PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			C 01/27	//2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STAT 308 WEST MEADOWVIEW RO GREENSBORO, NC 27406	OAD	, 011211	72020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)	_	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conducted 01/27/23. The facility		F	000			
	revisit follow up surv	nplaint investigation, and ey were conducted from /27/23. Event ID# 3R3911 12.					
	1/27/23. However, no of the recertification survey that was cond	d F925 were corrected as of ew tag was cited as a result /complaint investigation ducted at the same time as y is still out of compliance.					
	The following intake	s were investigated					
	; NC00197354 ; NC0 NC00196751; NC00 NC00194774; NC00 NC00191317; NC00 NC00190209; NC00	the followings: NC00197413 00197257; NC00196967; 196610; NC00196441; 193414; NC00192880; 190317; NC00190207; 189008; NC00188556; 188412; and NC00188065					
F 550 SS=D	14 of the 46 complai substantiated resultin Resident Rights/Exe CFR(s): 483.10(a)(1)	ng in deficiencies. rcise of Rights	F t	550		3/	/6/23
ADODATORY	self-determination, a	Rights. ght to a dignified existence, nd communication with and		TITLE		///	3) DATE

Electronically Signed 02/20/2023

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		TE SURVEY MPLETED
		345448	B. WING			C 1/27/2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		1/2//2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	outside the facility, in this section. §483.10(a)(1) A facil with respect and digresident in a manner promotes maintenan her quality of life, recindividuality. The fac promote the rights of §483.10(a)(2) The faces to quality car severity of condition, must establish and in practices regarding the provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident cor resident of the Un §483.10(b)(1) The faces interference, coercio from the facility.	ity must treat each resident and in an environment that are or enhancement of his or rognizing each resident's lility must protect and if the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her of the facility and as a citizen	F 55	· ·		
	reprisal from the faci rights and to be supp exercise of his or her subpart. This REQUIREMEN' by:	lity in exercising his or her corted by the facility in the rights as required under this T is not met as evidenced		Maple Grove Health and Reha	abilitation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	\ , ,	(X3) DATE SURVEY COMPLETED	
		345448	B. WING		04/		
NAME OF D	ROVIDER OR SUPPLIER	0.0.10		STREET ADDRESS, CITY, STATE, ZIP CO		27/2023	
NAME OF T	NOVIDEN ON 3011 EIEN			, , ,			
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER		308 WEST MEADOWVIEW ROAD			
	ı			GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 550	Continued From p	age 2	F 5	550			
F 3300	and staff interview Resident #392, 1 catheter care, with have Resident #2 privacy and dignit. The findings included revealed she was on 8/24/22 with m 01/13/23. Her diag disease, sepsis, userview of Reside (MDS) assessment was cognitively intextensive assistant living, such as, turn toileting, bathing, Resident #392 also catheter. On 01/23/23 at 12 observed sitting in of her room. Her the side of her whuncovered. From	rs the facility failed to treat of 1 resident reviewed for n dignity. The facility failed to 39's catheter bag covered for y.		Center acknowledges receip Statement of Deficiencies and this Plan of Correction to the the summary of findings is facorrect and in order to main compliance with applicable a provisions of quality of care. The Plan of Correction is su written allegation of compliance with and Recenter response to this State Deficiencies does not denot with the Statement of Deficiency is accurate. Furth Greenhaven 526.43 Nursing Rehabilitation Center reservate any of the deficiencies Statement of Deficiencies Statement of Deficiencies the Informal Dispute Resolution appeal procedure and/or an administrative or legal proce F550 Resident Rights/Exerce Resident #239 (on sample li is identified as #392) indwel catheter bag was covered, t	and proposes e extent that actually tain rules and of residents. bmitted as a nce. habilitation ement of e agreement encies nor ion that any er, y and es the right to s on this rough formal y other eeding. eise of Rights st of residents ling urinary		
		ved on the wheelchair or in the		completed by the Director of 1/23/23.			
	observed ambulat hallway with the u hanging from her was again visible urine catheter bag	2:50 PM Resident #392 was ing in her wheelchair in the ncovered urine catheter bag wheelchair. Dark amber urine due to no privacy cover on the J. w and observation on 01/23/23		On 1/23/23, the Director of N initiated an audit of all reside urinary catheter bags to ens covered. The Director of Nu and/or Assistant Director (A Nursing will address all condidentified through the audit.	ents with ure they were rsing (DON) DON) of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING				C / 27/2023	
NAME OF P	ROVIDER OR SUPPLIER		1	STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 01/	12112023	
NAME OF T	TO VIDEIT OR GOLT EIER				8 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND I	REHABILITATION CENTER			REENSBORO, NC 27406			
(X4) ID	SUMMARY	/ STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE	
F 550	Continued From page	age 3	F 5	550				
	at 3:24 PM Reside	ent #392 was observed in her			On 2/14/23 the DON/ADON initiated a	ın		
	wheelchair in the v	vending area. Her catheter bag			in-service with all nurses, and nursing			
		privacy bag. She revealed the			assistants, to include agency and con-			
		covered after staff observed			staff on covering urinary catheter bags	s to		
	surveyors looking	at her catheter bag in the			maintain dignity and privacy In-service	will :		
	•	er revealed the catheter bag			be completed by 3/6/23. After, 3/6/23	•		
	had not been cove	ered since her admission. She			nurses, nursing assistants, agency an			
		nave liked for her catheter bag			contract staff who have not worked or			
		ered since her admission so that			received the in-service will be in-service	ced		
her urine was not visible to other residents and		visible to other residents and			prior to next scheduled work shift. All			
	visitors.				newly hired nurses, nursing assistants	ί,		
	A ! 4!	NIA #7 04/00/00 -+ 0.00 DNA			agency and contract staff will be	_		
		NA #7 on 01/26/23 at 3:26 PM			in-serviced during orientation regardin	g		
		typically assigned to Resident as familiar with the Resident.			covering urinary catheter bags.			
		not remember a time when the			An audit of all residents with urinary			
		atheter bag was covered with a			catheter bags will be completed by the	د		
		7 stated she would normally			DON/ADON and/or Unit Manager (UM			
		g was below the bladder, free of			time weekly x 4 weeks, then monthly x	,		
		in a privacy bag. She further			month utilizing the audit tool. This aud			
		ed a resident with an uncovered			to ensure all residents with urinary			
	catheter bag, she	could obtain a bag from central			catheter bags have their bags covered	t		
	supply or ask a nu				appropriately. The DON will address a	ıll		
					concerns identified during the audit to			
		w with the Senior Administrator			include re-training of nursing staff.			
		6 PM revealed there should be						
		sident not to have a privacy			The Director of Nursing will present th			
		neter bag. She stated her			findings of the Audit Tool to the Quality			
		rine catheter bags would be			Assurance Performance Improvement			
		s with a privacy bag to ensure			(QAPI) committee monthly for 2 month			
	the resident's priva	acy was protected.			The QAPI Committee will meet month	ly		
	la an internitere 10	la tha a fa ailite. A almainin internation			for 2 months and review the Urinary			
		h the facility Administrator on			Catheter Bag Audit Tool to determine			
		AM he stated that the facility			trends and/or issues that may need	d to		
		esident's urine to be in plain tated it was his expectation for			further interventions put into place and determine the need for further frequen			
		e covered with a privacy cover			of monitoring.	Су		
	_	sident's dignity and privacy.			or mornioning.			
	to maintain the Ne	sidente dignity and privacy.			Date of Alleged Compliance 3/6/23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			01/2	7/2023
