| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345448 | A. BUILDING _____ B. WING _____ | C 04/07/2017 |

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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>There were no citations written as a result of the complaint survey ending 4/7/17. Event #VRWF11. | F 000 | | |
| F 247 SS=D | 483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE<br><br>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:<br><br>(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff, family member and resident interviews and record review the facility failed to notify the responsible party of a room change for Resident #147. This was evident in 1 of 1 resident reviewed for a room transfer.<br><br>Findings included:<br>Resident #147 was admitted to the facility on 9/29/16 with cumulative diagnoses which included Senile dementia with behavioral disturbances and diabetes.<br><br>Review of the quarterly MDS dated 1/5/17 revealed Resident was noted to be alert and oriented.<br><br>Review of the progress notes dated 10/3/16 10:13 PM revealed Resident #147 was transferred to another room on another hall but was not happy being transferred. The resident was noted crying and the social worker and medication technician tech returned the resident | F 247 | Maple Grove Health and Rehabilitation 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 is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Maple Grove Health and Rehabilitation 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 Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other | 5/8/17 |

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

Electronically Signed | 05/04/2017

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| F 247 | Continued From page 1<br>back to her previous room. The note continued to indicate the resident stated she needed to finish crying once she returned to her previous room.<br><br>Review of the progress notes dated 10/7/16 at 2:06 PM indicated the resident was alert with mild confusion and seemed to be very content in her original room with her roommate.<br><br>Interview on 04/05/2017 at 11:51 AM with the responsible party revealed the facility move their family member about 2 weeks after admission to the facility. Continued interview revealed she was not notified of the move until after her family member was relocated.<br><br>Interview on 04/06/2017 at 11:48 AM with the Social Worker (SW) (responsible for notifying the resident and the responsible party of transfers) revealed in the past (unable to provide a date), the responsible party requested the resident to be moved from the Resident's current unit. Continued interview with the SW revealed "I did not notify the responsible party or the resident" that we were going to move her to another unit/room that day."<br><br>Interview on 04/06/2017 at 3:34 PM with Resident #147 revealed she was unable to focus and could not recall the transfer or whether she was notified of the room transfer.. After further interviewing the resident recalled being transferred to another "building" and started crying when she spoke of other issues unrelated to the transfer.<br><br>Review of the medical record revealed no documentation to support the resident had been made aware of the move or the responsible party | F 247 | administrative or legal proceeding.<br><br>F □ 247<br>Resident # 147 required no intervention.<br><br>In serviced the social worker from the administrator on working with the interdisciplinary team to identify resident requiring a room change. Notification to resident and responsible party of resident being transferred and resident and responsible party of new roommate. Documentation of transfer and notification in point click care.<br><br>Social worker will prepare resident for change of room as soon as possible once identified. Give timely notice to the resident and family before a room change happens by telephone and document in the progress notes. Communicating the room change to facility staff with a locator slip. Monitoring the resident's adjustments to the new room.<br><br>Upon decision of room change, SW will notify responsible parties via telephone before the room changes occurs. Document communication in the progress notes. Use locator slip to effectively notify interdisciplinary team of care plan dates.<br><br>The medical records supervisor will monitor the transfer of residents, and notification of resident and responsible parties. Monitoring will be weekly X 8 weeks, then bi- monthly X 2 months, then | |

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| F 247 | Continued From page 2<br>was made aware of the move.<br><br>Interview on 04/06/2017 at 2:11 PM with the administrator revealed Resident #147's responsible party had previously requested (unable to provide a date) the facility move her from one unit to another so we moved the resident. Continued interview revealed Resident #147 cried and we moved her back to her original unit. | F 247 | monthly X 2 months. Results will be reported by the medical records supervisor to the QI committee for review. The QI committee consist of the social worker, DON, ADON, activities director, housekeeping supervisor, accounts receivable bookkeeper dietary manager, and medical records supervisor.<br><br>The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X3. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed .<br>The first meeting has convened on April 27, 2017 @ 3pm. | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than | F 274 | | 5/8/17 |

