STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LEAF HEALTH CARE	1101 MAPLE CARE LANE STATESVILLE, NC 28625

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	F656 1. Corrective action was accomplished for the alleged deficient practice by the MDS Coordinator updating the care plan on 3/16/18 for Resident #26 indicating cast application. 2. All residents with a cast have the potential to be affected by this alleged deficient practice. The RCMD and MDS Coordinator completed an audit of all care plans to ensure that all cast application and cast management approaches were care planned for all residents wearing casts. This audit was completed on 4/6/18. 3. The District Director of Clinical Services re-educated RCMD and MDS Coordinator on 3/16/18 regarding updating care plans for cast application and management. The RCMD will randomly audit five care plans per week for 12 weeks to ensure that the care plans have been updated for cast application and management. Opportunities will be corrected as identified. 4. To monitor the effectiveness of the above action plan for	4/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie K. Simon — TITLE: Administrator — (X6) DATE: 4/7/18

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.

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop a care plan to include cast care for 1 of 5 residents reviewed for accidents (Resident #26). The findings included: Resident #26 was admitted to the facility on 01/11/18 with diagnoses which included heart failure, osteoarthritis and age related physical debility. The most recent Minimum Data Set (MDS) dated 01/18/18 indicated she had severely impaired cognition and required extensive assistance with the physical assist of 2 staff for transfers. The MDS also indicated Resident #26 was not steady and only able to stabilize herself with human assistance. The MDS noted Resident #26 required a walker and or a wheelchair for ambulation. Review of Resident #26's medical revealed she had a fall on 01/31/18 which resulted in a fracture of her right wrist that required a cast which was applied on 02/02/18. Review of Resident #26's Care Plan for falls dated 02/01/18 (revision) revealed she was at high risk and had a fall on 01/31/18 and sustained an injury to her right arm. There was no mention of a cast application or the management of a cast added to the care plan. On 03/16/18 at 11:52 AM during an interview with MDS Coordinator #1 (MDSC) she stated she was	F 656	updating care plans, the RCMD will review the findings of the care plan reviews in the QAPI meeting monthly for 3 months beginning 4/13/18. The QAPI Committee will evaluate the effectiveness of the plan for updating care plans for cast application and management and make recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	4/13/18

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F 656	Continued From page 2 responsible for writing the care plans based on the regular assessments (except for activity care plans) as well as for problems or acute changes that occurred between the assessment periods. The MDSC admitted she would write a care plan for a fall that resulted in a fracture and required a cast application.	F 656		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to maintain water temperatures at safe levels to avoid putting residents at risk at resident bathroom sinks in 2 of 2 sampled and occupied resident rooms (Room #110 & #112) and 2 of 2 resident bath and shower rooms. Findings included: A review of the facility's Water Temp logs from February 12th, 2018 through March 9th, 2018 revealed water temperatures were recorded on a daily basis on the 100, 200, 300 and 400 halls along with the 200 and 300 hall shower rooms, the front lobby and in the kitchen and laundry room. The logs revealed the most recent recorded water temperatures were documented on 3/9/18 as follows:	F 689	F 689 1. Corrective action was accomplished for the alleged deficient practice by the Maintenance Director adjusting the water temperature at the mixing valve immediately on 3/13/18. The temperatures were checked hourly until 10:00 pm to ensure that temperatures were maintained at or below 116 degrees. 2. All residents have the potential to be affected by the alleged deficient practice. On 3/13/18, the Maintenance Director conducted immediate rounds on each hall to monitor water temps throughout the facility. There were no other observations of elevated water temps greater than 116 observed.	4/13/18

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F 689	Continued From page 3 100 Hall recorded water temperature of 107 degrees Fahrenheit (F) 200 Hall recorded water temperature of 109 degrees F 200 Hall Shower recorded water temperature of 106 degrees F 300 Hall recorded water temperature of 106 degrees F 300 Hall Shower recorded water temperature of 107 degrees F 400 Hall recorded water temperature of 112 degrees F Dietary recorded water temperature of 152 degrees F Front Lobby recorded water temperature of 106 degrees F Laundry Room recorded water temperature of 152 degrees F On 3/13/18 at 3:26 PM an observation of hot water at the sink in resident room #110 revealed the water being warm when first turned on but after a short time the water became hot to touch, reddening skin and an observation of steam rising from the sink. On 3/13/18 at 3:18 PM an observation of hot water at the sink in resident room #112 revealed the water to be warm but quickly becoming too hot to touch with further observations of steam rising from the sink. An interview with Resident #48 on 3/13/18 at 3:26 PM revealed she knew the water could get very hot. Resident #48 denied any significant injury but stated the hot water had "reddened" her skin before. She further reported the shower water being very hot at times as well. An interview with the Maintenance Director at	F 689	3. Measures put in place to ensure that the alleged deficient practice does not recur include: Maintenance Director will continue to complete daily (Mon. thru Fri.) spot checks of water temps in one room per hall and in both shower rooms to ensure temps are maintained at or below 116 degrees. Maintenance Director will make any needed adjustments to the mixing valve based upon his checks of the water temps. 4. To monitor the effectiveness of the above action plan for elevated water temps, the Administrator and Maintenance Director will the review the findings of water temperatures weekly and review in the QAPI meeting monthly for 3 months beginning 4/13/18. The QAPI Committee will evaluate the effectiveness of the plan for elevated water temps and make	4/13/18

