong		
		t dose, the right route."			QI audit tool will be utilized.	. •	
	2. Resident #145 wa	as admitted to the facility on			Results of medication pass audits will	be	
		der for Potassium Chloride			submitted to the quality committee mo	onthly for	ļ
	(KCI) 20 meq (millie	quivalents) to prevent	İ		review.		

PRINTED: 03/09/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345391	B. WING_			C 02/25/2016
	ROVIDER OR SUPPLIER ND LIVING & REHAB	AT THE MOSES H CONE MEM H		STREET ADDRESS, CITY, STATE, ZIP COD 1131 NORTH CHURCH STREET GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREEI) TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 332	concurrent long stamedication for the failure. Medication administ conducted on 2/24. Aide #2 was obsert KCI, throwing away potassium, and the obtain more KCI 10 give to Resident #1 Upon questing Med 11:00 AM, she reveload given only KCI needed more of the of 20 meq KCI. The requested to obtain the recycle bin and Resident #145. More to the empty blister potatal prescribed do prescribed, and cout order or administration.	stration observation was 20 AM. Medication wed administering 20 meq of 20 the empty blister pack of 30 meq from the pharmacy to	FS	332		
	2/24/16 at 5:00 PM recently changed pt KCI 10 meq and at Resident #145, bu administer one tab My expectation is according to the 3	rsing was interviewed on 1. She stated "We have charmacies. We used to get diminister two tablets to the nown we are supposed to only let of the full 20 meq KCI dose. That the medications are given rights of medication, the right te."			' .	

Event ID: ZVQW11

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE S COMPL	ETED .
		345391	B. WING			02/2	; 25/2016
	ROVIDER OR SUPPLIER ND LIVING & REHAE	AT THE MOSES H CONE MEM H		11	REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401	•	
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	2/5/16 with orders mouth daily as precerebral vascular had orders, from a that could be crus Medication Admin conducted on 2/24 Aide #2 was obse Aspirin 325 mg frothe medication pri Resident #193 by Upon interviewing "I did not know than to be crushed." a copy of Do Not realized that enter it. The Director of Not realized that enter it. The Director of Not realized that the medication, the rights of medication, the rights of medication, the rights of medication was a rights of medication of STORE/PREPAR. The facility must - (1) Procure food for considered satisfa authorities; and	was admitted to the facility on to Take Aspirin 325 mg by eventative treatment for a accident. Resident #193 also admission, to crush medications thed for easy administration. distration observations was 4/16 at 8:00 AM. Medication rived taking one Enteric Coated on a stock bottle and crushing or to administering it to mouth. Medication Aide #2, she stated at enteric coated aspirin could She was readily able to provide Crush Medication list and ric coated items were listed on wursing was interviewed on the stated "My expectation tions are given according to the tion administration; the right dose, the right route." PROCURE, E/SERVE - SANITARY			The facility will ensure food is stored, distributed and served under sanitary conditions. For Residents Cited and All Resident	,	3-24-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/09/2016 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILUIN	G	,	<u>,</u>
		345391	B. WING			25/2016
NAME OF P	ROVIDER OR SUPPLIER	I	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		***
	et.			1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	e 10	F 3	71 Food identified as unlabeled or incorre labeled, dated or stored, was discarded time of survey. The cabinet under the imachine in the dining room was cleaned.	d at the	%-241b
	by: Based on obse4rvati interview, the facility items. The facility fai the floor. The facility	ons, record review and staff failed to label and date food led to store food items off failed to have floors, carpets en, dining room and dry		time of survey. The drain underneath the cabinet where the ice machine is located repaired at the time of survey. The outside the cabinets in the dining room were cluthe time of survey.	he ed was side of	t
	storage area that wer	e clean, free from cracks umulation of dark brown		The floors in the kitchen and dining roc including the accumulation of red subsunder the bread shelf and accumulation black substance at the entrance to the kitchen, around the substance of the s	tance n of he	3-24-16
	Observation with the (FSM) during the initi 10:35 AM revealed: Walk in refrigerator: There was 1 (5 ppimento cheese spre	Food Service Manager al kitchen tour on 2/22/16 at bounds) opened containers of ad that was undated. If liquid whole eggs that were		perimeter of the kitchen, and in the dry area were cleaned. The carpet in the d area, and the area where the steam tal stored were cleaned. The trays used to store the drinking g the dining area were replaced.	ining ble is	
	not dated when open There was a plastic by 2/2/16. There was The FSM indicated the was sliced corn beef, in color. Further intended that the corn beef neon there was a plastic between the original container dated. There was a plastic becheese. The actual of the container dated.	ore-boiled eggs that were		The cracked floor tile in the dining are front panel of the stove, the water sup the tilt skillet, and the cove base miss the corners in the dining room, and the frame where entering and exiting the was repaired.	oply to ling on le door	3-24-16
		rag with slices of meat that labeled. FSM indicated the am.				

