PRINTED: 01/18/2023 FORM APPROVED OMB NO. 0938-0391

| I ' '                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|---|-----|---|-------------------------------|----------------------------|
|                          |   | 345448   | B. WING                                 |     |   | C<br><b>12/13/2022</b>        |                            |
|                          | ROVIDER OR SUPPLIER  ROVE HEALTH AND RE   | HABILITATION CENTER  |   | 308 | REET ADDRESS, CITY, STATE, ZIP CODE<br>WEST MEADOWVIEW ROAD<br>BEENSBORO, NC 27406                                    | 1 2                           | 10,2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENTS  | 3  | F                                       | 000 |   |                               |                            |
| F 580<br>SS=D            | GGKY11. Immediate  CFR 483.40 at tag F1 (K)  CFR 483.90 at tag F2 (J)  The tag F742 constitution  The tag F742 constitution  The tag F742 constitution  The following intakes  NC00195654 and NC  3 of the 3 complaint a substantiated.  Notify of Changes (Interpretation  CFR(s): 483.10(g)(14)  §483.10(g)(14) Notifit (i) A facility must immediate consistent with his or representative(s) who consistent with his or representative(s) who consistent with the residution in the consistent charmental, or psychosocideterioration in health status in either life-th clinical complications | Jeopardy was identified at: Je | F                                       | 580 |   |                               | 12/13/22                   |
| LABORATORY I             | <br>DIRECTOR'S OR PROVIDER/   | SUPPLIER REPRESENTATIVE'S SIGNATURE  | <u> </u>                                |     | TITLE   |                               | (X6) DATE                  |

Electronically Signed 01/06/2023

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<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---|---|-------------------------------|--|
|   |   | 345448   | B. WING                                 |   | C<br><b>12/13/2022</b>        |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 12/10/2022                    |  |
|   |   |  |   | 308 WEST MEADOWVIEW ROAD  |                               |  |
| MAPLE G   | ROVE HEALTH AND REI   | HABILITATION CENTER  |   | GREENSBORO, NC 27406  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  | BE COMPLÉTION                 |  |
| F 580   | commence a new form (D) A decision to transesident from the facing \$483.15(c)(1)(ii). (ii) When making noting (14)(i) of this section, all pertinent information is available and proving physician. (iii) The facility must a resident and the resi | e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph . record and periodically mailing and email) and | F 58                                    |   |                               |  |
|   | when a resident (Res  | iew, staff, and family<br>failed to notify the family<br>ident #1), with a known<br>sis, had an increase in a  |   | Maple Grove Nursing and Rehabilitat<br>Center acknowledges receipt of the<br>Statement of Deficiencies and propos<br>this Plan of Correction to the extent th | es                            |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |   |     | (X3) DATE SURVEY<br>COMPLETED   |                            |         |
|--|---|--|---|-----|---|----------------------------|---------|
|  |   | 345448   | B. WING   |     |   |                            | C       |
|  | 20//255 05 0//25//55  | 345446   | B. WING_  |     | TREET ARRESTS OF THE CORE   | 12/                        | 13/2022 |
| NAME OF PI   | ROVIDER OR SUPPLIER   |  |   |     | TREET ADDRESS, CITY, STATE, ZIP CODE  |                            |         |
| MAPLE G  | ROVE HEALTH AND REI   | HABILITATION CENTER  |   |     | 08 WEST MEADOWVIEW ROAD   |                            |         |
|  |   |  |   | G   | REENSBORO, NC 27406   |                            |         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |     |   | (X5)<br>COMPLETION<br>DATE |         |
| F 580  | F 580 Continued From page 2   |  | F 5   | 580 |   |                            |         |
| F 300  | behavior of refusing a care needs and refus to a stage 4 sacral properties to a stage 4 sacral properties which is a stage 4 sacral properties which is a sacral properties which is a stage 4 sacral properties which is a sacral properties which is a stage 4 sacral properties which is a sacral properties | ectivities of daily living (ADL) ed pressure ulcer treatment essure ulcer for greater than irred in 1 of 1 resident on of change.  :  initted to the facility on coses that included, bipolar umatoid arthritis with t, chronic obstructive and type II diabetes mellitus. years old.  erly Minimum Data Set ated 9/20/2022 indicated initively intact for decision incontinent of bowel and ensive assistance of one mobility and dressing, and t on staff for toilet use and | correct and in order to main compliance with applicable provisions of quality of care. The Plan of Correction is since written allegation of compliance.  Maple Grove Nursing and Incenter response to this State deficiency is accurate. Furt Grove Nursing and Rehab reserves the right to refute deficiencies on this Statem Deficiencies through Inform Resolution, formal appeal pand one gr, and e and F580 Notify of Changes |     | -   | a<br>nt<br>y<br>ter        |         |
|  | indicated Resident #1 two stage 2 pressure ulcers and one stage 4 pressure ulcer.   |  |   |     | Resident #1 had a change in condition with a decreased level of consciousnes shallow respirations, and a temperature  | ss,                        |         |
|  | focus area that read, problematic manner i characterized by inap to treatment/care rela (ADL), refusing incon being weighed, medic and grooming of hair.  | n which she acts, propriate behavior, resistive ted to activities of daily living tinence care, medications, cal procedures, showers, The interventions included being resisted per facility   |   |     | 99.9. The nurse made the physician aware with an order to send the reside to the emergency room for evaluation. The resident's daughter and responsib party was called to be notified of the transfer and a message was unable to left due to voice mail was full. EMS arri at the facility at approximately 10:15 ar on 12/3/22 to transport the resident to the emergency department. | nt<br>le<br>be<br>ved<br>n |         |
|  | approaches.   | , ,  |   |     | • On 12/7/2022, and 12/9/22 the   |                            |         |

Facility ID: 923456

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:             | , , ,         | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---------------------|--|---------------|---|--|-------|-------------------------------|--|
|   |                     |  |               |   |  |       | С                             |  |
|   |                     | 345448   | B. WING _     |   |  | 12    | 2/13/2022                     |  |
| NAME OF P   | ROVIDER OR SUPPLIER | •  |               | ST                                      | REET ADDRESS, CITY, STATE, ZIP CODE  |       |                               |  |
|   |                     |  |               | 30                                      | 8 WEST MEADOWVIEW ROAD   |       |                               |  |
| MAPLE G   | ROVE HEALTH AND     | REHABILITATION CENTER  |               | GI                                      | REENSBORO, NC 27406  |       |                               |  |
| (X4) ID   | SUMMAR              | Y STATEMENT OF DEFICIENCIES                                    | ID            |   | PROVIDER'S PLAN OF CORRECTION  |       | (X5)                          |  |
| PRÉFIX<br>TAG                                       | ,                   | IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG | X                                       | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)     |       | COMPLETION<br>DATE            |  |
| F 580   | Continued From բ    | page 3   | <br>  F !     | 580                                     |  |       |                               |  |
|   |                     |  | , ,           |   | Director of Nursing, Assistant Director  | · of  |                               |  |
|   | Δ review of the Tr  | eatment Administration Record                                  |               |   | Nursing, Staff Development Coordina  |       |                               |  |
|   |                     | nt #1 had documented Resident                                  |               |   | and Treatment Nurse reviewed wound   |       |                               |  |
|   | ` ′                 | atments for the stage 4 sacral                                 |               |   | documentation, progress notes, point   |       |                               |  |
|   |                     | m 11/16/2022 through   |               |   | care documentation for activities of da  |       |                               |  |
|   | *                   | 3/2022. The wound care to the                                  |               |   | living (ADL) care x 30 days for all  | ,     |                               |  |
|   | _                   | remities was documented as                                     |               |   | residents to identify residents that are                                       | at    |                               |  |
|   | administered.       |  |               |   | risk related to non-compliance with wo   |       |                               |  |
|   |                     |  |               |   | care, and ADL care. The purpose of the   | ne    |                               |  |
|   | An interview was    | conducted, on 12/08/2022 at                                    |               |   | audit is to ensure the physician, family                                       | /,    |                               |  |
|   |                     | urse #1 and she revealed she                                   |               |   | and psychiatry services has been noti  |       |                               |  |
|   |                     | ınd treatments for Resident #1                                 |               |   | of residents with consistent refusals o  | f     |                               |  |
|   |                     | s. She stated during the last                                  |               |   | wound care treatment and change of   |       |                               |  |
|   | *                   | 022 the Resident had begun to                                  |               |   | condition. The audit was completed or  | า     |                               |  |
|   |                     | care constantly. She revealed                                  |               |   | 12/9/22.   |       |                               |  |
|   |                     | nt was readmitted on 11/12/2022                                |               |   | <ul> <li>On 12/9/2022, 100% in-service w</li> </ul>                            | as    |                               |  |
|   |                     | nit manager to assess the                                      |               |   | initiated by the Staff Development   | ina   |                               |  |
|   |                     | 2022. After that assessment, the all dressing changes to her   |               |   | Coordinator with the Nurses and Nurs<br>Assistants regarding refusals of care, | ing   |                               |  |
|   |                     | essure ulcer. The Nurse added                                  |               |   | changes in condition, alternatives to  |       |                               |  |
|   |                     | ad to beg the Resident to do                                   |               |   | treatment, notifications to family and   |       |                               |  |
|   |                     | and sometimes came back 6                                      |               |   | physician, referrals to psych services   | with  |                               |  |
|   | · ·                 | quest permission to complete                                   |               |   | notification of behaviors, and   | ••••  |                               |  |
|   |                     | She indicated success with the                                 |               |   | documentation. In-service will be  |       |                               |  |
|   |                     | g wraps/dressing changes but                                   |               |   | completed by 12/9/2022. On 12/9/22,  | the   |                               |  |
|   |                     | he sacral dressing changes.                                    |               |   | in-services were sent by the Nursing   |       |                               |  |
|   |                     | I been refusing almost all ADL                                 |               |   | Home Administrator to the remaining  |       |                               |  |
|   | care and this was   | an increase in the frequency of                                |               |   | facility staff who had not worked via ca                                       | are   |                               |  |
|   | the Resident's pre  | evious refusal pattern. She                                    |               |   | feed (an electronic communication sys  | stem  |                               |  |
|   |                     | an and family had been made                                    |               |   | for facility staff). All staff will be require                                 | ∍d to |                               |  |
|   |                     | of the refusal. She added the                                  |               |   | sign an in-service sheet on arrival to t                                       | neir  |                               |  |
|   |                     | successful in the past when the                                |               |   | next scheduled shift. The Staff  |       |                               |  |
|   |                     | but she had not personally                                     |               |   | Development Coordinator will review  |       |                               |  |
|   | called the family s | since the 11/12/2022 admission.                                |               |   | education and validate staff knowledg  |       |                               |  |
