STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 11/15/2021

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MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 000	INITIAL COMMENTS A complaint survey was conducted from 11/4/21 through 11/15/21. 1 of the 12 complaint allegations was substantiated resulting in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/26/21 and was removed on 11/11/21. A Partial extended survey was conducted.	F 000		
F 689 SS=J	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 record review, observation, resident, staff and physician interviews, the facility failed to ensure 1 of 3 residents (Resident #1), who was on an anticoagulant (blood thinner) and required extensive assistance with Activities of Daily Living (ADL) care, was provided care safely to prevent injury. During a bed bath provided by nursing assistant (NA) #1 on 10-26-21, Resident #1 was	F 689	Maple Grove Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of	12/13/21

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

Electronically Signed | 12/01/2021

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F 689	Continued From page 1 positioned on her left side on an air mattress when NA #1 turned away and Resident #1 rolled off the bed onto the floor resulting in 4 fractures to her left leg, acute blood loss, and a 10-centimeter laceration to her left lower leg. Resident #1 was hospitalized for 3 days. Immediate Jeopardy began on 10-26-21 when Resident #1 was being provided a bed bath and rolled out of bed onto the floor causing serious injury that included 4 fractures to her left leg, acute blood loss and laceration to her left lower leg. This resulted in Resident #1 spending 3 days in the hospital and ongoing "intolerable" pain. Immediate Jeopardy was removed on 11-11-21 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" no actual harm with potential for more than minimal harm that is not Immediate Jeopardy to ensure monitoring systems put in place are effective. Findings included: Resident #1 was admitted to the facility on 4-30-18 with multiple diagnoses that included chronic anemia, congestive heart failure, below knee amputation right side, history of pathological fracture, osteomyelitis, pulmonary embolism and spina bifida. Resident #1's active care plan dated 7-16-21 revealed a goal that Resident #1 would have fewer falls. The interventions for the goal were in part; assist during transfer and mobility, bed in lowest position after staff administered care and rehab/therapy referral. The resident's active care plan also included an area focused on Activities	F 689	Correction is submitted as a written allegation of compliance. Maple Grove Nursing and Rehabilitation Center s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F689 Free of Accident Hazards/Supervision/Devices Resident #1 continues to remain in the facility. Resident #1 was discharged to the hospital after this accidental fall. Resident #1 had the following diagnoses at the hospital: 4 fractures: right leg (right ankle pilon fracture, right tibial plateau fracture with history of right transtibial amputation), left leg (left tibial plateau fracture, left medial femoral condyle fracture), acute blood loss requiring transfusion of 3 units packed red blood cells and a laceration to her left lower leg. Resident #1 was hospitalized for 3 days and returned to the facility on 10/29/2021. Resident #1 continues to be treated in the facility for the above diagnoses and continues scheduled and as needed pain medications. The facility investigation determined the root cause of the fall: Nursing assistant	

