

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

PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2011
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NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406
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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews the facility failed to provide supervision for a dependent resident who was at high risk for falls. This was evident for 1 of 3 residents in the sample reviewed for falls. (Resident #1)</p> <p>Findings included:</p> <p>Resident # 1 was admitted to the facility on 9/6/11 with cumulative diagnosis which included advanced Alzheimer's. According to the MDS (minimum data set) dated 10/18/11 revealed Resident #1 had impaired cognition for daily decision making and was totally dependent on the staff for all activities of daily living (ADL). Resident#1 was also dependent on staff for mobility and transfers into and out of the bed or chair.</p> <p>Review of the Initial Falls Assessment dated 9/17/11 Resident #1 was a falls risk and required constant supervision.</p> <p>Review of the care plan initiated on 9/17/11 and</p>	F 323	<p>Maple Grove acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Maple Grove reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p>F323 Resident #1 will have care plan interventions followed by staff. Staff was re-inserviced October 25, 2011 on the care plan intervention "to place the resident behind the nursing station for close monitoring." A note was also left at the nursing station reminding staff of this care plan intervention.</p> <p>Resident #1's care plan was reviewed on November 9, 2011 to ensure that all fall interventions were being followed; and the care guide was updated. Resident #1 is now going to the SPARKS unit during the day where she can be monitored closely and still be involved in social activities</p> <p>In-services were completed on December 7, 2011 for all direct care staff on fall prevention and interventions by the Director of Nursing. This in-service included the importance of checking the resident care guide daily so that they are aware of new fall interventions.</p>	10/25/11 11/9/11 12/7/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dorinda M. Pate	TITLE Administrator	(X6) DATE 12-7-11
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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.

M.J. P.B. X

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F 323	Continued From page 1 updated on 10/06/11 in part revealed: a risk for recurrent falls characterized by a history of falls related to impaired balance, impaired mobility, unsteady gait, impaired cognition. The goals included the resident will remain free from injury as evidenced by no recurrent falls or accidents. The interventions in part included: falls risk protocol, provide close supervision as needed by placing the resident at the nurses' station. During a tour of the facility on 11/09/11 at 11:40 AM Resident #1 was observed sitting behind the nurses' station. She was noted to have a scab on her left forehead. An interview with social worker (SW) on 11/09/11 at 11:42 AM revealed Resident #1 had a fall on 10/22/11 and since then she has been placed at the nurses' station when she is out of bed. An observation on 11/09/11 at 11:50 AM of the nurses' station revealed instructions which included in part; DO NOT put [Resident #1] in the dayroom. She is to sit behind the nurses' station when she is not being directly supervised. On 11/09/11 at 12 noon an interview with the DON (director of nursing) revealed after the 9/30/11 fall, she placed this notice at the nurses' station for all the staff to be aware that Resident#1 was to be directly supervised when out of bed. The DON indicated Resident #1 fidgets in her wheelchair and tries to reach down, touch her feet or pick things up off the floor. The NA (nursing assistants) knows the care needs of the resident by using the Kardex (a document used to individual the resident's care needs) located in the resident's closet. A review Resident#1's Kardex revealed no notation that the resident was to be placed at the nurses' station or that the resident required supervision. During an interview with the DON on 11/09/11 at	F 323	Resident Care guides were audited 100% to ensure that they were accurate and the most recent interventions are reflected on the care guide. These audits were completed November 18, 2011 by the Corporate Nurse Consultants, Director of Nursing, Assistant Director of Nursing, and Quality Improvement Nurse. The MDS Nurse will notify the Quality Improvement Nurse in writing whenever there is a change in fall interventions during assessments so that the care guide can be updated. Care plans for residents with falls or residents noted to be at risk for falls will be updated as needed and those resident care guides will also be updated if needed at that time by the Quality Improvement Nurse The Quality Improvement Nurse will audit care guides weekly x4, and then monthly x2 utilizing a QI tool to ensure that interventions have been added appropriately. Results of the audits will be discussed with the Care Plan Quality Improvement Team on December 7, 2011 and at the Quarterly Quality Improvement Committee meetings. The Administrator is responsible for ensuring that action is taken if potential concerns are identified	11/18/11 12/7/11 + ongoing 12/7/11 + ongoing 11/21/11 + ongoing 12/7/11 + ongoing	

