DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES						APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X	COMP	
		345448	B. WING				(
NAME OF P	ROVIDER OR SUPPLIER	37770	5		STREET ADDRESS, CITY, STATE, ZIP CODE		08/	11/2017
					08 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND REP	ABILITATION CENTER		Ģ	GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 157 SS=D			F	157				9/6/17
	(g)(14) Notification of	Changes.						
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-						
	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;							
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or						
	a need to discontinue	erse consequences, or to						
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).							
	(14)(i) of this section, all pertinent information	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the						
		also promptly notify the lent representative, if any,						
	(A) A change in room	or roommate assignment						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	Ē		TITLE			(X6) DATE
Electroni	cally Signed							09/03/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/12/201 MAPPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345448	B. WING			08	C 8/11/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		
	ROVE HEALTH AND REI			308 WEST MEADO	WVIEW ROAD		
				GREENSBORO,	NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORREC I CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 1	F 1	57			
	as specified in §483.						
	1 0						
		ent rights under Federal or ons as specified in paragraph 					
	update the address (record and periodically mailing and email) and					
		resident representative(s).					
		iew, staff, pharmacist and			e Health and Rehabili		
		nterviews the facility failed to			es receipt of the State		
		hysician that Marinol had not r 7 days to Resident #3.			s and proposes this Pla o the extent that the su		
		of 4 residents in the sample			s factually correct and	-	
	reviewed for physicia	n notification.			compliance with applic		
	Findings included:				ovisions of quality of c		
	Resident #3 was adm	nitted to the facility on 8/2/17			he Plan of Correction i s a written allegation o		
	with cumulative diagr	-		compliance.			
	diabetes mellitus.				e Health and Rehabilit		
				· ·	this Statement of Defi		
		sion physician orders dated nol 10 milligrams (mg) by			note agreement with the fill of the fill o		
		Aarinol is a drug used to			n admission that any		
	nausea, vomiting and			-	s accurate. Further, Ma	-	
	Dovious of the Martin	ation Administration Desard			th and Rehabilitation re		
		ation Administration Record nol 10 milligrams (mg) by		-	refute any of the deficiencies the second seco		
		id blank spaces and circled			spute Resolution, forma	-	
	initials indicating the	drug had not been		appeal proc	edure and/ or any othe	er	
	administered from 8/2	5		administrativ	ve or legal proceeding		
		v revealed no evidence that an was notified that Marinol		F- 157			
		sed from the pharmacy since		-	received Marinol into	o the	
		ms with the resident having			midnight on 8/10/2017		
	nausea, vomiting or p	poor appetite.		began recei	ving prescribed dose		

Event ID:8GVT11

Facility ID: 923456

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	G		
		345448	B. WING			С
	ROVIDER OR SUPPLIER	545440		STREET ADDRESS, CITY, STATE, ZIP		8/11/2017
NAME OF P	ROVIDER OR SUPPLIER				CODE	
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
						(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 157	Continued From page	e 2	F 15	57		
	who stated she spoke	e with the attending				
		juired for the pharmacy but		An audit was performed b	y the Interim	
	cannot remember the	e date or time.		Director of Nursing (IDON) to ensure that	
				medications were dispens		
		at 8:10 AM with Nurse #3		pharmacy or medication r		
		t notified the attending		secondary to adverse rea		
		nol not available from the		attending physician was n	otified on	
		ten prescription was sent to		8/11/2017.	oting was	
	the pharmacy.			On August 22, 2017 a me conducted at Maple Grove		
	Interview on 8/10/17	at 8:30 AM with Nurse #9		Rehabilitation, participants		
		cy required a written script		Neil Medical Director of C		
	-	r controlled substances.		Neil Medical pharmacy co		
		y will fax the facility and the		Grove administrator, IDO		
	doctor requesting the	e script. The facility faxed		record supervisor. The pro	ocess of	
	request for the writter	n script was placed in the		required script from physic		
		e #9 was unsure which nurse		dispensing to facility was	reviewed.	
		doctor's book and that she				
		ttending physician about a		Licensed nurses in service	•	
	administered Marinol	esident #3 had not been		medications from the phane 8/11/2017.	macy on	
		with Nurse #9 revealed		License nurses in service	d on notification	
		d to the facility on 8/10/17.		of attending physician tha		
				required from pharmacy a		
	Interview on 8/10/17	at 1:40 PM via the phone		before pharmacy will disp		
	with the pharmacist fi	-		8/11/2017 by the IDON. A		
	pharmacy revealed c			licensed nurses will be in		
		ipt and the pharmacy faxed		orientation by the Staff Fa	cilitator (SDC).	
	this need to the atten					
	-	that a follow-up fax would				
		irs or the pharmacy would		The facility will monitor ne		
		no longer needed the		prescriptions and medicat		
		ed interview revealed the n was for the attending		delivery and availability da weekly. Any medications		
	physician to response			retrieved from back up		
		.		reported to the IDON/adm		
	Interview on 8/10/17	at 5:00PM with the attending		intervention. All new admi		
		o one ever called him or		medications will be check		
		the need for a written script.		weekly by the IDON, Dire		

Facility ID: 923456

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	, ,	· · · · · · · · · · · · · · · · · · ·	· · ·	OMPLETED
						С
		345448	B. WING			08/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 157	Continued From pag	e 3	F 15	7		
	During the interview indicated Marinol wa substance and the p	the attending physician s a scheduled 3 controlled harmacist could have called yesterday (referring to		Assistant Director of Nursing, SDC/Quality Improvement (Q ensure the attending physicia notified for any scripts require pharmacy.	l) nurse to n has been	
	Director of Nurses re facility to communica	at 1:50 PM with the interim evealed she expected the ate and notify the attending Marinol was not available to		A Quality Improvement comm formed on 8/28/2017 consistin IDON, ADON, SDC/QI nurse, rehabilitation director, Minimu nurses, activity director, dietal assistant dietary manager, su environmental supervisor, soo and medical records superviso The QI committee will meet w weeks, then bi-monthly for 2 monthly for 2 months. All disc will be reported to the Adminis immediately for review of the	ng of the m Data Set ry manager, pply clerk, tial worker or. eekly X 8 nonths, then repancies strator	
				The Administrator will report of the executive quality improver committee quarterly X2. The B Committee consist of: medica administrator, DON, pharmac dietary manager, activities dir medical record director. Recommendations to continue modify will be discussed at the	ment Executive al director, y consultant, ector and e, alter or	
F 278 SS=D		SMENT DINATION/CERTIFIED	F 27	8		9/6/17
		ssments. The assessment ect the resident's status.				
	(h) Coordination A registered nurse m	ust conduct or coordinate				

Facility ID: 923456

If continuation sheet Page 4 of 41

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/12/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 08/11/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 278	the assessment is co (2) Each individual wi assessment must sig that portion of the ass (j) Penalty for Falsific (1) Under Medicare a who willfully and know (i) Certifies a materia resident assessment penalty of not more th assessment; or (ii) Causes another in and false statement i subject to a civil mon \$5,000 for each asse (2) Clinical disagreen material and false stat This REQUIREMENT by: Based on staff interv facility failed to accur	h the appropriate n professionals. e must sign and certify that mpleted. ho completes a portion of the n and certify the accuracy of sessment. eation and Medicaid, an individual wingly- I and false statement in a is subject to a civil money han \$1,000 for each ndividual to certify a material n a resident assessment is ey penalty or not more than ssment.	F 27		ent of
		1 of 3 sample residents eceiving pain medications I:		Correction to the extent that the sum of findings is factually correct and is to maintain compliance with applicat rules and provisions of quality of care residents. The Plan of Correction is submitted as a written allegation of	order

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 5 of 41

		ND HUMAN SERVICES MEDICAID SERVICES					RM APPROVE NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345448	B. WING			0	C 8/11/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				30	8 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		GF	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	Continued From page	a 5	F 27	70			
1 270	-		F ZI	0	aamalianaa		
		nitted to the facility on t ' s cumulative diagnoses			compliance.		
	included diabetes.				Maple Grove Health and Rehabilitat	ion	
					response to this Statement of Defici		
		ed the facility after a hospital			does not denote agreement with the		
		7/17. The resident 's			Statement of Deficiencies nor does	it	
		medications included 5			constitute an admission that any		
	milligrams (mg) oxyc				deficiency is accurate. Further, Map		
	as needed for moder	en by mouth every 4 hours			Grove Health and Rehabilitation res the right to refute any of the deficient		
		en as two tablets (10 mg) by			on this Statement of Deficiencies th		
		for severe pain. Oxycodone			Informal Dispute Resolution, formal		
	is a controlled substa				appeal procedure and/ or any other		
					administrative or legal proceeding.		
		#7 's June 2017 Medication					
		d (MAR) for 6/17/17 to			F-278		
		doses of oxycodone were However, a review of the					
	- -	d Substance Receipt/Count			Resident # 7 had an modification se	nt to	
		ventory of a controlled			the National Repository on 9/1/2017		
		n) for the 5 mg oxycodone			indicate resident # 7 did receive pair		
	tablets revealed one				medication during the look back per		
	oxycodone was pulle	d from the medication cart			Receipt of acceptance from the Nati	onal	
	for administration to t 8:30 PM.	the resident on 6/28/17 at			Repository obtained 9/1/2017.		
					An in serviced was conducted on		
		#7 's most recent quarterly			8/14/2017 by the RAI Reimburseme		
		IDS) assessment dated			Auditor on accurate coding of Section		
		d. Section J of the MDS			to observe the Medication Administr		
		t was not on a scheduled nen and did not receive any			Record (MAR) as well as the Contro Substance receipt/ Count Sheet.	neu	
		an as needed (PRN) basis			An in serviced was conducted by the	e	
	during the 7-day look				Interim Director of Nurses on 8/11/2		
		P			licensed nurses and medication aide		
		ducted on 8/10/17 at 10:23			the documentation of as needed (pr	n)	
		s MDS nurses (MDS Nurse			medication on the Medication		
		2). Upon inquiry, MDS			Administration Record (MAR).		
		the dates used for the 7-day			A mandatory training for Minimum D		
	look back period for t	he 7/1/17 quarterly MDS			Set nurses will be conducted 8/21-8	5/22,	

