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 05/15/2024

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

(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
E 000	Initial Comments An unannounced recertification and complaint investigation were conducted on 05/12/24 through 05/15/24. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID: TLDE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted on 05/12/24 through 05/15/24. Event ID# TLDE11. The following intake was investigated: NC00216757. 1 of 4 allegations resulted in a deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Nurse Practitioner interviews the facility failed to protect a resident's right to be free from abuse when Resident #17 asked Nurse Aide (NA) #1 multiple times to let go of his right arm during	F 600	F600 1.Corrective action was accomplished for alleged deficient practice on 5/15/24 when a formal abuse investigation was initiated and subsequently completed and	5/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 05/31/2024

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.

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 05/15/2024

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F 600	Continued From page 1 incontinent care and when she did not Resident #17 pulled his right arm away from NA #1 and during the interaction received a small skin tear with a red/purple bruise that was approximately the size of a half dollar on his right forearm for 1 of 3 residents reviewed for accidents. Resident #17 stated that NA #1 ignored his request to let go of his arm and then laughed at him. The skin tear required a treatment with calcium alginate (dressing used for management of draining wounds) three times weekly and as needed. The findings included: Resident #17 was readmitted to the facility on 10/12/23 with diagnoses that included dysphagia, cognitive communication deficit, hypertension, diabetes, heart failure, and chronic obstructive pulmonary disease. Review of a physician order dated 11/06/23 read, Aspirin 81 milligram (mg) by mouth every day. Resident #17's quarterly Minimum Data Set (MDS) dated 04/20/24 revealed that he was cognitively intact for daily decision making and had verbal behaviors 1 to 3 days, was frequently incontinent of bladder and required extensive assistance of two staff members for bed mobility. A care plan revised on 04/03/24 read, Resident #17 has a behavior problem. At increased risk for falls/injury related to overt behaviors, noncompliant with medication and treatments frequently. The goal read; Resident #17 will have no evidence of behavior problems by the review date. The interventions included: administer medications as ordered, caregivers to provide opportunities for positive interactions and	F 600	unsubstantiated on 5/16/24. Resident #17 was provided with immediate treatment and care for the small skin tear and bruise. NA#1 was individually educated on definitions of abuse/neglect and given specific examples/scenarios and had individual education on turning/repositioning residents. 2.All residents have the potential to be affected. Interviews were completed by Unit Managers with alert and oriented residents with a BIMS greater than 13 in the building to allow them to discuss if they had feelings of being mistreated verbally or physically. Skin assessments were completed on all residents in the building by a nurse on 5/15/24. No further concerns were noted to indicate allegations or suspicions of abuse. 3. The Administrator and/or DON educated all staff on 5/15/24 regarding definitions of abuse/neglect, immediate reporting of abuse/neglect, identification of abuse/neglect and to be aware of nervous laughter. Facility staff educated on definitions of abuse/neglect and given specific examples/scenarios. Facility staff were also educated in reporting of abuse/neglect and rapid identification of abuse/neglect and immediate reporting to the Administrator/DON. Future staff/new hires will receive the same education regarding Abuse. 4. The DON and/or designee will interview/observe five residents per week	

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 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600

Continued From page 2

attention, monitor behavior episodes and attempt to determine underlying cause (consider location, time of day, persons involved, and situation), and praise any indication of the resident's progress/improvement in behavior.

An observation and interview were conducted with Resident #17 on 05/12/24 at 11:00 AM, Resident #1 was resting in bed with his head of bed elevated and had a long sleeve flannel shirt on and was covered with a sheet. Resident #17 reported that at approximately 3:00 AM he was awakened by the Nurse Aide (later identified as NA #1) who stated she was going to change him. Resident #17 stated she "grabbed my right arm" while standing on the left side of the bed and was trying to turn him towards her but because of her "girth" he could not turn over and "I kept telling her that she was hurting my arm, and she would not let go so I had to pull my arm away from her." Resident #17 pulled up the right sleeve of his flannel shirt to reveal a dime size red/purple bruise that had a small 2 x 2 bordered gauze over it. He reported that the nurse (Nurse #1) had put the dressing on this morning. Resident #17 stated that NA #1 was in his room alone that night with no other staff present.

Nurse #1 was interviewed on 05/12/24 at 11:30 AM who stated that Resident #17 reported when NA #1 was changing him through the night she held his arm too tight, and he had a "discolored area and a small skin tear." Nurse #1 stated she had cleaned the area and put a gauze over the area.

NA #1 was interviewed via phone on 05/13/24 at 12:09 PM, she confirmed that she had worked on Saturday night (05/11/24) to Sunday (05/12/24)

F 600

and five staff per week for twelve weeks to ensure residents do not have any allegations of abuse/neglect or non-verbal signs of abuse and to identify any staff members with any knowledge of abuse/neglect allegations.

To monitor the effectiveness of the above plan, the Administrator and/or DON will report the results of the resident and staff interview audits in the facility□s monthly QAPI meeting for twelve weeks. The Administrator and/or DON will review the audit to identify patterns/trends and will adjust the plan to maintain compliance. The QAPI Committee will evaluate the effectiveness of the plan and make recommendations for changes in the plan as indicated.
5. Date of Compliance 5/22/24.

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 05/15/2024

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

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F 600	Continued From page 3 morning and was caring for Resident #17. She explained that she was not very familiar with Resident #17 and had only cared for him while in training with NA #2 for one shift. NA #1 stated that "he gave me a hard time that night" and NA #2 told Resident #17 to be nice referring to the first time she cared for Resident #17 while in training. She added, Resident #17 "did not like me from day 1." NA #1 stated that she went into Resident #17's room on 05/12/24 but could not recall the time and asked to check him and see if he was soiled and he agreed. She stated his blanket was on the floor, so she picked it up and placed it at the foot of the bed because she was getting ready to change Resident #17. NA #1 stated "I grabbed his elbow and turned him towards me, and he said why are turning me so fast?" NA #2 replied in a jovial manner "I am not turning you fast, but I am sorry." When NA #1 was asked which elbow she grabbed she replied, "I did not grab his elbow, I had one hand on his shoulder and one hand on his hip" and when asked to explain why she stated previously she stated she had grabbed his elbow she replied, "I never grabbed his elbow, and he had a place on his wrist already." NA #1 stated that Resident #17 was insistent that she put cream on his bottom but the only cream he had was for arthritis and she told him she would finish caring for him and ask the nurse about the cream. NA #1 stated that she closed Resident #17's brief, put the sheet and blanket on him, and lowered his bed and went and told Nurse #3 that Resident #17 "was fussing a me" and she stated, "he does that to everyone." NA #1 again stated, "I never had my hand on his right arm, his skin looks like it tears easily, and he had something on his wrist already. He had on long sleeves, and he called the nurse, and she inspected his wrist, but I did not touch his	F 600		

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	345340	A. BUILDING ______ B. WING ______	C 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4	F 600		

arm."