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F 689	Continued From page 2 of Daily Living (ADL) care. The interventions included: bathing 1-2 persons total assist, personal hygiene extensive assistance and bed mobility extensive assistance with one person. Physician order dated 8-31-21 revealed Resident #1 was ordered Percocet (pain medication) 5/325mg (milligrams) four times a day. The quarterly Minimum Data Set (MDS) dated 10-13-21 revealed Resident #1 was cognitively intact and required extensive assistance with one person for bed mobility toileting and personal hygiene and total assistance with one person for bathing. The MDS also documented Resident #1 was coded for impairments with upper/lower extremity range of motion, history of falls, resident height as 5 feet 2 inches and weighed 313 pounds, and she received anticoagulant medication and pain medication on 7 of 7 days. Physician order dated 10-17-20 revealed Resident #1 was ordered Eliquis (blood thinner) 2.5mg (milligrams) twice a day. NA #1 was interviewed on 11-4-21 at 10:55am. The NA acknowledged she was the NA bathing Resident #1 on 10-26-21. NA #1 described rolling Resident #1 onto her left side to wash her back. NA #1 said she had looked away and removed her hands from the resident, who was still laying on her left side, to reach for a towel on the nightstand that was approximately arm's length away and the resident had fallen on the floor. She also stated she did not see the resident fall and could not remember the position the resident was laying on the floor. NA #1 was interviewed by telephone on 11-6-21 at 9:38am. Discussed with NA #1 that Resident #1 had indicated she had	F 689	(NA) performing activity of daily living (ADL) care (bed bath) rolled resident #1 to her left side without additional assist or siderails to assist resident with bed perimeters/device to assist with turn and position. The interventions indicated to apply side rails to resident bed and increase ADL care assistance during bed baths, transfers, and positioning. Bed rails have been added to Resident #1's bed as of 10/29/21 upon return to the facility from the hospital, to assist with turning and positioning and to assist her with bed perimeters. As of 10/29/21 upon return to the facility from the hospital, additional staff has been added for Resident #1's activities of daily living care (positioning, bathing, changing, transfers) for added safety. Resident #1 has had no additional falls from bed to floor since this incident. All residents have the potential to be affected. On 10/29/21 the interim Director of Nursing (DON), Unit Supervisor, interim facility administrator, and regional support staff completed in-servicing on positioning, safety devices (bed rails), and required assistance for amputees to all direct care staff including direct care agency staff. The education provided was as follows: "Whenever you are giving ADL care make sure resident is in safe position while turning. Educate resident to use side rail properly and if you feel you need help notify charge nurse to get additional assistance." An additional in-servicing was completed	

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F 689	Continued From page 3 rolled the resident too hard and had rolled her off the bed. NA #1 reported she had not rolled Resident #1 too hard but explained the resident often had her left foot hanging off the edge of the bed as she did on 10-26-21. She stated she had not thought Resident #1 was close enough to the edge of the bed to fall out of bed. Also discussed leaving Resident #1 to obtain a basin of water out of the bathroom. NA #1 stated she had not left Resident #1's side and that she had retrieved all of her supplies needed prior to starting ADL care. Resident #1 was interviewed on 11-4-21 at 10:11am. The resident described the circumstances in which she fell out of bed as follows; NA #1 pulled Resident #1 close to her using the draw sheet then rolled Resident #1 onto her left side and the resident slid out of the bed. Resident #1 stated she spent 3 days in the hospital and now had 4 fractures in her left leg and a cut on her left lower leg. She discussed having pain issues prior to falling out of bed but described her pain now as intolerable. During the interview Resident #1 was noted to be grimacing. Resident #1 stated she planned on having a discussion with her physician to have her pain medication moved from every 6 hours to every 4 hours as needed. A second interview occurred with Resident #1 on 11-4-21 at 12:50pm. Resident discussed the nursing assistant (NA #1) was providing her with a bed bath on 10-26-21. The resident explained when NA #1 rolled her to her left side, the NA rolled her too hard rolling her off the bed and she fell on the floor. Resident #1 stated she did not have any side rails at the time, and she was on an air mattress. She explained there was usually only one NA present to provide care unless she asked for 2 NA's to be present due to her larger than average size and difficulty	F 689	on 11/10/21 by the interim DON, Unit Supervisor, interim facility administrator, and regional support staff to all direct care staff and direct care agency staff to include all residents for positioning, safety devices and required assistance in bed during care. This education included the following: resident is positioned in center of bed during care with safety devices (bed rails, wedges, call lights) as indicated are in place before moving away from resident and considering all mattress surfaces (pressure relief mattress, air mattress or specialty mattress). This education also includes information on an air mattress: air alternates with weight distribution causing an uneven (higher area) surface in areas where there is no weight on an air mattress. No direct care staff including direct care agency staff will be eligible to work until he/she has completed this education. This education has been added to the facility new hire and agency staff orientation packet. The interim administrator and interim Director of Nursing will be responsible for tracking and assuring that all nursing staff receive the required education. On 11/10/21 the interim DON, Unit Supervisor, interim facility administrator, and regional support staff completed observations on resident ADL care and resident positioning during care to ensure direct care staff including direct care agency staff, understand safe positioning of resident during care. No direct care staff will be allowed to	

