STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the attending physician when the prescribed pain relief medication was	F 157	Maple Grove Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	3/3/15

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

Electronically Signed | 02/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157	Continued From page 1 not effective and Resident #4 continued with complaints of pain. This was evident in 1 of 3 sampled residents where notification of physician was reviewed. Findings included: The facility has a policy titled " Notification of Changes " dated 1/2009 that read in part: The facility will inform the resident ' s physician when there is a need to alter treatment or to commence a new treatment. Resident #4 was originally admitted to the facility on 9/11/14 via Hospice for respite care and discharged to home on 9/16/14. On 11/7/14 Resident #4 was readmitted to the facility after a hospitalization with cumulative diagnoses which included acute encephalopathy, chronic systolic and diastolic heart failure and failure to thrive. At this time the resident was not participating in Hospice. Review of the hospital discharge summary (undated) revealed Resident #4 was taken off of Morphine, hydrated with improvement of her mental status. The hospital summary indicated prior to this hospitalization, Morphine dosages had been increased by the community Hospice staff and increasing lethargy and poor intake occurred. The family requested Morphine be discontinued because they believed this caused severe confusion to Resident # 4. Review of the admission physician ' s note dated 11/1/14 revealed resident with osteoarthritis, lumbar spondylosis with known history of hip and low back pain. Review of the admission Minimum Data Set assessment dated 11/14/14 revealed Resident #4 was able to make her needs known with the ability to understand others. Resident # 4 had some impaired cognition and required extensive	F 157	this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Defienciees through Informal Dispute resolution, formal appeal procedure and / or any other administrative or legal proceedings. Resident #4 was discharged from the facility on November 24,2014. 2.100% audit of all residents initiated 02/06/15 and completed on 02/09/15 by DON, ADON, QI Nurse, and Staff Facilitator to assess all residents for pain utilizing Pain Assessment Tool for documentation of signs and symptoms of pain. The MD was immediately notified of all residents having breakthrough pain and ineffective pain management by the ADONs. PCC Dash Board will be reviewed daily by ADONs . This is to ensure MD/RP notification was completed by the hall nurse for all residents noted with breakthrough pain, new pain, or ineffective pain management.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157	Continued From page 2 assistance from staff for the completion of activities of daily living (ADL). Review of the 11/7/14 admission physician orders revealed the attending physician approved the hospital discharge orders which included Tramadol 37.5-mg/acetaminophen 325-mg combination tablets (also refer as Ultracet) by mouth (po) one (1) every 6 hours as needed for pain. Review of the " Pain management assessment form for residents unable to self-report " dated 11/7/14 at 11:25 PM and authored by Nurse #1 revealed Resident #4 with moderate pain. Grimacing was noted as the behavior exhibited by the Resident #4 that may be indicative of pain. Continued record review revealed the origin of the resident ' s pain was sometimes the legs and most times unable to ascertain the location. Review of the nurses ' progress notes revealed: On 11/13/14 at 12:25 PM Resident #4 complained of (c/o) pain and Ultracet was provided. There was no documentation of the effectiveness of the medication. On 11/17/14 at 10:54 PM Nurse #1 authored Resident #4 appeared to be in a lot of pain this shift. Resident #4 was medicated with Ultracet at 3:45 PM and 5 PM when awakened to check the oxygen level. " She [referring to Resident #4] instantly began to cry. I asked her if she was in pain and she nodded her head. " There was no indication that additional measures to relieve pain was implemented. On 11/18/14 at 8:17 PM Nurse #1 authored Resident #4 intermittently yelled out in apparent pain. She also cried when moved for ADL. Ultracet given for pain. Results not positive. " MD (Medical Doctor) notified of situation. " There was no indication a physician follow-up occurred.	