An observation and interview were conducted with Resident #17 on 05/13/24 at 1:10 PM. Resident #17 was resting in bed with his head of bed elevated and was alert and verbal. Resident #17's right forearm continued to have a red/purple bruise that extended to the size of a quarter and continued to have a small, bordered gauze covering the skin tear. Resident #17 was asked to repeat how the skin tear and bruise occurred. Resident #17 stated, "that girl was about 300 pounds which isn't her fault, and she grabbed my right arm and tired to turn me into her but because of her stomach I could not turn over anymore and I told her she was hurting my arm and to let go and she just ignored me and laughed at me." "I reached over and removed her hand and pulled my arm away" and there was red place where she had ahold of my arm. Resident #17 confirmed that NA #1 was alone in the room providing care to him that night. He explained the first night NA #1 had taken care of him she was training and was with NA #2 but this night 05/12/24 she was by herself.

A review of Resident #17's medical record on 05/13/24 revealed no documentation of the incident, or red/purple bruise or skin tear. The medical record contained no order for treatment of the skin tear.

The Administrator was interviewed on 05/13/24 at 5:45 PM. She stated that she was unaware of the incident with Resident #17 and NA #1 but stated that there should be documentation of the skin tear in his medial record. The Administrator was made aware that there was no documentation of the skin tear or incident in Resident #17's medical

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	345340	A. BUILDING ______ B. WING ______	C 05/15/2024

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

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F 600		F 600		

Continued From page 5
record.

Review of a progress note written by the Administrator on 05/13/24 at 7:15 PM read, spoke with Resident #17 about skin tear on right forearm. Resident stated that when NA was changing him, she began to roll him to his left side, he stated he pulled his arm loose from her and grabbed her arm to make her turn loose. He said he did it because she was not allowing him to assist with rolling.

Unit Manager (UM) #2 was interviewed on 05/14/24 at 9:42 AM, she stated that she was instructed by the Administrator to go and talk to Resident #17 late in the evening on 05/13/24. She stated that Resident #17 stated the aide got ahold of his arm and pulled him over, and "I pulled away from her and that is what probably caused the skin tear." UM #2 stated to Resident #17 that NA #1 "was trying to help" and when UM #2 was asked why Resident #17 would have to pull away from NA #1, she replied that is just Resident #17.

An observation and interview were conducted with Resident #17 on 05/14/24 at 3:36 PM. He was observed to have a small dressing on his right forearm with a red/purple bruise that was now the size of half dollar. Resident #17 stated, "I forgot to tell you that I have a pulled muscle in that arm and that was why it hurts when they grab it." Resident #17 stated three ladies have been down here to talk to me about the incident and I told them the same thing I told you. Resident #17 was asked to explain what happened again, he stated "she had me by my arm pulling me toward her and I kept telling her to let me go and she ignored me and laughed at me and finally it got to

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 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

hurting and I had to make her turn me loose." He again confirmed that NA #1 provided care to him that night by herself.

The Director of Nursing (DON) was interviewed on 05/14/24 at 5:03 PM. She stated that UM #2 went down and talked to Resident #17 and the story she got was it occurred during turning and repositioning and Resident #17 reached out and grabbed NA #1's her arm to remove her hand from his arm and that was what caused the skin tear/bruise. The DON stated she called Nurse #1 and asked her why she did not do the incident report or the change in condition and made her come back to the facility to complete them. She also stated that she spoke to NA #1 who stated she had her hand on Resident #1's shoulder and hip and that was how she rolled him and when he complained of pain, she (NA #1) reported to Nurse #3 who looked at Resident #17's arm and stated that there was nothing there except two scabbed area. The DON added she had UM #1 go and talk to Resident #17 as well and she got the same story. The DON stated she did not feel the incident was abuse and she believed that Resident #17 caused the area when he jerked his arm away from NA #1.

Nurse #3 was interviewed via phone on 05/15/24 at 6:28 AM who confirmed that she worked Saturday night (05/11/24) into Sunday Morning (05/12/24). She stated that the only thing NA #1 reported to her was that Resident #17 was being rude to her and was being non complaint with incontinent care and she told NA #1 to not take it personal. Nurse #3 stated that Resident #17 was do a blood sugar check on Sunday morning so around 6:30 AM she went in to check his blood sugar. Resident #17 stated to Nurse #3, "when

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7	F 600		

these aides roll me from my arms they hurt me." She stated he unbuttoned his right sleeve and showed me 2 spots near his elbow that were scabbed over, and I asked him if those happened with NA #1, and he said no. Nurse #3 stated Resident #17 usually required two staff members so that they always had a witness, but this night NA #1 was in there by herself.

A follow up interview was conducted with the Administrator and DON on 05/15/24 at 10:42 AM. The Administrator stated they completed a grievance on the issues, talked to Resident #17, talked to his family, and at his request they added grab bars to Resident #17's bed to aide in turning and repositioning. The Administrator stated that she had spoken with Resident #17 as did the DON and explained that Resident #17 had a history of telling different stories to different people. They spoke to NA #1 and Nurse #3 and the incident report was completed as was the change in condition. The Administrator stated that NA #1 told her that she did nothing with his arm and she rolled him with his shoulder and hip and he was fighting against her and he jerked his arm away from her. Nurse #3 saw 2 scabbed areas. The Administrator stated did not identify this as abuse but that she would start their investigative process. The DON stated that Nurse #1 did not report the issue and had not completed the incident report which was where she would have caught the potential abuse situation.