Facility ID: 923456

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 08/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/11/2017
MAPLE G	ROVE HEALTH AND REF	ABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
F 278	assessment. The 7-d reported to be 6/25/17 An interview was com AM with MDS Nurse a she had completed R 7/1/17. The nurse sta that time the resident pain medication (oxyc look back period. MD the information on the complete the MDS. T had been aware of the been given to Reside period, she would hav accordingly. An interview was com AM with the facility 's interview, the Adminis	lay look back period was 7 - 7/1/17. ducted on 8/11/17 at 8:51 #2. MDS Nurse #2 reported esident #7 ' s MDS dated ated she was not aware at had received a dose of the codone) during the 7-day S Nurse #2 stated she used e resident ' s MAR to The nurse reported if she e pain medication having nt #7 during look back ve coded the MDS ducted on 8/11/17 at 11:40 e Administrator. During the strator reported her ne MDS assessments to be	F 278	 2017 by Corporate Clinical Quality/Reimbursement Director . MDS nurses and administrator sch for an in service on 9/26/2017 Cod Accuracy with Special Presentation Baseline Care Planning by Judy W Brandt, RN, QCP, RAC-MT, DNS-C An auditing tool was initiated for the Minimum Data Set nurses to monit administration of as needed (prn) medications to ensure accurate core Section J. The auditing tool to be u with all assessments beginning 9/1 Interim Director of Nursing, Staff Facilitator, and Director of Nursing monitor daily X5 days weekly to enneeded medications signed out on Medication Administration Record. Licensed nurses and Medication ai auditing every shift daily X 7days to ensure all medications signed on Medication Administration Record son 8/21/2017. A QI committee was formed on 8/2 consisting of the Interim Director of Nursing Rehabilitation Director, Minimum D nurses and Medical Records Supe The Quality Improvement Committe meet weekly X 8 weeks, then bi-me for 2 months, then monthly for 2 me All discrepancies will be reported to Administrator immediately for reviet the process. 	eduled ing n on filhide CT e or ding on tilized /2017. to sure as the des o starting 28/2017 f ing, vata Set rvisor. ee will onthly onths. o the

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 7 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/12/20 [;] M APPROVE <u>D. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COM	E SURVEY PLETED
		345448	B. WING				C / 11/2017
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND REP	ABILITATION CENTER			8 WEST MEADOWVIEW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	Continued From page	97	F 2	278	The Administrator will report quarter the executive quality improvement committee quarterly X2. The Execut Committee consist of: medical direct administrator, DON, pharmacy cons dietary manager, activities director a medical record director. Recommendations to continue, alte modify will be discussed at that time	tive ctor, sultant, and r or	
F 279 SS=D	assessments comple months in the residen results of the assessr		F 2	279	moony win be discussed at that time	2.	9/6/17
	comprehensive perso each resident, consis set forth at §483.10(c includes measurable to meet a resident's n and psychosocial nee comprehensive asses care plan must descri (i) The services that a or maintain the reside physical, mental, and	develop and implement a on-centered care plan for tent with the resident rights (2) and §483.10(c)(3), that objectives and timeframes nedical, nursing, and mental eds that are identified in the ssment. The comprehensive					

If continuation sheet Page 8 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/12/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 08/11/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
MAPLE G	ROVE HEALTH AND REP	ABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 279	Continued From page	8	F 279	9	
	under §483.24, §483 provided due to the re	would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 8.10(c)(6).			
	rehabilitative services provide as a result of recommendations. If	a facility disagrees with the RR, it must indicate its			
	(iv)In consultation wit resident's representa	h the resident and the tive (s)-			
	(A) The resident's goard desired outcomes.	als for admission and			
	future discharge. Fac whether the resident's community was asse	s desire to return to the ssed and any referrals to s and/or other appropriate			
	plan, as appropriate, requirements set forth section.	n the comprehensive care in accordance with the n in paragraph (c) of this is not met as evidenced			
	Based on observatio review the facility faile comprehensive care and interventions to a	plan with measureable goals iddress Resident #9 bilateral his was evident in 1 of 1		Maple Grove Health and Rehabilita acknowledges receipt of the Statem Deficiencies and proposes this Plan Correction to the extent that the sun of findings is factually correct and is to maintain compliance with applica	ent of of nmary order

Facility ID: 923456

If continuation sheet Page 9 of 41

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	TE SURVEY MPLETED
			A. BUILDING	2		С
		345448	B. WING		a	8/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				308 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 279	Continued From page	e 9	F 27	9		
				rules and provisions of qu	ality of care of	
	Findings included.:			residents. The Plan of Co		
		nitted to the facility on		submitted as a written alle	egation of	
		ative diagnoses which		compliance.		
	included cerebral pal	sy.		Maple Crove Health and	Dehabilitation	
	Review of the 5/19/1	7 quarterly Minimum Data		Maple Grove Health and response to this Statement		
		nt revealed Resident #9 was		does not denote agreeme		
	. ,	mpaired with functional		Statement of Deficiencies		
	limitation of range of	motion in her upper		constitute an admission th	hat any	
	-	es (contracture of both		deficiency is accurate. Fu		
	hands).			Grove Health and Rehabi		
	Deview of the energy	ational thereasy (OT) notes		the right to refute any of t		
		ational therapy (OT) notes 7 through 7/10/17 Resident #		on this Statement of Defic Informal Dispute Resoluti		
	9 received therapy for	•		appeal procedure and/ or		
		OT notes indicated on		administrative or legal pro		
	-	as provided to the nursing				
	staff regarding the bi	lateral application of the sand the wear schedule.		F-279		
				Resident #9 with function	al limitation of	
	·	lan updated 7/10/17 did not		range of motion in her up		
		ge of motion or bilateral		both sides (contracture of	,	
	hand contractures.			had palm guards placed a 8/11/2017 by the C.N.A		
	Review of the care care care care care care care car	ard posted inside of		was update on 8/24/2017		
		did not reflect the status of		Data Set nurse and care		
	the limited range of n			updated on 8/11/2017 by	•	
	_			Director of Nursing both t	o reflect the use	
		sign posted in the room with		of the bilateral palm guard	ds .	
		g the use of the palmer				
	protector revealed to			An audit was conducted of		
		nds daily for 6 to 8 hours.		assess residents that exh of motion have received t	-	
	Interview on 8/11/17	at 9 AM with the MDS		prevent further decrease		
		acare plan should have		motion to ensure on care	-	
	been developed to a	-		plan by the Interim Direct		
	contractures.			and Staff Facilitator .	J	
				A 100% in service was ini	itiated to all	

Event ID: 8GVT11

Facility ID: 923456

If continuation sheet Page 10 of 41

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 09 FORM AP OMB NO. 09	PROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
	345448	B. WING		C 08/11/2	017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.1.1.2	
MAPLE GROVE HEALTH AND RE		308 WEST MEADOWVIEW ROAD			
MAPLE GROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CC	(X5) MPLETION DATE
F 279 Continued From pag	e 10	F 27	nursing staff to place orthotics of residents, care guides, and care once recommended by therapy completed on 9/3/2017 by the ID Director of Nursing and Staff Fa All new hires will receive same in orientation by the Staff Facili An in-service was initiated on by the Administrator with Rehat Manager, Interim Director of Nut Minimum Data Set nurses that education provided to staff by t department will be reviewed by Director of Nursing, Assistant E Nursing, Staff Facilitator and M Data Set nurses. A signature w present to ensure continuity of residents with functional limitati received treatment to prevent fi decrease in range of motion. A in stated positions will be in ser orientation by Staff Facilitator. A mandatory training for MDS r be conducted 8/21-8/22, 2017 Corporate Clinical Quality / Reimbursement Director MDS nurses and administrator for an in service on 9/26/, 2017 Accuracy With Special Present Baseline Care Planning The Staff Facilitator will conduct audits for all residents with orde use of orthotics to ensure care guide and care plan. The audits weekly X8 the every other wee monthly X2.	e plan y services interim acilitator. in service tator. 8/28/2017 bilitation ursing, and all he therapy the Director of linimum will be care to ions have urther Il new hires viced in hurses to by scheduled y Coding ation on ct weekly ers for the on care s will be	

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 11 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09 FORM AP OMB NO. 09	PROVE
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345448	B. WING		C 08/11/2	2017
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE CC D TO THE APPROPRIATE CIENCY)	(X5) MPLETION DATE
F 279 F 287 SS=D	483.20(f)(1)-(4) ENCO RESIDENT ASSESS (f) Automated Data F (1) Encoding Data. V completes a resident must encode the follo resident in the facility (i) Admission assess (ii) Annual assessme (iii) Significant chang (iv) Quarterly review a (v) A subset of items reentry, discharge, ar	DDING/TRANSMITTING MENT Processing Requirement Vithin 7 days after a facility ving information for each : ment. nt updates. e in status assessments. assessments. upon a resident's transfer,	F 2	A QI committee was for consisting of the Interin Nursing, Assistant Dire Staff Facilitator Rehab Minimum Data Set nu Records Supervisor. The QI committee will weeks, then bi-monthly monthly for 2 months. will be reported to the immediately for review The Administrator will the executive quality in committee quarterly XI Committee consist of: administrator, DON, pl dietary manager, activ medical record directo Recommendations to of modify will be discussed	m Director of ector of Nursing, illitation Director, irses and Medical meet weekly X 8 y for 2 months, then All discrepancies Administrator v of the process. report quarterly to mprovement 2. The Executive medical director, harmacy consultant, ities director and r. continue, alter or	/17