F 157	100% in-service initiated by the weekend manager and the administrator on 02/07/15 and was completed by 02/09/15 by the DON with all CNA□s and therapy staff regarding reporting to hall nurse, signs and symptoms of pain. CNA□ All newly hired CNA□s and therapy staff will be in-serviced by Staff Facilitator upon hire in orientation on reporting to hall nurse signs and symptoms of pain. 100% in-service initiated by the Director of Nursing and completed 02/09/25 by DON with Licensed Nurses regarding assessment of pain to include pain and notification to MD of new signs and symptoms of pain and/or ineffective pain management. All newly hired Licensed Nurses will be in-serviced upon hire in orientation by Staff Facilitator regarding assessment of pain and notification to MD of new signs and symptoms of pain and/or ineffective pain management. Charges nurses will review and report to oncoming shifts any change of condition to include onset new pain or ineffective current pain management. 3. All resident progress notes, Pain Alerts, Behavior Documentation, and incident reports will be monitored by ADON, QI nurse, Treatment Nurse, MDS Coordinator, and MDS Nurse utilizing Pain Audit Tool to ensure all residents identified with new signs and symptoms of pain and/or ineffective pain management and has been assessed by the hall nurses,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157	Continued From page 3 On 11/19/14 at 1:46 AM Nurse #2 authored Resident #4 will burst into tears and when asked why she was crying she was unable to give the reason. There was no facial grimacing " will continue to monitor. " Review of the Medication administration Record revealed by 11/19/14 at 10 AM Ultracet given for pain but no indication of the effectiveness or response to the pain medication. Review of the attending physician ' s progress notes dated 11/20/14 emailed on 02/09/2015 at 5:07 PM revealed the " patient appears to be alert and crying without reason. Does not complaint of pain. Drooling. Did not recognize me but does not answer questions. " The plan revealed orders written for Rocephin (an antibiotic), push fluids, discontinue " Toradol and place patient on Hydrocodone APAP 5/325 mg every 6 hours. " However, further review of the resident ' s medical record confirmed that Toradol was not ordered until 11/24/14. On 11/20/14 at 11:11 PM Nurse #1 authored Resident#4 yelled out in apparent pain. New orders were obtained to discontinue Ultracet and start Hydrocodone Bitartrate 5 mg and acetaminophen 325 mg tablets po (Norco) every 6 hours prn. Norco is an opioid used to relieve moderate to severe pain. This note further stated Resident #4 was spitting out her fluids and spit out her pain medication. Interview with Nurse #1 on 2/06/15 at 3:10 PM revealed " I know I notified him (referring to the physician). " Nurse #1 indicated she was unaware of dates and the physician was called or whether the physician called back. Interview on 2/6/15 at 5:10 PM with Nurse #1 revealed " I tried to give her the PRN (as needed) Norco, but she couldn ' t swallow. I gave her Tylenol Suppository for her fever, but it did not affect her pain; she was still moaning. Nurse #1	F 157	intervened, and MD/RP notified. All identified areas of concern were corrected by DON and ADON. Pain Audit Tool will be completed 5 x week x 4 weeks, 3 x week x 4 weeks, then weekly x 4 weeks by QI Nurse, Staff Facilitator, Treatment Nurse, MDS Coordinator, and MDS Nurse. Pain Audit Tool will be monitored for completion by Administrator, DON, or ADON 2 x week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month utilizing QI Tool for New Signs of Pain and/or Ineffective Pain Management. 4.The QI committee will review the results of the audits at weekly QI meeting for identification of potential issues with follow up taken as deemed appropriate and to determine the continued need and frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157	Continued From page 4	F 157		

indicated she had not notified the attending physician. . She had pain on movement, and we had to move her every two hours or more frequent. I knew when she was in pain because of her facial grimacing and her moaning. I did not request the assistance of my supervisor. "
On 11/21/14 at 6:56 AM Nurse #2 indicated Resident #4 burst into tears and was groaning. The resident spit out her medications when administered. The responsible party was notified but no indication that the attending physician was notified. Interview on 2/6/15 at 10:12 AM via the phone with Nurse #2 revealed he remembered the resident well. Did not remember calling the attending physician about her pain management
On 11/22/14 at 12:02 AM Nurse #2 indicated the resident usually moans when turned and repositioned.
On 11/22/14 at 6:50 PM Resident #4 was moaning in pain when moved or during incontinent care. Tylenol suppository was administered for an elevated temperature of 101 degrees Fahrenheit. Resident #4 did not eat or drink. No indication that he attending physician was notified.