A follow up interview with Nurse #1 was completed on 05/15/24 at 11:46 AM via phone. She stated she had not completed the incident report because the incident occurred on third shift, and she thought Nurse #3 had completed the required information. She confirmed that

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 05/15/2024

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

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F 600	Continued From page 8 Resident #17 reported to her on Sunday 05/12/24 that the aide had "held his arm too tight" during incontinent care and he needed a dressing put on his forearm. She further explained that Resident #17 stated that he may have caused the area when he pulled his arm from her. Nurse #1 stated she did not think that was abuse or she would have immediately reported it to the DON. UM #1 was interviewed via phone on 05/15/24 at 12:41 PM. She stated she had spoken to Resident #17 about the skin tear and bruise on his right forearm. He reported that "the girl was rolling me over towards the window and she grabbed my arm" and he pulled his arm away from her stating that he wanted to do it on his own. UM #2 stated that was the only conversation she had with Resident #17 regarding the incident. The Wound Nurse (WN) was interviewed on 05/15/24 at 1:08 PM. She stated Resident #17's skin tear to his right forearm was draining serosanguinous (clear) drainage and she was using a calcium alginate product that was gentle on the skin and less likes to tear the skin when removed. The Nurse Practitioner was interviewed on 05/15/24 at 2:32 PM. She stated she had evaluated and spoke to Resident #17 who reported that the aide tried to roll him over and he told her to let him go so he could show her how to roll him and he pulled his arm away. The NP stated that calcium alginate was very appropriate for treatment of the skin tear.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	F 607		5/22/24

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 05/15/2024

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

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F 607	Continued From page 9 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interview this facility failed to identify abuse and then failed to implement and follow their abuse policy and procedures in in the areas of reporting and protection for 1 of 3 residents reviewed for accidents (Resident #17). The findings included:	F 607	F607 1. Corrective action was accomplished for alleged deficient practice on 5/15/24 when a formal abuse investigation was initiated and subsequently completed and unsubstantiated on 5/16/24. Individual education provided to NA#1, Nurse #1 and Nurse #3 on facility□s abuse	

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 05/15/2024

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

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F 607

Continued From page 10

Review of the facility's Abuse and Neglect Protocol revised on 06/13/21 read in part, any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record.

A complete copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator immediately after the occurrence. If an incident of suspected abuse occurs, facility shall report immediately, but not later than 2 hours after forming the suspicion if the event that caused the suspicion resulted in serious bodily injury, or not later than 24 hours if the events that caused the suspicion do not result in serious bodily injury to designated state agency. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the state agency within 5 working days or as designated by state law.

Employees of this facility who have been accused of resident abuse shall be suspended from duty until the results of the investigation have been reviewed by the Director of Nursing/Designee or Administrator.

Resident #17 was readmitted to the facility on 10/12/23 with diagnoses that included dysphagia, cognitive communication deficit, hypertension, diabetes, heart failure, and chronic obstructive pulmonary disease.

F 607

prevention policy and procedures.

2. All residents have the potential to be affected.
Interviews were completed by Unit Managers on 5/15/24 with alert and oriented residents with a BIMS greater than 13 in the building to allow them to discuss if they had feelings of being mistreated verbally or physically and Skin assessments were completed on all residents in the building by a nurse on 5/15/24. No further concerns were noted to indicate allegations or suspicions of abuse.

3. The Administrator and/or DON educated all staff on the facility□s abuse prevention policy and procedures on 5/15/24. The Administrator and/or DON educated all staff on 5/15/24 regarding definitions of abuse/neglect, immediate reporting of abuse/neglect, identification of abuse/neglect and to be aware of nervous laughter. Facility staff educated on definitions of abuse/neglect and given specific examples/scenarios. Facility staff were also educated in reporting of abuse/neglect and rapid identification of abuse/neglect and immediate reporting to the Administrator/DON. The Regional Clinical Director educated the Administrator and DON on abuse prevention policies and procedures on 5/15/24. Future staff/new hires and Department Heads will receive the same education regarding Abuse Policies/Procedures.

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 607

Continued From page 11

Resident #17's quarterly Minimum Data Set (MDS) dated 04/20/24 revealed that he was cognitively intact for daily decision making and had verbal behaviors 1 to 3 days, was frequently incontinent of bladder and required extensive assistance of two staff members for bed mobility.

An observation and interview were conducted with Resident #17 on 05/12/24 at 11:00 AM, Resident #1 was resting in bed with his head of bed elevated and had a long sleeve flannel shirt on and was covered with a sheet. Resident #17 reported that at approximately 3:00 AM he was awakened by the Nurse Aide (later identified as NA #1) who stated she was going to change him. Resident #17 stated she "grabbed my right arm" while standing on the left side of the bed and was trying to turn him towards her but because of her "girth" he could not turn over and "I kept telling her that she was hurting my arm, and she would not let go so I had to pull my arm away from her." Resident #17 pulled up the right sleeve of his flannel shirt to reveal a dime size red/purple bruise that had a small 2 x 2 bordered gauze over it. He reported that the nurse (Nurse #1) had put the dressing on this morning. Resident #17 stated that NA #1 was in his room alone that night with no other staff present.

Nurse #1 was interviewed on 05/12/24 at 11:30 AM who stated that Resident #17 reported when NA #1 was changing him through the night she held his arm too tight, and he had a "discolored area and a small skin tear." Nurse #1 stated she had cleaned the area and put a gauze over the area.

The Administrator was interviewed on 05/13/24 at 5:45 PM. She stated that she was unaware of the

F 607

4. The DON and/or designee will interview/observe five residents per week and five staff per week for twelve weeks to ensure residents do not have any allegations of abuse/neglect and to identify any staff members with any knowledge of abuse/neglect allegations neglect or non-verbal signs of abuse.

To monitor the effectiveness of the above plan, DON and/or designee will report the results of the resident and staff abuse audit in the facility□s monthly QAPI meeting for twelve weeks. The Administrator and/or DON will review the audit to identify patterns/trends and will adjust the plan to maintain compliance. The QAPI Committee will evaluate the effectiveness of the plan and make recommendations for changes in the plan as indicated.
5. Date of Compliance 5/22/24.

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 12	F 607		

incident with Resident #17 and NA #1 but stated that there should be documentation of the skin tear in his medial record. The Administrator was made aware that there was no documentation of the skin tear or incident in Resident #17's medical record.

The Director of Nursing (DON) was interviewed on 05/14/24 at 5:03 PM. She stated that Unit Manager (UM) #2 went down and talked to Resident #17 and the story she got was it occurred during turning and repositioning and Resident #17 reached out and grabbed NA #1's her arm to remove her hand from his arm and that was what caused the skin tear/bruise. The DON stated she called Nurse #1 and asked her why she did not do the incident report or the change in condition and made her come back to the facility to complete them. She also stated that she spoke to NA #1 who stated she had her hand on Resident #1's shoulder and hip and that was how she rolled him and when he complained of pain, she (NA #1) reported to Nurse #3 who looked at Resident #17's arm and stated that there was nothing there except two scabbed area. The DON stated she did not feel the incident was abuse and she believed that Resident #17 caused the area when he jerked his arm away from NA #1.