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	į.		E CONSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			;
		345391	B, WING			1	, 25/2016
NAME OF D	ROVIDER OR SUPPLIER		- 		STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1131 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB	BAT THE MOSES H CONE MEM H		ı	GREENSBORO, NC 27401		
		A STATE HEALT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE.	COMPLETION DATE
F 371	Continued From p	page 11	F	371	I		3-24-16
	In the walk in free:	zer:			System Changes		
	· There was a	pan of cheese cake (identified			a control of the cont	ina proper	
	by FSM) prepared	by the facility staff that was not			Dietary staff will be educated regard	dating	
	labeled or dated.				food storage to include labeling and	ualing or Diotary	
	In the dry storage	:			and storage of food items off the floo	nrocess of	
	· There was a	case of 12 (93 pounds 2			staff will be educated regarding the	tu work	
	ounces) tomato so	oup cans stored on the floor.			reporting needed repairs in the faciliorder system. Dietary staff will be ed	ty work	
	· A container o	f peanut butter that had been			order system. Dietary stall will be et	kitchen	
	opened was stick	y. The lid and the lip of the			regarding cleaning schedules for the	KILCHEH	
	l.	anut butter spilled and dried on			and dining room.		
	the outside.	and a substitute of the original			Cleaning schedules in the kitchen w	ill he	
	There was dr	ry cereal out of the original			revised to include detail cleaning for	dinina	1
	package stored in	n a plastic bag that was t dated. The FSM identified the			room cabinets, dining room floors, a	nd kitchen	
					floors and walls.	ina mionon	
	cereal as uncooke	ed oatmeal. n unsealed 10 pound plastic bag			TIOOTS and wails.		
					Manitara		3-24-16
	of uncooked past	a. lastic food wrapping on the floor.			Monitors		
	Intention on 2/24	/16 at 12:30 PM with Dietary			Dietary manager or designee will co	onduct	
	aide #1 (DA) reve	ealed once a food package was			audit of kitchen and dining room five	e times	
	opened the nacks	age should be labeled and			weekly ongoing to include food labe	eling and	
	dated.	ago onodia de ladere a ama			dating, needed repairs, and cleanling	ness of	
		/16 at 12:35 PM with DA #2			floors and walls. Issues will be corre	ected at	
	revealed the dieta	ary staff was responsible for			the time they are identified. A QI to	ol will be	
	labeling and datir	ng the package once a food item			utilized.	- · · · · · · · · · · · · · · · · · · ·	
ĺ	was opened then	placed in a plastic bag.			utilizea.		1
	Continued observ	vation on 2/22/16 during the			QI audits will be submitted to the m	onthly	3-24-16
	initial tour at 10:3	0 AM revealed the following			facility quality committee for review		
	environmental iss	sues:			donity quality committee is fortest		
	· In the walk in	n freezer there were 4 (4 ounce			·		
	size) cups of ice	cream on the floor.					
		n freezer there were 3 white					
		n a food box packaging laying on					
	the floor.						
		under the bread shelf was					
	heavily stained w	vith a red colored substance.					
	The water su	upply to the tilt skillet was leaking					
	water down onto	the floor creating a puddle.					