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| F 274 | Continued From page 3<br>one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment for 1 of 5 sampled residents reviewed for unnecessary medications. (Resident #105). The facility failed to complete a significant change comprehensive assessment for 1 of 1 resident who was started on hospice services (Resident #124).<br><br>Findings included:<br><br>1. Resident #105 had cumulative diagnoses which included advanced dementia.<br><br>Review of the significant change MDS assessment dated 3/2/2017 revealed the MDS was still in "progress"(referring to not being completed) as of 4/6/2017. Continued record review revealed Sections A (Admission Identification), B (Hearing, Speech and Vision), E (Behavior),G (Functional Status),GG (Functional Abilities and Goals),H (Bladder and Bowel),I (Active Diagnoses), J (Health Conditions),L (Oral/Dental Status),M (Skin Conditions), N (Medications),O (Special Treatments, Procedures, and Programs),V (Care Area Assessment (CAA) Summary )were noted as not completed.<br><br>Interview on 04/06/2017 at 2:28 PM with the MDS coordinator revealed she was in the process of updating and "catching up" on completing the MDS. | F 274 | Maple Grove Health and Rehabilitation 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 is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Maple Grove Health and Rehabilitation 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 Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.<br><br>F □ 274<br><br>Resident #105 significant change assessment with ARD of 3/2/2017 was closed due to no significant change from prior assessment by the MDS coordinator. Resident # 124 significant change assessment with ARD of 3/28/2017 was completed on 4/25/2017 by MDS | |

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| F 274 | Continued From page 4<br><br>Interview on 04/06/2017 at 2:35 PM with the Administrator revealed she expected the MDS to be accurate and completed timely.<br><br>2. Resident #124 was admitted to the facility on 1/30/17 and her diagnoses included end stage renal disease, heart failure, malnutrition and dysphagia.<br><br>An admission minimum data set dated 2/13/17 for Resident #124 revealed she received dialysis treatment, required limited to extensive assistance with her activities of daily living (ADL) and her cognition was intact.<br><br>A review of the physician ' s orders for Resident #124 revealed an order dated 3/1/17 for a hospice consult.<br><br>A review of the physician ' s orders for Resident #124 revealed an order dated 3/6/17 for comfort care, no tube feeding and no intravenous fluids.<br><br>A review of the initial hospice assessment dated 3/15/17 revealed that Resident #124 had chosen to stop dialysis treatment and start hospice services.<br><br>An observation of Resident #124 on 4/5/17 at 10:12 am revealed she was lying in bed asleep and was wearing oxygen.<br><br>A significant change comprehensive MDS for Resident #124 was started on 3/28/17. A review of the assessment on 4/6/17 revealed that the vision/hearing, behavior, bowel/bladder, diagnoses, pain, dental, medications, restraints and discharge sections were not completed. | F 274 | coordinator. The completed assessment for resident #124 was transmitted to the National Repository and accepted on 4/28/2017.<br>On 4 /26/2017 100% of hospice residents were audited by the minimum data set (MDS) Coordinator to ensure a significant change assessment has been completed. Significant change assessments were scheduled as needed and will be completed by 4/28/2017.<br><br>Residents identified in the audit reviewed significant change assessment needing closed. On 4/28/2017 4 significant change assessments transmitted and accepted by the National Repository.<br><br>On 4/28/2017 the MDS coordinator was in serviced by the director of nursing on the identification of, guidelines for, and completion of significant change in status assessment to include residents admitted to hospice as per the RAI manual v1.13. .<br><br>On 5/3/2017 the Interdisciplinary Care Team members were in-serviced by the MDS coordinator related to the identification of, guidelines for, and completion of significant change in status assessment to include residents admitted to hospice as per the RAI manual v1.13. .<br><br>On 5/1/2017 the MDS coordinator was in serviced by the administrator to use the communication tool in the point click care | |