|   |                     |  |               |   | and understanding of the education. A  |       |                               |  |
|   |                     | conducted with the Director of                                 |               |   | contracted staff including agency that   |       |                               |  |
|   |                     | OR) on 12/08/2022 at 3:43 p.m.                                 |               |   | not worked, will receive the in-service  |       |                               |  |
|   |                     | the Occupational therapy and                                   |               |   | upon the next scheduled shift. Staff   | tha   |                               |  |
|   | priysical therapy ( | department had been working                                    | 1             |   | Development Coordinator will monitor   | เกย   | 1                             |  |

| F 580  Continued From page 4 with Resident #1. She added they had worked with the Resident in the past and had picked her back up for therapy after her last readmission, on 11/12/2022. She revealed, prior to 11/12/2022, the staff would update the Resident in the morning that she would have therapy that day. The therapist would in encelve with the nursing assistant and nurse to see if they would assist the Resident to be ready for her therapy appointment. The Resident would refuse therapy in the past, but the therapist had usually been able to work with her on bed mobility, rolling side to side, and other bed bound areas. She reported that since the last hospital stay and readmission, the refusals had gotten worse and the resident was refusing to be changed, dressed, groomed or anything. She added the facility had recently changed her mattress, but it took several staff members to convince the Resident #1's family member, on 12/09/2022 at 11:19 a.m. She revealed the staff do not update the family on her mother's condition. She reported the last time she received a phone call from the facility was when her mother was going to be transferred to the hospital on 12/3/2022. At that time, she had not received a phone call regarding her mother's refusal of care or to update the family on her status, since the previous hospital admission and discharge. She stated she had not been informed that her mother had an increase in the number of refusals for care and had not been informed that her mother had an increase in the number of refusals for care and had not been called during November regarding the refusals. She indicated   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |           | (X2) MULTIPLE CONSTRUCTION |  |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---------------------|--|-----------|----------------------------|--|-------------|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER  MAPLE GROVE HEALTH AND REHABILITATION CENTER  (X4) ID SUMMANY STATEMENT OF DEPICIENCIES (EXCH DEPICIENCY MAYS) THE PRECEDED BY FILL REGULATORY OR LSC DEPITIFY MAY DEPICIENCY MAYS THE PRECEDED BY FILL REGULATORY OR LSC DEPITIFY MAY DEPICIENCY MAYS THE PRECEDED BY FILL REGULATORY OR LSC DEPITIFY MAY DEPICIENCY MAY THE PROVIDERS PLAN OF CORRECTION (EXCH CORRECTION AND SHOULD BE CHOSEN REPRESENTED AND SHOULD BE CHOSEN REPRESENTED AND SHOULD BE CHOSEN REPRESENTED AND THE APPROPRIATE COMMENTION OF THE PROPRIATE COMMENTATION OF THE PROPRIATE COMME |   |                     |  | A. BUILDI | NG _                       |  | l .         | 2                             |  |
| MAPLE GROVE HEALTH AND REHABILITATION CENTER  MAPLE GROVE HEALTH AND REHABILITATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEVELOPMENT TO THE APP |   |                     | 345448   | B. WING   |                            |  | 1           |                               |  |
| Company   Display   Disp   | NAME OF P   | ROVIDER OR SUPPLIER |  |           | S                          | TREET ADDRESS, CITY, STATE, ZIP CODE     | <u>,</u>    |                               |  |
| SUMMARY STATEMENT OF DEFICIENCES   1.0   PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFYING INFORMAT   |   |                     |  |           | 30                         | 08 WEST MEADOWVIEW ROAD                  |             |                               |  |
| F 580  Continued From page 4 with Resident #1. She added they had worked with the Resident be back up for therapy after her last readmission, on 11/12/2022. She revealed, prior to 11/12/2022, the staff would update the Resident in the morning that she would have therapy that day. The therapist would then check with the nursing assistant and nurse to see if they would assist the Resident to be ready for her therapy in the past, but the therapist had usually been able to work with her on bed mobility, rolling side to side, and other bed bound areas. She reported that since the last hospital stay and readmission, the refusals had gotten worse and the resident was refusing to be changed, dressed, groomed or anything. She added the facility had recently changed her mattress, but it took several staff members to convince the Resident she needed a fresh mattress because of the urine saturation.  An interview was conducted with Resident #1's family member, on 12/09/2022 at 11:19 a.m. She revealed the staff do not update the family on her status, since the previous hospital admission and discharge. She stated she had not been informed that her mother had an increase in the number of refusals for care and had not been called during November regarding the refusals. She indicated   | MAPLE G   | ROVE HEALTH AND R   | EHABILITATION CENTER                               |           | G                          | REENSBORO, NC 27406                      |             |                               |  |
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| back up for therapy after her last readmission, on 11/12/2022. She revealed, prior to 11/12/2022, the staff would update the Resident in the morning that she would have therapy that day. The therapist would then check with the nursing assistant and nurse to see if they would assist the Resident to be ready for her therapy appointment. The Resident would refuse therapy in the past, but the therapist had usually been able to work with her on bed mobility, rolling side to side, and other bed bound areas. She reported that since the last hospital stay and readmission, the refusals had gotten worse and the resident was refusing to be changed, dressed, groomed or anything. She added the facility had recently changed her mattress, but it took several staff members to convince the Resident she needed a fresh mattress because of the urine saturation.  An interview was conducted with Resident #1's family member, on 12/09/2022 at 11:19 a.m. She revealed the staff do not update the family on her mother's condition. She reported the last time she received a phone call from the facility was when her mother was going to be transferred to the hospital on 12/3/2022. At that time, she had not received a phone call regarding her mother's refusal of care or to update the family on her status, since the previous hospital admission and discharge. She stated she had not been informed that her mother had an increase in the number of refusals for care and had not been informed that her mother had an increase in the number of refusals for care and had not been informed that her mother had an increase in the number of refusals for care and had not been called during November regarding the refusals. She indicated   |   |                     |  |           |                            |  |             |                               |  |
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|  |   |                     |  |           |                            | _  |             |                               |  |
| that the staff would call have in the past and   |   |                     |  |           |                            | _ · · · · · · · · · · · · · · · · · · ·  | 21.4        |                               |  |
| that the staff would call her, in the past, and determine the need for further frequency   |   |                     |  |           |                            | T  | .y          |                               |  |
| request she speak with her mother to convince of monitoring.  her to allow care, and this had not occurred in a Date of corrective action completion   |   |                     |  |           |                            | _  | nn -        |                               |  |
| while. She stated the talks with a family member 12/13/2022  |   |                     |  |           |                            | T  | <i>/</i> 11 |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--|--|---------------------|---|-------------------------------|
|  | 345448   | B. WING             |   | C<br><b>12/13/2022</b>        |
| NAME OF PROVIDER OR SUPPL MAPLE GROVE HEALTH A   | ND REHABILITATION CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MEADOWVIEW ROAD  GREENSBORO, NC 27406                       | 12/13/2022                    |
| PRÉFIX (EACH DE  | MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               |
| family desired not available a family had proven the family had proven the contact list included by the family had not increase from had not inform and wound car with the family begin a discus for the family begin a discus for the family begin and seement for the family of the family of the family begin and seement for the family of the family of the family begin and seement for the family of the family begin and seement for the family of the family begin and seement family begin and seement for the family begin and seement family begin and se | been successful. She revealed the to be kept updated and if she was at the time a call was placed, the vided multiple emergency contacts. It is electronic emergency luded three emergency contacts are Resident.  It is electronic emergency luded three emergency contacts are Resident.  It is conducted with the facility Social 109/2022 at 2:08 p.m. and revealed 109/2022 at 2:08 p.m. and revealed 109/2022, for Resident #1, were an 109/2022, for Resident #1, were an 109/2022, for Resident #1, were an 109/2024, for Resident #1, were an 109/20 | F 74                |   |                               |

PRINTED: 01/18/2023 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                           | ` IDENTIFICATION NUMBER:  |                     | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---------------------------|---|---------------------|--|--|------|-------------------------------|--|
|  |                           |   |                     | _                                      |  |      | 0                             |  |
|  |                           | 345448  | B. WING _           |  |  | 12/  | 13/2022                       |  |
| NAME OF PR   | ROVIDER OR SUPPLIER       |   |                     | S                                      | TREET ADDRESS, CITY, STATE, ZIP CODE   |      |                               |  |
| MADLECI  | DOVE HEALTH AND DE        | HABILITATION CENTER   |                     | 3                                      | 08 WEST MEADOWVIEW ROAD  |      |                               |  |
| WAPLE GI   | ROVE REALITIAND RE        | ENABILITATION CENTER  |                     | G                                      | REENSBORO, NC 27406  |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN            | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG |  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE    |  |
| F 742  | Continued From pag        | ge 6  | F7                  | 742                                    |  |      |                               |  |
|  | mental health diagno      | osis and had an increase in a   |                     |  | with a decreased level of consciousnes   | SS,  |                               |  |
|  |                           | food, activities of daily living  |                     |  | shallow respirations, and a temperature  |      |                               |  |
|  | _                         | ssure ulcer treatments for  |                     |  | 99.9. The nurse made the physician   |      |                               |  |
|  |                           | eks. The facility did not   |                     |  | aware with an order to send the reside   | nt   |                               |  |
|  |                           | ons to address the mental   |                     |  | to the emergency room for evaluation.  |      |                               |  |
|  |                           | ne resident had an increase in  |                     |  | The resident's daughter and responsib  | le   |                               |  |
|  |                           | ADL care, and treatment of  |                     |  | party was called to be notified of the   |      |                               |  |
|  |                           | Γhe increase in the refusals  |                     |  | transfer and a message was unable to   | be   |                               |  |
|  | •                         | Resident was discovered to be   |                     |  | left due to voice mail was full. EMS arri  |      |                               |  |
|  |                           | /3/2022 and was sent to an  |                     |  | at the facility at approximately 10:15 ar  |      |                               |  |
|  |                           | During the transfer of the  |                     |  | on 12/3/22 to transport the resident to  | he   |                               |  |
| Resident to the hospital the Resident was discovered to have maggots in her bed and in her |                           | •   |                     |  | emergency department. The Administr  |      |                               |  |
|  |                           |   |                     | instructed housekeeping to deep clean  |  |      |                               |  |
|  | skin folds that includ    | led the sacral pressure ulcer.  |                     |  | Resident #1's room and replace the   |      |                               |  |
|  | The Resident was d        | iagnosed with sepsis at the   |                     |  | mattress to ensure there were no larva   | e in |                               |  |
|  | hospital and require      | d intubation (the insertion of  |                     |  | the room.  |      |                               |  |