A follow up interview was conducted with the Administrator and DON on 05/15/24 at 10:42 AM. The Administrator stated they completed a grievance on the issues, talked to Resident #17, talked to his family, and at his request they added grab bars to Resident #17's bed to aide in turning and repositioning. The Administrator stated that she had spoken with Resident #17 as did the DON and explained that Resident #17 had a

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 05/15/2024

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

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F 607	Continued From page 13 history of telling different stories to different people. They spoke to NA #1 and Nurse #3 and the incident report was completed as was the change in condition. The Administrator stated that NA #1 told her that she did nothing with his arm and she rolled him with his shoulder and hip, and he was fighting against her, and he jerked his arm away from her. Nurse #3 saw 2 scabbed areas. The Administrator stated she did not identify this as abuse but that she would start their investigative process which included interviewing the resident, staff, suspending NA #1, and reporting to the appropriate agencies. The DON stated that Nurse #1 did not report the issue and had not completed the incident report which was where she would have caught the potential abuse situation. A follow up interview with Nurse #1 was completed on 05/15/24 at 11:46 AM via phone. She stated she had not completed the incident report because the incident occurred on third shift, and she thought Nurse #3 had completed the required information. She confirmed that Resident #17 reported to her on Sunday 05/12/24 that the aide had "held his arm too tight" during incontinent care and he needed a dressing put on his forearm. She further explained that Resident #17 stated that he may have caused the area when he pulled his arm from her. Nurse #1 stated she did not think that was abuse or she would have immediately reported it to the DON.	F 607		
F 689 SS=D	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	F 689		

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 05/15/2024

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

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F 689	Continued From page 14 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 staff interviews, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised and without knowledge of the staff. On 04/23/24 between the hours of 6:00 PM and 7:00 PM Resident #325 was observed by Nurse Aide (NA) #2 in the back parking lot walking away from the building approximately 30 yards away from the exit door. The findings include: Resident #325 was admitted to the facility on 02/06/24 with diagnoses that included coronary artery disease, hypertension, atrial fibrillation and cerebral vascular accident (CVA). The admission Minimum Data Set (MDS) assessment dated 02/10/24 revealed that Resident #325's cognition was severely impaired, and she ambulated independently with a walker. No wandering behaviors were noted during the observation period. On 05/12/24 at 6:30 AM during an interview with Nurse Aide (NA) #2 the NA explained that one evening of 04/23/24 he was working second shift instead of his normal third shift and was assigned to the hall that Resident #325 resided on which was the first time he had worked with the Resident. The NA described Resident #325's behavior that day as having to be redirected	F 689	Past noncompliance: no plan of correction required.	

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 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

multiple times back to her room. He continued to explain that after he collected the supper trays, he took the meal cart back to the kitchen and on his way, he stopped at the nursing desk to inform Nurse #4 who was the Nurse on the hall that he was going to take his break. The NA reported when he came back from the store and was sitting in his car in the back parking lot, he saw Resident #325 walking away from the building toward his car approximately 30 yards from an exit door holding a plastic bag with her clothes in it with no staff following her. NA #2 stated he did not know which exit door the Resident went out of to leave the facility. The NA stated he redirected Resident #325 to the entrance door to the service hall and as they approached the door Nurse #4 and Nurse #5 were running up to them to bring the Resident back inside the facility. NA #2 reported he did not know which exit door Resident #325 left out of, but he heard that it was determined to be the exit door at the end of 400 hall which was the hall the Resident resided on. The NA stated he did not notice any cuts or bruises on Resident #325 that would indicate she had fallen while outside the facility.

An observation of the back parking lot was made on 05/12/24 at 6:47 AM. The back parking lot contained a flat black top surface that was surrounded by a wooded lot. The parking lot contained several parking spaces that staff used but no other obstacles, structures, or hazards were noted.

An interview was conducted with Nurse Aide #3 on 05/12/24 at 12:19 PM. The NA explained that she did not remember the day, but she was on 100 hall and looked out the exit door at the end of the hall and noticed a resident bending over to

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 689 Continued From page 16
pick up something from the ground behind a truck. When the Resident stood up, she realized that she was one of the residents and went toward the nursing desk to alert the nurses when as she passed the service hall she noticed NA #2 bringing the Resident back into the building. By that time the NA stated the nurses were at the service hall and met NA #2 with the Resident.

F 689

An interview was conducted with Nurse #4 on 05/12/24 at 9:51AM who confirmed she was the Nurse on the hall when Resident #325 left the building unsupervised on 04/23/24. The Nurse explained that the Resident was acting like her usual self that evening in that she was pleasantly confused and would "piddle" around in her room and mess in her drawers which was what she always did. The Resident ate her supper meal sitting in her chair in her room. Nurse #4 continued to explain that she and Nurse #5 were sitting at the nursing desk when NA #2 stopped by to let her know that he would be taking his break after he delivered the meal cart back to the kitchen. Approximately 10-15 minutes later Nurse Aide #3 was down on 100 hall hollered up to the desk and asked if we had a resident walking around outside. At that time Nurse #4 and Nurse #5 ran to the service hall and out the door to find Nurse Aide #2 had already gotten to Resident #325 and was bringing her back into the building. Nurse #4 reported the Resident was carrying a water pitcher and a bag of clothes and she was wearing a sweat outfit of a pink top and gray pants and shoes. The Nurse explained that they got a wheelchair and took her back to her room where she conducted a full body skin assessment to determine if she had fallen when she was outside and there were no areas like cuts or bruises noted on her skin assessment. The

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 05/15/2024

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

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F 689	Continued From page 17	F 689		

Nurse stated after the skin assessment Resident #325 sat in her chair in her room for a while then went to bed where she stayed for the rest of the shift (11:00 PM). Nurse #4 reported that as she assessed the Resident, Nurse #5 called the facility management to inform them of Resident #325 exiting the building. She stated the management came to the facility and a resident "head count" was conducted to ensure every resident was accounted for. The Nurse continued to explain that the management team investigated the incident and determined Resident #325 exited the building from the exit door at the end of 400 hall because they found the door had been left unlocked.

A review of Resident #325's progress note dated 04/23/24 at 9:56 PM written by Nurse #5 read wander guard placed to left ankle at this time. Checked the device to make sure it was working properly.