	ROVIDER OR SUPPLIER ROVE HEALTH AND REH	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	E	, , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 565 SS=E	CFR(s): 483.10(f)(5)(§483.10(f)(5) The res and participate in resi (i) The facility must progroup, if one exists, wreasonable steps, wit to make residents and upcoming meetings in (ii) Staff, visitors, or oresident group or fam the respective group's (iii) The facility must providing assistance requests that result frought in the facility providing assistance requests that result frought in the facility must be group concerning is in the facility. (A) The facility must be groups concerning is in the facility must be groups concerning is in the facility must implement and (B) This should not be facility must implement equest of the resident should be facility must implement for the participate in family groups (s) The resident in family groups concerning is in the facility must implement facility must implement for the resident of the resident in family groups (s) The resident in family groups (s) The residents in the facility must implement in family groups (s) The residents in the facility member(s) or concerning in family groups (s) The residents in the facility must implement in family groups (s) The residents in the facility must implement in family groups (s) The residents in the facility must implement in family groups (s) The residents in the facility must implement in family groups (s) The residents in the facility must implement in family groups (s) The residents in the facility must implement in family groups (s) The resident in fam	ident has a right to organize ident groups in the facility. To ovide a resident or family with private space; and take the happroval of the group, defamily members aware of the atimely manner. There guests may attend tilly group meetings only at a sinvitation. To ovide a designated staffered by the resident or family and who is responsible for and responding to written to me group meetings. To onsider the views of a tup and act promptly upon the ecommendations of such the sues of resident care and life to eable to demonstrate their the for such response. The construed to mean that the the strength of the sues of the sues of the to demonstrate their that as recommended every the or family group. Ident has a right to have other resident the tin the facility with the expresentative(s) of other	F 5	F565 Resident/Family Group	Respons		3/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345448	B. WING				С
		343446	B. WING_			01	/27/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND F	REHABILITATION CENTER		3	08 WEST MEADOWVIEW ROAD		
				G	GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	Continued From page	age 5	F 5	565			
	interviews, and rev	view of the Resident Council					
	Minutes, the facility	y failed to record and respond			On 1/25/23 the Administrator reviewed	the	
	1	by residents during Resident			grievance log for resident council		
	Council meetings f	for 8 of 12 months (April, May,			grievances, that were not in the reside	nt	
	July, August, Sept	ember, October, November			council minutes. The Administrator for	nd	
	and December 202	22).			grievances from Residents #18, #32, #	<i>‡</i> 47,	
					#48, #52, #67, #73, #87 and #392 fror	n	
	Findings included:				resident council that had been written	on	
					the facility concern forms instead of		
		ncil minutes were reviewed for			recorded on the Resident Council Mee	ting	
	' ' ' ' ' ' '	ugust, September, October,			Minutes from April, May, July, August,		
	November and December 2022 and revealed no				September, October, November and		
	_	inces were documented from			December. The Administrator was able	e to	
		nutes indicated Resident #18,			determine the grievances were		
		dent #47, Resident # 48, dent #67, Resident #73,	investigated and a resolution was obtained on the resident council concerns.				
		Resident # 392 attended these			obtained on the resident council conce	лнъ.	
		ntified Residents were			On 1/25/23 the Administrator provided	the	
		a BIMS (brief interview mental			Activities Director with a copy of the	uio	
	status) greater tha	,			Resident Council Grievance Follow-up)	
	, 0				form. This form is to be used for the		
	On 01/24/23 at 10:	:30 am a Resident Council			Resident Council Grievances lodged		
	meeting was held	and attended by Resident #67,			during the Resident Council Meeting.		
	Resident #48, Res	ident # 86, Resident #392,			On 2/24/23 the Administrator complete	: d	
		sident #47, Resident #52,			an in-service for the Activities Director		
		ident #65 and Resident #73.			the correct forms to use for the Reside		
		g the residents were notified			Council Meeting Minutes, on including	-	
		ew of the Resident Council			grievances or concerns from the coun-	oil	
		May, July, August, September,			meeting in the minutes and using the		
	· ·	er and December no concerns			Resident Council Grievances Follow-u		
	· ·	e residents. The residents in			form. New Activities Director hired after	r	
		ed this was not true and that			2/24/23, will be in-serviced during	•	
		n reported each meeting for the			orientation regarding Resident Counci	ı	
	l -	at #48 stated that concerns with			Meeting Minutes, on including any	ail.	
		food, bathing and missing			grievances or concerns from the count	ااذ	
		g concerns that had been			meeting in the minutes and using the	.	
		s. The residents stated the			Resident Council Grievances Follow-u	μ.	
		ld them at the beginning of vances and concerns were not			The Administrator will audit 1 time more	athly	
	i cacii meetiiig gile	various ariu coriudiris Well Hol	1		I THE AUTHINISHARD WILL AUGIL I WILL HILL HILL	ILITIY	1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						(c
		345448	B. WING _			01/	27/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				30	08 WEST MEADOWVIEW ROAD		
MAPLE GI	ROVE HEALTH AND RE	HABILITATION CENTER		G	REENSBORO, NC 27406		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 565	Continued From pag		F:	565			
	reported in the minutes. The residents also				x 3 months utilizing Audit Tool. This au		
	stated that their cond				is to ensure all resident grievances and		
		were unaware of efforts to			concerns are being recorded appropria		
	resolve their concern	is as they remained ongoing.			in the meeting minutes for review at ea	ch	
					meeting. The Administrator will addres		
		Resident # 32 explained the			all concerns identified during the audit		
	Council Members vo				include re-training of Activities Director	•	
	•	meetings, however the					
	_	nces were never resolved by			The Administrator will present the finding		
	-	#32 added the facility has			of the Resident Council Grievance Aud	it	
		ors within the year, and		Tool to the Quality Assurance Performance Improvement (QAPI)			
	nothing was being do	one for our concerns.					
	Б	111 11 A 11 11 D: 1			committee monthly for 2 months. The	_	
	•	with the Activity Director on			QAPI Committee will meet monthly for		
		the Activity Director stated			months and review the Resident Council Grievance Audit Tool to determine trends		
		sident Council meetings and utes but not concerns or				ıs	
					and/or issues that may need further		
	-	ed she was told by the document concerns and			interventions put into place and to	20.4	
		nutes but on a separate			determine the need for further frequency of monitoring.	у	
	-	Activity Director provided the			of monitoring.		
		rn form from the Resident			Date of Alleged Compliance 3/6/23		
		no concerns were recorded.			Date of Alleged Compliance 5/6/25		
	The Administrator wa	as interviewed on 01/26/23 at					
	1:13 pm. The Admini	strator indicated that the				ĺ	
	Resident Council me					ĺ	
	grievances and conc	erns in the meeting but if					
	there were private is:	sues, they were having they					
	could come to him or	rthe SW individually. He					
	stated he did attend	the Resident Council					
	-	2023. He indicated that he				ĺ	
	= -	its to feel free to voice their				ĺ	
		nces, during their Resident				ĺ	
	Council meetings and	-				ĺ	
	•	cumented in the Council				ſ	
	minutes as well as a	grievance form filed.				ĺ	
F 623 SS=B	Notice Requirements	s Before Transfer/Discharge	F (623			3/9/23