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F 323	<p>Continued From page 2</p> <p>6:30 PM revealed she placed the note at the nurses ' station after Resident #1 fell in September. The information was also placed on her care plan and the staff should be reviewing the care plan. I should have written it on the care guide which is on the resident ' s closet door. This is where the NAs look to see what care the resident ' s need. "</p> <p>A review of Nurses ' Note (NN) dated 9/30/11 at 7:30 PM revealed the resident was found on the floor in dayroom.</p> <p>A review of the incident report revealed on 9/30/11at 9:30 PM completed by Nurse #1 revealed Resident #1 was observed lying on the floor next to her wheelchair in the dayroom. She was assessed to have no injuries.</p> <p>A review of the NN dated 10/5/11 at 4:27 PM revealed Resident #1 was observed sitting on the floor in front of her wheelchair. There was a 2 cm (centimeter) red area noted to the right side of the resident ' s back. The resident was placed at the nurses ' station for direct supervision.</p> <p>A review of the incident report dated 10/05/11 at 4:18 PM revealed the resident was observed sitting on the floor in front of her wheelchair. The resident was unable to give a description of the incident. It was noted she was disoriented. The nurse ' s statement read in part: " resident observed sitting on floor in front of her wheelchair. There was a red area 2 cm in length on the right side of her back. "</p> <p>Review of the OT (occupational therapy) notes dated 10/12/11 revealed impaired sitting balance, reaching for objects and repetitive movements. The OT noted Resident#1 to be non compliant</p>	F 323			

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F 323	<p>Continued From page 3 with instructions by staff.</p> <p>A review of NN dated 10/22/11 at 11:07 PM completed by Nurse #1 revealed the resident was found on the floor in the dayroom by NA #1. The resident was assessed to have an abrasion to her left forehead. Resident #1 was then placed in front of the nurses ' station.</p> <p>A review of incident report dated 10/22/11 at 7:50 PM revealed the resident was noted lying on the floor next to her wheelchair in the day room by NA #1. The resident was assessed to have an abrasion on the left side of her forehead, and no other apparent injuries. The resident was assisted back to her wheelchair and placed in front of nurses ' station.</p> <p>A telephone interview with Nurse #1 on 11/09/11 at 3:58 PM revealed the fall on 10/22/11 occurred during the change of shift around 7PM. NA #1 was walking done hall and called out " I need help; there is a lady on the floor. " Resident #1 was on the floor in the dayroom, lying face down. She had an abrasion on her left side across her forehead. Resident #1 was confused, and stated "I don ' t know what happened". Nurse #1 stated " I assessed her and we put her back in her wheelchair. We then placed her at the at nurses ' station. " She further stated " I am not sure what staff member put her in the dayroom. " Nurse # 1 indicated she was aware of the notice posted at the nursing station indicating the required supervision for Resident#1.</p> <p>During a telephone interview with Nurse #2 on 11/09/11 at 4:10 PM revealed on 10/22/11, Resident #1 was in the dayroom during change of shift with other residents but no staff. Nurse#2 indicated that NA #1 called out that Resident#1</p>	F 323			

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F 323	Continued From page 4 was on the floor in the dayroom. Nurse # 2 revealed that she was not aware of any postings, special instructions or care needs for this resident. She further stated that Resident # 1 had impaired sitting balance, but the staff was able to see her when they passed by the day room. During an interview with NA #1 on 11/09/11 at 3:50 PM (who worked 3p-11p on 10/22/11) revealed she saw Resident #1 was on the floor in the dayroom and she told Nurse #1. NA # 1 indicated she was not aware this resident was not to be placed in the dayroom unsupervised. She continued that Resident #1 was always in the dayroom when she was out of bed and always leaned over to try to pick things up on the floor even though there was nothing on the floor. During a telephone interview with at NA # 2 on 11/09/11 at 4:22 PM (who cared for this resident on 10/22/11) revealed Resident #1 required total care and had a special cushion in her chair with a 1/2 tray on her wheelchair. During a telephone interview on 11/09/11 at 4:47 PM with NA # 3 revealed that she cared for this resident and she required total care from staff. She continued that the (NAs) were told by the DON to place the resident at the nurses ' station. She further stated she remembers an in-service about a month ago indicating not to place the resident in the dayroom unsupervised but did not remember the posted note placed at the nurses ' station. A telephone interview with NA #4 on 11/09/11 at 5:12 PM (she was assigned to Resident #1 on 10/22/11) revealed she did not remember who put Resident #1 in the dayroom that day. She continued to indicate that the staff is not to leave Resident #1 in the dayroom unsupervised, but to	F 323			

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F 323	Continued From page 5 place her behind the nurses ' station when she is out of bed. NA#4 indicated the DON posted a note at the nursing station indicating these instructions. During an interview with Nurse #3 on 11/09/11 at 5:22 PM revealed she held a quick meeting with her NA regarding the DON ' s posted notice to inform them of the intervention for Resident #1 ' s safety.	F 323			