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F 689	Continued From page 4 with mobility due to her below the knee amputation of her right leg. The resident stated she had not been able to roll herself over but if she had a side rail, she could hold herself over on her side. She stated she was sent to the hospital and needed a blood transfusion because she was anemic from losing blood. Resident #1 was observed grimacing during the interview and she stated she had always had pain but now it was almost intolerable. The resident discussed her pain medication being effective but would prefer to have the medication moved to every 4 hours. The Wound Care (WC) nurse was interviewed on 11-4-21 at 4:35pm. The WC nurse acknowledged she and the Director of Nursing were the first to respond after Resident #1 had fallen out of the bed on 10-26-21. She stated Resident #1 had informed her while she was applying the bandage that her left leg started coming off the bed pulling her down onto the floor. The WC nurse stated she had questioned NA #1 after she had completed dressing Resident #1's left lower leg and the NA informed her that she had rolled Resident #1 onto her left side and then left the resident to go to the bathroom to obtain the basin of water and when she returned the resident was on the floor. During an interview with the Director of Nursing (DON) on 11-4-21 at 4:46pm, the DON stated she entered Resident #1's room on 10-26-21 after she had heard NA #1 state the resident was on the floor. She said when she entered Resident #1's room, the resident explained that her leg was coming off the bed and she fell on the floor. The DON explained after the resident had been sent to the hospital, she interviewed NA #1 who stated she had turned to get a washcloth out of the	F 689	provide ADL care that involves positioning in bed until observation of care has been completed. Observations will be conducted by the interim DON, Assistant DON, Unit Supervisor, assigned special project nurse, and/or regional support staff before a newly hired direct staff or new agency staff is able to perform resident care and positioning safely. The interim administrator and the Interim Director of Nursing will be responsible for tracking audits related to staff observations. On 11/10/21 an audit completed by the interim DON and unit managers with the assist of the therapy department, to identify any resident requiring bedrails for assistance to turn and position. Identified residents requiring bed rails was then applied to identified resident bed by the maintenance department. On 11/10/21 an audit completed by the interim DON and unit managers of identified residents requiring 2 or more staff members. Any resident identified requiring 2 or more staff for ADL care has been identified on resident individual Care Guide. Beginning 11/10/2021, the (interim) director of nursing, unit manager, (interim) administrator, and/or assigned project nurse will audit 6 NAs performing ADL care for safe positioning weekly for 3 months to ensure all residents are being positioned safely during and after ADL care. The audit will be documented on the F689 Free of Accident Hazards/Supervision/Devices audit tool.	

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F 689	Continued From page 5 basin and when the NA turned back around the resident had fallen on the floor. She further commented NA #1 should have received assistance from another NA which would have avoided the residents fall. The DON discussed two new interventions were added for Resident #1 that included the assistance of 2 people when providing care and quarter rails to Resident #1's bed. Review of the nursing note completed by Nurse #1 dated 10-26-21 revealed at 11:10am Resident #1 was receiving care from NA #1. The resident's bed was at the height of the NA. Documented text revealed while Resident #1 was lying on her left side, the residents lower body started to slide off the bed and the upper body proceeded to come off the bed. Resident #1 complained of left hip and leg pain. The resident left the facility by ambulance at 11:45am. Review of the incident report completed by Nurse #1 dated 10-26-21 revealed Resident #1 was lying on the floor on her left side with her upper body towards the foot of the bed and her lower body towards the head of the bed. The report documented a large amount of blood to the left lower extremity, the resident's bed was at the height of the nursing assistant (NA #1) (approximately three and a half feet) with the air mattress inflated. The incident report revealed the resident complained of left hip and leg pain. Resident #1's statement in the documentation read resident was lying on her left side while receiving care and her lower body started to slide off the bed and then her upper body. Documentation showed the resident representative and physician were notified and the resident was transported to the hospital.	F 689	Beginning 11/10/2021, the (interim) Director of Nursing/Assistant Director of Nursing will review results of the audits during the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring to maintain regulatory compliance. Alleged date of compliance 12/13/2021	