Facility ID: 923456

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 01/27/2023
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	, U.Z2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLÉTION
F 623	resident, the facility (i) Notify the resider representative(s) of the reasons for the relanguage and mann facility must send a representative of the Long-Term Care On (ii) Record the reaso discharge in the res accordance with para and (iii) Include in the no paragraph (c)(5) of the §483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required to made by the facility resident is transferre (ii) Notice must be no before transfer or di (A) The safety of income the beendangered und this section; (B) The health of income be endangered, und this section; (C) The resident's h allow a more immediate transfer paragraph (c) (D) An immediate transference	e before transfer. sfers or discharges a must- t and the resident's the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a e Office of the State abudsman. ons for the transfer or ident's medical record in ragraph (c)(2) of this section; tice the items described in his section. g of the notice. ed in paragraphs (c)(4)(ii) and the notice of transfer or under this section must be at least 30 days before the ed or discharged. hade as soon as practicable	F 62	3	

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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	I DE	0112112023	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL F		ID PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 623	under paragraph (c)((E) A resident has no days. §483.15(c)(5) Contennotice specified in paramust include the follo (i) The reason for tra (ii) The effective date (iii) The location to what transferred or dischar (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities of the Developmental disabilities of the Developmental disabilities of the Developmental disabilities and telephone or related disemail address and telephone or related disemail address and telephone or responsible for advocacy of individual	ts of the notice. The written ragraph (c)(3) of this section wing: Insfer or discharge; Insfer or discharge; Inster or discharge; Inste	F	523			

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	ROVIDER OR SUPPLIER	EHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COI 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 623	effecting the transfe must update the rectas practicable once becomes available. §483.15(c)(8) Notice In the case of facility the administrator of written notification pto the State Survey. State Long-Term Cathe facility, and the rectain well as the plan for the relocation of the result 483.70(I). This REQUIREMENT by: Based on record refacility failed to prove Responsible Party (reason for a hospital reviewed for hospital 4442 and 480). The findings included 1. Resident #342 was 03/23/2022. A Modification of Ad (MDS) assessment Resident #342 was A review of Resident	ges to the notice. the notice changes prior to r or discharge, the facility ipients of the notice as soon the updated information e in advance of facility closure r closure, the individual who is the facility must provide rior to the impending closure Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate idents, as required at § T is not met as evidenced view and staff interviews, the ide the resident and/or RP) written notification of the I transfer for 3 of 3 residents lization (Residents #342, d: as admitted to the facility on mission Minimum Data Set dated 03/30/2022, indicated	F	F623 Requirements Before Transfer/Discharge On 2/13/23, the Director of Ninitiated an audit of resident and #80 discharged to deternotice of acute discharge not completed and given to the resent to the resident represen Director of Nursing (DON) and Assistant Director (ADON) of address all concerns identified the audit. Resident #342, #44 have all passed away. On 2/13/23, the Corporate Concerns identification and Social Worker in audit of all residents discharge.	#342, #442 mine if the tice was esident and tative. The nd/or f Nursing will ed through 42 and #80 linical nitiated an	
	04/24/2022 for naus	ea and vomiting and was o the facility. There was no		30 days to determine if the addischarge notice was comple	cute	

Facility ID: 923456

PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345448	B. WING _				C 27/2023
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				3	08 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		G	GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From pag	e 10	F6	523			
	documentation that a was provided to the r reason of the transfe	written notice of transfer resident and/or the RP for the			given to the resident and sent to the resident representative. The DON/ADC will address all concerns identified thro the audit.		
	conducted with Unit I was the nurses ' responsibility writing to the residenthe discharge to the I On 01/26/23 at 11:37 conducted with Assis Nursing/Infection Control Preventionist was the nurses ' responsification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing responsible to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing responsible to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing responsible to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the Coshe was unable to locate notification in writing reason of a discharge On 01/26/23 at 12:16 conducted with the One of the Coshe was unable to locate notification in writing reason of a discharge One One of the One of th	Manager #1. She stated it by to send the notification in t and family for the reason of hospital. AM an interview was stant Director of (ADON/ICP). She stated it ponsibility to send the to the resident and RP for the to the hospital. BY PM an interview was clinical Director. She stated fication in writing of discharge sident #342's hospital			On 2/14/23 The DON/ADON in-service the nurses and Social Worker to includ agency and contract staff on the Acute Discharge Notice is to be completed withe resident is transferred to the hospit for an acute issue. The form must be given to the resident by the nurse and sent to the resident representative by the Social Worker when the resident is transferred to an acute care hospital. In-service will be completed 3/6/23. Aft 3/6/23 any nurses, agency and contract staff who have not worked or received in-service will be in-serviced prior to ne scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding the Acute Discharged Notice form.	e hen al he Fhe er tt the ext	
	conducted with Nurse worked at the facility December. She also she sent to the emerincluded the face she on why they are bein room (ER), last labs, then stated she was at the nurses' station notice of transfer for She further stated sh	B PM an interview was e #7. She stated she had through agency since stated the information that gency room with a resident eet, vital signs, information g sent to the emergency and list of medications. She not familiar with an envelope that contained the written the resident and/or the RP. e thought the Social Worker, Nursing, or the Unit Manager			The DON/ADON will audit 1 times wee x 4 weeks, 1-time monthly x 2 months utilizing the Audit Tool. This audit is to ensure all resident transferred or discharged to the hospital are given the Acute Discharge Notice From and it is sent to the resident representative. Th DON will address all concerns identifie during the audit to include re-training o nurses. The DON will present the findings of th Audit Tool to the Quality Assurance Performance Improvement (QAPI)	e e d	