On 05/13/24 at 11:45 AM during an interview with Nurse #5, the Nurse explained that he was at the nursing desk with Nurse #4 when NA #3 called to the desk that a resident was outside in the parking lot. When he and Nurse #4 got to the service hall NA #2 was bringing Resident #325 back into the building. They put her in a wheelchair and took her to her room where Nurse #4 did a head-to-toe assessment to determine if there were any injuries on her and there were no injuries on the Resident. Nurse #5 continued to explain that the management team was notified of the Resident exiting the facility and soon after the management team arrived at the facility. The Nurse stated he applied a wander guard bracelet on Resident #325's left ankle and made sure the device was working properly. He reported they

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 689 Continued From page 18 F 689

conducted a resident head count to make sure all the residents were accounted for, then they started an investigation to determine how Resident #325 got out of the facility. When they checked all the exit doors to ensure they were locked they found that the exit door at the end of 400 hall was unlocked therefore they determined Resident #325 left out of that door. Nurse #5 described Resident #325 as being pleasantly confused and liked to "piddle" around in her room or near her room but that he had not known of her having exit seeking behaviors.

On 05/13/24 at 1:29 PM during an interview with the Maintenance Supervisor (MS) the Supervisor stated that on the evening of 04/23/24 he was called back to the facility because Resident #325 was discovered outside the building. He explained that he completed an investigation of all the exit doors and found that the exit door at the end of 400 hall where the Resident resided was unlocked. He continued to explain that the power to the exit door was turned off and the switch was in the off position. He continued to explain that you must have a key to unlock the door and the key was in the unlocked position as well. The MS reported that the only time the door was unlocked was for deliveries and the oxygen company delivered oxygen supplies earlier that same day and he was the one who unlocked the door for the delivery. The MS stated he stayed at the door during the delivery and made sure he locked the door after the delivery was complete. The MS continued that the door had a screamer alarm and when the cover was raised it should have made a loud sounding alarm, but no staff admitted to hearing an alarm during the evening shift. The MS explained in response to the incident he made two rounds every day on all the

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

exit doors to ensure the doors were locked and when he was not at the facility the weekend office staff made the rounds in his place. He also added the facility was in the process of installing cameras throughout the facility as well.

An interview was conducted with the Wound Nurse on 05/13/24 at 1:05 PM. She explained that the management team was called back to the facility on the evening of 04/23/34 because Resident #325 had gotten out of the facility unsupervised. It was determined that she exited the facility from the exit door at the end of 400 hall because the door was not locked. The Nurse stated she conducted a head-to-toe assessment on Resident #325 when she returned to the facility and found no indication of injuries that she could have attained through a fall or injury.

Interviews were conducted with the Nurse Practitioner (NP) on 05/13/24 at 12:23 PM and 3:26 PM. The NP explained that Resident #325 had a history of a brain bleed (CVA) that left her cognition impaired, but she was physically getting stronger with her ambulation. She continued that she was notified by the facility the evening of 04/23/24 that Resident #325 exited from the building, and she visited the Resident the next day. The NP performed a thorough assessment on the Resident and found no skin tears or injuries. The facility conducted a complete resident count and checked the exit doors and wander guards. They moved Resident #325 to the locked unit shortly after that. The NP stated that because of her history and poor safety awareness Resident #325 was not cognitively safe to be outside on her own.

An interview was conducted with the Medical

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 689 Continued From page 20

Director (MD) on 05/14/24 at 12:23 PM. The MD explained that Resident #325 had a history of spontaneous brain hemorrhage which left her cognition compromised but she was progressing slowly physically with skilled therapies. He continued that he saw the Resident during his rounds on the Tuesday (04/23/24) and Thursday (04/18/24) prior to the incident and found her to be as her normal behavior of walking from chair to chair. The MD reported that he was notified the evening of the incident and was informed that they would be moving Resident #325 to the locked unit on 300 hall which he stated was more appropriate for her.

A review of Resident #325's progress note dated 04/26/24 at 4:23 PM written by the Director of Nursing read interdisciplinary team (IDT) meeting held to discuss Resident ambulating outside. The Resident was moved to 300 hall locked unit and a wander guard bracelet was applied. The Resident has adjusted well and seems to like her new room. No further concerns at this time.

An interview was conducted with the Director of Nursing (DON) on 05/13/24 at 2:18 PM. The DON explained that Resident #325 was alert but confused and mainly "piddled" around in her room which was nothing out of the ordinary. She was not on their radar of wandering. The DON continued that on the evening of 04/23/24 she was notified by Nurse #5 that Resident #325 was found outside of the facility in the back parking lot and was brought back inside the building. She explained that she instructed them to do a head-to-toe assessment on the Resident and do a resident head count to ensure all the residents were accounted for. The DON stated that by the time she arrived at the facility Nurse #4 or Nurse

F 689

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345340	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

#5 had discovered that the exit door at the end of 400 hall was unlocked and locked it back. She reported that by that time most of the management team was at the facility, and she instructed the Wound Nurse to conduct another head-to-toe skin assessment on Resident #325 and found nothing. The DON explained at that time they conducted a reenactment of the situation and had NA #2 and both Nurses #4 and #5 walk them through the entire situation and it was determined that Resident #325 left the facility out of the unlocked exit door at the end of 400 hall since that was the only exit door found unlocked. The DON reported the last time the 400 hall exit door was known to be used was earlier in the day when the Maintenance Supervisor unlocked it for the oxygen company to deliver the oxygen. She stated the Maintenance Supervisor insisted that he locked the door back but there was no other explanation as to why the door was unlocked since the door required a key and a code to unlock the door. The DON stated she had Nurse #5 place a wander guard bracelet on Resident #325, and she called the Resident's family member and explained the situation to them. She informed the family member of the situation and that they had placed a wander guard bracelet on the Resident and that they wanted to move her to the locked unit for her protection which they did move the Resident to the unlocked unit. The DON reported that she notified the Nurse Practitioner that evening. The DON added that the facility was in the process of installing cameras facility wide for surveillance.