On 11/23/14 4:38 AM authored by Nurse #3 revealed Resident #4 was lethargic and moaned in pain upon any movement. Norco was administered but resident could not swallow. The RP was notified and requested liquid pain medication due to resident ' s refusal. MD notified by writing in the doctor ' s book (MD) located at the facility. Interview on 2/6/15 at 5:10 PM with Nurse #3 revealed the off going nurse (could not remember the nurse) called the physician and he did not respond. Because he did not call back, I decided to put it in the communication book. Continued interview with Nurse #3 revealed she tried to administer Norco,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157	Continued From page 5 but Resident #4 couldn ' t swallow. Nurse #3 indicated she gave a Tylenol Suppository for a fever, but it did not affect her pain. Resident #4 was still moaning with pain when moved by staff every two hours or more frequent. Further interview revealed she knew when Resident #4 was in pain because of her facial grimacing and her moaning. " I did not request the assistance of my supervisor " Record review revealed no indication that the attending physician was aware of the information written in the MD book or if the facility attempted to call the physician regarding the lack of effectiveness of the pain medication and spitting out her medications. There was no indication that the medical director was notified. On 11/23/14 at 8:28 PM Situation Background Assessment Planning (SBAR) and progress note authored by Nurse #4 revealed Resident #4 was not eating or drinking, spitting out medications and not communicating as normal. The note continued to indicate under the column labeled family concerns revealed a reconsidered for Hospice Care and other measures for comfort. A call was made to the physician ' s answering machine. No indication that the physician returned the call or that the medical director was contacted. On 11/24/14 12:30 AM Nurse #3 indicated Resident #4 moans in pain upon movement. Norco given at 11:30 PM with little effect. By 11/24 at 12:15 PM the MD communicated with the facility and prescribed Toradol 30 mg every 6 hours for 24 hours. Toradol is in a group of drugs called nonsteroidal anti-inflammatory drugs (NSAIDs). It works by reducing hormones that cause inflammation and pain in the body. Toradol is used short-term (5 days or less) to treat moderate to severe pain.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157	Continued From page 6 On 11/24/14 at 2:16 PM Resident #4 was transferred to the hospital and admitted to the Hospice program. Interview on 2/6/15 at 4 PM with the administrator and director of nurses (DON) was held. The DON indicated her expectations were staff to follow the policy for notification, not to use the MD notebook but to contact the physician directly.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and physician interviews the facility failed to conduct ongoing assessments for the severity of pain and failed to provide effective pain management for 1 of 2 sampled residents reviewed for pain management (Resident #4). Findings included: Review of the assessment form titled " Pain management log for the resident unable to self-report [PMLRUSR] and Pain management log for the resident able to self-report [PMLRASR] revised 1/28/2008 " revealed: · Facial gestures that indicated the degree of pain on a scale from 0 (with no pain) to 10 (unbearable pain). · Rate of the resident ' s sedation.	F 309	Maple Grove Health and Rehabilitation Center 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 the applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple	3/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 309	Continued From page 7 · Date/Time · Possible pain behaviors · Medicine or Non -drug pain control method · Results · Possible behaviors indicating pain relief, side effects. · Respiratory rate. There were no instructions provided with this form by the Director of Nurses (DON). Resident #4 was originally admitted to the facility on 9/11/14 via Hospice for respite care and discharged to home on 9/16/14. On 11/7/14 Resident #4 was readmitted to the facility after a hospitalization with cumulative diagnoses which included acute encephalopathy, chronic systolic and diastolic heart failure and failure to thrive. At this time the resident was not participating in Hospice. Review of the hospital discharge summary (undated) revealed Resident #4 was taken off of Morphine, hydrated with improvement of her mental status. The hospital summary indicated prior to this hospitalization, Morphine dosages had been increased by the community Hospice staff and increasing lethargy and poor intake occurred. The family requested Morphine be discontinued because they believed this caused severe confusion to Resident # 4. Review of the admission physician ' s note dated 11/1/14 revealed resident with osteoarthritis, lumbar spondylosis with known history of hip and low back pain. Review of the admission Minimum Data Set assessment dated 11/14/14 revealed Resident #4 was able to make her needs known with the ability to understand others. Resident # 4 had some impaired cognition and required extensive assistance from staff for the completion of activities of daily living (ADL).	