Facility ID: 923456

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345448	B. WING		01	C /27/2023	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 623	conducted with Nurse worked at the facility stated the information emergency room with sheet, vital signs, chaform, last labs, nursir residents 'medication does not know about station that contained written notice of trans RP. She preceded to Worker, Assistant Dii Manager would send On 01/26/23 at 04:43 folder that listed the inthe resident to the hospit written reason for tra RP. On 01/27/2023 at 10 conducted with the Stated the facility had notification of a hospithe RP. She also state the written notification on 01/27/23 at 11:13 conducted with the Abusiness office was to follow up the hospital transfer I send a	mation to the RP. 3 PM an interview was e #3. She stated she has for a year and half. She also in that she sent to the in a resident included the face range in condition evaluation ing notes, and a list of the ins. She then stated she in an envelope at the nurses' it the bed hold policy or a sfer for the resident and/or estate she thought the Social rector of Nursing, or the Unit that information to family. 3 PM The facility provided a information to be sent with insport for the resident or the insport for the resident or the interview was enior Administrator. She is not been sending written ital transfer to the resident or the ital transfer to the resident or the ital transfer to the resident or the ital transfer to the resident or ited the facility was unaware	F 62	committee monthly for 2 mo QAPI Committee will meet in months and review the Transfer/Discharge/Bed Holi determine trends and/or issu need further interventions put and to determine the need for frequency of monitoring. Date of alleged compliance	nonthly for 2 d Audit Tool to ues that may ut into place or further		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345448	B. WING		01/27/2023	
MAPLE GROVE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	, , , , , , , , , , , , , , , , , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 623	Continued From page 2. Resident #442 was 08/24/22.	ge 12 as admitted to the facility on	F 62	3		
	transferred to the howas no documentation transfer was provided RP for the reason of A Significant Changus assessment dated 1 Resident #442 was On 01/26/23 at 11:3	e Minimum Data Set (MDS) 1/28/2022, indicated severely cognitively impaired. 6 AM an interview was				
	was the nurses' responsibil writing to the resider the discharge to the On 01/26/23 at 11:3 conducted with Assi Nursing/Infection Control Preventionis was the nurses' res	7 AM an interview was stant Director of st (ADON/ICP). She stated it sponsibility to send the potential to the resident and RP for				
	conducted with Nurs worked at the facility December. She also she sent to the eme included the face sh on why they are beil room (ER), last labs then stated she was	3 PM an interview was see #7. She stated she had a through agency since to stated the information that argency room with a resident eet, vital signs, information ag sent to the emergency, and list of medications. She not familiar with an envelope on that contained the written				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			C 01/27/2023	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	•	0112112025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623		ge 13 the resident and/or the RP. ne thought the Social Worker,	F 6	23			
	Assistant Director of would send that info	Nursing, or the Unit Manager rmation to the RP.					
	conducted with Nurs worked at the facility stated the information	6 PM an interview was se #3. She stated she has of for a year and half. She also on that she sent to the th a resident included the face					
	sheet, vital signs, ch form, last labs, nursi residents ' medicati	ange in condition evaluation ng notes, and a list of the ons. She then stated she t an envelope at the nurses'					
	written notice of tran RP. She preceded to Worker, Assistant D	d the bed hold policy or a sfer for the resident and/or o state she thought the Social irector of Nursing, or the Unit d that information to family.					
		3 PM The facility provided a information to be sent with					
		ital. The folder did not list a ansport for the resident or the					
	conducted with the stated the facility han notification of a hosp	0:00 AM an interview was Senior Administrator. She d not been sending written bital transfer to the resident or ated the facility was unaware on was to be sent.					
	conducted with the A business office was to follow to	3 AM an interview was Administrator. He stated the up with family the day after by phone and they are to					

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345448	B. WING			C 1/27/2023
NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	transfer. 3. R Resident #80 w 11/08/22. Resident #80's med transferred to the honosebleed. There we written notice of transfer. A Significant Change assessment dated 0 #80 was severely conducted with Unit was the nurses ' responsibil writing to the resident the discharge to the On 01/26/23 at 11:3 conducted with Assin Nursing/Infection Control Preventionis was the nurses ' responsibil writing to the resident the discharge to the On 01/26/23 at 11:3 conducted with Assin Nursing/Infection Control Preventionis was the nurses ' responsibil writing reason of a discharge on 01/26/23 at 12:2 conducted with Nursing/Infection Control Preventionis was the nurses ' responsibility at the nurses of the	RP giving the reason for the as admitted to the facility on ical record revealed she was spital on 01/11/22 for a as no documentation that a sfer was provided to the RP for the reason of the e Minimum Data Set (MDS) 1/13/23, indicated Resident ignitively impaired. 6 AM an interview was Manager #1. She stated it ity to send the notification in and family for the reason of hospital. 7 AM an interview was stant Director of t (ADON/ICP). She stated it sponsibility to send the to the resident and RP for	F 62	23		

D. WING	;
345448 B. WING 0.1/3	27/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	11/2023
308 WEST MEADOWVIEW ROAD	
MAPLE GROVE HEALTH AND REHABILITATION CENTER GREENSBORO, NC 27406	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623 Continued From page 15 F 623	
on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the written notice of transfer for the resident and/or the RP. She further stated she though the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to the RP. On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy or a written notice of transfer for the resident and/or RP. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to family. On 01/26/23 at 04:43 PM The facility provided a folder that listed the information to be sent with the resident to the hospital. The folder did not list a written reason for transport for the resident or the RP. On 01/27/2023 at 10:00 AM an interview was conducted with the Senior Administrator. She stated the facility had not been sending written notification of a hospital transfer to the resident or the RP. She also stated the facility was unaware the written notification was to be sent.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 01/27/2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	1 011211/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 623	business office was to follow the hospital transfer send a written letter to the F transfer.	Administrator. He stated the up with family the day after by phone and they are to RP giving the reason for the	F 62		
F 625 SS=B	CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d) (1) Notice nursing facility trans the resident goes or nursing facility must the resident or resid specifies- (i) The duration of th any, during which th return and resume re facility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facil bed-hold periods, wl paragraph (e)(1) of t resident to return; ar (iv) The information of this section. §483.15(d)(2) Bed-h the time of transfer of hospitalization or the facility must provide resident representat specifies the duratio	f bed-hold policy and return- e before transfer. Before a fers a resident to a hospital or a therapeutic leave, the provide written information to ent representative that the state bed-hold policy, if the resident is permitted to the esidence in the nursing the payment policy in the state to of this chapter, if any; ity's policies regarding the nust be consistent with this section, permitting a the payment policy in the state to of this chapter, if any; ity's policies regarding the number of the payment policy in the state to of this chapter, if any; ity's policies regarding the payment policy in the state the provide the provide the provide the payment policy in the state the provide written information to	F 62	55	3/9/23

PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345448	B. WING			1	27/2022
NAME OF P	ROVIDER OR SUPPLIER	0.707.70			STREET ADDRESS, CITY, STATE, ZIP CODE	01/.	27/2023
NAME OF FI	NOVIDER OR SUFFLIER						
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER			808 WEST MEADOWVIEW ROAD		
					GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	e 17	F 6	325			
	This REQUIREMENT by:	is not met as evidenced					
		iews and record review, the le notice of the bed hold			F625 Notice of Bed Hold Policy Before/Upon Transfer		
	hospitalizations (Resi	of 3 resident reviewed for idents #342, #442, #80).			On 2/13/23, the Director of Nursing initiated an audit of resident #342, #44 and #80 discharged to determine if the	:	
	The findings included	i:			notice of Bed Hold Policy was complet and given to the resident and/or	ed	
	1. Resident #342 was 03/23/2022.	s admitted to the facility on			discussed with the resident representative. The Director of Nursin (DON) and/or Assistant Director (ADO	-	
		nission Minimum Data Set ated 03/30/2022, indicated			of Nursing will address all concerns identified through the audit. Resident		
	Resident #342 was co	ognitively intact.			#342, #442 and #80 have passed awa	y.	
		#342's medical record			On 2/14/23, the Corporate Clinical		
		nsferred to the hospital on			Director and Social Worker initiated an		
		a and vomiting and was			audit of all residents discharged in the	last	
		the facility. There was no			30 days to determine if the Bed Hold		
		ne bed hold policy was given			Policy notice was completed and giver	ı to	
		the Responsible Party.			the resident and sent to the resident representative. The DON/ADON will		
	On 01/26/23 at 11:36				address all concerns identified through	ı	
	was the	Manager #1. She stated it			the audit.		
		y to send the bed hold policy			On 2/14/23 The DON/ADON in-service	٠d	
	to the hospital with th				the nurses to include agency and conti		
	transfer.	e resident at time of			staff on the Bed Hold Policy to be completed when the resident is	acı	
	On 01/26/23 at 11:37	AM an interview was			transferred to the hospital for an acute		
	conducted with Assist				issue. The form must be given to the	ĺ	
	Nursing/Infection	and Director of			resident and discussed with the reside	nt	
		(ADON/ICP). She stated it			representative when the resident is	110	
		consibility to send the bed			transferred to an acute care hospital, tl	he	
	hold	John Silling to Solid the Dea			floor nurse will be responsible for givin		
		with the resident at time of			the resident the bed hold and the	9	
	transfer.	mar are recident at affic of			Business Office Manager will discuss v	vith	

Facility ID: 923456

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		345448	B. WING			01/	27/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADLECI	DOVE HEALTH AND DEL	LARU ITATION CENTER		30	08 WEST MEADOWVIEW ROAD		
MAPLE GI	ROVE HEALTH AND REI	HABILITATION CENTER		G	REENSBORO, NC 27406		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 625	Continued From page	e 18	F	625			
					the family. The in-service will be		
		PM an interview was			completed by 3/6//23 After 3/6/23, any		
		linical Director. She stated			nurses, agency and contract staff who		
	she was				have not worked or received the		
		umentation that the bed hold			in-service will be in-serviced prior to ne	Χl	
	during	342 's was sent with her			scheduled work shift. All newly hired nurses, nursing assistants, agency and	ı	
	the hospital transfer of	on 04/24/2022			contract staff will be in-serviced during		
	the hospital transfer c	311 04/24/2022.			orientation regarding the Bed Hold Poli	CV.	
	On 01/26/23 at 12:23	PM an interview was				٠,٠	
	conducted with Nurse	e #7. She stated she had			The DON/ADON will audit 1 times wee	kly	
	worked at the facility	through agency since			x 4 weeks, 1-time monthly x 2 months		
	December. She also	stated the information that			utilizing the Audit Tool. This audit is to		
	she sent to the emerg	gency room with a resident			ensure all resident transferred or		
		et, vital signs, information			discharged to the hospital are given the)	
		g sent to the emergency			Acute Discharge Notice From and it is		
	, ,	and list of medications. She			sent to the resident representative. Th		
		not familiar with an envelope			Director of Nursing (DON) will address	all	
		that contained the bed hold			concerns identified during the audit to		
	-	ated she thought the Social rector of Nursing, or the Unit			include re-training of nurses.		
	Manager would get th				The DON will present the findings of th	_	
	resident and/or the R				Audit Tool to the Quality Assurance	C	
					Performance Improvement (QAPI)		
	On 01/26/23 at 12:26	PM an interview was			committee monthly for 2 months. The		
	conducted with Nurse	e #3. She stated she has			QAPI Committee will meet monthly for	2	
	worked at the facility	for a year and half. She also			months and review the		
	stated the information				Transfer/Discharge/Bed Hold Audit Too		
		n a resident included the face			determine trends and/or issues that ma	-	
	_	ange in condition evaluation			need further interventions put into place	Э	
		ng notes, and a list of the			and to determine the need for further		
		ns. She then stated she			frequency of monitoring.		
		an envelope at the nurses' I the bed hold policy for the			Date of alleged compliance 3/6/23		
		onsible Party. She preceded			Date of alleged compliance 3/0/23		
	-	he Social Worker, Assistant					
		or the Unit Manager would					
	send that information	-					
		-					