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| F 274 | Continued From page 5<br><br>An observation of Resident #124 on 4/6/17 at 9:45 am revealed she was lying in bed in a fetal position. She was wearing oxygen and was asleep.<br><br>An interview on 4/6/17 at 1:46 pm with Nurse #1 revealed that she was the nurse for Resident #124. She stated that Resident #124 had been going to dialysis but had decided to stop treatment and Resident #124 was now hospice care. She stated that Resident #124 ' s condition had declined significantly and that she was much weaker, utilizing oxygen and starting to complain of some pain.<br><br>An interview with the MDS nurse on 4/6/17 at 1:57 pm revealed she was aware that Resident #124 had a significant change in her health condition since stopping dialysis and starting hospice. The MDS nurse stated that she should have completed a significant change assessment for Resident #124 within 14 days of her change of condition. She confirmed Resident #124 ' s hospice services were started on 3/15/17 and she should have completed a new assessment by 3/29/17.<br><br>An interview with the Administrator on 4/6/17 at 12:03 pm revealed it was her expectation that significant change assessments were completed in a timely manner. | F 274 | system to alert the team of a significant change and date of completion required.<br><br>All residents eligible for hospice services will be discussed daily X 5 days during Medicare meeting with the interdisciplinary team, significant change assessment completion according to RAI manual v.1.13..<br><br>Beginning 5/4/2017 the director of nursing (DON), staff development coordinator (SDC), and/or quality improvement (QI) nurse will audit residents with a significant change to include residents admitted to hospice using the significant change audit tool to ensure assessments are completed per the RAI manual. The audit will be completed weekly x 8 weeks then monthly x 2 months. Any negative findings will be addressed immediately.<br><br>The DON and/or Administrator will present findings to the weekly QI committee for 8 weeks then monthly X 2 months. The QI committee will review the results of Significant Change Audit Tool for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance.<br><br>The Administrator will report quarterly to the executive quality improvement committee quarterly X3. The Executive | |

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| F 274 | Continued From page 6 | F 274 | Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than | F 278 | | 5/4/17 |

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| F 278 | Continued From page 7<br>$5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to accurately code the oral status of Resident #92 on the Minimum Data Set (MDS) assessment tool in 1 of 3 residents reviewed for dental services. The facility failed to accurately code on the MDS to reflect PASRR (Preadmission screening and Resident Review) level 2 (two) for 1 of 1 resident in the sample reviewed for PASRR (Resident #21).<br>Findings included:<br><br>1.Resident #92 had cumulative diagnoses which included advanced dementia with behaviors. Observation on 04/05/2017 at 3:32 PM revealed Resident #92 was noted without any natural teeth.<br><br>Review of the annual MDS dated 1/2/2017 revealed under oral/dental revealed no natural teeth or tooth fragments (edentulous) section was not checked.<br><br>Interview on 04/07/2017 at 11:26 AM with Nursing Assistant #14 who stated Resident #92 does not have teeth.<br><br>Interview on 04/06/2017 at 2:35:16 PM with the administrator revealed she expected the MDS to be accurate and completed timely.<br><br>2. Resident # 21 was admitted on 01/26/2017 | F 278 | Maple Grove Health and Rehabilitation 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 is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Maple Grove Health and Rehabilitation 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 Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.<br><br>F- 278<br>On 4/26/2017 resident #92's minimum data set (MDS) annual assessment dated 1/2/2017 was modified to accurately code resident # 92's dental status by the MDS nurse. On 5/3/2017 the modified assessment was transmitted and accepted by the MDS coordinator to the National Repository. Resident # 21's | |

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| F 278 | Continued From page 8<br>with cumulative diagnoses which included schizophrenia.<br><br>Review of PASRR (Preadmission Screening and Resident Review) Determination notification form revealed that Resident #21 was determined to be a PASRR level 11 since February 2, 2017 with no expiration date.<br><br>Review of the Annual Minimum Data Set (MDS) assessment dated 2/2/2017 revealed Section A of the MDS was not coded to reflect PASRR determination.<br><br>During an interview with Social Worker on 4/06/2017 at 3:15 PM who stated that she was not responsible for completing the PASRR section on the MDS assessment.<br><br>During an interview with MDS Coordinator on 4/06/2017 at 3:30 PM she stated that she was responsible to code section A for PASRR level and she coded the wrong code. MDS indicated that he came from another facility as a PASRR level 11 (2).<br><br>During an interview with the Administrator on 4/7/2017 at 5PM revealed her expectations were the MDS Coordinator complete and code the MDS accurately. | F 278 | MDS annual assessment dated 2/2/2017 was modified to accurately code resident # 21's PASRR. On 4/11/2017 the accurate assessments were transmitted to the National Repository by the MDS coordinator. On 4/11/2017 the modified assessment was transmitted and accepted by the National Repository.<br><br>On 5/2/2017, the medical records supervisor completed a 30 % audit of current resident in the facility for Level II PASSR. All resident that were identified with Level II PASSR will have a modification transmitted to the National Repository by the MDS staff by 5/19/2017. On 5/3/2017 the DON/ADON completed auditing MDS assessments for 25% of facility current residents for dental /oral status using the MDS Audit Tool. No residents identified for modification at this time.<br><br>On 5/2/2017 the MDS Coordinator and MDS nurses were in-serviced by DON on correctly coding section A (PASRR level) and section L (dental/oral status).<br>On 5/2/2017 DON, ADON and medical record supervisor in serviced on usage of audit tool for accurate assessment of coding on section A (PASSR) and section L (dental/ oral).<br>On 5/2/2017 medical records supervisors and unit secretaries in serviced to upload all PASSR information in Point Click Care within 72 hours after admission.<br>On 5/2/2017 the medical records supervisor in serviced the MDS | |