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F 689	Continued From page 4 3/13/18 at 3:28 PM revealed he reportedly checked water temperatures in the facility every morning when he arrived for work. At this time he retrieved the thermometer he used to temp water in the building and proceeded to temp the water in resident room #110. The water in resident room #110 proceeded to temp at 118 degrees F. The Maintenance Director at that time stated "it's running too hot". He further reported the temperature earlier in the day when he temped the water on the 100 hall to be at 108 degrees F. The Maintenance man proceeded to temp the 300 Hall shower room where the water temped at 119.1 degrees F. At that time, the Maintenance Director stated he felt the water was too hot throughout the building. He reported the facility's water was "on a loop" and it could take "a while" for the hot water to complete the loop through the facility and back to the mixer's thermometer to tell it to turn on. An interview with Nurse Aide #2 on 3/13/18 at 3:55 PM revealed the facility's shower water gets very hot and she has to mix it to ensure it is not too hot for the residents. She reported putting her hands under the running water to make sure it is not too hot before putting a resident in the shower. She further reported if she did not mix the shower water it would be too hot for residents. In a follow-up interview with the Maintenance Director on 3/13/18 at 4:03 PM he stated he was going to complete a "building bleed" of the hot water and begin running hourly checks while logging the water temperatures to ensure they were within a safe range. He reported he had gone to the mixing valve and made adjustments to lower the temperature of the water. At this time the Maintenance Director reported the	F 689	recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	4/13/18

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F 689	Continued From page 5 facility's hot water boiler was set to a temperature of 160 degrees F. He further reported if water stayed in the facility's system and became "stagnant" then the initial water temperatures "would probably temp lower" that when water was being consumed at "high use" times (i.e. while laundry and dishes were being washed and resident showers occurring). An interview with the Administrator on 3/16/18 at 2:42 PM revealed she expected "Water temperature to be checked and adjusted to resident preference".	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 812	F812 1. Corrective action was accomplished for the alleged deficient practice by the Dietary Manager discarding the frozen pizza on 3/13/18 and by providing re-education on hair containment to the Dietary Aide on 3/15/18. 2. All residents have the potential to be affected by the alleged deficient practice. The Administrator re-educated the Dietary Manager and RCS #1 regarding proper food storage in the nourishment room on 3/13/18. Additionally, the Dietary Manager re-educated dietary staff regarding proper hair containment on 3/15/18.	4/13/18

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F 812	Continued From page 6 record review the facility failed to remove expired food from 1 of 1 nourishment freezer and failed to serve foods under sanitary conditions by wearing a hair restraint that fully covered staff's hair for 1 of 1 meal service. The findings included: 1. On 03/13/18 at 9:41 AM observations were made of the facility's nourishment room with the Dietary Manager (DM). Contents of the freezer were observed and noted to have a frozen pizza with the expiration date of 08/28/17. The item was labeled with a resident's name. The DM was interviewed and explained that Resident Care Specialist (RCS) #1 was responsible for checking the unit daily to remove expired food. The DM offered no explanation why an expired food item was stored for resident use. On 03/13/18 at 1:14 PM RCS #1 was interviewed and stated she checked the nourishment room refrigerator and freezer daily for expired foods. She explained she had not checked the unit freezer at the time of the observation the day of 03/13/18 because she was late for work due to weather. 2. On 03/15/18 at 11:44 AM observations were made of the lunch meal service. During the meal service Dietary Aide #1 was noted to be working the tray line. Closer observations reveled her	F 812	3. Measures put in place to ensure that the alleged deficient practice does not recur include: The Dietary Manager will conduct daily (Mon. thru Fri.) checks of the nourishment room to ensure expired items are discarded. The Dietary Manager will also conduct daily (Mon. thru Fri.) observations of hair containment of dietary staff. Opportunities will be corrected as identified. 4. To monitor the effectiveness of the above action plan for proper food storage and hair containment, the Administrator and Dietary Manager will review the findings of both areas and review in the QAPI meeting monthly for 3 months beginning 4/13/18. The QAPI Committee will evaluate the effectiveness of the plan for food storage and hair containment and make recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	4/13/18

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F 812	Continued From page 7 hairnet did not contain her hair. The hairnet was positioned behind the aide's bangs, allowing them to be exposed. The aide was noted to assist with food service and standing at the steam table with uncovered food. On 03/15/18 at 3:40 PM the Dietary Manager (DM) and District Manager were interviewed. The DM stated she had never been asked about hair containment and had not noticed dietary aide #1 failed to cover all her hair with a hairnet. During the same interview the District Manager explained employees were expected to have "all their hair covered."	F 812		