During an interview with the Administrator on 05/13/24 at 2:50 PM. The Administrator explained that she was notified of Resident #325's elopement by the DON on the evening of

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

04/23/24 and had the management team return to the facility for the investigation. She continued to explain that through a reenactment with the staff involved they determined the Resident left the building through the exit door at the end of 400 hall which was found unlocked at the time of the incident. She reported at that time the only time the exit door was used was when the oxygen company delivered oxygen once a week and they happened to deliver oxygen earlier that same day as the elopement. She stated the only explanation was that the door had mistakenly been left unlocked. The Administrator reported to ensure Resident #325's safety they placed a wander guard bracelet on her and moved her to the locked unit. The Administrator continued to explain that the facility developed a plan of correction that included the exit door at the end of 400 hall was not used for anything including the oxygen company delivery and that all deliveries had to go through the front main entrance.

The facility provided the following corrective action plan with the completion date of 04/25/24.

All items listed on this self-imposed action plan were complete and implemented on 04/23/24 with ongoing monitoring to ensure compliance. This includes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 04/25/24.

The facility identified concerns regarding Resident #325 exited side door and observed in the parking lot by staff and
returned to the facility without issue on 04/23/24.

CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:

F 689 Continued From page 23 F 689

On 04/23/24 Resident #325 was assisted into the facility by CNA and assessed by licensed nurse with no injury noted.

On 04/23/24 licensed nurse notified responsible party and medical provider of incident.

On 04/23/24 Resident #325's elopement assessment was updated by licensed nurse to reflect current wandering behaviors.

On 04/23/24 an order for wander guard device obtained from provider by licensed nurse and applied to the Resident. On 04/23/24 the Resident's photograph was placed in the Elopement risk book at the front desk and nurses' station.

On 04/23/24 the Resident's care plan was updated by licensed nurse to reflect new orders and new behaviors.

On 04/23/24 all exit doors were checked by the Maintenance Director to validate that doors were functioning/locked/alarming properly with any unlocked / non alarmed door reset to ensure proper locking and alarming.

On 04/23/24 Administrator educated the Maintenance Director on assurance of locking/alarming doors after any vendor enters the facility.

IDENTIFICATION OF OTHER RESIDENTS:

On 04/23/24 licensed nurses conducted a 100% audit of current residents to validate all residents were accounted for. All residents were present

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 05/15/2024

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

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F 689	Continued From page 24 and accounted for. On 04/23/24 licensed nurses reviewed wandering assessments for all current residents to ensure appropriate interventions are in place for those residents identified as a wandering risk. No one was out of compliance, but we did identify a resident who had a change of status, and we placed a wander guard bracelet on her. On 04/23/24 the licensed nurses conducted an audit of residents identified with wander guard bracelets to validate that the bracelets were in place and functioning. MEASURES FOR SYSTEMIC CHANGE: The process to address residents identified with new behavior of wandering or exit seeking was updated to include Educated all staff to notify management if a resident begins to have new behaviors of wandering or exit seeking. When management is notified, a new assessment will be completed to determine if a wander guard needed to be initiated. Process to address all doors checked whenever vendor enters/exits to ensure locked, and alarm activated: Maintenance Director was educated by the Nursing Home Administrator on 04/23/24 regarding validation of exit door lock and alarm after use and routine checks twice daily on all exit door locks and alarms. The Administrator will appoint another Department Head if the Maintenance Director is absent/vacation and the weekend receptionist responsible for doing checks on weekends. Director and/or Administrator completed education for all staff on or before 04/24/24 regarding identification of and response to	F 689		

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 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 25	F 689		

residents with exit seeking behaviors, missing residents and process to check that doors are properly secured. Education will be provided for all new hires in orientation.

HOW CORRECTIVE ACTION WILL BE MONITORED:

The decision to formulate how the corrective action will be monitored was made on 04/23/24. The Director of Nursing and or the Administrator will review progress, wandering assessments and 24-hour reports 5 days a week times 4 then 3 times a week for 2 months to identify residents with wandering or exit seeking behaviors and validate that appropriate interventions are initiated. The Administrator will audit the exit door securement logs five days a week for four weeks and then weekly for eight weeks to ensure twice daily checks completed.

The Administrator and or Director of Nursing will review the audit to identify patterns and trends and will adjust the plan to maintain compliance.

The Administrator and or Director of Nursing and interdisciplinary team inclusive of Medial Director and or the Nurse Practitioner held an ad hoc QAPI to review incident and root cause analysis in its entirety with proposed plan of correction interventions.

The Administrator or Director of Nursing will review the plan during the monthly QAPI meeting, and the audits will continue at the direction of the QAPI committee.

Validation Statement: During the recertification and complaint survey investigation the facility

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 05/15/2024

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

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F 689	Continued From page 26 provided information through observations and interviews from staff to support the facility conducted a 100 % audit of resident census on 04/23/24 after Resident #325 was discovered outside the building in the back parking lot. The facility also provided information such as exit door audits twice a day, 100% facility wide education to current employees and new hires on the new process, the elopement risk assessments and the updated elopement notebook and the clinical morning meeting of discussion of the information and audits conducted. The completion date of 04/25/24 was validated.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		5/22/24

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 05/15/2024

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

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F 761	Continued From page 27 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to remove expired medications available for use from a medication refrigerator in 1 of 1 medication room reviewed for medication storage. The findings included: A review of the manufacturer's recommendation for Purified Protein Derivative (PPD) storage, PPD vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. On 05/14/24 at 11:25 AM during an observation of the medication room refrigerator with Nurse #2 and Unit Manager (UM) #1 the observation yielded 2 open vials of PPD solutions. One vial was in a box with an open date of 04/01/24 printed on the box and one vial was in a box in a plastic pouch with an open date of 04/03/24 printed on the box. During interviews with both the Unit Manager and Nurse #2 on 05/14/24 at 11:25 AM neither nurse knew how long the PPD solution could be used after opening. The UM explained that she inspected the refrigerator the previous evening and there was one PPD vial in the refrigerator, but the solution was not out-of-date. The UM stated she could not remember the date on the vial or if the vial was in a box or plastic pouch. The UM left the medication room and returned at 11:28 AM and reported the PPD solution was	F 761	F761 1.Corrective action was accomplished for the alleged deficient practice by disposing of the two expired PPD vials. Unit Manager #1 disposed of the expired PPD vials on 5/14/24. 2. All residents have the potential to be affected. The DON and Unit Managers audited for expired medications in the med room refrigerator, med room and all med carts to ensure all expired medications have been properly handled and discarded on 5/15/24. 3. The DON and/or designee educated all licensed nurses and certified medication aides on 5/20/24 on proper storage parameters for PPD vials and other medications. Future staff/new hires for licensed nursing/certified medication aides will receive same education on proper storage paremeters for medications. 4. The DON and/or designee will monitor the med storage refrigerator for expired medications five times a week for twelve weeks. Opportunities will be immediately corrected as identified. To monitor the effectiveness of the above plan, the DON will report the results of the medication storage audits in the facility□s	