Facility ID: 923456

If continuation sheet Page 12 of 41

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345448	B. WING				
	ROVIDER OR SUPPLIER	ABILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 08 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 287	 facility completes a refacility must be capate CMS System information contained in the MDS standard record layout and that passes stand CMS and the State. (3) Transmittal require after a facility complete a facility must electro accurate, and complete System, including the (i) Admission assessment. (ii) Admission assessment. (iii) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, are (viii) Background (faction initial transmission of does not have at (4) Data Format. The in the format specified the CMS. This REQUIREMENT by: 	ssment. Within 7 days after a sident's assessment, a ble of transmitting to the tion for each resident in a format that conforms to uts and data dictionaries, dardized edits defined by ements. Within 14 days tes a resident's assessment, nically transmit encoded, te MDS data to the CMS following: ment. nt. e in status assessment. tion of prior full assessment. ion of prior quarterly s upon a resident's transfer,	F	287	Maple Grove Health and Rehabilitatio	n	
		ete two Minimum Data Set			acknowledges receipt of the Statemen		

Facility ID: 923456

If continuation sheet Page 13 of 41

		MEDICAID SERVICES			OMB NO. 09	
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
					С	
		345448	B. WING		08/11/2	017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COL	(X5) MPLETIO DATE
F 287	Continued From page	e 13	F 28	7		
F 201	(MDS) discharge ass entry/re-entry tracking time frame for 1 of 1 who had multiple disc re-entries back to the The findings included Resident #7 was adm 3/28/17. A review of the facility indicated Resident #7 hospital on 7/1/17 an 7/3/17. The resident hospital on 7/19/17 a 7/23/17. A review of Resident (MDS) records revea assessment for 7/1/1 tracking record for 7/2 completed. Further r revealed the discharg and the entry/re-entry had not been comple An interview was con AM with the facility 's #1 and MDS Nurse # inquiry was made in r	essments and two MDS g records within the required sampled resident reviewed charges to the hospital with a facility (Resident #7). I: nitted to the facility on y 's census documentation 7 was discharged to the d re-entered the facility on was again discharged to the nd re-entered the facility on #7 's Minimum Data Set led the discharge 7 and the entry/re-entry 3/17 had not been eview of the MDS records ge assessment for 7/19/17 y tracking record for 7/23/17	F 28	 Deficiencies and proposes this PI Correction to the extent that the s of findings is factually correct and to maintain compliance with appli rules and provisions of quality of a residents. The Plan of Correction submitted as a written allegation a compliance. Maple Grove Health and Rehabili response to this Statement of Defi does not denote agreement with a Statement of Deficiencies nor doe constitute an admission that any deficiency is accurate. Further, M Grove Health and Rehabilitation r the right to refute any of the defici on this Statement of Deficiencies Informal Dispute Resolution, form appeal procedure and/ or any oth administrative or legal proceeding F-287 Resident # 7 had a discharge (7/² assessment transmitted to the Na Repository and accepted on 9/1/2 Resident # 7 had a reentry (7/3/2) transmitted and accepted at the N Repository on 8/29/2017. Residen had a discharge (7/19/2017) trans 	ummary is order cable care of is of tation ficiencies the es it aple reserves iencies through al er g. (/2017) ttional 2017. 017) lational nt # 7	
	census report, MDS I missed a couple of di The MDS nurses stat assessments (from 7 entry/re-entry tracking	on review of the facility 's Nurse #2 stated, "We ischarges and re-entries." ted the missed discharge /1/17 and 7/19/17) and g records (from 7/3/17 and been completed and		and accepted at the National Rep 9/1/2017. Resident #7 had reentu (7/23/2017) transmitted and acce the National Repository 8/29/201	ry pted at	

Facility ID: 923456

If continuation sheet Page 14 of 41

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/12/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 08/11/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD	
	NOTE TEACHT AND THE			GREENSBORO, NC 27406	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 287	AM with the facility 's interview, the Admini- made aware the facil records, including two re-entries in July 201 she did not have a Q process in place for "	ed. Iducted on 8/10/17 at 11:00 s Administrator. During the strator reported she was ity missed submitting 4 MDS	F 28	 An in serviced was conducted on 8/14/2017 by the RAI Reimbursem Auditor on completion of entry/ ree resident within 14 days and complet discharged resident within 7 days of discharge to the Minimum Data Senurses A mandatory training for MDS nurse be conducted 8/21-8/22, 2017 by Corporate RAI Reimbursement Dir MDS nurses and administrator sch for an in service on 9/26/, 2017 Co Accuracy with Special Presentation Baseline Care Planning An audit of missed entry/ reentry assessments and discharges was completed on 9/1/2017 by the Med Records Supervisor. An audit of or entries / reentries a discharges will be conducted week the Medical Records Supervisor X weeks the bi monthly X 2 months t monthly X2. A remote audit will be conducted b RAI Reimbursement Auditor spora to ensure that entries/ reentries an discharge assessments are done t A QI committee was formed on 8/2 consisting of the Interim Director of Nursing, Assistant Director of Nurs Staff Facilitator, Rehabilitation Dire Minimum Data Set nurses and Med Records Supervisor. 	entry etion of of et ses to rector. heduled oding n on dical und kly by 8 hen y the dically d imely. 28/2017 f sing, ector, dical
	7(02-99) Previous Versions Oh	solete Event ID-8GVT		The QI committee will meet weekly weeks, then bi-monthly for 2 month monthly for 2 months. All discrepant	ns, then

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 15 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/12/20 MAPPROVE D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345448		B. WING				C / 11/2017
NAME OF P	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND REI	ABILITATION CENTER			8 WEST MEADOWVIEW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG			ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 287 F 312 SS=D		RE PROVIDED FOR		312	will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director administrator, DON, pharmacy consulta dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	ant,	9/2/17
	services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio record reviews the fa genitals. The facility damp powder under f failed to comb Reside evident in 1 of 3 reside evident in 1 of 3 reside personal hygiene and Findings included: Resident #9 was adm 11/12/14 with cumula included cerebral pal Review of the 5/19/17 Set assessment reve severely cognitively in	 is not met as evidenced is not met as evidenced in, staff interviews and cility failed to cleansed the failed to wash the clumps of the skin folds. The facility ent #9's hair. This was dents dependent on staff for d bathing. (Resident #9) nitted to the facility on tive diagnoses which sy. 7 quarterly Minimum Data aled Resident #9 was mpaired, always incontinent and totally dependent on 			Maple Grove Health and Rehabilitation acknowledges receipt of the Statement Deficiencies and proposes this Plan of Correction to the extent that the summ of findings is factually correct and is ore 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. Maple Grove Health and Rehabilitation response to this Statement of Deficience does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple	t of ary der of	

Facility ID: 923456

If continuation sheet Page 16 of 41

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
				С	
		345448	B. WING		08/11/2017
NAME OF P	ROVIDER OR SUPPLIER	-	STREET ADDRESS, CITY, STATE, ZIP CODE		
		HABILITATION CENTER	:	308 WEST MEADOWVIEW ROAD	
	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)		ULD BE COMPLETIO
F 312	Continued From pag	e 16	F 312		
	Review of the care-p a focus of incontinen impairment. One of pericare after each ir second focus was re personal hygiene wit providing total care a Review of the care care Resident's #9 closet "hygiene/grooming" s comb hair, wash/dry 1. Observation on 8/ incontinence care wa Assistant (NA) #1 an conducted. NA #1 re to an episode of inco premoistened dispos right side and left sid Resident#9 legs wer cleanse the perineal repositioned the resid	lan updated 7/10/17 revealed ce due to cognitive the interventions included noontinent episode. A quired assistance for h interventions that included and to comb hair. ard posted inside of revealed under section stated to "provide total care, face/hands and perineum.		 Grove Health and Rehabilitation retheright to refute any of the deficiency on this Statement of Deficiencies to Informal Dispute Resolution, formation appeal procedure and/ or any otheradministrative or legal proceeding F-312 Resident # 9 who is dependent for immediately received perineal care inclusive of powder residue at the abdominal fold by another C.N.A. presence of the IDON. Resident# was combed by another C.N.A. also that time. C.N.A. # 1 was removed from care and in serviced on ADL care for the dependent resident. C.N.A. # 1 was observed by Interim Director of Nu on skills checklist before returning resident care area on 8/11/2017. 	encies hrough al er ADL's e in the 9 hair so at e area e as ursing
	resident's rectum in a clean brief was being NA #1 and NA #2 wh regarding the conditi- residents abdominal skin under the folds of revealed the skim was white substance simi #1 and NA #2 contine NA #1 stated that sho the resident's abdom Interview on 8/10/17 stated that this was h incontinence care. N sure why she did not	a back to front motion. A placed on the resident by en an inquiry was made on of the skin under the folds. Observation of the of the resident's abdomen as damp and clumps of a lar to powder was noted. NA ued to fasten the clean brief. e placed the powder under		On 8/10/2017 an in-service was in by the Interim Director of Nursing of care for the dependent resident into of perineal care and combing hair completed by 9/2/2017. A management round was conduct 8/10/2017 by department heads to all residents dependent for ADL's I combed. On 8/10/2017 the Interim Director Nursing initiated skill check list on C.N.A.'s pertaining to perineal care dependent resident completed on	on ADL clusive 100 % ted on o ensure nair was of all