|  | an artificial airway),    | antibiotics, and had an   |                     |  | <ul> <li>On 12/7/2022, the Director of</li> </ul>  |      |                               |  |
|  | unplanned weight lo       | ss. The facility did not obtain   |                     |  | Nursing, Assistant Director of Nursing,  |      |                               |  |
|  | a psychiatric review      | of the Resident's   |                     |  | Staff Development Coordinator, and   |      |                               |  |
|  | decision-making sta       | tus or intent of self harm for 1  |                     |  | Treatment Nurse reviewed wounds, me  | eal  |                               |  |
|  | of 3 residents (Residents | dent #1) reviewed for   |                     |  | intake for 72 hours, and Activities of Da  | aily |                               |  |
|  | pressure ulcers.          |   |                     |  | Living (ADL) documentation for all   |      |                               |  |
|  |                           |   |                     |  | residents, including residents with men  | tal  |                               |  |
|  | The immediate jeop        | ardy started on 11/16/2022  |                     |  | disorders and/or who have a history of   |      |                               |  |
|  | when Resident #1 re       | efused all pressure ulcer   |                     |  | trauma and/or post-traumatic stress  |      |                               |  |
|  | dressing changes to       | a stage 4 sacral pressure   |                     |  | disorder that are at risk related to   |      |                               |  |
|  | ulcer. Immediate Je       | opardy was removed on   |                     |  | non-compliance with wound care, mea  | l    |                               |  |
|  | 12/10/2022 when the       | e facility implemented a  |                     |  | intake and ADL care to the point of  |      |                               |  |
|  |                           | f immediate jeopardy  |                     |  | extreme detriment up to including  |      |                               |  |
|  |                           | will remain out of compliance   |                     |  | potential self-harm and self-injurious   |      |                               |  |
|  |                           | d severity of E (No actual  |                     |  | behavior. The purpose of the audit is to   | )    |                               |  |
|  | •                         | or more than minimal harm   |                     |  | ensure all identified residents are  |      |                               |  |
|  |                           | e jeopardy) to ensure the   |                     |  | receiving the necessary treatment. The   |      |                               |  |
|  | 0                         | stems put into place and to   |                     |  | were no identified areas of concern. The   | ie   |                               |  |
|  | complete facility em      | ployee training.  |                     |  | audit was completed on 12/7/22.  |      |                               |  |
|  |                           |   |                     |  | Effective 12/7/22 The Director of Nursi  | -    |                               |  |
|  | The findings include      | d:  |                     |  | or Assistant Director of Nursing will me   | et   |                               |  |
|  |                           |   |                     |  | with the psychiatric Nurse Practitioner  |      |                               |  |
|  | Resident #1 was ad        | mitted to the facility on   |                     |  | before resident visit to discuss newly   |      |                               |  |

Facility ID: 923456

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  G   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|---------------------|---|---|-------------------------------|--|
|   |   | 345448  | B. WING             |   |   | C<br><b>12/13/2022</b>        |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   |   | <u> </u>            | STREET ADDRESS, CITY, STATE, ZIP COD  |   | 2/10/2022                     |  |
|   |   |   |                     | 308 WEST MEADOWVIEW ROAD  |   |                               |  |
| MAPLE G   | ROVE HEALTH AND RE  | HABILITATION CENTER   |                     |   |   |                               |  |
|   |   |   |                     | GREENSBORO, NC 27406  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)   | SHOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 742   | Continued From pag  | ne 7  | F 74                | 12  |   |                               |  |
| F 742   | 6/10/2019 with diagral disorder, juvenile rhe systemic involvemer pulmonary disease, The Resident was 56. A review of the Psychesident #1 was see 8/26/2022 for psychimanagement. The Preported no behavior Resident reported no visual hallucinations and homicidal ideation her sleep and appetit Resident reported a verbal abuse by her reviewed was Cymb treat depression and was the only Psychia electronic medical real A review of the physic Cymbalta HCL capsimilligram (mg) give of times a day for depredisorder.  A review of Resident Administration Recodocumented the Cyradministered as order | noses that included, bipolar eumatoid arthritis with at, chronic obstructive and type II diabetes mellitus. By years old.  hiatry notes revealed en for an initial visit on atric medication MHNP documented the staff ral concerns at that time. The observed denied suicidal ideation on. The Resident reported the were appropriate. The history of emotional and ex-husband. The medication alta, a medication used to a generalized anxiety. This eatry consult visit in the ecord.  ician orders included ulle delayed release 30 one capsule by mouth two dession related to bipolar at #1's Medication ard (MAR) for November 2022 anbalta 30 mg dose was ered. | F 74                | referred residents and resider on case load, with potential for and self-injurious behavior, to psychiatric services understaturgency and the behaviors are On 12/9/2022, 100% in-sinitiated by the Staff Developer Coordinator with the Nurses, Nurse and Nursing Assistants refusals of care, alternatives to notifications, recognizing meridisorders, referrals to psychial and documentation. The foculin-services is to train staff to a refusals of care, worsening missues, providing alternatives and proper notification throug documentation of refusals pricesident displaying self-harm self-injurious behavior. In-services were sent by the Action to the remaining staff who have a care feed (an electronic communication system for state contracted staff including age not worked, will receive the in upon the next scheduled shift be required to sign an in-servicer arrival to their next scheduled Staff Development Coordinate the education and validate state knowledge and understanding | or self-harm of ensure inds the e addressed. ervice was ment Treatment is regarding to treatment, intal atric services, is of the address early idental health to treatment, h or to a and vice was 12/9/22, the administrator d not worked aff). All incy that has in-service is All staff will ice sheet on is shift. The or will review aff g of the |                               |  |
|   | Resident #1 weighed<br>She did not have and<br>since 7/7/2020, 223.   | cal record documented d 225.0 pounds on 9/14/2022. other documented weight 2 pounds. terly Minimum Data Set   |                     | education. All contracted staff agency that has not worked, with the in-service upon the next shift. Staff Development Coomonitor the schedule for new agency staff to ensure they all  | will receive<br>cheduled<br>rdinator will<br>assigned   |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                    |
|---|---|--|--|-----|--|-------------------------------|--------------------|
|   |   |  | 71. 501251                             | _   |  | , ا                           | 2                  |
|   |   | 345448   | B. WING                                |     |  | 1                             | 13/2022            |
| NAME OF P   | ROVIDER OR SUPPLIER                             |  |  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 12-/                          | 10/2022            |
|   |   |  |  | 3(  | 08 WEST MEADOWVIEW ROAD  |                               |                    |
| MAPLE G   | ROVE HEALTH AND RE                              | HABILITATION CENTER  |  |     | REENSBORO, NC 27406  |                               |                    |
| (X4) ID   | SUMMARY ST                                      | ATEMENT OF DEFICIENCIES                                    | ID                                     |     | PROVIDER'S PLAN OF CORRECTION  |                               | (X5)               |
| PREFIX<br>TAG                                       | (EACH DEFICIENC                                 | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG                           |     | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | COMPLETION<br>DATE |
| F 742   | Continued From page                             | e 8  | F                                      | 742 |  |                               | '                  |
|   | (MDS) assessment d                              | ated 9/20/2022 indicated                                   |  |     | prior to their scheduled shift. All new hi   | re                            |                    |
|   | Resident #1 was cognitively intact for decision |  |  |     | nurses and certified nursing assistance  |                               |                    |
|   | _   | incontinent of bowel and                                   |  |     | will receive training during orientation a   |                               |                    |
|   |   | ensive assistance of one                                   |  |     | annually thereafter.   |                               |                    |
|   |   | mobility and dressing, and                                 |  |     | Behaviors including refusals will be   | e                             |                    |
|   | was totally dependen                            | t on staff for toilet use and                              |  |     | monitored through the Cardinal   |                               |                    |
|   | bathing. The Resider                            | nt had documented  |  |     | Interdisciplinary Team Meeting (IDT) us  | sing                          |                    |
|   | behaviors of rejection                          | n of care, 1 to 3 days, during                             |  |     | the Behavioral Monitoring Audit Tool by  | ,                             |                    |
|   |   | The assessment further                                     |  |     | review of the progress notes and beha  | vior 💮                        |                    |
| indicated Resident #1 had two stage 2 pres          |   | - ·  |  |     | documentation 5 x per week x 2 month   |                               |                    |
|   | ulcers and one stage                            | 4 pressure ulcer.  |  |     | by the Director of Nursing and Assistar  |                               |                    |
|   |   |  |  |     | Director of Nursing and referrals will be  | :                             |                    |
|   | -   | an, dated 10/20/2022, had                                  |  |     | made by social services to psychiatric   |                               |                    |
|   | focused areas with in                           | terventions as follows:                                    |  |     | services related to consistent refusals a  | and                           |                    |
|   | 4) Decident #4 head                             | a much lamatia manusanin                                   |  |     | self-injurious behaviors. The Social   |                               |                    |
|   |   | a problematic manner in                                    |  |     | Worker is in attendance of the IDT   |                               |                    |
|   | which the Resident a<br>inappropriate behavior  | _  |  |     | meeting where the discussion will take place on the urgency of the referral. All     |                               |                    |
|   |   | d to activities of daily living                            |  |     | identified areas of concerns will be   |                               |                    |
|   |   | itinence care, refuses                                     |  |     | addressed immediately during the audi  | t hv                          |                    |
|   | , ,   | o be weighed, refuses                                      |  |     | the Director of Nursing/ Nursing Home  | CDy                           |                    |
|   |   | refuses showers, refuses                                   |  |     | Administrator (NHA). The Director of   |                               |                    |
|   | -   | e interventions included to                                |  |     | Nursing/ NHA will review and audit the   |                               |                    |
|   |   | resisted per facility protocol                             |  |     | audit tool 5x's weekly x 2 months to   |                               |                    |
|   | _   | of patterns in behavior.                                   |  |     | ensure completion and that all areas of  | :                             |                    |
|   |   | ent of pressure ulcers                                     |  |     | concerns were addressed. The Directo   | _                             |                    |
|   |   | f resisting care from staff                                |  |     | Nursing/ NHA will forward the results o  | f                             |                    |
|   | with examples of ADI                            | _ care, repositioning, and                                 |  |     | the Behavior Monitoring Audit Tool to the  | ne                            |                    |
|   | wound care. Risk of t                           | further decline of wounds                                  |  |     | Quality Assurance Performance  |                               |                    |