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| F 278 | Continued From page 9 | F 278 | coordinators on the PASSR admission information will be uploaded in Point Click Care with 72 hours by the unit secretaries.<br><br>The medical records supervisor will audit of all comprehensive assessments completed within 30 days for the coding of Level II PASSR weekly X8 weeks then monthly X 4 months. The medical records supervisor will report to the QI committee findings.<br>The DON/ ADON will audit of all comprehensive assessments completed within 30 days coding of section L pertaining to dental/ oral. The DON/ ADON will report findings to the QI committee status weekly X 8 weeks then monthly X4.<br>The monthly QI committee will review the results of the MDS Audit Tool weekly X 8 weeks then monthly X4 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance .<br>The QI committee consist of: MDS coordinators, medical record supervisor, DON, ADON, assistant dietary manager, social worker and activities director.<br><br>The Administrator will report quarterly to the executive quality improvement committee quarterly X3. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. | |

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| F 278 | Continued From page 10 | F 278 | Recommendations to continue, alter or modify will be discussed at that time. The first executive QI committee meeting convened on April 27, 2017@ 3pm. | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse | F 279 | | 5/9/17 |

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| F 279 | Continued From page 11<br>treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to develop a care plan which addressed a therapeutic activity program. This was evident in 1 of 5 residents reviewed for unnecessary medications. (Resident #60).<br>Findings included:<br><br>Resident #60 was admitted to the facility on 1/20/17 with cummulative diagnoses which included dementia.<br>Record review of the 5 day Minimum Data Set | F 279 | Maple Grove Health and Rehabilitation 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 is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br>Maple Grove Health and Rehabilitation | |

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| F 279 | Continued From page 12<br>(MDS) assessment tool dated 1/27/2017 revealed activities was triggered on the Care Area Assessment (CAA) Summary due to little interest or pleasure in doing things. There was a decision to proceed with the development of a care plan. Review of the care plans revealed no activity care plan had been developed for activities.<br><br>An interview with Resident #60 was unsuccessful due to his poor cognition.<br><br>Interview on 04/07/2017 at 9:56 AM with the Assistant Activities director who was responsible for developing the care plan could not explain why the care plan was not done.<br><br>Interview with the administrator on 04/07/2017 at 4:43 PM revealed she expected a care plan be developed for any triggered sections of the MDS. | F 279 | 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 Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.<br><br>F- 279<br>Resident #60 care plan was reviewed and developed by the assistant Activities Director on 4/25/2017 to reflect resident with a plan of care for activities.<br><br>All residents care plans were audited to ensure they had an accurate and appropriate care plan to include preferences, updates as necessary.<br><br>Activity staff in-serviced on the development of care plans on all residents. Inclusive of monitoring reviews of care plan prior to CAA (Care Area Assessment) on 4/25/2017.<br>Activity staff in serviced on the components of a completed care plan to include focus, goal and interventions appropriate to the resident. The staff was further in serviced on the need to sign and lock the care plan to assure completion on 4/25/2017. All new hires in the activity department will be in serviced during orientation period of care plan expectations, | |