Facility ID: 923456

If continuation sheet Page 17 of 41

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		(X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	` '			1 Y /	MPLETED
						с	
		345448	B. WING				08/11/2017
AME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				30	8 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 312	Continued From nor	- 17					
1 512	· · · · · · · · · · · · · · · · ·	e I/	F S	312			
	needed. "	at 10 AM with the interim			All new hires will be in serviced in		
		at 10 AM with the interim ated her expectation was the			orientation by the Staff Facilitator.		
		ned to cleanse the perineal					
		ectum from front to back and					
	remove the clumps of				10% of residents dependent for ADI	_ care	
	· · · · · · · · · · · · · · · · · · ·				will be monitored daily X7 days for 8		
	2. Observation on 8/	10/17 at 10:10 AM revealed			weeks, 3 X weekly for 4 weeks, 2 X	week	
		as uncombed with hair			for 4 weeks , weekly X 4 weeks then		
		laits and partially matted in			every other week X 4 weeks.		
	the back portion of the						
		/17 at 10:30 AM revealed					
		as uncombed with hair			A QI committee was formed on 9/1/	2017	
	the back portion of the	laits and partially matted in			consisting of the Interim Director of	2017	
		/17 at 11:10 AM revealed			Nursing, Assistant Director of Nursin	a	
		ontinued to be uncombed with			Staff Facilitator, Rehabilitation Direct		
		he plaits and partially matted			and Minimum Data Set nurses, Activ		
	in the back portion o				Director, Dietary Manager, Assistant	•	
	Observation on 8/10	/17 at 3 pm revealed			Dietary Manager, Supply Clerk,		
		mained uncombed with hair			Environmental Supervisor, Social W	orker	
		laits and partially matted in			and Medical Records Supervisor.		
	the back portion of the						
		/17 at 5:20 PM revealed			The QI committee will meet weekly >		
	Resident #9's hair.	in the appearance of			weeks, then bi-monthly for 2 months		
	Resident #95 nail.				monthly for 2 months. All discrepance will be reported to the Administrator	162	
	Interview on 8/11/17	at 9:53 AM with NA #1			immediately for review of the proces	9	
		t hair was combed on her					
		evening shift but was not sure			The Administrator will report quarterl	y to	
		ted that she had not combed			the executive quality improvement	-	
	Resident #9 hair on	8/10/17.			committee quarterly X2. The Executi		
		at 10 AM with the interim			Committee consist of: medical direc		
		ated her expectation was			administrator, DON, pharmacy consu		
		ir combed or brushed			dietary manager, activities director a	nd	
	whenever necessary				medical record director.	or	
					Recommendations to continue, alter		
	1				modify will be discussed at that time		1

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 18 of 41

					FC	TED: 09/12/2017 ORM APPROVED
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) D/	NO. 0938-0391 ATE SURVEY DMPLETED
		345448	B. WING		C 08/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
				308 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REP	HABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	Continued From page	<u>-</u> 18	F 31	8		
F 318 SS=D	483.25(c)(2)(3) INCR DECREASE IN RANG	EASE/PREVENT	F 31			9/1/17
00 5	(c) Mobility.					
	(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.					
	appropriate services, to maintain or improv practicable independent mobility is demonstra	hited mobility receives equipment, and assistance e mobility with the maximum ence unless a reduction in bly unavoidable. is not met as evidenced				
	review the facility faile daily to Resident #9's	n, staff interview and record ed to apply palm protectors contracted hands. This residents reviewed for		Maple Grove Health and Reh acknowledges receipt of the S Deficiencies and proposes this Correction to the extent that the of findings is factually correct a	tatement of s Plan of ne summary	
	Findings included.			to maintain compliance with a rules and provisions of quality	oplicable of care of	
	Resident #9 was adm 11/12/14 with cumula included cerebral pals	tive diagnoses which		residents. The Plan of Correct submitted as a written allegatic compliance.	on of	
	Set assessment reve severely cognitively in limitation of range of	7 quarterly Minimum Data aled Resident #9 was mpaired with functional motion in her upper es (contracture of both		Maple Grove Health and Reha response to this Statement of does not denote agreement w Statement of Deficiencies nor constitute an admission that a deficiency is accurate. Further Grove Health and Rehabilitatio	Deficiencies ith the does it ny r, Maple on reserves	
		ational therapy (OT) notes 7 through 7/10/17 Resident # r orthotic (splint)		the right to refute any of the de on this Statement of Deficienc Informal Dispute Resolution, for appeal procedure and/ or any	ies through ormal	

Facility ID: 923456

If continuation sheet Page 19 of 41

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 09/12/20 RM APPROVE IO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345448	B. WING		0	C 08/11/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
MAPLE GROVE HEALTH AND REHABILITATION CENTER			308 WEST MEADOWVIEW ROAD				
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 318	Continued From pag	ie 19	F 31	8			
	10	OT notes indicated on		administrative or legal proce	edina		
		as provided to the nursing			cuirig.		
	staff regarding the bi	ilateral application of the sand the wear schedule.		F-318			
				Resident #9 with functional I	imitation of		
		plan updated 7/10/17 did not		range of motion in her upper			
	reflect the status of t	he limited range of motion.		both sides (contracture of bo			
	Deview of the same of	and posted inside of		had palm guards placed as o			
	Review of the care of Resident's #9 closet	did not reflect the status of		8/11/2017.The care plan was 8/24/2017and care guide wa			
	the limited range of r			8/11/2017 both to reflect the			
	the inflited fullye of t			bilateral palm guards .			
	Record review of the	e sign posted in the room with					
	instructions regardin	g the use of the palm		An audit was initiated on 8/2	7/2017 by the		
	protector revealed to			administrator and completed			
		ands daily for 6 to 8 hours.		by the Interim Director of Nu Staff Facilitator to assess res	sidents that		
		/17 at 10:10 AM revealed no		exhibit limited range of motio			
	· · ·	e applied to both hands.		received treatment to prever			
		/17 at 10:30 AM revealed no e applied to both hands.		decrease in range of motion A 100% in service was initial			
		/17 at 11:10 AM revealed no		nursing staff to place orthotic			
		e applied to both hands.		residents, care guides, and o			
		/17 at 3:00 PM revealed no		once recommended by there			
	palm protectors were	e applied to both hands.		completed 9/3/2017. All new			
		/17 at 5:20 PM revealed no		receive same in service in or	rientation by		
	palm protectors were	e applied to both hands.		the Staff Facilitator.			
	Internieuu 0/44/47			An in-service was initiated			
		at 9:30 AM with Rehab esident #9 was able to		by the administrator with reh manager, interim director of			
		palm protectors without pain		Minimum data Set nurses th	•		
	or reddened skin.			education provided to staff b			
				department will be reviewed	• • • •		
	Interview on 8/11/17	at 9:53 AM with NA #1		Director of Nursing, Assistar			
		remember to apply the palm		Nursing, Staff Facilitator, and			
	-	ands but was aware they		Data Set nurses. A signatur			
	should have been ap	oplied.		present to ensure continuity			
	Intonvious on 9/11/17	at 10 AM with the interim		residents with functional limit			
	Interview on 8/11/17	at 10 AM with the interim		received treatment to prever	it iuitiler		

Facility ID: 923456

If continuation sheet Page 20 of 41

				OMB NO. 0938-03	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING		с	
	345448	B. WING		08/11/2017	
ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
			308 WEST MEADOWVIEW ROAD		
NOVE HEALIN AND N			GREENSBORO, NC 27406		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI	
Continued From page	ge 20	F 31	3		
palm protectors sho	uld be applied in the morning		decrease in range of motion. All n in stated positions will be in servic orientation by the Staff Facilitators	ed in	
			The Staff facilitator will audit all re with orthotics in place to ensure co of care for residents with functional limitations have received treatmer prevent further decrease in range motion. Monitoring will occur weel weeks then every other week X 2 monthly X 2.	ontinuity al of kly X 8	
			A QI committee was formed on 8 consisting of the Interim Director of Nursing, Assistant Director of Nur Rehabilitation Director, Minimum I nurses and Medical Records Supe The QI committee will meet weekl weeks, then bi-monthly for 2 month for 2 month of the process will be reported to the Administrate immediately for review of the process.	of sing, Data Set ervisor. ly X 8 ths, then ancies or	
			The Administrator will report quart the executive quality improvemen committee quarterly X2. The Exec Committee consist of: medical dir administrator, DON, pharmacy co dietary manager, activities directo medical record director. Recommendations to continue, al modify will be discussed at that tir	t cutive rector, nsultant, r and ter or ne.	
		F 329		9/6/17	
483.45(d) Unnecess Each resident's drug	sary Drugs-General.				
	AROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROVE HEALTH AND RI SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From par Director of Nurses s palm protectors sho when the resident w 483.45(d)(e)(1)-(2) FROM UNNECESS	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345448	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345448 B. WING ROVIDER OR SUPPLIER ROVE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Director of Nurses stated her expectation was palm protectors should be applied in the morning when the resident was transferred out of bed. 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	pr DEFICIENCIES (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING ROVIDER OR SUPPLIER STREETADDRESS, CITY, STATE, ZIP CODE 30 WEST MEADOWNEW ROAD GREENSBORO, NC 27406 ROVIDER OR SUPPLIER STREETADDRESS, CITY, STATE, ZIP CODE 30 WEST MEADOWNEW ROAD GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Director of Nurses stated her expectation was paim protectors should be applied in the morning when the resident was transferred out of bed. F 318 A QI committee was transferred out of bed. The Staff facilitator will audit all re with orthotics in place to ensure co of care for residents with function- limitations have received treatmer prevent further decrease in range motion. Monitoring will occur weel weeks, then every other week X 2 monthly X 2. A QI committee was formed on 8 consisting of the Interim Director o Nursing, Assistant Director Nur Rehabilitation Director, Minimum nurses and Medical Records Sup. The QI committee will meet week weeks, then bi-monthly for 2 month will be reported to the Administrat immediately for review of the proc monthly for 2 months. All discreps will be reported to the Administrat immediately for review of the proc committee quality improvemen committee quality X. The Exec PROM UNNECESSARY DRUGS	