|   | due to treatment refu                           | sal. Interventions included to                             |  |     | Improvement (QAPI) committee month   | ly                            |                    |
|   |   | rsonnel of changes in eating                               |  |     | for 2 months. The QAPI committee will  |                               |                    |
|   | or drinking patterns.                           |  |  |     | meet monthly for 2 months and review   | the                           |                    |
|   |   | PASRR (preadmission  |  |     | Behavior Monitoring Audit Tool to  |                               |                    |
|   | _   | nt review) that does not                                   |  |     | determine trends and/or issues that ma   | -                             |                    |
|   |   | osis of Bipolar. The goal                                  |  |     | need further interventions put into place  | 9                             |                    |
|   |   | monitor as needed to identify                              |  |     | and to determine the need for further  |                               |                    |
|   | _   | ition through the next review                              |  |     | frequency of monitoring.   |                               |                    |
|   | and the interventions                           | were to monitor.<br>vchotropic drugs with the              |  |     | Date of corrective action completion     12/13/2022                                  | )TI                           |                    |
|   | 4) Resident has be                              | vanonodia aruas Willi III <del>e</del>                     | 1                                      |     | 1 1/113//0//   |                               |                    |

| ` '                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                                       |
|--------------------------|---|---|---|--|---|-------------------------------|---------------------------------------|
|                          |   | 345448  | B. WING _                               |  |   | 12/1                          | )<br>13/2022                          |
|                          | ROVIDER OR SUPPLIER   | HABILITATION CENTER   |   | STREET ADDRESS, CITY, STATE, ZIP COL<br>308 WEST MEADOWVIEW ROAD<br>GREENSBORO, NC 27406 | )E  |                               | · · · · · · · · · · · · · · · · · · · |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE            |
| F 742                    | cardiac, neuromuscu or due to a diagnosis read; the Resident we effects of medications review. The intervent Resident's mental state ongoing basis.  An interview was conton 12/08/2022 at 3:20 was an Administrator October 2022 she was 41 while he was out to became aware Resident and had refused (ADL) care with urine that time, she met with that refusing care was allowing the room to can become a health not acceptable. She she sident and negotian Resident would be read wound care contowhen the staff came. Resident's oxygen sate and emergency medicalled. The Resident hospital. She stated she facility when the Resident #1 was discussed to the facility when the Resident 10/20/2022 and read 10/25/2022. | cterized by side effects of lar, gastrointestinal systems, of bipolar disorder. The goal build show minimal/no side is taken through the next itons included to observe the attus functioning on an | F7                                      | 742  |   |                               |                                       |
|                          | 10/25/2022, docume  | tal discharge record dated<br>nted Resident #1 was sent to<br>tment on 10/20/2022 for an  |   |  |   |                               |                                       |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|-------------------------|---|--|-------------------------------|--|
|  |  | 345448  | B. WING _               |   |  | C<br><b>12/13/2022</b>        |  |
|  | ROVIDER OR SUPPLIER  ROVE HEALTH AND R   | EHABILITATION CENTER  | 1                       | STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFI)<br>TAG     | PREFIX (EACH CORRECTIVE ACTION SHOULD   |  | (X5)<br>COMPLETION<br>DATE    |  |
| F 742  | absence of enough sustain bodily funct from the facility was refusing wound can weeks. On the day facility staff rolled the sacral wound, here to 50% on 5 liters of one emergency room stour purulent drainage from the discharge on 12/3/2/2022.  A review of the hose 11/12/2022 and was 11/12/2022.  A review of the hose 11/12/2022 docume from the skilled number of the skilled number of the facility.  A review of Resident treatments included calcium alginate with dressing every More until healed. The ore with an indefinite stour extremities we were form to open all with Kerlix and Cobe Monday, Wednesday, Wednesday | acral wound and hypoxia (an oxygen in the tissues to ions). The reported history is the Resident had been e checks for the last two of the admission, when the ne Resident to address her oxygen saturation dropped to oxygen. At the hospital, the raff reported foul-smelling from the stage 4 sacral wound.  Scharged to the hospital on a readmitted to the facility on pital discharge record dated ented, according to the report sing facility, Resident #1 had a fusing all sacral pressure ulcer at #1's physician orders for the silver, cover with a proximal maday, Wednesday, and Friday der was started on 11/14/2022 op date, 2) Cleanse bilateral ith normal saline, apply reas, cover with ABD, wrap an three times a week, on | F7                      | 742   |  |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ′               | PLE CONSTRUCTION  |           | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---------------------|---|-----------|-------------------------------|--|
|   |  | 345448  | B. WING             |   |           | C<br><b>12/13/2022</b>        |  |
|   | ROVIDER OR SUPPLIER  | EHABILITATION CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406           |           | 211312022                     |  |
| (X4) ID<br>PREFIX<br>TAG                            | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 742   | 12/8/2022 at 2:52 p cognitive impairmer Resident #1. She re in the facility since s room and had seen added that Residen and staff sometimes room overnight. The food and stuff. She let the staff give her turning her, changin care. She stated sh not like the smell in  An interview was code: 4:12 p.m., with Nurshad provided wound for several months. part of October 202 refuse the wound cowhen the Resident she allowed the unit wound on 11/15/202 Resident refused all sacral stage 4 pressible felt like she had any care for her and times a day to require dressing changes. So lower extremity leggino success with the The Resident had be care and this was a the Resident's previous proposed to the sident's previous and the sacral stage at the Resident's previous and the sacral stage at the Resident's previous and | anducted with Resident #4, on .m. Resident #4 had moderate at. She was the roommate of evealed she had observed flies she had moved to her current a lot of fruit flies at night. She t #1 does not eat very much, is leave her meal tray in the effies like to fly around her added Resident #1 would not any care, that included up her sheets, and wound e informed staff that she did | F 74                | 12  |           |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |      | (X3) DATE SURVEY<br>COMPLETED |  |
|---|----------------------|--|--------------------|---|---|------|-------------------------------|--|
|   |                      |  | A. BUILDI          | NG                                      | <del></del>   |      |                               |  |
|   |                      | 345448   | B. WING            |   |   |      | C                             |  |
| NAME OF D   | ROVIDER OR SUPPLIER  |  |                    | STDE                                    | ET ADDRESS, CITY, STATE, ZIP CODE   | 12   | /13/2022                      |  |
| NAME OF T   | NOVIDEN ON 3011 EIEN |  |                    |   |   |      |                               |  |
| MAPLE G   | ROVE HEALTH AND      | REHABILITATION CENTER  |                    |   | VEST MEADOWVIEW ROAD  |      |                               |  |
|   |                      |  |                    | GREI                                    | ENSBORO, NC 27406   |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFIC          | Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG | x                                       | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 742   | Continued From p     | page 12  | F                  | 742                                     |   |      |                               |  |
|   | the Physician or F   | Psychiatry provider had been   |                    |   |   |      |                               |  |
|   |                      | e last admission, she stated the   |                    |   |   |      |                               |  |
|   |                      | documented on the chart. She   |                    |   |   |      |                               |  |
|   |                      | had been successful in the past  |                    |   |   |      |                               |  |
|   | 1                    | nt refused but she had not   |                    |   |   |      |                               |  |
|   | personally called    | the family since the 11/12/2022  |                    |   |   |      |                               |  |
|   |                      | eported the family had brought   |                    |   |   |      |                               |  |
|   | the Resident food    | I, trying to get her to eat  |                    |   |   |      |                               |  |
|   | because the Resi     | dent would refuse to eat her   |                    |   |   |      |                               |  |
|   | meal trays.          |  |                    |   |   |      |                               |  |
|   | An interview was     | conducted with the Director of   |                    |   |   |      |                               |  |
|   | Rehabilitation (D0   | OR) on 12/08/2022 at 3:43 p.m.   |                    |   |   |      |                               |  |
|   | and she reported     | the Occupational therapy and   |                    |   |   |      |                               |  |
|   | physical therapy     | department had been working  |                    |   |   |      |                               |  |
|   | with Resident #1.    | She added they had worked  |                    |   |   |      |                               |  |
|   |                      | in the past and had picked her   |                    |   |   |      |                               |  |
|   |                      | oy after her last readmission, on  |                    |   |   |      |                               |  |
|   |                      | revealed, prior to 11/12/2022,   |                    |   |   |      |                               |  |
|   |                      | date the Resident in the   |                    |   |   |      |                               |  |
|   | _                    | would have therapy that day.   |                    |   |   |      |                               |  |
|   |                      | uld then check with the nursing  |                    |   |   |      |                               |  |
|   |                      | se to see if they would assist the   |                    |   |   |      |                               |  |
|   |                      | ady for her therapy appointment.   |                    |   |   |      |                               |  |
|   |                      | uld refuse therapy in the past,<br>nad usually been able to work                           |                    |   |   |      |                               |  |
|   |                      | nobility, rolling side to side, and  |                    |   |   |      |                               |  |
|   |                      | areas. She reported that since   |                    |   |   |      |                               |  |
|   |                      | tay and readmission, the   |                    |   |   |      |                               |  |
|   |                      | en worse and the resident was  |                    |   |   |      |                               |  |
|   | _                    | anged, dressed, groomed or   |                    |   |   |      |                               |  |
|   |                      | ded the facility had recently  |                    |   |   |      |                               |  |
|   |                      | ress, but it took several staff  |                    |   |   |      |                               |  |
|   |                      | ince the Resident she needed a   |                    |   |   |      |                               |  |
|   | fresh mattress be    | cause of the urine saturation.   |                    |   |   |      |                               |  |
|   | An interview was     | conducted with the primary care  |                    |   |   |      |                               |  |
|   |                      | n 12/08/2022 at 5:21 p.m. and  |                    |   |   |      |                               |  |
|   |                      | dent #1 had refused care for her   |                    |   |   |      |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN |   | IPLE CONSTRUCTION  IG   |                     | ATE SURVEY<br>DMPLETED   |           |                            |
|--|---|---|---------------------|--|-----------|----------------------------|
|  |   | 345448  | B. WING _           |  |           | C<br>12/13/2022            |
|  | OVIDER OR SUPPLIER  OVE HEALTH AND RE   | HABILITATION CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>308 WEST MEADOWVIEW ROAD<br>GREENSBORO, NC 27406  |           | 12/10/2022                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE ADDEDICION OF THE ADD | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
|  | perfectly good sense when he began to di immediately begin to education regarding of care were provide occasions that include death. When asked Resident had an including November 20   | ge 13 and that she would make when talking with her but scuss wound care, she would be refuse care. He stated the consequences of refusal and to the Resident on multiple ded the risk of infection or if he had been informed the rease in refusals of care 122, he stated he had been and he could not say if he  | F 7                 | 42   |           |                            |