F 309	Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Defienciees through Informal Dispute resolution, formal appeal procedure and / or any other administrative or legal proceedings. F- 309 Resident #4 assessed on 11/24/14 by DON, MD notified of assessment and new order received for alternative pain medication. The Physician called the facility shortly after new order was given for Torodol and gave an order to send resident to ER for further evaluation. Resident #4 not present at time of survey. A 100% audit of all residents initiated 2/6/2015 and completed on 2/9/2015 by the DON , ADON, Qi nurse and Staff Facilitator to assess all residents for pain utilizing Pain Assessment Tool for documentation of signs and symptom's of pain. The physician was immediately notified all residents having breakthrough pain and ineffective pain management by the ADON's. Point Click Care dashboard will be reviewed daily by the DON, ADON's and QI nurse This is to ensure MD/RP notification was completed by the hall nurse for all residents noted with breakthrough pain, new pain, or ineffective pain management. A 100 % in service initiated by the Weekend manager and the Administrator on 2/7/2015 and was completed on 2/9/15 by the DON with all C.N.A.'s and therapy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 309	Continued From page 8 Record review revealed no care plan had been developed. Review of the 11/7/14 admission physician orders revealed the attending physician approved the hospital discharge orders which included Tramadol 37.5-mg/acetaminophen 325-mg combination tablets (also refer as Ultracet) by mouth (po) one (1) every 6 hours as needed for pain. Review of the " Pain management assessment form for residents unable to self-report " dated 11/7/14 at 11:25 PM and authored by Nurse #1 revealed Resident #4 with moderate pain. Grimacing was noted as the behavior exhibited by the Resident #4 that may be indicative of pain. Continued record review revealed the origin of the resident ' s pain was sometimes the legs and most times unable to ascertain the location. Review of the nurses ' progress notes revealed: On 11/13/14 at 12:25 PM Resident #4 complained of (c/o) pain and Ultracet was provided. There was no documentation of the effectiveness of the medication. On 11/17/14 at 10:54 PM Nurse #1 authored Resident #4 appeared to be in a lot of pain this shift. Resident #4 was medicated with Ultracet at 3:45 PM and 5 PM when awakened to check the oxygen level. " She [referring to Resident #4] instantly began to cry. I asked her if she was in pain and she nodded her head. " There was no indication that additional measures to relieve pain was implemented. On 11/18/14 at 8:17 PM Nurse #1 authored Resident #4 intermittently yelled out in apparent pain. She also cried when moved for ADL. Ultracet given for pain. Results not positive. " MD (Medical Doctor) notified of situation. " There was no indication a physician follow-up occurred.	F 309	staff regarding reporting to hall nurse signs and symptoms of pain. All newly hires hired C.N.A'S and therapy staff will be in-serviced by Staff Facilitator upon hire in orientation on reporting to hall nurse signs and symptoms of pain. A 100 % in-service initiated by the Director of Nursing and completed 2/9/15 by DON with Licensed Nurses regarding assessments of pain to include pain and notification to MD of new signs and symptoms of pain and / or ineffective pain management. Licensed nurses will be in serviced upon hire in orientation by Staff Facilitator regarding assessment of pain and notification to the MD of new signs and symptoms of pan and/ or ineffective pain management. All residents progress notes, Pain Alerts, Behavior Documentation and incident reports will be monitored by DON, ADON's and QI nurse utilizing Pain Audit Tool to ensure all residents identified with new signs and symptoms of pain and / or ineffective pain management has been assessed by he hall nurses, intervened, and MD/RP notified. All identified areas of concern were corrected by DON and ADON's. Pain Audit Tool will be completed 5 X week for 4 weeks, 3 X week X 4 weeks, then weekly X4 weeks then monthly X 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 309	Continued From page 9 On 11/19/14 at 1:46 AM Nurse #2 authored Resident #4 will burst into tears and when asked why she was crying she was unable to give the reason. There was no facial grimacing " will continue to monitor. " Review of the Medication Administration Record revealed by 11/19/14 at 10 AM Ultracet given for pain but no indication of the effectiveness or response to the pain medication. On 11/20/14 at 11:11 PM Nurse #1 authored Resident #4 yelled out in apparent pain. New orders were obtained to discontinue Ultracet and start Hydrocodone Bitartrate 5 mg and Acetaminophen 325 mg tablets po (Norco) every 6 hours prn. Norco is an opioid used to relieve moderate to severe pain. This note further stated Resident #4 was spitting out her fluids and spit out her pain medication. On 11/21/14 at 6:56 AM Nurse #2 indicated Resident #4 burst into tears and was groaning. The resident spit out her medications when administered. On 11/22/14 at 12:02 AM Nurse #2 indicated the resident usually moans when turned and repositioned. On 11/22/14 at 6:50 PM Resident #4 was moaning in pain when moved or during incontinent care. Tylenol suppository was administered for an elevated temperature of 101 degrees Fahrenheit. Resident #4 did not eat or drink. On 11/23/14 4:38 AM authored by Nurse #3 revealed Resident #4 was lethargic and moaned in pain upon any movement. Norco was administered but resident could not swallow. The RP was notified and requested liquid pain medication due to resident ' s refusal. MD notified in DR book. Will continue to monitor. There was no indication of monitoring until 11/23/14 at 9 AM when Norco was administered.	F 309	months by QI nurse, Staff Facilitator.. Pain Audit Tool will be monitored for completion by the Administrator, DON or ADON's2 X week for 4 weeks, then weekIX4 weeks, then monthly X 4 month utilizing QI Tool for New Signs and / or ineffective Pain Management . The QI Committee including the consultant pharmacist will review the results of the audits at weekly QI meeting for identification of ineffective pain management and need for further intervention from the consultant pharmacist for recommendations and for further the MD intervention.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 309	Continued From page 10	F 309		

There was no indication that an order was received for liquid pain medication.