Facility ID: 923456

If continuation sheet Page 21 of 41

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/12/2017 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRU		(X3) DAT	E SURVEY IPLETED
		345448	B. WING			08/11/2017	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		308 WEST I	DRESS, CITY, STATE, ZIP CODE MEADOWVIEW ROAD BORO, NC 27406		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T		HOULD BE	(X5) COMPLETION DATE
F 329	drug when used (1) In excessive dose therapy); or (2) For excessive dur (3) Without adequate (4) Without adequate (5) In the presence o which indicate the do discontinued; or (6) Any combinations paragraphs (d)(1) thr 483.45(e) Psychotrop Based on a compreh resident, the facility n (1) Residents who ha drugs are not given the medication is necess	An unnecessary drug is any e (including duplicate drug ration; or monitoring; or indications for its use; or f adverse consequences se should be reduced or of the reasons stated in ough (5) of this section.	F 3	229	DEFICIENCY)		
	gradual dose reduction interventions, unless an effort to discontinu This REQUIREMENT by: Based on staff interv	clinically contraindicated, in			e Grove Health and Reha wledges receipt of the St		

Facility ID: 923456

If continuation sheet Page 22 of 41

			000		OMB NO. 093	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
			A. BUILDING	t	с	
		345448	B. WING		08/11/20	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				308 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REP	HABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COM THE APPROPRIATE	(X5) PLETIO DATE
F 329	Continued From page	a 99	Ear	20		
1 525			F 32		this Dlan of	
		s to determine the insulin isure the blood glucose		Deficiencies and proposes Correction to the extent th		
	-	I in accordance with the		of findings is factually corr	-	
		3 of 3 sampled residents		to maintain compliance wi		
		apy (Resident #7, Resident		rules and provisions of qu		
	#4 and Resident #3).			residents. The Plan of Cor		
				submitted as a written alle	gation of	
	The findings included	1:		compliance.		
	1. Resident #7 was a	dmitted to the facility on		Maple Grove Health and F	Rehabilitation	
		t 's cumulative diagnoses		response to this Statemen		
	included diabetes.			does not denote agreeme	nt with the	
				Statement of Deficiencies		
		#7 's most recent quarterly		constitute an admission th	-	
	-	IDS) assessment dated esident had intact cognitive		deficiency is accurate. Fur	-	
		n making. The resident		Grove Health and Rehabil the right to refute any of th		
	-	ssistance from staff for all of		on this Statement of Defic		
		Living (ADLs), with the		Informal Dispute Resolution	9	
		limited assistance for		appeal procedure and/ or		
		tion on/off the unit, and		administrative or legal pro	ceeding.	
		ith eating. Section N of the				
		sident received an insulin		F- 329		
	period.	days during the look back		Resident # 7 blood glucos documentation on the Med		
				Administration Record tha		
	Resident #7 was disc	harged to the hospital on		recorded on 7/25/2017-7/3		
		tered the facility on 7/23/17.		8/11/2017 the attending pl	nysician was	
		17 re-admission orders at		notified by the Interim Dire	-	
	-	5 units of Lantus insulin (a		of the 5 missing blood glue		
		be injected subcutaneously		documentation and no new received. Also resident #		
		edtime, 2 units of Humalog g insulin) to be injected SQ		Administration Record ext		
		M, 1:00 PM, and 6:00 PM;		documentation of blood gl	<u> </u>	
		hecks to be done four times		from 8/1/2017- 8/6/2017.		
	_	30 AM, 4:30 PM, and 9:00		physician was again notifie	-	
		sulin to be provided as		by the Interim Director of N		
		SSI) with meals (no SSI		missed documented blood	-	
	coverage provided at	bedtime). SSI coverage		and no new orders were re	eceived.	

Facility ID: 923456

If continuation sheet Page 23 of 41

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/12/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/11/2017	
		345448	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ROVE HEALTH AND REF			30	08 WEST MEADOWVIEW ROAD		
				G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	was dependent on the result at the designate utilized the following p If BG is 201-250, insulin; If BG is 251-300, insulin; If BG is 301-350, insulin; If BG is 351-400, insulin; If BG is 401-450, insulin; If BG is 451 or g Humalog insulin;	e of insulin administered e resident's blood glucose ed time. The SSI ordered parameters: give 2 units of Humalog give 4 units of Humalog give 6 units of Humalog give 8 units of Humalog give 10 units of Humalog reater, give 12 units of	F	329	Resident # 4 blood glucose results fr 7/21/2017 7/24/2017 without documentation on the Medication Administration Record. ON 8/11/2013 Interim Director of Nursing notified the attending physician of the 2 missing b glucose documentation and no new orders were obtained. Resident #3 blood glucose with missi documentation on the Medication Administration Record for 8/3/2017@ am was reported to the attending physician on 8/11/2017 by the Interim Director of Nursing, and no new order were obtained.	7 the e blood ng 8:30	
	Administration Recom 7/31/17 revealed the results and/or SSI cor documented as havin following dates/times: On 7/25/17 at 6 coverage were not re On 7/25/17 at 1 coverage were not re On 7/26/17 at 1 coverage were not re On 7/31/17 at 6 coverage were not re On 7/31/17 at 4 there was no docume A review of Resident Medication Administra	g been completed on the 3:30 AM: BG result and SSI corded; 1:30 AM: BG result and SSI corded; 1:30 AM: BG result and SSI corded; 3:30 AM: BG result and SSI corded; 4:30 AM: BG result was 414; antation of SSI coverage.			An in-service was conducted for 100% licensed nurses and medication aides signing the Medication Administration Record (MAR) and documenting bloo glucose recordings and insulin covera The in service was conducted by the Interim Director of Nursing and compl on 9/2/2017. An audit tool was initiated by the Inter Director of Nursing that the Medicatio Administration Record (MAR) has to checked at the end of each shift with signature indicating the Medication Administration Record has been check by the licensed nurse and / or medication aide. The signature indicates that the are no holes and all blood glucose recordings and insulin has been documented. The tool was in serviced	s on d age. eted rim n be n a ked tion ere	

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 24 of 41

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	E CONSTRUCTION	· · ·	E SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING			C
		345448	B. WING		0	B/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND REP	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 329	Continued From page	e 24	F 329			
	sugar results and/or s documented as havin following dates/times On 8/1/17 at 11 coverage were not re On 8/4/17 at 11 coverage were not re On 8/6/17 at 11 coverage were not re An interview was con PM with the facility 's During the interview, she had noticed there where the facility was glucose levels or indi- were used to manage pharmacist stated she facility whenever she	SSI coverage were not ing been completed on the : :30 AM: BG result and SSI corded; :30 AM: BG result and SSI corded; :30 AM: BG result and SSI corded; :30 AM: BG result and SSI corded. ducted on 8/10/17 at 1:33 s consultant pharmacist. the pharmacist was asked if e were multiple instances		 the Interim Director of nursing completion on 9/2/2017. A mandatory in service for all I nurses will be conducted on d blood glucose and insulin cove 9/17/2017 and 9/18/2017. Medication administration audi performed by pharmacy consultation Director of Nursing, an Facilitator to licensed nurses a medication aides. Audit of Medication Administration aides. Licensed nurses and Medication aides. <!--</td--><td>icensed liabetes, erage on its ultant , d Staff and tion Record I nurses and on aides erim facilitator onthly for 2</td><td></td>	icensed liabetes, erage on its ultant , d Staff and tion Record I nurses and on aides erim facilitator onthly for 2	
	AM with the facility 's interview, the Adminis reviewed Resident #7 records and stated sh "holes" identified in th record. The Administ glucose checks shoul recorded, with insulin An unsuccessful atten 10:05 AM to conduct	ducted on 8/11/17 at 8:00 s Administrator. During the strator reported she had 7 's blood glucose/insulin he had difficulty with the he resident 's medical trator reported the blood Id have been completed and a dministered as ordered. mpt was made on 8/11/17 at a telephone interview with was assigned to care for 17 at 6:30 AM.		A QI committee was formed o consisting of the Interim Direct Nursing, Assistant Director of I Staff Facilitator, Rehabilitation Minimum Data Set nurses and Records Supervisor. The QI committee will meet we weeks, then bi-monthly for 2 m monthly for 2 months. All discr will be reported to the Adminis immediately for review of the p	tor of Nursing, Director, I Medical eekly X 8 nonths, then repancies trator	

If continuation sheet Page 25 of 41

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/12/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345448	B. WING) 08/	C 11/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
MAPLE G	ROVE HEALTH AND REF	IABILITATION CENTER			08 WEST MEADOWVIEW			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	shift) on 7/25/17, 7/26 During the interview, it to the checking of Res and SSI coverage. N medication aides (me checks. However, sh running a low blood g issue, she would do th nurse reported if a me s BG, the nurse was r BG results in both the The nurse was unable regards to the missing and/or SSI coverage. A follow-up interview y Administrator on 8/11, interview, the Adminis expectation was for th and sliding scale insu with the physician ' s of 2. Resident #4 was a 7/21/17 from a recent cumulative diagnoses Record review revealed Minimum Data Set as been completed. Review of the admiss 7/21/17 included: Blood glucose (BS) cl meals with a sliding s Novolog insulin (fast-a sugar results as noted	A sesident #7 at 11:30 AM (1st //17, 8/1/17, and 8/4/17. nquiry was made in regards sident #7 's blood glucose urse #4 reported the d aides) usually did the BG e stated if the resident was lucose or there was another ne BG check herself. The ed aide checked a resident ' responsible to document the MAR and the computer. e to recall specifics in g blood glucose results was conducted with the /17 at 11:40 AM. During the strator stated her he residents ' blood glucose lin coverage to correlate orders. dmitted to the facility on hospitalization with which included diabetes. ed no 14 day admission sessment or care plan had ion physician orders dated mecks three times a day with cale (SSI) coverage with acting insulin) for blood	F	329				