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| F 279 | Continued From page 13 | F 279 | A 100% audit of all activity care plans initiate on 4/25/17 and completed on 4/46/2017 to ensure all residents have a current appropriate activity care plan.<br><br>The activity department will review 10 resident care plans weekly, following the MDS calendar.<br>The Activity director will review all CAA for development of appropriate activity care plans weekly.<br>An audit tool was developed to<br><br>A Quality Improvement committee was established which consist of activity director, assistant activity directors, social worker, dietary manager, director of nursing and assistant director of nursing.<br>The Activity director will report weekly to the QI committee that activity care plans were reviewed for development of a care plan for resident requiring a CAA.<br>The QI committee will meet weekly X 8 weeks, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process.<br>The Administrator will report quarterly to the executive quality improvement committee quarterly X3. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. .<br>Recommendations to continue, alter or modify will be discussed at that time.<br>The first meeting convened on April 27, 2017@ 3pm | |

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| F 280 | Continued From page 14 | F 280 | | |
| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(i) Facilitate the inclusion of the resident and/or resident representative.<br><br>(ii) Include an assessment of the resident's strengths and needs. | F 280 | | 5/8/17 |

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| F 280 | Continued From page 15<br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the | F 280 | | |

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| F 280 | Continued From page 16<br>comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations,, record review and staff and family interviews, the facility failed to invite the Responsible Party (RP) to participate in Care Plan meetings for 2 of 2 residents (Resident #147 and Resident #8) reviewed for notification of participation in Care Plan meetings.<br>Findings included:<br><br>1. Resident #147 was admitted to the facility on 9/26/16 with cumulative diagnoses which included diabetes and dementia. The Admission Minimum Data Set (MDS) dated 10/5/16 indicated that Resident #147 was cognitively intact.<br><br>Medical Records review from September 2016 until the time of the survey revealed no documentation of RP or Resident being invited to the care plan meeting nor any documentation of RP participating in the meeting.<br><br>On 04/06/2017 at 3:34 PM an interview was attempted with Resident #147 and she could not focus or understand the question.<br><br>An interview was conducted with Resident # 71's Responsible Party on 04/05/2017 at 11:51 AM. The RP stated she never received any notification of Care plan meetings.<br><br>Interview on 04/06/2017 at 11:39 AM with the Social Worker (SW) revealed she mails a post card to notify the responsible party almost a month advance. The SW stated "I do not keep a record of who I sent a notice to attend the care plan meeting. | F 280 | Maple Grove Health and Rehabilitation 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 is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Maple Grove Health and Rehabilitation 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 Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.<br><br>F 280<br>Resident # 147 had a scheduled care plan meeting with the interdisciplinary team on 4/26/2017, resident refused to participate, but the responsible party was present. Resident # 8 and responsible party were invited to care plan meeting 5/10/2017 @ 11:30 both resident and responsible party expected to participate.<br><br>In service by the Administrator to the | |

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| F 280 | Continued From page 17<br><br>The facility was unable to provide any documentation that Resident #147 or RP had ever been invited to her care plan meeting.<br><br>An interview with the Administrator on 04/06/2017 2:26 PM revealed she expected the facility would invite family members (RP) and residents to all Care Plan meetings.<br><br>2. Resident # 8 was admitted to the facility on 4/15/13 with cumulative diagnoses which included end stage renal disease and diabetes.<br><br>Review of the annual Minimum Data Set (MDS) assessment tool dated 11/9/2016 revealed resident was alert and oriented. Review of the Quarterly MDS dated 2/6/17 continued to reveal the resident was alert and oriented.<br><br>Review of the care plans completed 6/10/16, 8/29/16, and 2/9/17 revealed no documentation that the resident nor responsible party was invited or informed of the care plan meeting.<br><br>Interview on 04/04/2017 at 4:33 PM with Resident #8 revealed she was not invited to participate in the care plan meetings.<br><br>Interview on 04/06/2017 at 11:39 AM with the Social Worker (SW) revealed she mails a post card to notify the responsible party almost a month advance. The SW stated "I do not keep a record of who I sent a notice to attend the care plan meeting.<br><br>The facility was unable to provide any documentation that Resident #147 or RP had ever been invited to her care plan meeting. | F 280 | social worker on 4/10/2017 to invite resident and responsible parties 1-2 weeks in advance of scheduled care plan conference. Follow-up with responsible party to ensure participation. Also telephone conference an option for care plan meeting. Documentation will be in Point Click Care pertaining to notification and interdisciplinary meeting.<br><br>Social Worker will invite responsible party to care plan meetings according to MDS schedule. Mail care plan invitations 1-2 weeks before the schedules meeting and document.<br>Make follow up call to ensure card was received and to see if the family will be in attendance and document. If family member unable to attend an alternate date and time or offer review via telephone and document. Use of daily sheet to effectively notify interdisciplinary team of care plan dates.<br><br>Social worker will use calendar to track care plan dates.<br>Social worker will schedule care plan meetings as MDS assessments are done. Use of an auditing tool spreadsheet to tack invitations being sent out. Social worker will use daily sheet to effectively notify interdisciplinary team of care plan dates.<br><br>The MDS coordinator will monitor the schedule of care plan meetings according to the MDS calendar weekly X 8 weeks, then bi- monthly X 2 months, then monthly | |