On 11/23/14 at 8:28 PM Situation Background Assessment Planning (SBAR) and progress note was written by Nurse #4 revealed Resident#4 was not eating or drinking, spitting out medications and not communicating as normal. The note continued to indicate under the column labeled family concerns revealed a reconsidered for Hospice Care and other measures for comfort.
On 11/24/14 at 12:30 AM Nurse #3 indicated Resident #4 moans in pain upon movement. Norco given at 11:30 PM with little effect.
On 11/24/14 at 12:15 PM the MD returned a call and a new order was received for Toradol 30 mg every 6 hours for 24 hours. Toradol is in a group of drugs called nonsteroidal anti-inflammatory drugs (NSAIDs). It works by reducing hormones that cause inflammation and pain in the body. Toradol is used short-term (5 days or less) to treat moderate to severe pain.
Record review revealed the PMLRUSR and the PMLRASR form was not used for Resident #4. The resident was transferred at 2:16 PM on 11/24/14 to the hospital and admitted to a Hospice program.
Interview on 2/6/15 at 10:12 AM via the phone with Nurse #2 revealed he remembered the resident well. Resident # 4 had difficulty expressing her needs. " She would have expressions on her face as if in pain especially when she was moved. " When asked about the pain protocol of the facility and how he accurately assessed the resident ' s pain he replied " could tell by her facial grimacing that she was in pain. " Nurse #2 indicated he did not have to administer pain medication during his shift.
Interview on 2/6/15 at 10:22 AM with Nurse #1 via

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 309	Continued From page 11	F 309		

the phone revealed Resident #4 on initial admission to the facility could verbalize freely when she was in pain. Continued interview indicated when medication for pain was given it was not effective. Nurse #1 indicated on the occasion when the pain medication helped it would not last (no determined time). Further interview with Nurse #1 revealed the pain medications became less effective and did not control her pain at all. " When the resident became unable to verbalize her thoughts I would look at her facial gestures. "

Interview on 2/6/15 at 2:13PM with the attending physician revealed he was familiar with the resident for years and did not believe the resident was pain but a behavior response due to a declining mental status. An inquiry was made about why pain medication was prescribed the attending physician indicated he ordered these medications in response to the family.

Interview on 2/6/15 at 5:10 PM with Nurse #3 revealed " I tried to give her the PRN (as needed) Norco, but she couldn ' t swallow. I gave her Tylenol Suppository for her fever, but it did not affect her pain; she was still moaning. She had pain on movement, and we had to move her every two hours or more frequent. I knew when she was in pain because of her facial grimacing and her moaning. I did not request the assistance of my supervisor. "

Interview on 2/6/15 at 4 PM with the administrator and DON was held. The DON indicated her expectation was staff to complete the PMLRUSR or the PMLRASR form and to have residents pain free and comfortable.