Facility ID: 923456

If continuation sheet Page 26 of 41

						FORM	APPROVED
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		345448	B. WING				-
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	11/2017
-							
MAPLE GI	ROVE HEALTH AND REF	ABILITATION CENTER					
(X4) ID					PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX							COMPLETION DATE
IAG	REGULATORTORT		PYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 329 F 329 inistration Record e BG result and SSI				
F 000							
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED AME OF PROVIDER OR SUPPLIER 345448 IN MING STREETADDRESS. CITY, STATE, JP CODE: MARE OF PROVIDER OR SUPPLIER 39 WEST MEADOWNEW ROAD GREENSBORO, NC 27400 STREETADDRESS. CITY, STATE, JP CODE: 39 WEST MEADOWNEW ROAD GREENSBORO, NC 27400 IVAID UCANI OF CORRECTION OF DEFICIENCIES. LCANI DEFICIENCED ANY STLE THERMONY MUST BE PRECIDED ANY LLL. IP DEFIX (PACI DEFICIENCY MUST BE PRECIDED ANY LLL. IP ONVIDERS PARAN OF CORRECTION IN CROSS REFERENCE NOILD BE COMPLETED TO THE APPROPRIATE COMPLETED (U) F 329 Continued From page 26 (U) IP STREET ADDRESS CITY, STATE, JP CODE: IP ONVIDERS PARAN OF CORRECTION IN CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY COMPLETED (COMPLETED THE APPROPRIATE DEFICIENCY) COMPLETED (COMPLETED THE APPROPRIATE DEFICIENCY) <td></td>							
	DEFICIENCY) Continued From page 26 F 329 (U) " 151 mg/dl -200 mg/dl 2U " 201 mg/dl -250 mg/dl 3U " 251 mg/dl -300 mg/dl 5U " 251 mg/dl -300 mg/dl 5U " 301 mg/dl -350 mg/dl 7U " 351 mg/dl -400 mg/dl 9U " >400 mg/dl all MD. Review of the Medication Administration Record revealed: " On 7/21/17 at 4:30 PM the BG result and SSI coverage were not recorded. Record review indicated no previous BG results. Record review reviewed the BG at 6:30 AM on 7/24/17 was 83						
	201 mg/ui -250 m						
	251 mg/ui -300 m	•					
	501 mg/ui -550 m	•					
		•					
		ation Administration Record					
		30 PM the BG result and SSI					
	· · ·						
		:30 AM the BG result and					
	SSI coverage were no	ot recorded.					
	Interview on 8/9/17 at	t 11:42 AM with Nurse #8					
		-					
	-	-					
	-						
		•					
	· ·	-					
	-	-					
		-					
	-	-					
		-					
	errors."	see as soing potential moa					
		ducted on 8/11/17 at 8:00					
	AM with the facility's						
	-	her expectation was for the					
	blood glucose checks						
		administered as ordered.					

Facility ID: 923456

If continuation sheet Page 27 of 41

	-	ID HUMAN SERVICES				FORM	APPROVED	
			(X2) MU				0.0938-0391	
-	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF		
			A. BUILDI	ING _			_	
		345448	B. WING					
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					308 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND REP	ABILITATION CENTER			GREENSBORO, NC 27406			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
TAG			IAG		DEFICIENCY)			
F 329	Continued From page	e 27	F	329				
3. Resident #3 was admitted to the facility on 8/2/17 from a recent hospitalization with								
		•						
		which included diabetes.						
		ed no 14 day admission						
	been completed.	ssessment or care plan had						
		ion physician orders dated						
	8/2/17 included:							
		hecks three times a day with						
		cale (SSI) coverage with						
		acting insulin) for blood						
	sugar results as note							
		er deciliter (mg/dl) -150						
	mg/dl 1U							
	" 151 mg/dl -200 n " 201 mg/dl -250 ı	•						
	" 251 mg/dl -300 i	•						
	" 301 mg/dl -350 i							
	" 351 mg/dl -400 i							
	" >400 mg/dl call							
	Review of the Medica	ation Administration Record						
		8:30 AM the BG result and						
	SSI coverage were no	ot recorded.						
	Intensions on 9/0/17 -	t 11:42 AM with Nurse #9						
		t 11:42 AM with Nurse #8 ot perform the blood glucose						
		30 am because the resident						
		g smoking. Further review						
	revealed the 12 noon							
		ducted on 8/10/17 at 1:33						
	-	consultant pharmacist.						
		the pharmacist was asked if						
		were multiple instances						
	where the facility was	-						
	-	cating what doses of SSI						
	-	e blood glucose levels. The e had made reports to the						
		was "seeing holes" in the						

Facility ID: 923456

If continuation sheet Page 28 of 41

		ID HUMAN SERVICES MEDICAID SERVICES					/ APPROVE). 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345448	B. WING				3 11/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	IREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 329	Continued From page	e 28	F	329			
		ese as being "potential med					
		ducted on 8/11/17 at 8:00 Administrator. The					
		her expectation was for the					
		s to be completed and administered as ordered.					
F 333	483.45(f)(2) RESIDE	NTS FREE OF	F	333			9/6/17
SS=D	SIGNIFICANT MED I	ERRORS					
	483.45(f) Medication	Errors.					
	The facility must ensu	ure that its-					
	(f)(2) Residents are fi medication errors.	ree of any significant					
		is not met as evidenced					
	Based on staff and p	hysician interviews and			Maple Grove Health and Rehabilitation		
		acility failed to administer			acknowledges receipt of the Statement	of	
		SSI) in the dose ordered by 3 sampled residents who			Deficiencies and proposes this Plan of Correction to the extent that the summa	arv	
	received insulin thera				of findings is factually correct and is or	der	
	The findings included	:			to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is		
	Resident #7 was adm	nitted to the facility on			submitted as a written allegation of		
	3/28/17. The residen	t 's cumulative diagnoses			compliance.		
	included diabetes.				Maple Grove Health and Rehabilitation		
	A review of Resident	#7 's most recent quarterly			response to this Statement of Deficience		
	Minimum Data Set (N	IDS) assessment dated			does not denote agreement with the		
		esident had intact cognitive			Statement of Deficiencies nor does it constitute an admission that any		
		n making. The resident sistance from staff for all of			deficiency is accurate. Further, Maple		
	-	Living (ADLs), with the			Grove Health and Rehabilitation reserv	es	
	exception of requiring	limited assistance for			the right to refute any of the deficiencie	S	
	transfers and locomo	tion on/off the unit, and			on this Statement of Deficiencies through	gh	

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 29 of 41

		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 08/11/2017
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP	
				308 WEST MEADOWVIEW ROAD	
MAPLE G	ROVE HEALTH AND REF	ABILITATION CENTER		GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 333	Continued From page	29	F 33	33	
		th eating. Section N of the	1.00	Informal Dispute Resolution	on, formal
		sident received an insulin		appeal procedure and/ or	-
	injection on 7 out of 7 period.	days during the look back		administrative or legal pro	-
				F- 333	
		harged to the hospital on		Resident # 7 Medication	
		tered the facility on 7/23/17.		Record review with 4 disc	
		17 re-admission orders at		dosing of sliding scale insi	•
	-	o units of Lantus insulin (a be injected subcutaneously		documentation of repeater on 2 of the 4 occurrences	-
		edtime, 2 units of Humalog		the physician on 8/11/201	
		insulin) to be injected SQ		Director of Nursing and no	
		<i>I</i> , 1:00 PM, and 6:00 PM;		were received.	
	blood glucose (BG) c	hecks to be done four times			
	-	80 AM, 4:30 PM, and 9:00			
		sulin to be provided as		A 100 % in service was ini	
		SSI) with meals (no SSI bedtime). SSI coverage		Interim Director of Nursing	
	01	e of insulin administered		and completed on 9/2/201 Rights of Medication Admi	
		e resident's blood glucose		licensed nurses and medi	
		ed time. The SSI ordered		A mandatory in service for	
	utilized the following p			nurses will be conducted b	
		give 2 units of Humalog		blood glucose and insulin	
	insulin;			9/17/2017 and 9/18/2017.	
		give 4 units of Humalog		An in-service was conduct	
	insulin; If BG is 301-350	give 6 units of Humalog		licensed nurses and medic signing the Medication Ad	
	insulin;	give o units or riundlog		Record (MAR) and docum	
		give 8 units of Humalog		coverage. The in service v	
	insulin;	- •		by the Interim Director of I	
		give 10 units of Humalog		completed on 9/2/2017.	
	insulin;			Medication administration	
	-	reater, give 12 units of		performed by pharmacy co	
	Humalog insulin; If the BG is still o	reater than 450, call the		Interim Director of Nursing Facilitator to licensed nurs	
	Medical Doctor (MD).			accurate dosing of insulin coverage 8/25/2017.	
		#7 ' s July 2017 Medication d (MAR) from 7/23/17 to			

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 30 of 41

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SL	0938-03 JRVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLE	TED
		345448	B. WING		С	
	ROVIDER OR SUPPLIER	545440		STREET ADDRESS, CITY, STATE, ZIP		/2017
	CONDER OR SOFFLIER			308 WEST MEADOWVIEW ROAD	CODE	
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 333	Continued From page	e 30	F 33	33		
		dose of SSI coverage was	1.00	A QI committee was form	ed on 9/1/2017	
	not consistent with th	e physician orders on the		consisting of the Interim D	Director of	
	following dates/time:			Nursing, Assistant Directo		
On		AM: BG result was 356; SSI		Staff Facilitator, Rehabilita		
	-	nented as 6 units of Humalog		Minimum Data Set nurses	and Medical	
	insulin were ordered.	men indicated 8 units of		Records Supervisor. The QI committee will me	et weekly X 8	
		PM: BG result was 475; SSI		weeks, then bi-monthly fo	-	
		iented as 2 units of Humalog		monthly for 2 months. All		
	insulin. The SSI regi	men indicated 12 units of		will be reported to the Adr	ninistrator	
		and the BG needed to be		immediately for review of	the process.	
	rechecked in 2 hours					
	s medical record.	BG recheck in the resident '				
		AM: BG result was 452; SSI				
	coverage was docum					
		e SSI regimen indicated 12				
		ordered and the BG needed				
	to be rechecked in 2					
	s medical record.	BG recheck in the resident '				
	A review of Resident	#7 ' s August 2017				
		ation Record (MAR) from				
		vealed the dose of SSI				
		nsistent with the physician				
	orders on the followin	•				
		M: BG result was 414; SSI iented as 6 units of Humalog				
		men indicated 10 units were				
	ordered.					
	A telephone interview	v was conducted on 8/11/17				
		se #2. Nurse #2 was				
	-	Resident #7 on 7/27/17 at				
		17 at 4:30 PM. Upon review				
		d SSI coverage from these reported the medication				

