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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Living & Rehab at the Moses H Cone Memor	1131 North Church Street Greensboro, NC 27401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and Responsible Party and staff interviews, the facility failed to dispose of a urinary catheter drainage bag left on the resident's sink for 1 of 3 residents (Resident #94) on 1 of 3 halls reviewed for clean, comfortable, and homelike environment. The findings included:Review of Residents #94's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired and was coded for use of an indwelling urinary catheter.Interview and observation with Residents #94's Responsible Party (RP) on 04/27/26 at 11:40 AM revealed concerns of cleanliness of Resident #94's bathroom. An observation conducted at the same time revealed a leg bag (a small, wearable urine collection bag used to collect urine from an indwelling catheter) laying on the resident's bathroom counter next to the sink. There was observation of approximately 50 milliliters (ml) in the catheter leg bag, but no signs of urine on the sink. The RP indicated the leg bag had laid there for multiple days and was not sure if it was Resident #94's catheter leg bag. The RP indicated she visited Resident #94 almost daily and observed it in the resident's bathroom at least a few days. The RP stated she had not vocalized concerns to staff, because she was not sure if it was placed there for a purpose and the resident did not use the restroom at all.Interview with Nurse #3 on 04/30/26 at 5:15 PM revealed last Wednesday (04/22/26) she was assigned to Resident #94 and Resident #94 had come back from a urologist appointment and his catheter leg bag was switched to an overnight drainage bag. Nurse #3 stated she had removed the bag and thought she had emptied it, but another resident required immediate attention down the hall, and she had left it sitting on the bathroom counter next to the sink. Nurse #3 revealed all catheter bags were to be discarded per facility policy, and she had made a mistake by leaving it on the sink.Interview with Housekeeper #1 on 04/27/26 at 1:35 PM revealed she had been assigned to Resident #94's room consistently for the past month. Housekeeper #1 further revealed last Thursday (04/23/26) she had cleaned Resident #94's bedroom and bathroom and observed the catheter leg bag on the bathroom counter next to the sink. The Housekeeper stated she cleaned around the catheter bag but did touch it. Housekeeper #1 indicated she did not report it to staff because she thought nursing staff had left it there for a reason and she had not been educated to report if a catheter bag had not been discarded.Interview with Nurse Aide (NA) #6 on 04/30/26 revealed she was assigned to Resident #94 on 04/25/26 and 04/26/26. NA #6 further revealed Resident #94 was incontinent and did not use the bathroom, but she had used the bathroom to retrieve water for personal hygiene needs. NA #6 stated she does not recall seeing a catheter leg bag on the counter of the sink. The NA indicated she would have immediately discarded the bag and notified the assigned Nurse.Phone interviews were attempted with Housekeeper #2, who was assigned to Resident #94's room on 04/26/26, on 04/29/26 at 3:30 PM and 04/30/26 at 9:20 AM but were not successful. Interview and observation with the Director of Nursing (DON) on 04/27/26 at 11:55 AM revealed the catheter leg bag on the sink in Resident #94's bathroom and the DON stated per facility policy catheter bags were to be discarded after use. The DON revealed Resident #94 was incontinent and nursing staff completed personal hygiene in the resident's room. The DON was observed discarding the catheter leg bag and cleaning (continued on next page)

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.