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	345340	A. BUILDING ______ B. WING ______	C 05/15/2024

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F 761	Continued From page 28 good for 30 days after opening. An interview was conducted with the Director of Nursing (DON) on 05/14/24 at 11:31 AM. The DON was informed of the findings in the medication room refrigerator and the DON stated the Unit Manager had looked in the refrigerator the prior evening and did not find any out-of-date PPD solution.	F 761	monthly QAPI meeting for twelve weeks. The Administrator and/or DON will review the audit to identify patterns/trends and will adjust the plan to maintain compliance. The QAPI Committee will evaluate the effectiveness of the plan and make recommendations for changes in the plan as indicated. 5. Date of Compliance 5/22/24.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		5/22/24

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 05/15/2024

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

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F 867	Continued From page 29	F 867		

Continued From page 29

and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on

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 05/15/2024

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

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F 867	Continued From page 30	F 867		

high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of

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 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 31 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the Recerfification and Compliant Survey on 03/01/23. This failure was for 2 deficiencies that were originally cited in the areas of (F600) Free from Abuse and Neglect and (F880) Infection Control that were subsequently recited on the current Recertification and Complaint Survey on 05/15/24. The repeat deficiencies during the 2 surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. The findings include: This tag is cross referenced to: F-600: Based on observations, record review, resident, staff, and Nurse Practitioner interviews the facility failed to protect a resident's right to be free from abuse when Resident #17 asked Nurse Aide (NA) #1 multiple times to let go of his right arm during incontinent care and when she did not Resident #17 pulled his right arm away from NA #1 and during the interaction received a small skin tear with a red/purple bruise that was approximately the size of a half dollar on his right forearm. The deficient practice occurred for 1 of 3 residents reviewed for accidents.	F 867	F867 1) Facility received repeat citations of F600(Free from Abuse and Neglect) and F880(Infection Control) during the previous survey cycle. A revised plan has been developed to address F600 and F880, with ongoing monitoring by the Quality Assurance and Performance Improvement Committee. 2) All residents have the potential to be affected. Root Cause Analysis was completed on 5/21/24 by the Interdisciplinary Quality Assurance Team for F600 and F880 to determine the systemic break that led to the deficient practice with revised plan to address. 3) Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Regional Director of Operations (QAPI Team consists of: Administrator, Director of Nursing, Business Office Director, Human Resource Manager, Maintenance Director, Social Services Director, Housekeeping/Laundry Manager, Unit Managers, Activities Director, Infection Preventionist, Medical Director, Dietary Manager and Therapy Director. Education included review of Quality Assurance and recognizing areas for Performance	

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 05/15/2024

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

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F 867	Continued From page 32 During the recertification and compliant survey on 03/01/23 the facility failed to provide supervision to prevent a cognitively impaired resident from attacking another cognitively impaired resident in their shared bathroom which resulted in a resident having a bloody right lower lip, left nostril and left cheek. Her wrist was swollen, bruised and painful and required evaluation and treatment at the emergency room. F-880: Based on observations, record reviews and interviews the facility failed to follow their infection control policy when the Wound Nurse failed to change her gloves after removing a soiled dressing, that contained a moderate amount of brown drainage, and before cleansing a sacral wound on 1 of 4 residents (Resident #18) reviewed for pressure ulcers. The facility also failed to follow their hand hygiene policy when the Unit Manager failed to change her gloves and preform hand washing hygiene after she provided incontinent care and before she applied a moisture barrier cream and touched other environmental surfaces for 1 of 3 residents (Resident #54) reviewed for incontinence care. During the recertification and compliant survey on 03/01/23 the Nurse failed to perform hand hygiene and change gloves after removing a dirty dressing, after cleansing a wound, and before applying a clean dressing to a wound. An interview was conducted with the Administrator on 05/15/24 at 3:30 PM who explained she was not the Administrator at the time of the last recertification when the previous citations were given but she felt as if the current citations were isolated issues and not a result of	F 867	Improvement, Root Cause Analysis, and monitoring of Performance Improvement Plans. New Department Heads/QAPI team members will receive the same edcuation regarding Quality Assurance, Performance Improvement, Root Cause Analysis and Performance Improvement monitoring. 4) The Administrator to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The QAPI Committee will review all active Performance Plans for compliance and any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to the plan as indicated. Regional Nurse to review all monthly QAPI Minutes x 6 months and attend QAPI Meetings quarterly to ensure that the Committee is maintaining implemented procedures/interventions to prevent recurring non-compliance. The Administrator will be responsible for the implementation of the plan. 5) Date of Compliance 5/22/24.	

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 05/15/2024

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

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F 867	Continued From page 33 facility failures. The Administrator indicated that through the plan of corrections for the citations the staff will be educated, audits will be conducted and monitored through the quality assurance committee. Hopefully the citations will not be repeated.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		5/22/24

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 05/15/2024

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

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F 880	Continued From page 34 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to follow their infection control policy when the Wound Nurse failed to	F 880	F880 1. Corrective action was accomplished for the alleged deficient practice on 5/15/24	

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 05/15/2024

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

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F 880

Continued From page 35

change her gloves after removing a soiled dressing that contained a moderate amount of brown drainage and before cleansing a sacral wound on 1 of 4 residents (Resident #18) reviewed for pressure ulcers. The facility also failed to follow their hand hygiene policy when the Unit Manager failed to change her gloves and preform hand washing hygiene after she provided incontinent care of stool and before she applied a moisture barrier cream and touched other environmental surfaces for 1 of 3 residents (Resident #54) reviewed for incontinence care.

The findings include:

1. A review of the facility's policy on "Dry Clean Dressing" dated 09/2013 revealed steps in the procedure,
6. Put on clean gloves. Loosen tape and remove soiled dressing.
7. Pull gloves over dressing and discard them into plastic or biohazard bag.
8. Wash and dry hands thoroughly.

On 05/14/24 at 2:02 PM an observation of wound care was made by the Wound Nurse. The Nurse washed her hands and donned clean gloves to remove the old, soiled dressing which was saturated with brown drainage from Resident #18's sacrum. With the same gloved hands, the Wound Nurse proceeded to cleanse the stage 3 sacral wound with a gauze saturated with wound cleanser then removed the gloves and washed her hands before she donned a clean pair of gloves to apply the ordered treatment to the sacral wound and secured the wound with a border dressing.