|  | An interview was condaughter, on 12/09/20 revealed the staff do mother's condition. So received a phone can her mother was goin hospital on 12/3/202 received a phone can refusal of care or to status, since the predischarge. She state that her mother had refusals for care and November regarding that the staff would converted the | informed in November. Inducted with Resident #1's 2022 at 11:19 a.m. She into the ported the last time she ill from the facility was when ing to be transferred to the 2. At that time, she had not ill regarding her mother's update the family on her vious hospital admission and an increase in the number of it had not been called during in the refusals. She indicated call her, in the past, and with her mother to convince in the talks with a family member successful.  Inducted with the PMHNP on our and she revealed she it on 8/26/2022 and this had attent with the Resident. She |                     |  |           |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | TIPLE CONSTRUCTION  NG  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--------------------|---|--------------------------------|-------------------------------|--|
|   |   | 345448   | B. WING            |   |                                | C                             |  |
|   | ROVIDER OR SUPPLIER   | REHABILITATION CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>308 WEST MEADOWVIEW ROAD<br>GREENSBORO, NC 27406   |                                | 2/13/2022                     |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIVE | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 742   | refusing care. She made aware the F care treatments for greater than 2 we the medications a an inpatient treatrous behavior was a krincreased in frequedecline in overall interventions or treated a reside even one week, would lead to seven health, and for an considered self-hat evaluation.  An interview was Worker on 12/09/2 she had not informed her their Resident were an refusals. She add services were distincted in the provider was had requested the her a list of what in new provider and on the list.  A review of the eler Resident #1 documersponsive by services by services were distincted in the list. | had an increase in a behavior of e revealed if she had been Resident was refusing wound or a stage 4 pressure ulcer, eks, she would have reviewed and considered recommending ment to have her mental status in e stated she had serious he was not updated regarding for changes, even if the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the state of the hown previous behavior but had been the previous and a decline in oriented resident this would be arm and required an inpatient conducted with the facility Social 2022 at 2:08 p.m. and revealed med the psychiatry provider of a dent #1 because staff had not refusals occurring for the increase from her prior ed that the Psychiatric provider continued on 11/19/2022 and a implemented. She stated she is clinical nursing staff to provide residents should be seen by the Resident #1 was not included bectronic medical record for mented she was discovered staff on 12/3/2022 and 911 was ent was sent to an acute care | F                  | 742   |                                |                               |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |           | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|---|-----------|-------------------------------|--|
|                          |  | 345448  | B. WING _           |   |           | C<br>2/13/2022                |  |
|                          | ROVIDER OR SUPPLIER  | HABILITATION CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>308 WEST MEADOWVIEW ROAD<br>GREENSBORO, NC 27406     | •         | ZI IOIZOZZ                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COP<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 742                    | (EMS) documentation Resident #1 for the control The Resident was mand during the transfit strong stench like new body cells or tissue to the sheet under the and yellow stains. During fell onto the mattress. An interview was contoly 12/12/2022 at 1:27 poly 12/3/2022 the team of a up a resident that was upon arrival the room added when the team the stretcher, maggod onto the bed.  A review of the hosp revealed Resident #1 with a diagnosis of Soon and staff documente Resident's abdominate perineum, and every required intubation for was admitted to the Resident's weight for 91.7 kilograms (201.)  An interview was contol #1 on 12/12/2022 at had been the nurse at 12/3/2022. He indicat two emergency room | gency Medical Services In was conducted for late of service on 12/3/2022. It oved onto the stretcher bed ler, the EMS staff observed a crotic tissue (the death of through disease or injury). Resident was soiled with red laring the transfer maggots of from the Resident's sheets.  Inducted with EMS staff #1 on In. and revealed on the arrived at the facility to pick is not responding. He stated in had a strong odor. He in transferred Resident #1 to the fell off of the sheet back  It was admitted on 12/3/2022 the piss, altered mental status, it dobserving maggots on the ill pannus, buttocks, fold of the groin. She or her respiratory status and critical care unit. The in the hospital admission was | F 7-                | 42  |           |                               |  |

| STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ′               | PLE CONSTRUCTION  G  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---------------------|--|--------------------------------|-------------------------------|--|
|   |  | 345448  | B. WING             |  |                                | C<br><b>2/13/2022</b>         |  |
|   | ROVIDER OR SUPPLIER  | EHABILITATION CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CO 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406      |                                | 2/13/2022                     |  |
| (X4) ID<br>PREFIX<br>TAG                          | (EACH DEFICIEN   | CTATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 742   | pressure ulcer with air, and maggots we buttocks, and in the respiratory status of because she was be sepsis" (sepsis is de overwhelming and li infection that can leafailure, and death. Of facilitate early recograpidly deliver a bur wound care to remo and wound was con area.  An interview was coon 12/09/2022 at 3:1 had not been aware increased from the his expectation that consulted for all resimental illness with a The Administrator wijeopardy on 12/09/20 Credible Allegation of Recipients who have suffer, a serious addithe non-compliance Resident #1 who had Disorder, had an incidere including incompliance. | to visualize a stage 4 sacral no dressing in place, open to be present on her skin folds, wound. He added the serious the Resident was the priority being treated as a "code of serious the body's fe-threatening response to an add to tissue damage, organ code sepsis was designed to serious of severe sepsis and adde of care) and therefore the verthe maggots from her skin ducted in the critical care and the refusals of behavior had resident's history, and it was psychiatry services be dents with a known history of a change in behavior.  The suffered or are likely to verse outcome as a result of the services of refusing tinence care from 1-3 days | F 7                 | 42   |                                |                               |  |
|   | the non-compliance<br>Resident #1 who ha<br>Disorder, had an inc<br>care including incon<br>per week. Resident<br>care for 17 days, fro<br>through December 3  | s a Diagnosis of Bipolar<br>crease in behaviors of refusing   |                     |  |                                |                               |  |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ′               | IPLE CONSTRUCTION NG  | (X3  | ) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|---|--|----------------------------|
|                          |  | 345448  | B. WING_            |   |  | C<br><b>12/13/2022</b>     |
|                          | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STAT 308 WEST MEADOWVIEW RG GREENSBORO, NC 2740 | OAD  | 12/13/2022                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ( (EACH CORRECT CROSS-REFERENC  | PLAN OF CORRECTION<br>TIVE ACTION SHOULD BE<br>SED TO THE APPROPRIATE<br>FICIENCY) | (X5)<br>COMPLETION<br>DATE |
| F 742                    | consistently refused to have decrease in register to have decreased in the facility did not continuous behavior incontinence care annew interventions and implement fly reductive ensuring doors are redevelopment of mags skin folds, buttocks, versity 12/3/2022.  On 12/3/22, at approximate the decreased and the temperature of 99.5 physician aware with resident to the emergency medicine that there were maggorate to the emergency medicine that there were maggorate to the maggots. The emaggots were id groin pannus skin folioperineal area.  All residents with medical decrease in residents with medical decrease in register to the service of the maggots were id groin pannus skin folioperineal area. | care for, and she was noted meal intake, resulting in ry services and the family ne consistent refusals and ors.  Fordinate with the psychiatry re resident's unresolved ors of refusals of ADL care, downed care, to establish do the facility's failure to con measures including of propped open resulted in gots on the groin pannus wound, and perineal area on eximately 9:30 am, Resident condition, with a decreased cas, shallow respirations, and condition, with a decreased cas, shallow respirations, and condition or evaluation.  The nurse made the can order to send the lency room for evaluation. Collity to transport the lency department. The technician notified Nurse #1 gots on resident #1 sheets.  Administrator. The led housekeeping to deep | F 7                 | 742   |  |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     | (X3) DATE SURVEY<br>COMPLETED  |       |                            |
|---|--|--|---|-----|--|-------|----------------------------|
|   |  | 345448   | B. WING                                 |     |  |       | C<br><b>13/2022</b>        |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 12/ | 13/2022                    |
| MAPLE G   | ROVE HEALTH AND REI  | HABILITATION CENTER  |   |     | 08 WEST MEADOWVIEW ROAD<br>REENSBORO, NC 27406   |       |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 742   | Continued From page  | e 18   | F F                                     | 742 |  |       |                            |
|   | •  | re at risk related to<br>wound care, ADL care, and<br>e the potential to be affected.  |   |     |  |       |                            |
|   | Director of Nursing, S<br>Coordinator, and Trea<br>wounds for all resided<br>mental disorders and<br>trauma and/or post-tr<br>are at risk related to a<br>care to the point of ex-<br>including potential se<br>behavior. The purposi<br>identified residents at<br>treatment. There wer<br>concern. The audit w   | atment Nurse reviewed ints, including residents with for who have a history of aumatic stress disorder that anon-compliance with wound atreme detriment up to lf-harm and self-injurious are of the audit is to ensure all are receiving the necessary are no identified areas of as completed on 12/7/22. |   |     |  |       |                            |
|   | residents including redisorders and/or who and/or post-traumation risk related to non-compurpose of the audit is residents are receiving There were no identificated audit was completed.  On 12/9/2022, the Dispirator of Nursing, State Coordinator, and Tredintake for 72 hours to disorders and/or who and/or post-traumation risk related to non-computation. | sidents with mental have a history of trauma estress disorder that are at impliance with ADL care. The s to ensure all identified ing the necessary treatment. Fied areas of concern. The on 12/7/22.  |   |     |  |       |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--|---|---|------------------------------|-------------------------------|--|
|  |   | 345448   | B. WING                                 |   |                              | C<br>2/13/2022                |  |
|  | ROVIDER OR SUPPLIER   | EHABILITATION CENTER   |   | STREET ADDRESS, CITY, STATE, ZIP COI<br>308 WEST MEADOWVIEW ROAD<br>GREENSBORO, NC 27406  |                              | 211312022                     |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 742  | Continued From pa   | ge 19  | F 74                                    | 42  |                              |                               |  |
|  | residents identified to psych services, r physician notificatio  * Actions taken to a failure to prevent a occurring or recurring.  On 12/9/2022, the Edirector of Nursing, Coordinator, and Treprogress notes x 30 to identify residents who have a history post-traumatic stress related to non-complexed, and nutritional extreme detriment uself-harm and self-inpurpose of the auditional residents. | Iter the process or system serious adverse outcome for any Director of Nursing, Assistant Staff Development eatment Nurse reviewed days and current diagnosis with mental disorders and/or of trauma and/or is disorder that are at risk oliance with wound care, ADL intake, to the point of up to including potential injurious behavior. The tis to ensure all identified ring the necessary physical |   |   |                              |                               |  |
|  | Nursing will meet we resident visit to discuss and residents alread for self-harm and seensure psych service and the behaviors at Behaviors including through the morning of the progress noted documentation 5 x Nursing and Assistate referrals will be made  | refusals will be monitored<br>g clinical meetings by review  |   |   |                              |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | TIPLE CONSTRUCTION  NG   |                                  | (X3) DATE SURVEY<br>COMPLETED |          |
|--------------------------|---|--|---------------------|--|----------------------------------|-------------------------------|----------|