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Nurse #1 was interviewed on 11-4-21 at 3:31pm. The nurse stated when she arrived at Resident #1's room on 10-26-21, the wound care nurse and Director of Nursing were already in the room. She stated she saw a pool of blood and the resident laying on the floor with her head at the foot of the bed and her feet at the head of the bed. The nurse discussed her interview with NA #1 when she entered the resident room stating NA #1 told her the resident was on her left side and just rolled out of bed. The nurse also stated she spoke with Resident #1 while obtaining vital signs and she told her the bottom half of her body started coming off the bed and then the top half of the body came off the bed and she fell on the floor. The nurse commented Resident #1 was unable to roll to either side on her own. Nurse #1 stated Resident #1 was sent to the emergency room.

Resident #1's hospital record dated 10-26-21 was reviewed. The hospital record documented Resident #1 arrived in the emergency room on 10-26-21 at 12:07pm presenting with a fall and laceration to her lower left extremity. Documentation from the emergency room revealed blood loss anemia and x-rays were completed showing multiple fractures including left proximal tibia, left distal tibia and fibula including open fracture, proximal left tibia, and distal left femur. The results of the emergency room exam showed Resident #1 would be admitted to the hospital for administration of antibiotics, immobilization and serial blood transfusion as necessary. Hospital records revealed Resident #1 was discharged back to the facility on 10-29-21 with an order for Percocet (pain medication) 10-325mg (milligrams) every 4

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F 689	Continued From page 7	F 689		

hours as needed, and wound care to left lower leg laceration daily using xeroform and a dry dressing. Discharge documentation also revealed Resident #1 had received 3 blood transfusions during her hospital stay related to blood loss from the resident's multiple fractures and laceration to her left lower extremity.

Resident #1's Physician was interviewed by telephone on 11-5-21 at 5:14pm. The Physician acknowledged Resident #1 had a significant fall. He stated the resident's weight and her diagnosis of Spina Bifida had impacted the seriousness of her fall.

The facility's Administrator was interviewed by telephone on 11-6-21 at 2:15pm. Discussed the facility's Performance Improvement Plan (PIP) dated 10-26-21 regarding Resident #1's fall on 10-26-21. The Administrator had acknowledged the Root Cause Analyses (RCA) had not addressed Resident #1's position on the bed or that the resident had an air mattress. The Administrator stated the facility's focus was the fact Resident #1 had an amputation which caused the resident's center of gravity to be altered resulting in the fall from the bed.

Observation of ADL care occurred on 11-4-21 at 10:25am. NA #1 was performing the ADL care with a second NA. The observation revealed, during bed mobility, Resident #1 was turned onto her right side by NA #1 with the resident's body on the edge of the mattress and the second NA holding Resident #1 on the bed while the resident held onto the side rail.

The Administrator was notified of Immediate Jeopardy on 11-6-21 at 1:29pm.

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F 689	Continued From page 8 The facility provided a credible allegation of Immediate Jeopardy removal dated 11-11-21. " Recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance On 10/26/21 during a bed bath Resident #1 was identified to have fallen off the bed onto the floor. The resident fell onto the floor with her upper body positioned at the foot of the bed and her lower body at the head of the bed. The nursing assistant (NA #1) involved was reaching for a towel at the foot of the bed when the resident moved her left leg (per resident statement to interim Director of Nursing (DON)) off the bed causing Resident #1 to fall from the bed to the floor. NA #1 was unable to validate exact cause of the fall as she had looked away from the resident to get the towel and was therefore not looking at the resident at the time of the fall. The resident stated immediately after the incident to the interim DON that she (Resident #1) moved her left leg over her right amputated leg to off the side of the bed causing her to fall off the bed. Resident # 1 was noted with acute bleeding and complaints of pain. Facility staff notified facility medical providers and obtained orders to send to hospital for acute evaluation. Evaluation at the hospital revealed 4 fractures: right leg (right ankle pilon fracture, right tibial plateau fracture with history of right transtibial amputation), left leg (left tibial plateau fracture, left medial femoral condyle fracture), acute blood loss requiring transfusion of 3 units packed red blood cells and a laceration to her left lower leg. Resident #1 was hospitalized for 3 days. All residents who require ADL assistance in bed have the potential to be affected by this deficient	F 689		

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practice.