l	 The front pa 	anel of the stove was partially					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345391	B. WING _			02/25/2016
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				STREET ADDRESS, CITY, STATE, ZIP COI 1131 NORTH CHURCH STREET GREENSBORO, NC 27401	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	2/24/16 at 11:20 A was still partially d The floor tile a had an accumulat corners. Observa continued to revea the kitchen had an substance in the c Observation of the perimeter of th the floor had an a substance. Obse revealed the perin remained with an substance. Observations the lunch meal re were stored on a black stains.	se of the stove. Observation on M the front panel of the stove letached. at the entrance to the kitchen ion of a black substance in the tion on 2/24/16 at 12:30 PM all the floor tile at the entrance to a accumulation of a black	FS	371		
	continued to reve on a red tray which one ared tray which one ared tray which one are tray which one are tray which one are tray and tray are tray	al drinking glasses were stored th had permanent black stains. on 2/22/16 at 11:50 AM of the aled the corners of the floor had sing with broken plaster. The ked with multiple areas of black he metal strip between the floor d an accumulation of a black e within the grooves. The carpet at the metal strip was so on 2/22/16 at 11:45 AM I in the dining Room was served team table. This table was e cook could plate the food. In the steam table was stored an a black substance and a dead has embedded in dust. After the			1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED		
		A. BUILD	NG		C			
		2.5024					02/25/2016	
		345391	B. WING		TARRESON CITY STATE ZIR CORE		02/25/2010	
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		Ì	
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H				1	NORTH CHURCH STREET			
HEARTLA	AND LIVING & REIND	AT THE MODES IT SOME INC.		GREE	ENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 371	corner were the ac substance and dea . Observation o in the cabinet under room had a white obrown/orange colo odor. The base of Continued observations is 35 PM revealed continued. By 2/23 administrator observations from the FSM revealed December 2015 (nice machine in the dripping from the to 2/24/16 at 12:15 Phousekeeping reversible to catch when he a 2/24/16 no specific was there to catch Continued intervier requested the area 2/23/16. The direct indicated the leak on 2/23/16. Further of tea occurs when during meals. Observation on 2/2 revealed: Observation on 2/2 revealed: Observation of direct in the dry accumulation of direct in the dry accumulation of direct in the corners and poshelves in the dry accumulation of direct in the dry accumulation of direct in the substantial to the corners and poshelves in the dry accumulation of direct in t	steam table was placed in the cumulation of the black and insect were observed. In 2/22/16 at 11:55 AM revealed are the ice machine in the dining colored cloth that had dried to a received. There was an offensive the cabinet was crumbling. There was an offensive the cabinet was crumbling. The status under the cabinet 3/16 at 5:45 PM the reved the condition under the dining area was leaking with the acontainer. Interview on M with the director of called he noticed the cloth in the revealed he noticed the cloth in the revealed the administrator as be cleaned and repaired on cotor of housekeeping services from the ice machine was fixed the interview revealed drippings in the staff obtained liquids 24/16 at 11:15 AM with the FSM of the dry storage area revealed of brown colored substance in the primeter of the floor. Under 8 storage area was an ust. Interview with the FSM on the interview with the	F	371				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345391	B. WING			C 02/25/2016	
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			3	11:	REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
F 372 SS=E	continued to reveal that and exiting the kitches scratched. The fram and chipped paint. To the kitchen had an substance in the corn Interview on 2/24/16 the Area Support Ma was held. The FSM five minute sanitation audits starting 12/30, session was done or on 2/24/16 at 2:28 P expectations for staffitems once opened a date food items should ditionally, the Cooffloor being cleaned in storage stock position storage floor being cresponsible for the dinterview revealed the floors are cleaned do Record review revealed the revealed her expitems should be labely kitchen be kept cleaned 483.35(i)(3) DISPOS PROPERLY	shelves. 2/24/16 at 12:30 PM ne two doors when entering en were chipped and e of the doors had peeling The floor tile at the entrance accumulation of a black ners. at 2:08 PM with FSM and nager for Nutrition Services revealed she conducted a n /compliance walk through /15. As a result a training n 1/27/16. Further interview M with the FSM indicated her f were to label and date food and any staff who see out of all be thrown away. Is was responsible for the n the production area, the n was responsible for the dry lean and dietary aides were ishwashing area. Continued he staff should make sure the aily. Alled a training session was 6 which included " all food is y labeled (double check Iministrator on 2/25/16 at 8:57 bectations were that open eled and dated and the		371			
	properly.	· · · · · · · · · · · · · · · · · · ·					

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE S COMPL	
AND PLAN OF	CORRECTION	IDENTIFICATION NOWIDEN.	A. BUILD	ING		C	
		345391	B. WING				5/2016
NAME OF PE	OVIDER OR SUPPLIER	040001	<u></u>		REET ADDRESS, CITY, STATE, ZIP CODE	1	<u> </u>
d				11	31 NORTH CHURCH STREET		
HEARTLA	ND LIVING & REHAB AT	THE MOSES H CONE MEM H		G	REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 372	Continued From pag	e 15	F	372	The facility will dispose of garbage a refuse properly.	.nd	3-24-16