|                          |   | 345448   | B. WING_            |  |                                  | C<br><b>12/13/2022</b>        |          |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP                                     | CODE                             | 12/13/2022                    | $\dashv$ |
|                          |   |  |                     | 308 WEST MEADOWVIEW ROAD   |                                  |                               |          |
| MAPLE G                  | ROVE HEALTH AND REI   | HABILITATION CENTER  |                     | GREENSBORO, NC 27406   |                                  |                               |          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE<br>THE APPROPRIA | DATE                          |          |
| F 742                    | Continued From page   | ⊋ 20   | F 7                 | 742  |                                  |                               |          |
|                          | attendance of the mo  | rs. The Social Worker is in rning clinical meeting where se place on the urgency of  |                     |  |                                  |                               |          |
|                          | On 12/9/2022, 100% the Staff Developmer Nurses, Treatment N regarding refusals of treatment, notification disorders, referrals to documentation. The furain staff to address worsening mental he alternatives to treatment through documentation resident displaying sebehavior. In-service of 12/9/2022. On 12/9/2025 by the Administrator of had not worked via communication systems staff including agency receive the in-services. | as, recognizing mental a psych services, and focus of the in-services is to early refusals of care, alth issues, providing ent, and proper notification on of refusals prior to a elf-harm and self-injurious will be completed by 2, the in-services were sent to the remaining staff who are feed (an electronic m for staff). All contracted of that has not worked, will a upon the next scheduled |                     |  |                                  |                               |          |
|                          | sheet on arrival to the Educator will review to staff knowledge and education. All contract that has not worked, upon the next scheducordinator will moni assigned agency stateducated prior to their * Date of corrective a On 12/13/2022 the fat  | cted staff including agency will receive the in-service uled shift. Staff Development tor the schedule for new f to ensure they are  |                     |  |                                  |                               |          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|---|---|---------------------|---|-----------------|
|   |   | 345448  | B. WING _           |   | C<br>12/13/2022 |
|   | ROVIDER OR SUPPLIER  ROVE HEALTH AND RE   | HABILITATION CENTER   | •                   | STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406                             |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLÉTION |
| F 742   | Continued From pag  |   | F 7                 | 42  |                 |
|   | in-services given to s<br>by staff managemen  | nced by record review of staff, and audits completed t. Validation was also ew of staff members from s.   |                     |   |                 |
|   | and reviewed. There in-services had beer alleged credible alleg facility's audits were                    | ce records were available was documentation that completed per the facility's gation of compliance. The also reviewed. There was audits had been completed.   |                     |   |                 |
|   | they had attended in<br>who are non-complia<br>signatures were veri<br>records. Staff memb                | ers from different terviewed and reported that -service training on residents ant or refuse treatment. Their fied on the in-service training pers were able to report e training they had received. |                     |   |                 |
|   | The immediate jeopa<br>12/10/2022.  | ardy was removed on   |                     |   |                 |
| F 925<br>SS=J   | Maintains Effective F<br>CFR(s): 483.90(i)(4)   | Pest Control Program  | F 9                 | 25  | 12/13/22        |
|   | program so that the<br>rodents.<br>This REQUIREMEN<br>by:<br>Based on observation<br>Hospital Nurse, Emer | in an effective pest control facility is free of pests and  T is not met as evidenced ons, record review and staff, ergency Medical Services of Representative interviews                           |                     | F0925<br>F 925 Maintains Effective Pest Contr<br>Program  | rol             |
|   | the facility failed to in<br>measures to protect<br>wounds from the dev                                   | nplement fly reduction vulnerable residents with velopment of maggots and s to the outside were not left  |                     | On 12/3/22, at approximately 9:<br>am, Resident #1 had a change in<br>condition, with a decreased level of      | 30              |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |      | (X3) DATE SURVEY<br>COMPLETED |  |
|---|----------------------|--|--------------------|---|--|------|-------------------------------|--|
|   |                      |  |                    |   |  |      | C                             |  |
|   |                      | 345448   | B. WING _          |   |  | 12/  | 13/2022                       |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                    | ST                                      | REET ADDRESS, CITY, STATE, ZIP CODE  |      |                               |  |
|   |                      |  |                    | 30                                      | 8 WEST MEADOWVIEW ROAD   |      |                               |  |
| MAPLE G   | ROVE HEALTH AND F    | REHABILITATION CENTER  |                    | GF                                      | REENSBORO, NC 27406  |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE        | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE    |  |
| F 925   | Continued From page  | age 22   | F 9                | 925                                     |  |      |                               |  |
|   |                      | entry of flies into the facility.  | ' `                | 020                                     | consciouences shallow recapitations of   | nd   |                               |  |
|   |                      | of 3 residents (Resident #1)   |                    |   | consciousness, shallow respirations, a a temperature of 99.9. The nurse made   |      |                               |  |
|   |                      | d care developing maggots on   |                    |   | the physician aware with an order to se  |      |                               |  |
|   |                      | nus (the area of excess skin   |                    |   | the resident to the emergency room fo  |      |                               |  |
|   |                      | over the pubic region),  |                    |   | evaluation. EMS arrived at the facility t  |      |                               |  |
|   |                      | the thin layer of skin between   |                    |   | transport the resident to the emergence  |      |                               |  |
|   |                      | g and anus), every fold of the   |                    |   | department. The emergency medicine   | -    |                               |  |
|   | groin, and sacral w  | <del>-</del>   |                    |   | technician notified Nurse #1 that there  |      |                               |  |
|   | ,                    |  |                    |   | were larvae on resident #1 sheets. The   |      |                               |  |
|   | Immediate Jeopard    | dy began on 12/3/2022, when  |                    |   | nurse notified the Administrator. The  |      |                               |  |
|   | Resident #1 was d    | iscovered to have maggots on   |                    |   | Administrator instructed housekeeping  | to   |                               |  |
|   | her mattress, shee   | ts, abdominal pannus,  |                    |   | deep clean resident #1's room and  |      |                               |  |
|   |                      | n, every fold of the groin, and  |                    |   | replace the mattress to ensure there w   | ere  |                               |  |
|   | _                    | und. The Immediate Jeopardy  |                    |   | no larvae in the room. On 12/7/2022, the   |      |                               |  |
|   |                      | 2/10/2022 when the facility  |                    |   | Administrator contacted the Pest Cont  | rol  |                               |  |
|   | 1 -                  | emented a credible allegation of   |                    |   | Company for additional treatment of  |      |                               |  |
|   |                      | y removal. The facility  |                    |   | Resident #1 room and the facility.   |      |                               |  |
|   |                      | mpliance at a lower scope and  |                    |   | <ul> <li>On 12/3/2022, a 100% audit of all</li> </ul>  |      |                               |  |
|   |                      | ctual harm with potential for harm that is not immediate                                     |                    |   | resident rooms, common areas, and a  |      |                               |  |
|   |                      |  |                    |   | entrances to the facility was completed  | -    |                               |  |
|   |                      | e the monitoring systems put ctive and education was   |                    |   | the Maintenance Director to identify an concerns related to pest control. There                                      |      |                               |  |
|   | completed.           | cuve and education was   |                    |   | were no other areas of concern identifi  |      |                               |  |
|   | compicted.           |  |                    |   | during the audit. On 12/7/2022, the  | cu   |                               |  |
|   | The findings include | led:   |                    |   | Administrator contacted Support Service  | ces  |                               |  |
|   |                      |  |                    |   | to order air curtains for the main entrar  |      |                               |  |
|   | Resident #1 was a    | dmitted to the facility on   |                    |   | and both courtyards used for smoking,  |      |                               |  |
|   |                      | gnoses that included, bipolar  |                    |   | aid in the prevention of flies entering th   |      |                               |  |
|   |                      | heumatoid arthritis with   |                    |   | center. The Administrator will oversee   | the  |                               |  |
|   | systemic involvement | ent, chronic obstructive   |                    |   | process to ensure the timely completic   | n of |                               |  |
|   | pulmonary disease    | e, obesity, and type II diabetes   |                    |   | the receipt and installation of the air  |      |                               |  |
|   | mellitus.            |  |                    |   | curtains. On 12/8/2022, the contracted   |      |                               |  |
|   |                      |  |                    |   | pest control company arrived, inspecte   | :d   |                               |  |
|   |                      | arterly Minimum Data Set   |                    |   | the facility for pests, and treated the  |      |                               |  |
|   |                      | t dated 9/20/2022 indicated  |                    |   | perimeter of the building with a chemic  | al   |                               |  |
|   |                      | ognitively intact, was always  |                    |   | solution to kill and deter flies.  | ĺ    |                               |  |
|   |                      | el and bladder, required   |                    |   | Wall-mounted fly lights were ordered o   |      |                               |  |
|   |                      | ce of one staff member for bed   |                    |   | 12/8/2022 by the pest control company  |      |                               |  |
|   | I MODULIN AND DIDECT | DO DOO WOO TOTOUN ACCOMACNE  | 1                  |   | the proced hear the folir collitivate door   |      |                               |  |

|                          |  | ` IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION  G  | · ,  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|--|-------------------------------|--|
|                          |  | 345448  | B. WING             |  |  | C                             |  |
| NAME OF D                | ROVIDER OR SUPPLIER  | 343440  | 1                   | STREET ADDRESS, CITY, STATE, ZIP CO  | •  | 12/13/2022                    |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   |                     |  | DDE  |                               |  |
| MAPLE GI                 | ROVE HEALTH AND REI  | HABILITATION CENTER   |                     | 308 WEST MEADOWVIEW ROAD   |  |                               |  |
|                          |  |   |                     | GREENSBORO, NC 27406   |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIVE)<br>CROSS-REFERENCED TO THE<br>DEFICIENCY  | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 925                    | Continued From page  | e 23  | F 9                 | 25   |  |                               |  |
|                          | two stage 2 pressure pressure ulcer.  A review of Resident record revealed, on D   | #1's electronic medical December 3, 2022, the   |                     | the exit door nearest Reside near the lobby entrance, and hallway. The Administrator with the process to ensure the time completion of the receipt an of the wall-mounted fly lights the Administrator conducted.  | d the 500/700 will oversee mely d installation s. On 12/8/22, l a resident   |                               |  |
|                          | Resident was transfe hospital due to a cha consciousness.  |   |                     | council meeting with 16 resi<br>attendance with the discuss<br>prevention, including not pro<br>open. On 12/9/22, the educa  | ion of pest<br>opping doors  |                               |  |