At the end of the exit conference held on 2/6/15 at 6:55 PM (attended by the administrator, DON and corporate representative), the DON indicated she had developed an action plan to address pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 309	Continued From page 12 management but was unable to locate the plan. On 2/6/15 at 7:15 PM, the DON confirmed she was not able to locate her action plan.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide nail care to 1 of 5 sampled residents reviewed for activities of daily living (Resident #16). The findings included: Resident #16 was admitted to the facility on 02/24/2012 with diagnoses including dementia and cerebral vascular accident. An annual Minimum Data Set (MDS) dated 11/28/14 revealed Resident #16 had severely impaired cognition. The annual MDS further revealed Resident #16 required extensive assistance from staff for personal hygiene and bathing. A review of the " Visual/Bedside Individual Care Service Plan Report " form located inside of Resident ' s #16 closet revealed in part Resident #15 with targeted behaviors of resisting activities of daily living and total care for hygiene and grooming which included washing and drying hands.	F 312	Maple Grove Health and Rehabilitation Center 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 the applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Defienciees through Informal Dispute resolution, formal appeal procedure and / or any other administrative or legal proceedings.	3/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 312	Continued From page 13 Review of a nurse aide assignment book revealed Resident #16 received showers three times a week during the 11:00 PM to 7:00 AM. The last shower was noted to be given on 2/6/15. During an initial observation on 2/4/15 at 11:14 am revealed the resident ' s finger nails had an accumulation of a brown colored substance under his nails. Continued observation on 02/5/15 at 7:30 am revealed Resident #16 was sitting in chair at the nursing station. Resident #16 ' s finger nails had an accumulation of a brown colored substance under them. Observation on 2/5/15 at 11:30 am revealed Resident #16 ' s nails had an accumulation of dark brown colored substance. Observation on 2/6/14 at 9:55 am revealed resident was being wheeled in hallway by the Quality Assurance Nurse. Resident #15 ' s nails still had an accumulation of dark brown colored substance under them. Interview on 2/6/15 at 1:36 pm with Nursing Assistant #1 (NA) revealed the nursing assistant on the 3rd shift was responsible for nail care and his ADLS. NA #1 indicated she was responsibility for incontinence care and transferring Resident #16 to bed after lunch. Continued interview indicated staff knew how to care for residents by the instructions posted in their closet. Continued interview with NA #1 revealed the NA who showered Resident #15 on 3rd shift did not reported to her that the nails needed to be clean. NA #1 indicated Resident #15 loved to grasp his hands and pull away. Further interview with NA #1 revealed Resident #15 pulled away from her yesterday (referring to 2/5/15) but did not report to the nurse. Interview on 2/6/15 at 1:45 pm with Nurse #5 revealed the 11 PM-7 AM staff gives showers and	F 312	F - 312 Resident #16 nails were immediately cleaned and cut again by the QI nurse. Resident on nail care schedule for future nail cutting. A 100 % audit completed by DON, ADON's and QI nurse for all residents to ensure that their nails are clean and cur appropriately. Those resident found to be in need of nail care had their nails cleaned and cur on 2/6/15. Resident that refused to have their nails done were also identified and noted on care guide. Nail care schedule was developed for nails to be done on the residents scheduled shower days. Hands and nails will be cleaned before meals and after meals as needed. Nursing staff in-serviced initiated on 2/18/15 regarding proper nail care along with performing ADL care for residents. Staff were in serviced that nail care (cutting) will be done on the scheduled shower days. The QA tool for ADL's that is in the QA manual will be utilized by the administrative nurses and the administrative managers during rounds to ensure that ADL care is being provided appropriately. This tool will be monitored weekly X 8 weeks then weekly X 4 weeks , then every 2 weeks X 4 weeks then monthly X4 months . The QI tool will be reviewed by the QI Committee weekly X 8 weeks, then weekly X 4 weeks then every 2 weeks X 4 weeks then monthly X 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 312	Continued From page 14 transfers the resident out of bed for breakfast in the mornings. Nurse #5 indicated no staff person reported to her that Resident #15 resisted care during these last several days (referring to 2/4/15-2/6/15). Interview on 2/6/15 at 2:05 pm with the Assistant Director of Nurses revealed the responsibility was everyone ' s (referring to the nursing staff) responsibility to clean resident nails. Interview on 2/6/15 at 4 PM with the administrator and Director of Nurses was held. The DON indicated that she expected all staff to keep resident nails clean.	F 312	months to identify trends and any areas of concern. The Executive QI committee will review monthly .	