Actions taken to alter the process or system failure to prevent a serious adverse outcome for occurring or recurring
On 10-26-21 the facility initiated an investigation and initiated a Performance Improvement Plan (PIP) which was completed 10/29/21. The facility investigation determined the root cause of the fall: NA performing ADL care (bed bath) rolled resident to side without additional assist or side rails to assist resident with bed perimeters. The interventions indicated to apply side rails to resident bed and increase ADL care assistance during bed baths, transfers, and positioning. Bed rails have been added to Resident #1's bed as of 10/29/21 upon return to the facility from the hospital, to assist with turning and positioning and to assist her with bed perimeters. As of 10/29/21 upon return to the facility from the hospital, additional staff has been added for Resident #1's activities of daily living care (positioning, bathing, changing, transfers) for added safety. Resident #1 has had no additional falls from bed to floor since this incident.
On 10/26/21 the interim DON, Unit Supervisor, interim facility administrator, and regional support staff initiated in servicing on positioning, safety devices (bed rails), and required assistance for amputees to all direct care staff. The education provided was as follows: "Whenever you are giving ADL care make sure resident is in safe position while turning. Educate resident to use side rail properly and if you feel you need help notify charge nurse to get help."

As a result of review during this survey we have broadened our review of residents who could be affected by falls from bed to floor. As of 11/6/21

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we are now addressing; 1) bed position during care, 2) bed position if staff member is not directly working with resident during care to assure, they are left in a safe position and 3) additional and similar bed position precautions to be taken for residents specifically on an air mattress. In expanding our broader scope of potential risk factors, it was determined that all residents who receive care in bed could be affected by this non-compliance.
On 11/6/21 in servicing was expanded to include all residents for positioning, safety devices and required assistance in bed during care to include the following: resident is positioned in center of bed during care with safety devices (bed rails, wedges, call lights) as indicated in place before moving away from resident and considering all mattress surfaces (pressure relief mattress, air mattress or specialty mattress). This education also includes information on an air mattress: air alternates with weight distribution causing an uneven (higher area) surface in areas where there is no weight on an air mattress. This education began 11/6/21 by the interim DON, Unit Supervisor, interim facility administrator, and regional support staff and will be completed 11/10/21. No direct care staff will be eligible to work until he/she has completed this education. The interim Administrator and interim Director of Nursing will be responsible for tracking and assuring that all nursing staff receive the required education.

The interim DON, Unit Supervisor, interim facility administrator, and regional support staff will observe resident ADL care and resident positioning during care to ensure staff understand safe positioning of resident during care. These

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 11/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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observations will begin 11/6/21 and be completed by 11/10/21. No direct care staff will be allowed to provide ADL care that involves positioning in bed until observation of care has been completed. The interim Administrator and the Interim Director of Nursing will be responsible for tracking audits related to staff observations.

Alleged date of IJ removal: 11/11/21.

The credible allegation was verified on 11/15/21. Education was provided to all staff 10/26 regarding positioning, safety devices, and required assistance. Education was provided on 11/6/21 regarding bed positioning, use of bed rails, air mattress safety, pressure relieving mattress, activity of daily living care provision, ensuring resident in center of bed. Staff completed quizzes after each in-service training. Facility staff conducted audits of persons with assistive and safety devices per plan of correction. Observation while in the facility revealed resident's resting in the center of bed. Interview with agency nursing staff at 4:50 PM on 11/15/21 revealed that she had recent training on repositioning and ensuring residents are placed in the center of the mattress. Interview with facility nursing assistant at 4:54 PM revealed that she received training on falls, turning and repositioning, and ensuring good bed placement prior to care provision. Review of 4 residents with falls since the date of compliance revealed no falls related to the provision of care or bed placement. The facility's date of compliance,11/11/21 was validated on 11/15/21.