|                          | (EMS) documentation<br>Resident #1 for the d<br>The Resident was me<br>and during the transfe<br>strong stench like ne-<br>body cells or tissue th<br>The sheet under the<br>and yellow stains. Du<br>fell onto the mattress<br>An interview was con<br>12/12/2022 at 1:27 p | ate of service on 12/3/2022.  byed onto the stretcher bed er, the EMS staff observed a crotic tissue (the death of nrough disease or injury). Resident was soiled with red uring the transfer maggots from the Resident's sheets.  Iducted with EMS Staff #1 on .m. and revealed on |                     | reviewed with all other alert residents that did not attend council meeting by the Adm 12/8/22, the Administrator of doors to ensure no doors we open for a point of entry for were no other identified area On 12/9/22, the Maintenanc placed an alarm on the cour (the door that's 40 feet from #1 room) to alert staff when access the courtyard so the doors are closed to prevent                   | the resident<br>inistrator. On<br>hecked all exit<br>ere propped<br>pests. There<br>as of concern.<br>e Director<br>tyard #1 door<br>the Resident<br>residents<br>y can ensure |                               |  |
|                          | 12/3/2022 the team as up a resident that was upon arrival the room added when the team the stretcher, maggoronto the bed.  A review of the Hospi revealed she arrived 12/3/2022 and staff of Resident's abdominate perineum, and every                                       | arrived at the facility to pick is not responding. He stated in had a strong odor. He in transferred Resident #1 to its fell off of the sheet back ital records for Resident #1 at the emergency room on observed maggots on the I pannus, buttocks,                                |                     | entry for pests. On 12/9/22, Maintenance Director adjust courtyard #2 door closure to door closes properly and se prevent the point of entry for On 12/7/2022, 100% in initiated by the Staff Develor Coordinator with the Admini Medical Records, Accounts Nurses, Nursing Assistants, Housekeeping staff, Social Accounts Payable, Therapy Maintenance Staff, reception Records or Supply Clerk in the | the ted the ensure the aled to r pestsservice was pment strator, Receivable, Worker, Staff, nist, Medical regards to   |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | PLE CONSTRUCTION IG  | 1, ,  | TE SURVEY<br>MPLETED       |  |
|--|---|--|---------------------|--|---|----------------------------|--|
|  |   |  |                     |  |   | С                          |  |
|  |   | 345448   | B. WING _           |  | 1   | /13/2022                   |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP (   | CODE  |                            |  |
|  |   |  |                     | 308 WEST MEADOWVIEW ROAD   |   |                            |  |
| MAPLE G  | ROVE HEALTH AND RE  | HABILITATION CENTER  |                     | GREENSBORO, NC 27406   |   |                            |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN  | TION SHOULD BE<br>THE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE |  |
| F 925  | Continued From page   | e 24   | F 9                 | 25   |   |                            |  |
| F 923  | had been the nurse at 12/3/2022. He indicated two emergency room resident to remove the facility. He was able to pressure ulcer with noting and maggots were buttocks, and in the was respiratory status of the because she was been sepsis (sepsis is defended overwhelming and lifting infection that can least failure, and death. Confacilitate early recognized rapidly deliver a bund wound care to remove and wound was confacted.  An observation was at 12/8/2022 at 2:10 p.m.   | assigned to Resident #1 on ted he was in the room while technicians rolled the se sheets from the nursing to visualize a stage 4 sacral or dressing in place, open to be present on her skin folds, wound. He added the she Resident was the priority and treated as a "code fined as the body's se-threatening response to an add to tissue damage, organ orde sepsis was designed to shitten of severe sepsis and alle of care) and therefore the see the maggots from her skin flucted in the critical care | F 9                 | pest control concerns and pest control concerns into Maintenance Work Order to and notification of Administ of Nursing and the Maintenand regarding to ensure the for pests including doors a by staff or residents. In-secompleted by 12/8/2022. At the Administrator will ensure in-services are mailed to a staff who has not worked at the in-service with instruct sign the in-service, and repevelopment Coordinator Nursing prior to next schedule for next scheduled so Development Coordinator schedule for new assigned ensure they are educated   | the tracking System trator, Director nance Director ne point of entry are not left open rvice will be After 12/8/2022, re the any remaining and not received ions to review, turn to the Staff or Director of duled work shift. In agency that we the in-service shift. Staff will monitor the diagency staff to prior to their |                            |  |
|  | was located between the 100 hall and the 200 hall. A door to the courtyard was open with a ½ inch gap open to the outside. The doors to enter the recreational room from the hall, were open. No flies were observed in the recreational room.  An interview was conducted with Resident #3 on 12/8/2022 at 2:31 p.m. The Resident was cognitively intact. When asked if he had seen any flies at the facility, he stated he had seen flies multiple times in the last month but had not seen any during the current week due to the cooler and wet weather. When the Resident was asked if he had seen where the flies came from, he stated to look at the meal tray situation. He lifted a meal tray and stated it was from the previous night. The tray was observed to be in a Styrofoam food |  |                     | scheduled shift. All new hi certified nursing assistance training during orientation thereafter.  • On 12/9/22, 100% audit and common areas will be the housekeeping and/or a weekly x 4 weeks then more for signs of pests utilizing a Audit Tool. All areas of corfimmediately addressed by Maintenance Director or A The Administrator will reviet the Pest Control Audit Tool weeks then monthly x 1 mall areas of concern were a Administrator will forward the Pest Control | e will receive and annually  dit of all rooms inspected by nursing staff onthly x 1 month the Pest Control neern will be the dministrator. ew and initial I weekly x 4 onth to ensure addressed. The  |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION NG   | (X3) DATE SURVE<br>COMPLETED  | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|--|--|---------------------|--|---|-------------------------------|--|--|
|   |  | 345448   | B. WING             |  | C   |                               |  |  |
|   |  | 343440   | D. WING _           | 077577 17777 2177 2177   | 12/13/20  | 22                            |  |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP (   | CODE  |                               |  |  |
| MAPLE G   | ROVE HEALTH AND  | REHABILITATION CENTER  |                     | 308 WEST MEADOWVIEW ROAD   |   |                               |  |  |
|   |  |  |                     | GREENSBORO, NC 27406   |   |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO ) DEFICIENCY   | TION SHOULD BE COMP<br>THE APPROPRIATE  | (X5)<br>PLETION<br>DATE       |  |  |
| F 925   | Continued From p   | age 25<br>lid closed. The Resident   | F 9                 | the Pest Control Audit Tool  | to the Quality  |                               |  |  |
|   | broccoli and ched<br>sandwiches was p<br>from two days ago<br>same hall as Resi  | and it contained a sandwich and dar soup. Another tray with two bresent and he revealed it was by the Resident resided on the dent #1 on the opposite side of a and was not in close proximity born. |                     | Assurance Performance In (QAPI) Committee monthly The QAPI committee will n 1 month and review the Perfools to determine trends a that may need further interinto place and to determine | x 1 month. neet monthly x est Control Audit and/or issues eventions put et the need for |                               |  |  |
|   | An observation was conducted of the 200 hall on 12/8/2022 at 2:50 p.m. and a Geri chair was stored in the hall, maroon in color. In the back storage area of the chair a crushed piece of food that looked like bread, the size of the palm of a hand was in the compartment with a soiled washcloth that had yellow dried stains and a dried out wet wipe.  An interview was conducted with Resident #4, on 12/8/2022 at 2:52 p.m. Resident #4 had moderate cognitive impairment. She was the roommate of Resident #1. She revealed she had observed flies in the facility since she had moved to her current room and had seen a lot of fruit flies at night. She added that Resident #1 did not eat very much, and staff sometimes left her meal tray in the room overnight. The flies like to fly around her food and stuff. She added that a staff member came around on 12/8/2022 spraying the hall area but did not enter their room. |  |                     | further and/or frequency of  Date of corrective acti completion12/13/2022  |   |                               |  |  |
|   |  |  |                     |  |   |                               |  |  |
|   | conducted on 12/8 were no flies presepresent in the faci investigation.  | Resident #1's room was 8/2022 at 2:52 p.m. and there ent. Resident #1 was not lity at the time of the conducted on 12/8/2022 at 4:12   |                     |  |   |                               |  |  |
|   |  | conducted on 12/8/2022 at 4:12<br>1 and she indicated the family   |                     |  |   |                               |  |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING |  |     | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|--------------------|---|--|-----|-------------------------------|--|
|                          |  | 345448   | B. WING _          |   |  | 1   | C<br><b>12/13/2022</b>        |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                    | S1  | FREET ADDRESS, CITY, STATE, ZIP CODE   | 12/ | 13/2022                       |  |
| MADLEC                   | ROVE HEALTH AND REI  | JARII ITATION CENTER   |                    | 30  | 8 WEST MEADOWVIEW ROAD   |     |                               |  |
| WAPLE G                  | ROVE HEALIH AND KEI  | ABILITATION CENTER   |                    | G   | REENSBORO, NC 27406  |     |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |     | (X5)<br>COMPLETION<br>DATE    |  |
| F 925                    | Continued From page  | e 26   | F 9                | 925                                       |  |     |                               |  |
|                          | of Resident #1 would trying to get her to ear would be left in the rock Resident would yell to food trays. She added the room on several of months and Resident swatter that her family.  An observation was of 4:30 p.m. of the 300 kl. A door to the be propped open. Nut the observation, and independent smokers the courtyard from the the nursing station or this was a longer wall leave the courtyard, the 300 hall. This doo open at that time. She square foot tiles to Reful and the smokers had bee propopen the doors, occur.  A review of the pest in November 2022 reverse September 27, 2022: had miscellaneous flithe exterior of the far recommendation to reprevent standing water the smokers and the same commendation to reprevent standing water the same commendation to represent standing water th | bring the Resident food, it, and then the meal trays from. She added the budly if staff removed the did that she had seen flies in occasions for the last three if #1 owned her own fly y provided.  Conducted on 12/8/2022 at hall that connected to the ecourtyard was observed to rise #1 was present during she revealed some of the softhe facility would enter eday room side, closer to have 200 hall. She added k so when the residents hey exit through the door on or was observed propped eassisted in counting the esident #1's room and it was dent's room. She added that in educated in the past to not but it had continued to |                    | 923                                       |  |     |                               |  |
|                          | October 24, 2022: five   | e pest summary locations   |                    |   |  |     |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                    |   | (X3) DATE SURVEY<br>COMPLETED  |                                   |              |  |
|---|--|--|--------------------|---|--|-----------------------------------|--------------|--|
|   |  | 345448   | B. WING            |   |  | 1                                 | C<br>43/2022 |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | 0.707.10   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 121                               | 13/2022      |  |
|   | ROVE HEALTH AND REI  | HABILITATION CENTER  |                    | 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 |  |                                   |              |  |
| (X4) ID<br>PREFIX<br>TAG  | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | TION SHOULD BE<br>THE APPROPRIATE |              |  |
| F 925   | Continued From page  | e 27   | F!                 | 925   |  |                                   |              |  |
|   | The general commer missing fly traps. The recommendation to reprevent standing wat The status was listed date of 8/23/2022.  November 22, 2022: had miscellaneous fli The exterior recomm downspouts not direct  | e exterior of the facility had a eroute the downspouts to er and attraction by pest. as pending with an initial five pest summary locations es found and totaled 120. endation continued to state, |                    |   |  |                                   |              |  |
|   | standing water and a   | ttraction by pest. The status  |                    |   |  |                                   |              |  |
|   | representative on 12/revealed he visited the an exterior inspection as needed and then vinspection with a pesstated he had electrofacility and since the construction, three flydemonstrated, by wathree missing fly trap in the recreational roopposite side of the composite side of the com | t control treatment. He<br>nic fly traps present in the  |                    |   |  |                                   |              |  |