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| F 280 | Continued From page 18<br><br>An interview with the Administrator on 04/06/2017 2:26 PM revealed she expected the facility would invite family members (RP) and residents to all Care Plan meetings. | F 280 | X 2 months. Results will be reported to the QI committee for review.<br>The QI committee consist of the social worker, DON, ADON, activities director, dietary manager, and rehab manager.<br><br>The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process.<br>The Administrator will report quarterly to the executive quality improvement committee quarterly X3. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director.<br>Recommendations to continue , alter or modify will be discussed at that time .<br>The first meeting has convened on April 27, 2017@ 3pm. | |
| F 463 SS=D | 483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>(g) Resident Call System<br><br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area -<br><br>(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the | F 463 | Maple Grove Health and Rehabilitation | 5/3/17 |

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| F 463 | Continued From page 19<br>facility failed to assure that all portions of the call light system were functioning properly, revealing call lights located outside and above the door for rooms 107 and 112 would not turn on for 2 out of 2 resident rooms located on 1 out of 5 halls.<br><br>On 04/05/2017 at 09:03 AM it was observed that the call light located outside and above the door to room 107 on the North Hall did not turn on when the call light button was pressed for resident # 36 located in 107-A Bed.<br><br>On 04/05/2017 at 09:18 AM it was observed that the call light located outside and above the door to room 112 on the North Hall did not turn on when the call light button was pressed for resident # 37 located in 112-A Bed.<br><br>Beginning at 1:20 PM on 4/7/17 the Maintenance Director, Environmental Services Manager, and the Administrator were accompanied for an environmental tour and the call lights for rooms 107 and 112 on the North Hall were checked for functioning. When the call light buttons were pressed for beds 107-A and 112-A, the light located outside the room above the door did not turn on. During these observations, the maintenance director and administrator stated that they were unaware of these lights not properly working and that the call lights above the doors were expected to turn on to notify staff. During an interview with the nursing home Administrator on 4/7/17 at 4:45 PM when asked what her expectations were for call lights functioning properly, she stated "My expectation is that they work". She also stated that staff was expected to routinely check call lights to ensure proper functioning and that following the tour earlier in the day on 4/7/17, a 100% facility audit | F 463 | 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 is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br>Maple Grove Health and Rehabilitation 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 Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.<br><br>F- 463<br>Room 107A North hall and room 112A North hall call cords were immediately replaced and in working condition once facility staff were notified.<br><br>A 100% audit was performed by maintenance director and administrative staff on 4/7/2017 when 2 areas identified and all areas corrected immediately.<br>An in service was initiated by the maintenance director on 4/24/2017 for staff to notify maintenance department of any malfunctioning call bells and to place a manual bell at bedside until repair completed. Manual bells in medication room. | |