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

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 04/30/2026
NAME OF PROVIDER OR SUPPLIER Heartland Living & Rehab at the Moses H Cone Memor		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 North Church Street Greensboro, NC 27401	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the sink. An interview with the Administrator on 04/20/26 at 4:10 PM revealed she expected nursing staff to discard catheter bags per facility policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, and Nurse Practitioner interviews, the facility failed to administer oxygen as specified in the physician order for 2 of 2 residents reviewed for oxygen therapy (Resident #53 and Resident #35).Findings included: 1. Resident #53 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (low levels of oxygen in body tissue which are common with chronic heart and lung conditions and causes symptoms like confusion, restlessness, difficulty breathing rapid heart rate and bluish skin), chronic obstructive pulmonary disease, and hypertension. Review of Resident #53's care plan dated 03/12/26 revealed the resident required oxygen at times or continuously. The resident was at risk for signs and symptoms of respiratory distress, dry or bloody nose, irritated skin around the ears from tubing or if mask is work, possible irritation round the mouth, increased fatigue, headaches. The goal was for Resident #53 to benefit mentally and physically with use of oxygen therapy. Interventions included to ensure oxygen was titrated to appropriate setting as ordered by the Medical Director, the oxygen concentrator was functioning properly, and oxygen saturations as ordered and PRN (as needed). Resident #53's quarterly Minimum Data Set (MDS) 04/15/26 revealed the resident was moderately cognitively impaired and required oxygen. The MDS further revealed Resident #53 required substantial to maximum assist with lying to sitting on side of the bed and sit to stand. Physician order dated 04/13/26 revealed Resident #53 was ordered oxygen at 3 liters per minute via nasal cannula every day and night shift for respiratory failure with hypoxia. An observation and interview with Resident #53 on 04/28/26 at 11:40 AM revealed Resident #53 in bed with a nasal cannula on and the oxygen tubing connected to the oxygen concentrator. The oxygen concentrator was adjacent to the upper half of the bed and at least two feet away from the bed. The oxygen flow meter was set at 4 liters per minute when the flow meter was viewed at eye level. Resident #53 shook her head that she had not changed the oxygen flow rate when asked. A phone interview with Nurse Aide (NA) #3 on 04/30/26 at11:40 AM revealed she was often assigned to Resident #53. NA #3 indicated Resident #53's health had declined the last few weeks and she had become weaker. NA #3 further revealed Resident #53 was unable to reach over and down towards the oxygen tank without falling out of bed and was unable to sit up without staff assistance. NA #3 revealed she never changed Resident #53's oxygen flow rate and it was the assigned nurse's responsibility to check the resident's oxygen and tubing. NA #3 stated she did not recall Resident #53 ever changing her oxygen flow rate. An interview with Nurse #3 on 04/28/26 at 12:15 PM revealed she had checked Resident #53's oxygen when she arrived on shift at 7:00 AM and indicated she recalled it set at 3 liters per minute. Nurse #3 further revealed Resident #53 was able to sit up on the side of the bed but could not stand without assistance. Nurse #3 indicated Resident #53 might have been able to change the oxygen but confirmed where the oxygen concentrator was placed Resident #53 would not be able to reach it and stated she did not know how Resident #53's oxygen was set at 4 liters per minute. An observation and interview with the Director of Nursing (DON) on 04/28/26 at 12:05 PM revealed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON reviewed Resident #53's records and stated the resident's oxygen concentrator should be set at 3 liters per minute. The DON was then accompanied to Resident #53's room and confirmed Resident #53's oxygen flow rate was at 4 liters per minute. The DON changed the oxygen flow rate from 4 liters per minute to 3 liters per minute. The DON stated she expected staff to check physician orders for oxygen settings and follow them. Interview with the Nurse Practitioner (NP) on 04/29/26, at 10:15 AM revealed she expected Resident #53's oxygen order to be followed. The NP further revealed Resident #53's oxygen level set at 4 liters per minute could cause an overload of oxygen to the resident. The NP indicated if Resident #53 required a different level of oxygen, then she would expect staff to notify her and there to be an order to change it. An interview with the Administrator on 04/30/26 at 4:00 PM revealed she expected Resident #53's oxygen order to be followed. 