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, interview with the consultant pharmacist and staff interviews the facility failed to be free from a significant medication error for 1 of 5 sampled residents reviewed for medication errors. An intermediate acting insulin was prepared to be administered instead of the correct dose of a rapid-acting insulin medication ordered. (Resident #15) The findings included: Resident #15 had cumulative diagnoses which included diabetes mellitus. Review of the physician orders for the February 2015 included Humalog 15 units (U)	F 333	Maple Grove Health and Rehabilitation Center 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 the applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any	3/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 333	Continued From page 15 subcutaneous (SQ) before each meal and inject 10 units additionally for a Capillary blood glucose (CBG) of 150 milligrams per deciliter (mg/dl) or more. Humalog is a rapid-acting insulin with an onset 15 to 20 minutes, peaking at 30 minutes to 2.5 hours with a duration effect of 3 to 6.5 hours. Review of the Medication Administration Record for February 2015 revealed the scheduled times for obtaining the CBG was 6:30 AM, 1:30 PM and 4:30 PM. The scheduled times for the administration of the Humalog was 8 am, 12 noon and 5 PM. Review of the " Weights and Vital Summary " form dated 2/5/2015 at 6:12 AM revealed Resident #15 CBG was 264 mg/dl. Observation on 2/5/15 at 8:15 am during the medication pass with Nurse #5 revealed Humulin N 25 U was drawn into a syringe and prepared to be administered to Resident #15 instead of the ordered Humalog 25 U until an inquiry was made. Humulin N is an intermediate acting insulin with an onset of 1-2 hours, a peak of 6-14 hours with a duration effect of up to 24 hours. Nurse #5 immediately spoke with the consultant pharmacist on site. The consultant pharmacist indicated during the interview Humalog and Humulin N were not the same drugs. The consultant pharmacist obtained a vial of Humalog from the backup stock located on the North wing. Nurse #5 then administered Humalog 25 units SQ. Interview during the medication pass with Nurse #5 revealed the pharmacy had not dispensed the Humalog so she obtained the Humulin N from the back-up. Interview on 2/6/15 at 4 PM with the administrator and Director of Nurses was held. The DON indicated that she expected her staff to follow the 5 rights for medication administration. The 5 rights were the right resident, the right drug, the	F 333	deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Defienciees through Informal Dispute resolution, formal appeal procedure and / or any other administrative or legal proceedings. F- 333 Humalog insulin was immediately obtained from the ED Kit for resident #15 by the Pharmacist. Humalog insulin was administered as ordered. Resident number # 15 orders were reviewed immediately to ensure that he was receiving the correct medication and that all orders were current for this resident and that the resident was receiving the medications as ordered by the physician, correct medication, correct dose, and correct route. Resident #15 Humalog insulin was obtained from back up pharmacy. The nurse that attempted to give the incorrect medication was immediately remove from the medication cart and reeducated on the 5 rights of medication administration. A 100% audit of all physician orders, medications carts was conducted to be sure that residents have the correct medications on hand. Any medications that were not in the facility were immediately ordered from the pharmacy. This audit was initiated on 02/05/15 and completed on 02/06/15. Medication pass audits were conducted using QI monitoring tool Medication pass audit with close emphasis on Right	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 333	Continued From page 16 right dose, the right route, and the right time.	F 333	Resident, Right medication and dose, Right time and frequency and Right route with nurses and medication aides. These audits were initiated on 02/05/15 and are currently ongoing. In-services conducted on medication administration, avoiding medication errors to include five rights of medication pass. In services also included making sure medications are ordered timely form the pharmacy. These in service was initiated 02/05/15 and completed on 02/09/15. QI monitoring tool will be utilized to monitor medication administration passes to ensure that medications are given correctly with emphasis on the administration of insulin. These medications passed were monitored Medication pass audits will be conducted daily x next 4 weeks then weekly x 4 weeks then as needed to assure that medications are given as ordered. The DON or /designee and QI nurse will monitor medication pass audits utilizing QI monitoring tools, Medication pass audits. The QI committee will review audits and make recommendations as needed. The results of the monitoring will be reviewed by the QI Committee including the a pharmacy consultant weekly x 4 weeks then every other week X 2 weeks ,then monthly X 4 months. The Executive Committee will review for evaluation of the action plan, trends, and determine the need for and/ or the frequency of continued QI monitoring monthly X 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	**308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406**

(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