Facility ID: 923456

If continuation sheet Page 31 of 41

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/12/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345448	B. WING				C 11/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
MAPLE G	ROVE HEALTH AND REF	IABILITATION CENTER		-	08 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333 F 514 SS=D	residents ' BG levels insulin. Nurse #2 cou dates discussed or the dose recorded. An unsuccessful atter 10:05 AM to conduct Nurse #3. Nurse #3 w Resident #7 on 7/26/1 (3rd shift). An interview was cond AM with the facility ' s interview, the Adminis expectation was for the insulin doses as order A telephone interview at 12:20 PM with Res facility. During the int between the resident administered was disc physician indicated so dosing may be attribut However, when all of reviewed, the physicia consider such discrep be a significant conce fluctuating BG levels. stated, "Oh absolutely 483.70(i)(1)(5) RES RECORDS-COMPLE LE (i) Medical records. (1) In accordance with standards and practice	and the nurse gave the ld not recall specifics of the e accuracy of the insulin npt was made on 8/11/17 at a telephone interview with vas assigned to care for 17 and 7/29/17 at 6:30 AM ducted on 8/11/17 at 11:40 Administrator. During the strator stated her he resident to receive the red by the physician. was conducted on 8/11/17 ident #7 's physician at the erview, the discrepancies 's BG results and SSI dose cussed. Initially, the ome of the discrepancies in ted to nursing discretion. discrepancies were an was asked if he would bancies of insulin dosing to orn for a resident with When asked, the physician /." TE/ACCURATE/ACCESSIB		514			9/6/17

Event ID:8GVT11

Facility ID: 923456

If continuation sheet Page 32 of 41

	-	ND HUMAN SERVICES				FO	ED: 09/12/201 RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		STRUCTION	· · ·	TE SURVEY MPLETED C
		345448	B. WING				8/11/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
				308 WE	EST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		GREE	NSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 514	Continued From page	e 32	F 5	514			
	(i) Complete;						
	(ii) Accurately docum	ented:					
	(iii) Readily accessibl						
	(iv) Systematically or	-					
	(5) The medical reco						
		ion to identify the resident;					
		sident's assessments;					
	(iii) The comprehensi provided;	ive plan of care and services					
	(iv) The results of any and resident review e determinations condu						
	(v) Physician's, nurse professional's progre	e's, and other licensed ss notes; and					
	services reports as re This REQUIREMENT by:	logy and other diagnostic equired under §483.50. Γ is not met as evidenced					
	facility failed to follow	iews and staff interviews, the established procedures for ccurate documentation of the trolled substance		ac De	aple Grove Health and Rehab knowledges receipt of the Stat ficiencies and proposes this P prrection to the extent that the	ement of Plan of	
	Record (MAR) and C Receipt/Count Sheet	for 1 of 1 sampled resident		to rul	findings is factually correct and maintain compliance with appl es and provisions of quality of sidente. The Blan of Correction	licable care of	
		ed a controlled substance t #7). The facility failed to			sidents. The Plan of Correctior bmitted as a written allegation		

Facility ID: 923456

If continuation sheet Page 33 of 41

		MEDICAID SERVICES					IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY IPLETED
		345448	B. WING			0	C B/11/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 •	
				308	WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		GR	EENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 514	Continued From page	e 33	F 51	14			
	document medication	is administered to Resident s in the sample reviewed for			compliance.		
	well being.				Maple Grove Health and Rehabilitation	n	
					response to this Statement of Deficie		
	The findings included	I:			does not denote agreement with the		
					Statement of Deficiencies nor does it		
		dmitted to the facility on			constitute an admission that any		
		t was discharged to the			deficiency is accurate. Further, Maple		
		nd re-entered the facility on			Grove Health and Rehabilitation rese		
		t's 6/17/17 re-admission			the right to refute any of the deficience		
	medications included	f minigrams (mg) I medication) to be given by			on this Statement of Deficiencies thro Informal Dispute Resolution, formal	ugn	
		as needed for moderate			appeal procedure and/ or any other		
		odone to be given as two			administrative or legal proceeding.		
		outh every 4 hours for			g pg		
	severe pain. Oxycod				F- 514		
	substance medication				Resident # 7 had no doses recorded	of	
					oxycodone from 6/17/2017 6/30/20	17	
		#7 's Controlled Substance			on the Medication Administration Rec		
		(a declining inventory record			Resident # 7 Medication Administration		
		olled substance medication			Record also indicated that the oxycoc		
		tion cart for a resident) for			was not recorded on July 30-31, 2017		
		tablets was completed for ne Controlled Substance			Facility Medical Director notified by th Interim Director of Nursing on 8/11/20		
		revealed one tablet of			and no new orders obtained	, , ,	
		d from the medication cart			Resident # 4 Medication Administratio	on	
		the resident on 6/28/17 at			Record was not signed for 3 medicati		
		on Aide (Med Aide) #1.			Neurontin 300 mg Keflex 500 mg and	-	
	However, Resident #	7 's June 2017 Medication			Metformin 500 mg) , although only on	ne	
		d (MAR) for 6/17/17 to			medication(Neurontin) was not given		
		doses of oxycodone were			The attending physician was notified	by	
	administered to the re	esident.			the Interim Director of Nursing on 8/11/2017 and no new orders were		
	Further review of Res	sident #7 ' s Controlled			obtained.		
	Substance Receipt/C	ount Sheet revealed 13			Resident # 3 Medication Administration	on	
		(10 doses of 1 tablet and 3			Record revealed 8/3/2017-8/5/2017		
		ere documented as removed			Cymbalta, Neurontin, Lisinopril and		
		cart for administration to the			Multivitamin with Minerals did not hav		
	resident during the m	onth of July 2017. The			initials indicating administration of the	;	

Facility ID: 923456

If continuation sheet Page 34 of 41

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(V2) D	NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
			A. BUILDING			С
		345448	B. WING			08/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/11/2017
				308 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REP	ABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETIC DATE
		,		DEFICIENCY)		
F 514		- 04				
F 314	· · · · · · · · · · · · · · · · ·		F 51			
		/codone was pulled from the		medication. Nurse admits to d		
		80/17 at 3:00 AM (2 tablets)		attending physician notified by		
	and 7/31/17 at 2:30 A	NVI (∠ TADIETS).		Director of Nursing 8/11/2017 v orders obtained.	with no new	
	A review of Resident	#7 ' s July 2017 MAR		orders obtained.		
		was administered to the		An in-service was conducted for	or 100% of	
		s (10 doses of 1 tablet and 1		licensed nurses and medicatio		
		ing the month. The July		signing the Medication Adminis		
	,	cument oxycodone was		Record (MAR) when medication		
		on either 7/30/17 or 7/31/17.		administered. The in service w		
	J			conducted by the Interim Direct		
	Attempts were made	to interview Med Aide #1 by		Nursing and completed on 9/2/		
	-	at 10:12 AM and on 8/11/17		An audit tool was initiated by the		
	at 12:08 PM. There v	was no answer and no voice		Director of Nursing that the Me	dication	
	mail message could b	be left to request a return		Administration Record (MAR)	has to be	
	telephone call. Med	Aide #1 was identified by her		checked at the end of each sl	nift with a	
	signature on the Cont	trolled Substance		signature indicating the Medica	ation	
	Receipt/Count Sheet	as having withdrawn 1 tablet		Administration Record has bee	n checked	
	of oxycodone labeled	for Resident #7 ' s use on		by the licensed nurse and / or		
	6/28/17 without docu	menting its administration to		aide. The signature indicates t		
	the resident on his M	AR.		are no holes and all administra	tion of	
				medication has been documen		
	-	was conducted on 8/11/17		tool was in serviced by the Inte		
	at 10:20 AM with Nur			Director of nursing with 100% of	completion	
	identified by her initia			on 9/2/2017.		
		ount Sheet as having pulled		NA direction and the state of	4-	
	-	e from the med cart for		Medication administration audi		
		17 and 7/31/17 without		performed by pharmacy consu		
	-	inistration to the resident on		Interim Director of Nursing, and Facilitator to licensed nurses a		
	his MAR. During the discussed the usual p			medication aides.	nu	
		cumenting pain medications		Audit of Medication Administra	tion Record	
		led (PRN) for this resident.		reviews every shift by licensed		
		when the resident indicated		medication aides.		
	-	ould assess him and check		Licensed nurses and Medicatio	on aides	
		give a pain medication. If		audit tools reviewed by the Inte		
		and timing were determined		Director of Nursing, and Staff f		
	-	rse #1 reported she would		weekly X 8 weeks, then bi- mo		
		ation. Upon inquiry, the		months, then monthly for 2 mo		