|   | An interview was con   | ducted with the  |                    |   |  |                                   |              |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                    |                      | (X3) DATE SURVEY<br>COMPLETED  |       |                            |  |
|---|---|--|--------------------|----------------------|--|-------|----------------------------|--|
|   |   | 345448   | B. WING            | B. WING              |  |       | C<br><b>12/13/2022</b>     |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  | 1                  | s                    | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 121 | 13/2022                    |  |
|   |   |  |                    | 3                    | 08 WEST MEADOWVIEW ROAD  |       |                            |  |
| MAPLE G   | ROVE HEALTH AND REI   | HABILITATION CENTER  |                    | GREENSBORO, NC 27406 |  |       |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |  |
| F 925   | revealed he had beer few months. He state of maggots at the fact 12/6/2022 when the Alogged into the hospit the Resident might be point, the team becar and deep cleaned Reno flies were present education to the staff conducted immediate. The Administrator procontrol visit reports for and stated a Mainten normally be the persocontrol representative but the facility did not Director and he was on A follow up interview. Administrator on 12/8 revealed he ordered of missing ones on 12/7 pest control representative was con Administrator and Con 12/9/2022 at 3:00 p.n. consultant stated the installed until an election. | as/2022 at 4:58 p.m. and he employed at the facility and he had been made aware illity for Resident #1 on Admission Coordinator tal system to review when the returning. He stated at that the aware of the maggots are sident #1's room. He stated at that time. He revealed and residents would be ally to not prop doors open. To brided copies of the pest for the previous three months ance Director would for working with the Pest and reviewing the reports, a have a Maintenance covering that role.  Was conducted with the signal fly traps to replace the registrative.  I ducted with the reportate missing fly traps cannot be trician reviews the devices.  Is notified of immediate 22 at 5:00 p.m. | F                  | 925                  |  |       |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | IPLE CONSTRUCTION   |                                | 3) DATE SURVEY<br>COMPLETED |  |  |
|---|---|---|---------------------|---|--------------------------------|-----------------------------|--|--|
|   |   | 345448  | B. WING_            |   |                                | C<br><b>2/13/2022</b>       |  |  |
|   | ROVIDER OR SUPPLIER   | REHABILITATION CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>308 WEST MEADOWVIEW ROAD<br>GREENSBORO, NC 27406 | •                              | 2/13/2022                   |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE DEFICIENCY       | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE  |  |  |
| F 925   | suffer, a serious at the non-compliant On 12/3/22, at ap #1 had a change level of conscious a temperature of 9 physician aware we resident to the emergency medic that there were lanurse notified the Administrator insticlean resident #1' mattress. On 12/3 an investigation to the larvae. The fareduction measure not propped open larvae on the groi wound, and perind All residents with affected related to maintaining an eff.  On 12/7/2022, the Director of Nursin Coordinator, and audit to visualize a wounds. This aud signs and sympto and no larvae in the other areas of cor The audit was cor | have suffered or are likely to dverse outcome as a result of                                    | FS                  |   |                                |                             |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDII  | IPLE CONSTRUCTION  NG |  | (X3) DATE SURVEY COMPLETED |                            |  |
|--|--|--|-----------------------|--|----------------------------|----------------------------|--|
|  |  | 345448   | B. WING _             |  |                            | C<br><b>12/13/2022</b>     |  |
|  | ROVIDER OR SUPPLIER  | EHABILITATION CENTER   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406      | •                          | 12/10/2022                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 925  | occurring or recurring on 12/3/2022, a 100 common areas, and was completed by the identify any concern. There were no othe during the audit. Or director did not observed on 12/7/2022, the AP Pest Control Compart On 12/7/2022, the AP Support Services to main entrance and I smoking, to aid in the center. Support curtains would arrive 12/13/2022 due to be subsequent installating receipt of items. The | serious adverse outcome for 19 0% audit of all resident rooms, all entrances to the facility ne Maintenance Director to serelated to pest control. The areas of concern identified in 12/3/22, the maintenance erve any doors propped open.  Indiministrator contacted the any for additional treatment.  Indiministrator contacted order air curtains for the control courtyards used for the prevention of flies entering. Services indicated that the air the by approximately being a special order, with ion by Support Services after the services to ensure the form of the receipt and | FS                    | DEFICIENCY)  |                            |                            |  |
|  | company arrived, in and treated the peri chemical solution to Wall-mounted fly lig 12/8/2022 by the period placed near the four door nearest resider entrance, and the 50 control company inclights would arrive a   | ontracted pest control spected the facility for pests, meter of the building with a kill and deter flies. hts were ordered on st control company to be courtyard doors, the exit ht #1 room, near the lobby 00/700 hallway. The pest licated the wall-mounted fly pproximately 12/12/2022, and s will install the wall-mounted   |                       |  |                            |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | PLE CONSTRUCTION  IG |  | (X3) DATE SURVEY COMPLETED |                            |
|--|--|---|----------------------|--|----------------------------|----------------------------|
|  |  | 345448  | B. WING _            |  |                            | C<br><b>12/13/2022</b>     |
|  | ROVIDER OR SUPPLIER  | EHABILITATION CENTER  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406    |                            | 12/10/2022                 |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 925  | F 925   Continued From page 31   |   | F9                   | 25   |                            |                            |
|  | fly lights once receiv   | ved. The Administrator will<br>s to ensure the timely<br>ceipt and installation of the  |                      |  |                            |                            |
|  | resident council med<br>attendance with the<br>prevention, including<br>On 12/9/22, the edu<br>other alert and orier   | ninistrator conducted a eting with 16 residents in discussion of pest g not propping doors open. cation was reviewed with all ated residents that did not council meeting by the                                |                      |  |                            |                            |
|  | On 12/8/22, the Administrator checked all exit doors to ensure no doors were propped open for a point of entry for pests. There were no other identified areas of concern. |   |                      |  |                            |                            |
|  | alarm on the courty<br>feet from the affecte<br>staff when residents   | ntenance Director placed an<br>ard #1 door (the door that's 40<br>ad resident's room) to alert<br>access the courtyard so they<br>re closed to prevent the point  |                      |  |                            |                            |
|  | the courtyard #2 do  | ntenance Director adjusted<br>or closure to ensure the door<br>sealed to prevent the point of   |                      |  |                            |                            |
|  | the Staff Developme<br>Administrator, Medie<br>Receivable, Nurses<br>Housekeeping staff,<br>Payable, Therapy S<br>receptionist, Medica                                     | 6 in-service was initiated by ent Coordinator with the cal Records, Accounts, Nursing Assistants, Social Worker, Accounts taff, Maintenance Staff, Il Records or Supply Clerk in trol to include (1) Prevention |                      |  |                            |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION NG   |             | X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|--|-------------|------------------------------|--|
|  |  | 345448  | B. WING _           |  |             | C<br><b>12/13/2022</b>       |  |
| NAME OF P  | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | <del></del> | 12/10/2022                   |  |
|  |  |   |                     | 308 WEST MEADOWVIEW ROAD   |             |                              |  |
| MAPLE G  | ROVE HEALTH AND REF  | IABILITATION CENTER   |                     | GREENSBORO, NC 27406   |             |                              |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE   | (X5)<br>COMPLETION<br>E DATE |  |
| F 925  | control concerns into Order tracking System Administrator, Director Maintenance Director completed by 12/8/20 Administrator will ensimaled to any remaining and not received the into review, sign the instaff Development Conversing prior to next scontracted staff include worked, will receive the scheduled shift. Staff will monitor the scheduled shift. Staff will monitor the scheduled shift.  On 12/9/2022, 100% the Staff Development Administrator, Medical Receivable, Nurses, I Housekeeping staff, S Payable, Therapy Stareceptionist, Medical regarding to ensure the including doors are not residents. In-service with 12/9/2022. After 12/9 ensure the in-service remaining staff who hereceived the in-service, and the staff provided in the in-service sign the in-service, and the staff provided in the service of the in-service, and the staff provided in the in-service of the in-service, and the staff provided in the in-service of the in-service, and the staff provided in the in-service of the in-service, and the staff provided in the in-service of the in-service, and the staff provided in the in-service of the in-service, and the staff provided in the in-service of the in-ser | the Maintenance Work and notification of ar of Nursing and the . In-service will be 22. After 12/8/2022, the ure the in-services are ang staff who has not worked an-service with instructions service, and return to the cordinator or Director of scheduled work shift. All ding agency that has not are in-service upon the next are Development Coordinator dule for new assigned at they are educated prior to din-service was initiated by at Coordinator with the all Records, Accounts Nursing Assistants, Social Worker, Accounts aff, Maintenance Staff, Records and Supply Clerk are point of entry for pests of left open by staff or will be completed by all 2022, the Administrator will as are mailed to any as not worked and not are with instructions to review, | F9                  |  |             |                              |  |
|  | required to sign an in-<br>their next scheduled s  | d work shift. All staff will be<br>service sheet on arrival to<br>shift. The Educator will<br>and validate staff knowledge  |                     |  |             |                              |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X' |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | PLE CONSTRUCTION  G  |             | TE SURVEY<br>MPLETED       |  |  |
|---|---|--|---------------------|--|-------------|----------------------------|--|--|
|   |   | 345448   | B. WING _           |  | 1           | C<br><b>12/13/2022</b>     |  |  |
|   | ROVIDER OR SUPPLIER   | HABILITATION CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MEADOWVIEW ROAD  GREENSBORO, NC 27406      |             | 211312022                  |  |  |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |  |
| F 925   | worked, will receive scheduled shift. Sta will monitor the sche agency staff to ensure their scheduled shift.  On 12/9/22, the Admicourtyard door monito to ensure the doors a *Date of corrective a On 12/13/2022 the fall mediate Jeopardy validation was eviderin-services given to suby staff management available showing explosed interest of the facility. Three installed or being insumber to five. New bringing the number that residents could installed on it to prevent and reviewed. The facility's in-services had been alleged credible alleged credible alleged. | f the education. All ding agency that has not the in-service upon the next off Development Coordinator dule for new assigned the they are educated prior to dinistrator began daily oring for the identified doors are not propped opened.  Action completion 12/10/2022 decility's credible allegation for the removal was validated. The need by record review of staff, and audits completed to the property of the staff, and audits completed to the property of the staff, and audits completed to the property of the staff, and audits completed to the property of the staff and fly lights were seen using installed. Validation by interview of staff members | F 9                 | 25   |             |                            |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED   |                     |   |   |     |                            |  |
|--|---|--|---------------------|---|---|-----|----------------------------|--|
|  |   | 345448   | B. WING _           |   |   | 12/ | C<br><b>13/2022</b>        |  |
|  | ROVIDER OR SUPPLIER  ROVE HEALTH AND REI  | HABILITATION CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MEADOWVIEW ROAD  GREENSBORO, NC 27406 |   |     |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | (EA   | PROVIDER'S PLAN OF CORRECTION<br>ACH CORRECTIVE ACTION SHOULD B<br>SS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |     | (X5)<br>COMPLETION<br>DATE |  |
| F 925  | Different staff member departments were interested they had attended in-Control. Their signatures in-service training reconstruction. | ers from different erviewed and reported that service training on Pest eres were verified on the cords. Staff members were edetails of the training they | FS                  | 025   |   |     |                            |  |