An interview was conducted with the Wound

F 880

by the DON educating the Wound Care nurse with return demonstration on proper hand hygiene during wound care. DON also educated Unit Manager #2 on proper hand hygiene during peri-care on 5/14/24 with return demonstration. Neither Resident #18 or #54 have shown any s/s of infection since that time.

2. All residents have the potential to be affected. The DON and/or Infection Preventionist performed Dry Dressing wound care competencies with all licensed nursing staff by 5/21/24. The DON and/or Infection Preventionist performed hand hygiene competencies with all nursing staff by 5/21/24.

3. The DON and/or Infection Preventionist educated all licensed nursing staff on 5/20/24 regarding proper hand hygiene during wound care. The DON and/or Infection Preventionist educated all nursing staff on 5/21/24 on proper hand hygiene during peri-care. Future licensed nursing staff/new hires will receive the same education regarding proper hand hygiene during wound care.

4. The DON and/or Infection Preventionist will conduct three observations per week of wound care for twelve weeks to ensure proper handwashing between dirty and clean dressings. The DON and/or Infection Preventionist will conduct five observations of nursing staff handwashing per week for twelve weeks. Opportunities will be immediately corrected as identified.

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 05/15/2024

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

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F 880

Continued From page 36

Nurse on 05/14/24 at 5:08 PM who explained she did not realize that she did not remove her gloves and wash her hands after she removed the soiled dressing from Resident #18's stage 3 pressure ulcer. She stated that it was her normal routine to remove her gloves and wash her hands after she removed the old dressing but that she was nervous being watched during the procedure.

An interview was conducted with the Wound Nurse Practitioner on 05/15/24 at 10:50 AM. The Nurse Practitioner explained that Resident #18's stage 3 sacral pressure ulcer was being closely monitored for signs and symptoms of osteomyelitis because of the near bone exposure. She continued to explain that she had not observed the Wound Nurse's dressing change technique as being bad but stated she normally documented her wound assessments while the Wound Nurse redressed the wounds on rounds.

During an interview with the Director of Nursing on 05/15/24 at 12:15 PM she explained that the Wound Nurse had already informed her of the wound treatment and stated that she would have to be more careful being sure to remove her gloves when she removed the old dressings.

2. A review of the facility's hand washing/hand hygiene policy revised on October 2023 read; Hand hygiene is indicated: immediately before touching a resident, before performing a aspect task, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching the residents environment, before moving from work on a soiled body site to a clean body site.

A continuous observation was made on 05/12/24

F 880

To monitor the effectiveness of the above plan, the DON and/or designee will report the results of the handwashing observations and the wound care observations in the facility□s monthly QAPI meeting for twelve weeks. The Administrator and/or DON will review the audits to identify patterns/trends and will adjust the plan to maintain compliance. The QAPI Committee will evaluate the effectiveness of the plan and make recommendations for changes in the plan as indicated.
5. Date of Compliance 5/22/24.

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 05/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 from 9:14 AM to 9:47 AM. Resident #54 was resting in his bed and was covered with a sheet. He reported he was wet with urine and needed to be changed. He explained that the last time the staff had provided care to him was around 3:00 AM to 3:15 AM and he was "pretty wet." Resident #54 was able to turn himself onto his right side using the grab bar. When he turned himself over it was noted that his brief was saturated to the very edge of the absorbent part of the incontinent product, the draw sheet under him was not wet. At 9:29 AM Resident #54 turned on his call light and stated, "they should have done been in here." At 9:31 AM a staff member entered the room and Resident #54 stated that he needed to be changed, the staff member stated she would let his Nurse Aide (NA) know and left the room. At 9:35 AM Unit Manager (UM) #2 entered Resident #54's room and Resident #54 told her he needed to be changed. UM #2 turned off the call light and stated she was going to get some gloves and would be right back. UM #2 returned to Resident #54's room with supplies and with NA #4 to assist. UM #2 obtained a rag with warm water and placed soap on the rag and proceeded to wash Resident #54's peri area, once she had rinsed and dried his peri area, Resident #54 grabbed his right grab bar and turned himself to his right side. Once Resident #54 was on his right side, using a different rag that was wet with soap and water UM #2 was observed to wash Resident #54's buttock that were noted to be soiled with stool. It took several attempts from UM #2 wiping and cleaning Resident #54's buttock to get all the stool off of his buttocks. Once clean and without changing her gloves UM #2 was observed to grab her name tag and put inside her scrub top, then grab a tube of cream from Resident #54's table and open the tube and apply a generous amount	F 880		

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THE GREENS AT MAPLE LEAF	1101 MAPLE CARE LANE STATESVILLE, NC 28625

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F 880	Continued From page 38	F 880		

to both buttocks. Once she had applied the cream without changing her gloves, UM #2 and NA #4 applied a new brief and covered him with a sheet before removing their gloves using hand sanitizer and exiting Resident #54's room at 9:47 AM.

UM #2 was interviewed on 05/14/24 at 9:29 AM, she explained that Resident #54 had been incontinent since he was admitted to the facility and at times, he would ring his call bell for assistance. UM #2 confirmed that she had provided incontinent care to Resident #54 on 05/12/24 and stated, "to be honest I forgot to change my gloves between clean and dirty and I knew immediately when I came out of the room I had messed up." She added that she should have removed her gloves used hand sanitizer and applied new gloves before applying the cream to Resident #54's buttocks and again before applying his clean brief.

The Infection Preventionist (IP) was interviewed on 05/14/24 at 3:47 PM who stated that during incontinent care staff were expected to perform hand hygiene before starting the procedure and again after cleaning the resident up and removing the soiled brief or incontinent product but before applying a clean incontinent product. The IP explained this was to ensure that the staff did not contaminate the environment with dirty gloves.

The Director of Nursing (DON) was interviewed on 05/14/24 at 5:24 PM. The DON stated that UM #2 was nervous during the incontinence change that was observed on 05/12/24. She stated that as soon as UM #2 came out of Resident #54's room she came and stated that she had "messed up" and had not taken her gloves off nor

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	345340	A. BUILDING ______ B. WING ______	C **05/15/2024**

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F 880	Continued From page 39 completed hand hygiene like she was supposed to. The DON stated she immediately reeducated UM #2 on the hand hygiene policy and also started a reeducation for all staff as well.	F 880		