2. Resident #35 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (low levels of oxygen in body tissue). The physician order dated 04/09/26 revealed Resident #35 was ordered to receive oxygen at 3 liters per minute via nasal cannula every day and night shift for respiratory failure with hypoxia. Review of Resident #35's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required oxygen. The MDS further revealed Resident #35 was dependent for moving from lying to sitting on side of the bed and from sit to stand. Review of Resident #35's care plan dated 04/15/26 revealed the resident required continuous oxygen. The goal for Resident #35 was to benefit mentally and physically with use of oxygen therapy. Interventions included to ensure oxygen was titrated to appropriate setting as ordered by the Medical Director, the oxygen concentrator was functioning properly, and oxygen saturations as ordered and PRN (as needed). An observation and interview with Resident #35 on 04/27/26 at 11:18 AM revealed the resident lying in bed on her back with a nasal cannula in her nostrils and the oxygen tubing connected to the oxygen concentrator. The oxygen concentrator was located on the floor on the left side of the bed adjacent to the headboard approximately two feet away from the bed. The oxygen flow meter was set at 2 liters per minute when the flow meter was viewed at eye level. When asked, Resident #35 stated she had been on her back all morning and was unable to reach the oxygen concentrator and she had not changed the oxygen flow rate. Resident #35 denied any shortness of breath. An observation and interview with Resident #35 on 04/27/26 at 2:22 PM revealed Resident #35 lying in bed on her back with a nasal cannula in her nostrils and the oxygen tubing connected to the oxygen concentrator. The oxygen flow meter was set at 2 liters per minute when the flow meter was viewed at eye level. Resident #35 denied any shortness of breath. Review of Resident #35's Medication Administration Record revealed Nurse #4 documented on (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/27/26 the resident's oxygen flow rate was set at 3 liters per minute for the 7:00 AM to 7:00 PM shift. An interview on 04/27/26 at 2:23 PM with Medication Aide (MA) # 1 revealed she thought the oxygen flow rate for Resident #35 was 2 liters per minute but needed to check. She stated the nurse was responsible for setting and monitoring the rate of oxygen and she (MA #1) checked the pulse oxygen saturation rate that morning and documented it at 98%. MA #1 further stated she was not sure what the oxygen flow rate was for Resident #35 and she would check with the nurse. On 4/27/26 at 2:27 PM the physician orders for oxygen administration for Resident #35 were reviewed with MA #1 and Nurse #4 present. Nurse #4 indicated she was Resident #35's assigned nurse that day and confirmed Resident #35's oxygen flow rate was 3 liters per minute. Nurse #4 and MA #1 were accompanied to Resident's #35's room. Nurse #4 and MA #1 observed the oxygen concentrator for Resident #35 and stated the oxygen flow rate was on 2 liters per minute. Nurse #4 changed the flow rate to 3 liters per minute. Nurse #4 stated she did not know why the rate was on 2 liters and did not recall when she last checked it that shift. An interview with Nurse Aide (NA) #6 on 04/30/26 at 9:25 AM revealed she was often assigned to Resident #35. NA #6 stated the resident was unable to reach over and down towards the oxygen concentrator without falling out of bed and was unable to sit up without staff assistance. She did not believe that Resident #35 was physically able to change the oxygen flow meter. NA #6 revealed she never changed Resident #35's oxygen flow rate. An interview was conducted with Nurse #7 on 04/30/26 at 10:00 AM who was the assigned nurse that day and stated she was familiar with Resident #35 as she was regularly assigned to care for her. Nurse #7 stated it was the nurse's responsibility to monitor the oxygen flow rate and monitor the respiratory status of all residents receiving oxygen. She stated the nurse should observe at the beginning of the shift to confirm the oxygen flow rate matched the physician order and the resident receiving it was not in respiratory distress. She further stated the oxygen flow rate would be changed only by the nurse. An interview was conducted with the Nurse Practitioner (NP) on 04/29/26 at 10:00 AM during which she stated the oxygen order for Resident #35 should be followed. The NP stated Resident #35's oxygen level set at 2 liters per minute could cause respiratory distress for the resident. The NP indicated if Resident #35 required a different level of oxygen, then she would expect staff to notify her and there to be an order to change it. An interview with the Director of Nursing on 04/30/26 at 11:45 AM revealed the nurse was responsible for setting and monitoring the oxygen flow rate and it should match the physician order. She reviewed Resident #35's record and stated the resident's oxygen concentrator should be set at 3 liters per minute. An interview with the Administrator on 04/30/26 at 4:30 PM revealed she expected Resident #35's oxygen order to be followed.