Facility ID: 923456

If continuation sheet Page 35 of 41

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		B NO. 0938-03 DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · · ·	COMPLETED
						С
		345448	B. WING			08/11/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	ROVE HEALTH AND REF	ABILITATION CENTER		308 WEST MEADOWVIEW ROAD		
				GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 514	Continued From page	e 35	F 51	4		
-		cally documented the med				
		front of the MAR, the back				
	of the MAR, and in th	e narcotic book (containing		A QI committee was formed	on 9/1/2017	
		ance Receipt/Count Sheet)		consisting of the Interim Dire		
		vas given. When asked,		Nursing, Assistant Director o	•	
	of what happened to	couldn ' t recall the specifics		Staff Facilitator, Director of N Assistant Director of Nursing	•	
		dication administration on		Rehabilitation Director, Minin		
	the resident 's MAR.			nurses and Medical Records		
				The QI committee will meet w	weekly X 8	
		pleted on 8/11/17 at 11:40		weeks, then bi-monthly for 2		
	-	Administrator. During the		monthly for 2 months. All dis		
	interview, the Adminis	ursing staff to sign the MAR		will be reported to the Admin immediately for review of the		
	-	ostance was given to a			process.	
		dicated the documentation		The Administrator will report	quarterly to	
	on a resident 's Cont	rolled Substance		the executive quality improve		
		and the resident 's MAR		committee quarterly X2. The		
		and coincide with one		Committee consist of: medic		
	another.	dmitted to the facility on		administrator, DON, pharmad dietary manager, activities di	•	
	7/21/17 from a recent	-		medical record director.	rector and	
		s which included diabetes.		Recommendations to continu	ue, alter or	
	•	ion physician orders dated		modify will be discussed at the		
		illigrams (mg) by mouth (po) eurontin is a drug used to				
	treat nerve pain					
		ree times a day. Scheduled				
	to be administered 9 /	AM, 1 PM and 9 PM. Keflex				
		ig po in the am with meals				
		me. Metformin is an oral				
	hypoglycemia pill.					
	Review of the Medica	tion Administration Record				
		ex 500 mg at 9 PM and				
	-	t bedtime on 7/21/17 were dministered to Resident #4.				

If continuation sheet Page 36 of 41

		D HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/12/2017 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	· /	TE SURVEY MPLETED
		345448	B. WING			0	C 8/11/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND REF	ABILITATION CENTER		-	08 WEST MEADOWVIEW ROAD BREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514	PM and Metformin 10 day of admission (on document. Record re- revealed an emergen- form showing Nurse # and Metformin 1000 r backup kit in the facilit An interview was com AM with the facility 's interview, the Adminis expectation was for n when medications are 3. Resident #3 was ac 8/2/17 with cumulative diabetes mellitus. Review of the admiss 8/2/17 included: " Cymbalta 60 milli once a day (QD). Cyt depression. " Neurontin 300 mg to treat nerve pain. " Lisinopril 20 mg p to treat high blood pre " Multivitamin with Review of the Medica (MAR) revealed Cym Multivitamin with Mine scheduled for 8/3/17, were not documented Interview on 8/9/17 at who stated she admir Multivitamin with Mine	tered Keflex 500 mg at 9 00 mg at bedtime on the 7/21/17) but did not eview with Nurse #5 cy drug kit replacement #5 retrieved Keflex 500 mg mg out of the medication ty. appleted on 8/11/17 at 11:40 Administrator. During the estrator stated her ursing staff to sign the MAR e administered. dmitted to the facility on e diagnoses which included ion physician orders dated igrams (mg) by mouth (po) mbalta is used to treat g qd po. Neurontin is used essure and heart failure. Minerals 1 qd po tion Administration Record balta, Neurontin, erals and Lisinopril 8/4/17 and 8/5/17 at 9 am I as administered. : 11:42 AM with Nurse #8 histered Cymbalta,	F	514			

Facility ID: 923456

If continuation sheet Page 37 of 41

		ID HUMAN SERVICES			FOR	D: 09/12/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	345448		B. WING		C 08/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
	ROVE HEALTH AND REI		30	8 WEST MEADOWVIEW ROAD		
MAPLE G	NOVE REALTH AND REP	ABILITATION CENTER	GI	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP! DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	Continued From page	e 37	F 514			
	An interview was con AM with the facility 's interview, the Adminis	npleted on 8/11/17 at 11:40 s Administrator. During the strator stated her sursing staff to sign the MAR				
F 520 SS=D	483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F 520			9/6/17
	(g) Quality assessme	nt and assurance.				
	(1) A facility must ma and assurance comm minimum of:	intain a quality assessment nittee consisting at a				
	(i) The director of nur	sing services;				
	(ii) The Medical Direc	tor or his/her designee;				
	staff, at least one of v	a board member or other				
	(g)(2) The quality ass committee must :	essment and assurance				
	coordinate and evaluation	n respect to which quality				
		ement appropriate plans of tified quality deficiencies;				
		rmation. A State or the quire disclosure of the				

If continuation sheet Page 38 of 41

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/12/2017 APPROVED 0.0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345448		B. WING			C 08/11/2017		
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
			308 WEST MEADOWVIEW ROAD					
			GREENSBORO, NC 27406					
(X4) ID PREFIX TAG				ID PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 520	 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 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. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place in April 2017. This was for one recited deficiency, which was originally cited during the facility 's recertification survey completed on 5/5/16, and recited during both the last recertification survey on 4/7/17 and the current complaint survey. The deficiency was in the area of assessment accuracy (F278). One additional deficiency originally cited during the last recertification survey or factor of the facility during three federal surveys of record show a pattern of the facility 's inability to sustain an effective QAA Program. The findings included: This tag is cross referred to: a) F278: Based on staff interviews and record review, the facility failed to accurately code the Minimum 		F	520	Maple Grove Health and Rehabilitati acknowledges receipt of the Stateme Deficiencies and proposes this Plan of Correction to the extent that the sum of findings is factually correct and is of to maintain compliance with applicab rules and provisions of quality of care residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficie 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 rese the right to refute any of the deficiency on this Statement of Deficiencies thro Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F- 520	nt of of mary order le of on ncies		
		ssment to reflect the use of 1 of 3 sample residents			F -520			

Facility ID: 923456

If continuation sheet Page 39 of 41

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 09/12/20 RM APPROVE NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			C 08/11/2017		
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				08 WEST MEADOWVIEW ROAD				
	KOVE REALTH AND RE	HABILITATION CENTER		REENSBORO, NC 27406				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG				(X5) COMPLETION DATE	
F 520	Continued From page	e 39	F 5	520				
		eceiving pain medications		20				
	(Resident #7).	ceeving pair medications			Corrective action has been taken for	the		
					identified concerns related to F -278			
	During the annual red	certification survey of 5/5/16,			Assessment			
	the facility was cited	F278 for failure to accurately			Accuracy/Coordination/Certified and	F		
		sment to reflect the active			279 Comprehensive Care Plans as			
		sample residents reviewed.			reflected in the plan of correction.			
	The facility was recite							
		of 4/7/17 for failure to			0.0/00/0047.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0			
	-	MDS on the oral status for 1 e PASRR Level II status for 1			On 8/30/2017 the Medical Director w	as		
	of 1 resident.	e PASKK Level II status Ior 1			notified by the Administrator of the Assessment Accuracy and			
	of Tresident.				Comprehensive Care Plan concerns			
	b) F279:				without additional recommendation			
		n, staff interview and record			besides reeducation of the Minimum	Data		
	review the facility fail	ed to develop a			Set nurses, licensed nurses to sign for	or as		
	comprehensive care	plan with measureable goals			needed medication on the Medication	ı		
	and interventions to a	address Resident #9 bilateral			Administration record and audits to			
		This was evident in 1 of 1			research for continued issues .			
	resident reviewed for	contractures.						
		tion survey of 4/7/17, the			The Quality Improvement Committee			
	•	-279 for failure to develop a			consist of the Interim Director of Nurs	sing,		
	-	essed a therapeutic activity			Staff Facilitator, Minimum Data Set			
	program for 1 of 5 res	sidents reviewed.			nurses, and Medical Record Supervis			
	The facility ' s Admini	istrator was interviewed on			The Quality Improvement Committee continue to meet at a minimum of mo			
	8/11/17 at 2:30 PM re				with the Executive QI committee mee	-		
		ective action taken for MDS			quarterly. The Executive QI Committee mee	•		
		ans. During the interview,			including the Medical Director, will re-			
	•	ted she expressed concerns			monthly compiled QI report information			
	about the accuracy o	f MDS assessments at a			review trends, and review corrective			
		ve Meeting. She stated			actions taken and the dates of compl			
		the MDS assessments			The Executive QI Committee will vali			
		w issues, so additional			the facility's progress in correction of			
		lities were provided for the			deficient practices or identify concern			
		dministrator also reported the			Any areas of concern that needs to b			
		te nurse come in to complete assessments. This audit			corrected or changed will be done at time. The administrator will be	ulis		
	an auuit on the MDS							

Facility ID: 923456

If continuation sheet Page 40 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, <i>,</i>	(X3) DATE	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
				с		
					/11/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
ROVE HEALTH AND REF	HABILITATION CENTER					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIOI DATE	
identified some misse The Administrator sta have to retrain them (bottom up to correct to the Administrator also deficiency for care pla plans were initially cit deficiency identified of survey involved anoth Administrator indicate instructed to update r	ed entries and discharges. tted, "The plan now is we (MDS nurses) from the this." During the interview, o discussed the recited ans. She indicated care ted for activities and the during the current complaint her care area. However, the ed the MDS nurses were residents ' care plans with	F 520	responsible for ensuring Comr concerns are addressed throu training or other interventions. administrator or her designee	gh further The will report		
	Continued From page identified some misse The Administrator also deficiency for care pla plans were initially cit deficiency involved anott Administrator indicate instructed to update r	CORRECTION IDENTIFICATION NUMBER: 345448 345448 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IDENTIFYING INFORMATION)	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING CORRECTION 345448 B. WING	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ABUILDING	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMIT 345448 STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWIEW ROAD GREENSBORO, NC 27406 ROVE HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWIEW ROAD GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 identified some missed entries and discharges. The Administrator stated, "The plan now is we have to retrain them (MDS nurses) from the bottom up to correct this." During the interview, the Administrator also discussed the recited deficiency identified during the current complaint survey involved another care area. However, the Administrator indicated the MDS nurses were instructed to update residents ' care plans with F 520	

If continuation sheet Page 41 of 41