DEFICIENCIES ORRECTION				(X3) DATE SURVEY COMPLETED	
	345448	B. WING _			C 1/27/2023
	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		11/21/2023
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
on 01/26/23 at 04:43 older that listed the esident to the hospital bed hold policy was on 01/27/23 at 11:13 onducted with the Ausiness office was to follow une hospital transfer end a opy of the bed hold party. Resident #442 was 8/24/22. Resident #442's mediansferred to the hospital transferred to the hospital transferred to the hospital was given to the resident #442 was son 01/26/23 at 11:36 onducted with Unit was the urses ' responsibility the hospital with the transfer.	an PM The facility provided a information to be sent with tal. The folder did not list that is to be sent with the resident. AM an interview was administrator. He stated the p with family the day after by phone and they are to policy to the Responsible admitted to the facility on dical record revealed he was spital on 11/10/2022. There on that the bed hold policy dent and/or the Responsible a Minimum Data Set (MDS) 1/28/2022, indicated severely cognitively impaired. AM an interview was Manager #1. She stated it they to send the bed hold policy he resident at time of	F 6	25		
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag On 01/26/23 at 04:43 colder that listed the ine esident to the hospital bed hold policy was on 01/27/23 at 11:13 conducted with the A cusiness office was to follow une hospital transfer ine end a copy of the bed hold carty. C. Resident #442 was 8/24/22. Resident #442's mediansferred to the hospital transfer in the policy was no documentation was given to the resident was given to the resident #442 was so On 01/26/23 at 11:36 conducted with Unit in the policy was responsibilities the hospital with the policy was in the hospital with the policy was inconducted with Assistant of the hospital with the policy was inconducted with Assistant in the policy was in the p	Assident #442 was admitted to the facility on 18/24/22. Resident #442 was admitted to the facility on 18/24/22. Resident #442 was admitted to the facility on 18/24/22. Resident #442 was severely cognitively impaired. Right at 18/28/2022, indicated Resident #442 was severely cognitively impaired. Right at 18/28/2023 at 11:36 AM an interview was onducted the hospital on 11/128/2022, indicated Resident #442 was severely cognitively impaired. Resident #442 was ed the bed hold policy of the hospital transfer the hospital on 11/10/2022. There was no documentation that the bed hold policy was given to the resident and/or the Responsible Party. Resident #442 was severely cognitively impaired. Resident #442 was severely cognitively impaired.	IDENTIFICATION NUMBER: 345448 B. WING WIDER OR SUPPLIER WE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 On 01/26/23 at 04:43 PM The facility provided a older that listed the information to be sent with the esident to the hospital. The folder did not list that a bed hold policy was to be sent with the resident. On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated the inspirate transfer by phone and they are to end a copy of the bed hold policy to the Responsible Party. I. Resident #442 was admitted to the facility on 18/24/22. Resident #442's medical record revealed he was ransferred to the hospital on 11/10/2022. There was no documentation that the bed hold policy was given to the resident and/or the Responsible Party. A Significant Change Minimum Data Set (MDS) issessment dated 11/28/2022, indicated Resident #442 was severely cognitively impaired. On 01/26/23 at 11:36 AM an interview was conducted with Unit Manager #1. She stated it was the urrses' responsibility to send the bed hold policy to the hospital with the resident at time of ransfer. On 01/26/23 at 11:37 AM an interview was conducted with Assistant Director of lursing/Infection	WIDER OR SUPPLIER WE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 On 01/26/23 at 04:43 PM The facility provided a older that listed the information to be sent with ne esident to the hospital. The folder did not list that bed hold policy was to be sent with the example of the bed hold policy to the Responsible array. Resident #442 was admitted to the facility on 18/24/22. Resident #442 was admitted to the facility on 18/24/22. Resident #442 was admitted to the facility on 18/24/22. Resident #442's medical record revealed he was ransferred to the hospital on 11/10/2022. There was no documentation that the bed hold policy was given to the resident and/or the Responsible Party. A Significant Change Minimum Data Set (MDS) issessment dated 11/28/2022, indicated Resident #442 was severely cognitively impaired. On 01/26/23 at 11:36 AM an interview was onducted with Unit Manager #1. She stated it was the usesses responsibility to send the bed hold policy to the hospital with the resident at time of ransfer. On 01/26/23 at 11:37 AM an interview was onducted with Assistant Director of function of function of the process of the proces	A BUILDING 345448 BY HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEPOISONES (EACH DEPICION VISITE BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION) DO 1/126/23 at 14:35 AM an interview was onducted with Unit Manager #1. She stated it was the uncess of responsibility to send the bed hold policy as the nospital will manager #1. She stated it was the uncess of responsibility to send the bed hold policy on the hospital will manager #1. She stated it was the uncess of responsibility to send the bed hold policy on the hospital will manager #1. She stated it was the uncess of responsibility to send the bed hold policy on the hospital will manager #1. She stated it was the uncess of responsibility to send the bed hold policy on the hospital will manager #1. She stated it was the uncess of responsibility to send the bed hold policy on the hospital will manager #1. She stated it was the uncess of responsibility to send the bed hold policy on the hospital will manager #1. She stated it was the uncess of responsibility to send the bed hold policy on the hospital will the resident at time of anafer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345448	B. WING			1	C 27/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	1 01/	2112023
MAPI F G	ROVE HEALTH AND REI	IABII ITATION CENTER		308 WEST N	MEADOWVIEW ROAD		
IIIAI EE O	NOVE HEAEIN AND REI	IABILITATION GENTER		GREENSB	ORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 625	Continued From page	⊋ 20	F 6	25			
	hold	oonsibility to send the bed with the resident at time of					
	conducted with Nurse worked at the facility December. She also she sent to the emergincluded the face she on why they are being room (ER), last labs, then stated she was at the nurses' station policy. She further sta Worker, Assistant Dir Manager would get the resident and/or the ROON 01/26/23 at 12:26 conducted with Nurse	esponsible Party. PM an interview was e #3. She stated she has					
	stated the information emergency room with sheet, vital signs, char form, last labs, nursin residents 'medicatio does not know about station that contained resident and/or Resputo state she thought to Director of Nursing, of send that information On 01/26/23 at 04:43 folder that listed the inthe	n a resident included the face range in condition evaluation ag notes, and a list of the range. She then stated she an envelope at the nurses' I the bed hold policy for the consible Party. She preceded the Social Worker, Assistant or the Unit Manager would					

STATEMENT OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345448	B. WING		C 01/27/2023
	OVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
	On 01/27/23 at 11:1 conducted with the abusiness office was to follow the hospital transfer send a copy of the bed hold Party. 3. Resident #80 was 11/08/22. Resident #80's med transferred to the honosebleed. There where bed hold policy was the Responsible Part A Significant Chang assessment dated 0 was severely conducted with Unit was the nurses ' responsibility to the hospital with the transfer. On 01/26/23 at 11:3 conducted with Assi Nursing/Infection Control Preventionis	as to be sent with the resident. 3 AM an interview was Administrator. He stated the up with family the day after by phone and they are to dipolicy to the Responsible admitted to the facility on ical record revealed she was espital on 01/11/22 for a reas no documentation that the given to the resident and/or rity. e Minimum Data Set (MDS) 01/13/23, indicated Resident engitively impaired. 6 AM an interview was Manager #1. She stated it lity to send the bed hold policy the resident at time of	F 62	5	

NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER X4)ID SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE) PREFIX (RACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE) PROVIDER'S PLAN OF CORRECTION AND COMPETION OF TAGE OF THE APPROPRIATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
MAPLE GROVE HEALTH AND REHABILITATION CENTER Some was measured and a supplied of the stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would get that information to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents and/or Responsible Party. She preceded to state she thought the Social Worker Assistant Director of Nursing, or the Unit Particular of the sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents moderated and/or Responsible Party. She preceded to state she thought the Social Worker Assistant Director of Nursing, or the Unit Particular of the presidents of the moderations of the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents of medications. She then the manufactor of Nursing, or the Unit Manager would get that information to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents of medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy for the resident and/or Responsible Party. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would and the condition of the Responsible Party. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would and the Particular of the Particular of the Particular of Particular of the Particular of Pa			345448	B. WING _				
FREEIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 625 Continued From page 22 On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the bed hold policy. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would get that information to the resident and/or the Responsible Party. On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy for the resident and/or Responsible Party. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would			HABILITATION CENTER		308 WEST MEADOWVIEW ROAD	CODE	311 <u>211232</u>	
On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the bed hold policy. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would get that information to the resident and/or the Responsible Party. On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy for the resident and/or Responsible Party. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIA	COMPLETION	٧
On 01/26/23 at 04:43 PM The facility provided a folder that listed the information to be sent with the resident to the hospital. The folder did not list that a bed hold policy was to be sent with the resident. On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated the	F 625	On 01/26/23 at 12:23 conducted with Nurse worked at the facility December. She also she sent to the emerincluded the face she on why they are bein room (ER), last labs, then stated she was at the nurses' station policy. She further st Worker, Assistant Din Manager would get the resident and/or the ROON 01/26/23 at 12:26 conducted with Nurse worked at the facility stated the information emergency room with sheet, vital signs, chaform, last labs, nursin residents ' medication does not know about station that contained resident and/or Respet to state she thought to Director of Nursing, conducted that information on 01/26/23 at 04:43 folder that listed the information on 01/26/23 at 04:43 folder t	B PM an interview was e #7. She stated she had through agency since stated the information that gency room with a resident set, vital signs, information g sent to the emergency and list of medications. She not familiar with an envelope that contained the bed hold ated she thought the Social rector of Nursing, or the Unit hat information to the desponsible Party. B PM an interview was e #3. She stated she has for a year and half. She also in that she sent to the in a resident included the face ange in condition evaluation ag notes, and a list of the sins. She then stated she has an envelope at the nurses' of the bed hold policy for the consible Party. She preceded the Social Worker, Assistant or the Unit Manager would a to family. B PM The facility provided a information to be sent with the resident. B AM an interview was	F	525			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345448	B. WING _		C 01/27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
MAPLE GI	ROVE HEALTH AND	REHABILITATION CENTER		308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 625	the hospital transfe send a copy of the bed ho Party.	age 23 v up with family the day after er by phone and they are to old policy to the Responsible d for Dependent Residents	F 6		3/9/23
SS=D	S483.24(a)(2) A re out activities of da services to mainta personal and oral This REQUIREME by: Based on observaresident and staff provide showers, is residents who need dependent on staff (ADL). This was for #79 and #80) review. The findings included the finding	esident who is unable to carry ily living receives the necessary in good nutrition, grooming, and hygiene; ENT is not met as evidenced ations, record review, and interview 's the facility failed to hail care, and mouth care to eded extensive and/or were for Activities of Daily Living or 2 of 2 residents (Resident ewed for ADL 's.		F677 ADL Care Provided for Residents On 1/25/23, the Certified Nurs Assistant (CNA) gave resident shower, washed his hair and trimmed his nails. Resident #iplaced on the shower schedu Sunday and Wednesday each 1/26/23, the CNA gave the resident #80. The resident har away. On 2/14/23, the Director of Nu (DON)/Assistant Director of Nu (DON)/Assistant Director of Nu (ADON)/Unit Manager (UM) in audit of ADL care of all depen residents to include nail care, washing hair and showers. The ensure all residents were assis ADL care and when refusal of documented in the electronic	Dependent sing tt #79 a cleaned and 79 was le for n week. On sident a bed nouth of s passed ursing lursing nitiated an ident mouth care, nis audit is to isted with f care, its

PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING				C 27/2023	
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					08 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND R	EHABILITATION CENTER			GREENSBORO, NC 27406			
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F 677	Continued From pa	nge 24	F	677				
	hygiene and bathin limitations in range of upper and lower	ent of one person for personal g. Resident #80 had functional of motion (ROM) on one side extremities. Her dental statusing she had no obvious or likely natural teeth.			DON/ADON/UM will address all concellidentified during the audit to include assisting dependent residents with ADI care and education of staff. Audit will be completed by 3/6/23. On 2/14/23, the DON/ADON/UM□s	L		
	11/08/22 with a rev a focus for Activitie following interventic Hygiene/Grooming and dry face, skin,	t #80 's care plan dated ision date of 12/10/22 revealed s of Daily Living with the ons: Personal -Provide total care for wash nails, hands, and perineum, ependence with one person			initiated an in-service with all nurses ar nursing assistants regarding ADL Care with emphasis on ensuring nails are cleand trimmed per resident preference a mouth care is provided for all depende residents. In-services will be completed 3/6/23. After 3/6/23, any nurse or nursi assistant to include agency and contrastaff who has not received the in-service.	ean nd nt d by ng ct		
	Resident #80 was of mouth open. Tonguteeth and side of mountyellowish/who Substance appears	nite substance noted. s hard on tongue and teeth.			will be in-serviced prior to next schedul work shift. All newly hired nurses and nursing assistants, agency and contract staff will be in-serviced during orientation regarding ADL Care.	led ct on		
	conducted on 01/2: of Resident #80 rev with mouth open. T between teeth and brown/yellowish/wh Substance appears Lips appeared soft Nurse #5 was conc resident is a "mouth mouth open all the mouth care every s and 11pm-7am). No mouth and stated it	d cracked. d interview with Nurse #5 were 3/23 at 03:48 PM. Observation wealed she was lying in bed ongue, teeth, gums and side of mouth with dry nite substance noted. s hard on tongue and teeth, and shiny. Interview with ducted. She stated that h breather" and keeps her time. She stated she gets shift (7am-3pm, 3pm-11pm, urse #5 assessed residents 't normally looks like that a gets dry from having mouth			The DON/ADON/UM□s will review Poi Click Care (PCC) documentation to ensure bath/showers, nail care, and mouth care are being completed as assigned. Resident observation, and checking the shower schedule daily, asking the resident if a shower was received or assessing the resident una to state shower was given, this will be performed by the DON/ADON/UM and Administrator to include resident #79, (resident #80 is no longer in the facility weekly x 4 weeks then monthly x 1 mo utilizing the ADL Audit Tool and the Shower/Bath Audit Tool. This audit is to ensure all dependent residents were assisted with ADL care and refusals of	ble) nth		

