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	02/26/2025

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

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** 38904 Based on observations, record review, and resident and staff interviews, the facility failed to ensure walls in a resident's room did not have stains (room [ROOM NUMBER]A) and failed to ensure a call light panel was securely attached to the wall behind a resident's bed (room [ROOM NUMBER]B) for 2 of 4 rooms on 1 of 3 halls (100 hall) reviewed for a safe, clean and homelike environment. Findings included: 1. On 2/23/2025 at 10:39 am the wall beside the bed in room [ROOM NUMBER]A had two 4-centimeters by 3-centimeters dried, dark brown stains. During observations on 2/24/2025 at 9:59 am and on 2/25/25 at 8:57 am the two 4-centimeters by 3-centimeters dried, dark brown stains remained on the wall beside the bed in room [ROOM NUMBER]A. On 2/25/2025 at 9:18 am Nurse Aide #2 was interviewed, and she stated she was assigned to room [ROOM NUMBER]A and housekeeping was responsible for cleaning the walls. Nurse #1 was interviewed on 2/25/2025 at 9:00 am and she stated room [ROOM NUMBER]A was on her assignment but had not noticed the two dried, dark brown stains to his wall. Nurse #1 stated housekeeping was responsible for cleaning the walls in the room. During an interview with Housekeeper #1 on 2/25/2025 at 9:12 am she stated the two 4- centimeters by 3-centimeters dried, dark brown stains on the wall beside the bed in room [ROOM NUMBER]A was dried stool. Housekeeper #1 stated she had the same assignment on 2/24/2025 and did not notice the stains on the wall beside the bed but housekeeping cleaned the walls twice a week in the residents' rooms. The Administrator was interviewed on 2/26/2025 at 9:15 am and she stated she was not aware of the two dried, dark brown stains on the wall beside his bed in room [ROOM NUMBER]A. She stated the walls should be washed daily when housekeeping completed the daily room cleaning and as needed. 2. On 2/23/2025 at 10:44 am an observation of room [ROOM NUMBER]B revealed the call light panel, which was above the head of the resident's bed, was detached from the wall and protruded 1 inch. The panel had a thick amount of caulk around the outer edges of the panel that was broken and the wiring to the panel was visible. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/2025 at 9:23 am an observation was made of room [ROOM NUMBER]B and the call light panel at the head of the bed continued to protrude from the wall 1-inch and the thick caulk around the edges of the call light panel and the caulk had broken away in areas. The wiring to the panel was visible. The resident in room [ROOM NUMBER]B stated she was afraid the panel would eventually fall out of the wall. During an interview with the Maintenance Director on 2/26/2025 at 8:59 am he stated he came to work at the facility about one month ago. He stated he had not been aware the call light panel in room [ROOM NUMBER]B was protruding from the wall, and it looked like someone had tried to repair around the panel by filling the area between the wall and the panel with caulk instead of fixing the panel flush with the wall. The Maintenance Director stated the protruded call light panel was not a danger to the resident. The Administrator was present during the observation and interview with the Maintenance Director on 2/26/2025 at 8:59 am and was then interviewed on 2/26/2025 at 9:02 am and stated they had fixed a lot of maintenance issues since she came to the facility a month ago and she was not aware the call light panel in room [ROOM NUMBER]B was protruding from the wall. The Administrator stated she was in room [ROOM NUMBER]B on 2/22/2025 and the call light panel was not protruding from the wall that day. The Administrator stated the call light panel should be attached to the wall and they would get it fixed immediately.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on observations, staff interviews, and record review, the facility failed to keep a urinary catheter bag and its tubing from touching the floor to reduce the risk of infection for 1 of 3 residents (Resident #55) reviewed with a urinary catheter. The findings included: Resident #55 was admitted to the facility on [DATE]. Her cumulative diagnoses included obstructive uropathy (a condition where the flow of urine is blocked, leading to a buildup of urine in the urinary tract). Resident #55's care plan included an area of focus related to the resident having an indwelling urinary catheter in place (Initiated on 2/6/25). An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had moderately impaired cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #55 required supervision or touching assistance for eating and personal hygiene; partial to moderate assistance for sit to stand and chair/bed to chair transfers; and substantial to maximum assistance for toileting, bathing, dressing and bed mobility. The MDS reported Resident #55 had an indwelling urinary catheter. An observation was conducted on 2/24/25 at 10:20 AM as Resident #55 was sitting in her wheelchair with a urinary catheter collection bag hanging from her wheelchair. At the time of this observation, 1 inch of the bottom of Resident #55's urinary catheter bag and approximately 2 inches of the catheter tubing were lying on the floor. The resident appeared confused at the time of the observation and could not provide any information regarding her urinary catheter. Another observation was conducted of Resident #55 on 2/26/25 at 8:20 AM as she laid in her bed with the head of the bed raised and her breakfast meal placed on the bedside tray table in front of her. One-half (1/2) of the resident's urinary catheter bag and approximately four (4) inches of the catheter tubing was observed to be lying on the floor. On 2/26/25 at 8:25 AM, Nurse Aide (NA) #1 was identified as the NA who was assigned to care for Resident #55. Accompanied by the NA to Resident #55's room, another observation was made of the resident's catheter bag and tubing lying on the floor. When NA #1 was asked what her thoughts were with regards to the position of the catheter bag and tubing, the NA stated, It shouldn't be on the floor. The NA was observed to wash her hands and don gloves as she prepared to address the positioning of the catheter bag and tubing. Upon her request, an interview was conducted on 2/26/25 at 8:53 AM with the facility's Director of Nursing (DON). The DON stated she was made aware of the concerns related to Resident #55's urinary catheter bag and tubing having been on the floor. She reported that the entire catheter bag and tubing system was replaced this morning since they had been observed to be lying on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/26/25 at 2:45 PM with the facility's Infection Preventionist. During the interview, the Infection Preventionist reported NA #1 told her about Resident #55's catheter bag and tubing found lying on the floor earlier that morning. The Infection Preventionist stated that because of this observation, she went ahead and changed the whole system. She stated that changing the system, brought it [the catheter bag] up and off the floor. When asked if the catheter bag and tubing should be on the floor, she reported they should not.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38904 Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 9 of 91 days reviewed for sufficient nurse staffing (September 2024, October 2024, November 2024). Findings included: Review of the facility's Posted Nurse Staffing for September of 2024 revealed there was not a Registered Nurse scheduled for at least 8 hours a day on September 6, 2024, September 7, 2024, September 21, 2024, and September 22, 2024. The Posted Nurse Staffing for October 2024 was reviewed and there was not a Registered Nurse scheduled for at least 8 hours a day on October 6, 2024 and October 20, 2024. The November Posted Nurse Staffing was also reviewed and there was not a Registered Nurse scheduled for at least 8 hours daily for November 3, 2024, November 16, 2024, and November 17, 2024. During an interview with the Director of Nursing on 2/25/2025 at 1:19 pm she stated she was responsible for the nurse staffing schedule in September 2024, October 2024, and November 2024. The Director of Nursing stated there was a staffing issue during those months and she was aware there was not a Registered Nurse in the facility for 8 hours on the dates in September 2024, October 2024, and November 2024. The Director of Nursing stated they had initiated a plan of correction for the scheduling of a Registered Nurse for 8 hours daily. The Administrator was interviewed on 2/26/2025 at 3:19 pm and she stated she expected nursing to have a Registered Nurse in the building 8 hours a day every day. The Administrator stated she was not the Administrator during September 2024, October 2024, and November 2024 but had reviewed the Plan of Correction initiated during that time.