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| F 463 | Continued From page 20<br>of call lights had been performed to ensure all other call lights were properly working. | F 463 | An in-service was conducted by the administrator on 4/28/2017 for medication aides to check call bell functioning daily, call bell audit tool, work order forms and manual bell location and usage.<br>An in service was initiated 5/1/17 for nursing staff to use clips on call bell cords and not to wrap them side rails.<br><br>20% of call bells for occupied rooms will be audited daily X 5days a week X 24 weeks, then 3 x week for 12 weeks, then 2 X weekly for 8 weeks, then weekly X 8 weeks by medication aides beginning on 4/28/2017.<br>Maintenance staff will conduct audit of all rooms twice weekly for 26 weeks, then weekly x26 weeks.<br>Maintenance Director to report weekly needed repairs to Quality Improvement team which consist of Maintenance Director, Director of Nursing ,Assistant Director on Nursing, Dietary manager, Assistant dietary manager ,and Activity Director. Reporting will be weekly X 24 weeks, then bi- monthly for 3 months, then monthly for 3 months. Repeated issues and issues that are not corrected to be reported to the Administrator immediately.<br>The Administrator will report quarterly to the executive quality improvement committee quarterly X4. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. . The executive committee will discuss recommendations | |

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| F 463 | Continued From page 21 | F 463 | to continue, alter or modify the current plan.<br><br>The first executive QI committee meeting convened on April 27, 2017@ 3pm.<br><br>. | |
| F 520 SS=D | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; | F 520 | | 5/4/17 |

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| 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 |
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| F 520 | Continued From page 22<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility ' s Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 5/5/16 annual recertification survey. This was for recited deficiencies in the areas of assessment accuracy (F278) and resident call system (F463). These deficiencies were cited again on the current recertification survey on 4/7/17. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective QAA Program.<br><br>Findings Included:<br><br>This tag is cross referenced to:<br><br>1. F278 - Accuracy of Assessment: Based on observation, record review and staff interviews the facility failed to accurately code the oral status of Resident #92 on the Minimum Data Set (MDS) assessment tool for 1 of 3 residents reviewed for dental services. The facility failed to accurately | F 520 | Maple Grove Health and Rehabilitation 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 is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Maple Grove Health and Rehabilitation 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 Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 520 | Continued From page 23<br>code on the MDS to reflect PASRR (Preadmission Screening and Resident Review) level 2 for 1 of 1 resident in the sample reviewed for PASRR (Resident #21).<br><br>During the annual recertification survey of 5/5/16 the facility was cited for F278 for failing to accurately code the MDS to reflect the active diagnoses for 1 of 4 sampled residents.<br><br>2. F463 - Resident Call System: Based on observations and staff interview, the facility failed to assure that all portions of the call light system were functioning properly for 2 out of 2 resident rooms located on 1 out of 5 halls.<br><br>During the annual recertification survey of 5/5/16 the facility was cited for F463 for failing to provide function call bells for 2 of 17 rooms.<br><br>An interview with the Administrator on 4/7/17 at 4:10 pm revealed that she led the facility QAA committee. She stated that the committee met quarterly and more often if the facility was working on a specific project. The members of the committee included the Director of Nursing, Medical Directors, Pharmacy Consultant, Dietary Manger, Activities Director, Rehab Manager, Social Service Director, Housekeeping Director and Maintenance Director. She stated the facility had identified concerns with MDS coding and timeliness of completion and a second MDS nurse had been hired. She stated that the facility had developed a tool to monitor call light functioning. | F 520 | F 520<br><br>On4/27/2017 the facility Executive QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.<br><br>On 4/26/2017 the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, social worker, activities director, QI nurse, rehab director, accounts payable, admissions coordinator, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 278 Assessment Accuracy/Coordination/Certified and F 463 Resident Call System.<br><br>As of 4/27/2017, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council | |

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| F 520 | Continued From page 24 | F 520 | minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations.<br><br>The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns.<br><br>. The root cause analysis for the call bell malfunctioning proved to be the wrapping of the cords around the side rails, causing wire breakage. All rooms were equipped with a clip to attach call bells to bed linens. Nursing staff were in serviced on the usage of clips and not to wrap call cords around side rails.<br>The root cause analysis for the MDS assessments consist PASSR level II information not available for MDS to code in section A. Also the MDS staff unable to repeat the alphabet used in the PASSR number meaning, therefore in servicing provided with reference sheet. The dental/ oral status was human error, but reeducation will correct the alleged deficit practice.<br><br>Corrective action has been taken for the identified concerns related to F 278 Assessment Accuracy/Coordination/Certified and F 463 Resident Call System as reflected in the plan of correction<br>The QI Committee will continue to meet at | |

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| F 520 | Continued From page 25 | F 520 | a minimum of monthly with the Executive QI committee meeting quarterly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting. | |