	by: Based on observation facility failed to maint dumpster areas. Findings included: Observation on 2/24 dumpster area with t (FSM) revealed trash white spoons, plastic bags, napkins, dispopeels were noted be front of the dumpster. There dumpster with trash During the observation of the dumpster with trash During the observation of housekeeping, lauservices) [DHLM] reverse was responsible for cleanliness of the duinterview and indicated dumpster area but he area. Observation of the con 2/24/16 at 11:50 was done. The direct on the ground and in addressed.	at 11:45 AM with the Director andry and maintenance wealed the floor tech (FT) the maintenance and ampster area. FT joined the red he was responsible for the ad not had a chance to clean ondition of the dumpster area AM with the DHLM and FT ctor indicated that the trash in the bushes needed to be			For Residents Cited and All Resident All trash including straws, plastic bag plastic spoons, napkins, banana peed disposable cups were removed from area around the dumpster. System Changes Dietary and housekeeping staff were educated regarding the requirement the area around the dumpster free of thousekeeping staff will monitor the dumpster area three times daily to eather area is kept clean. Monitors Facility dietary manager will audit the dumpster area for cleanliness five times weekly for cleanliness. A QI audit to utilized. Facility environmental services direct audit the dumpster area five times we cleanliness. A QI tool will be utilized. Results of audits of the dumpster are be submitted for facility quality commentations.	e to keep f trash. nsure e me ol will be ctor will weekly for	3-24-16 3-24-16
F 520 SS=E	AM revealed expect be kept clean. 483.75(o)(1) QAA	Iministrator 2/25/16 at 8:40 ation that the dumpster area BERS/MEET	F	520	review.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
, HE I LAN OF	55,11120,1014		A. BOILDING			С	
		345391	B. WING			02/25/2016	
NAME OF PROVIDER OR SUPPLIER HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H			;	11	REET ADDRESS, CITY, STATE, ZIP CODE 31 NORTH CHURCH STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page		F	520	The facility will maintain an effective assurance program	quality	
	assurance committee nursing services; a pl facility; and at least 3 facility's staff. The quality assessme committee meets at least issues with respect to and assurance activitely develops and implementation to correct iden. A State or the Secretic disclosure of the receivements of the requirements of this second faith attempts by the service of the second faith attempts by the second faith attempts	east quarterly to identify of which quality assessment ties are necessary; and nents appropriate plans of tified quality deficiencies. Itary may not require ords of such committee the disclosure is related to the committee with the section. The property of the committee to identify eficiencies will not be used as			For Residents Cited and All Residents Sr. district manager for facility plant operations and environmental services conducted a full audit of resident room facility hallways to identify ceilings in r painting, walls in need of repair, tile in repair, cove base in need of repair, mo need of repair and resident room floor resident bathroom floors and carpet in cleaning. Identified areas were cleane repaired and painted. System Changes Facility staff will be inserviced on iden issues with the resident environment a process for reporting issues with the r environment into the facility work orde for housekeeping and maintenance. F staff will also be inserviced on how to issues with the resident environment of	s and need of need of olding in s, need of d, tifying and the esident or system acility report	3-24-16
	by: Based on observation facility's Quality Assumed Committee failed to reprocesses that the facility remained for one recited deficiency on an annual recertify 5/29/15, and again of	ons and staff interview, the prance and Assessment maintain effective monitoring ecility had put into place on at the general environment of clean and orderly. This was ency that was originally cited fication survey conducted on the current recertification acy was in the area of			a member of the facility quality commit The facility administrator, district mana facility plant operations director will missues reported in the facility work ord weekly for four weeks and develop pla action as needed for correction of idea concerns. A QI audit tool will be utilized	ittee. ager and onitor er systen ans of ntified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	MDCD.			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBERS	A. BUILDI	A. BUILDING			;
		345391	B. WING			-	25/2016
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	failure of the facility surveys of record slinability to sustain a Program. Findings Cross refer this cita observations, record the facility failed to carpet. The facility floor tile in good represident units (Units The facility was record to develop and implementation of the During an interview 2/25/16 at 4:00 PM facility's QA Committed to the Committed of the During an interview 2/25/16 at 4:00 PM facility's QA Committed of the Administrator is committed of the Administrator is the Administrator is committed of the Administrator is the Administrator is committed of the Committed of the Administrator is committed of the Committed of the Administrator is committed of the Commit	maintenance. The continued during the two federal nows a pattern of the facility's n effective Quality Assurance included: tion to F253: Based on d review and staff interviews maintain clean floors and failed to maintain walls and vair. This was evident in 3 of 4 to 100, 200, and 300). Ited for F253 when they failed dement procedures and ventions to ensure the maintenance maintained a nvironment, as it related to the general environment. With the Administrator on the indicated that the the Medical Director, the of the facility's department aintenance and housekeeping. Indicated that the QA a quarterly basis and more For the citation dated 6/26/15, teated that the committee ring and fixing things in	F		Facility administrative staff will conduroom audits weekly ongoing to ensur continued compliance. A QI audit too utilized. Facility quality committee will meet monitor quality audit tools related to i resident environment. Plans of action developed and revised by the facility committee as needed.	re of will be nonthly to issues with ns will be	