Facility ID: 923456

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD CURRUED	343440	1 3: 11::10 -	CT	TREET ADDRESS OFF STATE ZID CODE	01	/27/2023	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER			8 WEST MEADOWVIEW ROAD			
		-		GI	REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Resident #80 was elevated, Residen with mouth open. between teeth and brown/yellowish si appear hard on to cracked. During observation Assistant (NA)/Me conducted on 01/2 #80 was observed mouth open, much small amount of yr. Teeth with yellowis appeared soft and NA/Medication Aid the shower chart parea to see who is shift. She stated smorning care. During observation #80 was observed mouth open, much open.	n on 01/24/23 at 09:45 AM, observed in bed. Head of bed t #80 was observed lying in bed Tongue, teeth, gums and d side of mouth with dry ubstance noted. Continues to ngue. Lips appear dry and n and interview with Nursing edication Aide #9 were 25/23 at 04:15 PM. Resident I in bed. Head of bed elevated, ous membranes moist with ellowish/brown material on it. sh substance on them. Lips I shiny. During interview with the #9 she indicated she checks orior to going to her assigned a scheduled a shower during her the includes mouth care in n on 01/26/23 at 11:20 Resident I in bed. Head of bed elevated, ous membranes moist with ellowish/brown material on it.	F6	577	care documented in the electronic recording DON/ADON/UM will address all concerns identified during the audit. The DON will review the ADL Audit Tool 1 to weekly x 4 weeks then monthly x 2 mound to ensure all concerns were addressed. The DON will forward the results of ADL Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 month and review the ADL Audit Tool to determine trends and / or issues that meed further interventions put into place and to determine the need for further at / or frequency of monitoring. Date of alleged compliance 3/6/23	ne me nth l. L		
	conducted with the expectation was for every shift and moth that received noth breather.	:13 AM an interview was e Administrator. He stated his or mouth care to be performed ore frequently with a resident ing by mouth and was a mouth :25 AM an interview was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	<u> </u>	3 HZ172023	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 677	performs mouth can three times during I appeared to have a between her botton attempted to get off mouth. She further frequent mouth car She always keeps her mouth out. Observation of Resconducted on 01/22 Director of Nursing Resident #80 's to mucous membrane material on it and h substance on them need to be perform expectation that nu (NA's) perform moshift. She further st nothing by mouth a breather, that resid frequent mouth car	ree #2. She stated she re on Resident #80 at least her shift. She also stated she a small amount of dried blood in teeth and bottom lip that she if but did not want to hurt her stated the resident needed he due to her mouth breathing. her mouth open which dries sident #80 and interview was ident #80 and inte	F 6	77			
		s admitted to the facility on losis of hemiparesis.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRU	(X3) DATE SURVEY COMPLETED		
		345448	B. WING _			1	27/ 2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER		308 WEST I	DRESS, CITY, STATE, ZIP CODE MEADOWVIEW ROAD BORO, NC 27406	1 0111	21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 27	F 6	577			
	Review of the admiss (MDS), dated 11/20/2 be cognitively intact a with bathing, dressing. Review of Resident # 11/26/22 with a revisi a focus for Activities with the following interequired total care for nail care and bathing. During observation and 9:13am, Resident #79 with fingernails on boilong, jagged and hair head. Resident #79 sonursing staff (unable assistance with trimms showers. An interview with Unition 1/24/23 at 10:28 Ashower list was located binder. She also stated the list in the AM to set the day. She stated the some residents did not shower shower the task or shower the next day, the resident refuses at the nurse, the nurse of the resident continue.	sion minimum data set 12, revealed Resident #79 to and require total assistance 15, and transfers. 1679's care plan dated 27 on date of 1/24/23 revealed 28 on date of 1/24/23 revealed 29 on date of 1/24/23 revealed 29 on date of 1/24/23 at 29 was observed lying in bed 29 was observed lying in bed 30 th hands that were very 31 that was matted to his 32 tated he had asked the 33 to recall names) for 36 ning his fingernails and 36 that the NAs were to view 36 at the nurses' station in a 36 at that the NAs were to view 36 at the increase that 37 to get staff to stay over to 38 staff would complete the 38 but it did not always occur. If 38 a shower the NA would tell 39 will ask the resident and if 30 d to refuse the NA and nurse					
		sal. / shower schedule was 3 at 9:11am. Resident #79					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		SURVEY PLETED
		345448	B. WING _			C /27/2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	•	12112020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From pag	e 28	F 6	577		
	handwritten note at t Resident #79's room During an observation	nere on this schedule and he bottom stating that number was missing. on on 1/25/23 at 11:49am of fingernails and matted hair d.				
	01/25/23 at 11:49 AN the NA assigned to r completed am care t aware Resident #79' that he needed a she has only worked at the checks the shower residents are on the nails are trimmed as	his morning. NA #13 was not s fingernails were long or ower. He indicated that he his facility for 2 days but that er book to know which of his schedule for a shower and needed. He reviewed the sted that he did not see				
	A review of Resident #79's Activities of Daily Living documentation from November 2022 to present revealed no documentation that showers had been provided and no refusals noted.					
	2022 to present revelop Resident #79 on that he had not gotte was that staff were to	ance logs from November saled a grievance submitted 12/27/22 with a complaint on a shower. The resolution to be educated that about ts are given showers on				
	revealed since he ha this facility, he has n	nducted with the 27/23 at 10:10 AM. He is been the administrator at ot experienced any staffing interfere with staff's ability to				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
							С
		345448	B. WING			01/	27/2023
	ROVIDER OR SUPPLIER ROVE HEALTH AND REF	IABILITATION CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 18 WEST MEADOWVIEW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 SS=D	stated he has not see decreased staffing an have not been pulled further stated staff sa relieve themselves of showers. The adminis was for the facility to preference for showe person-centered care Treatment/Svcs to Pr	o provide resident care. He en any indication of d administrative nurses to work in a NA role. He y that they are short to the responsibility to provide strator said his expectation honor the resident's r or bath by providing . event/Heal Pressure Ulcer		677			3/6/23
	resident, the facility m (i) A resident receives professional standard pressure ulcers and of ulcers unless the individemonstrates that the (ii) A resident with professional star promote healing, previous results are promoted in the resident with professional star promote healing, previous REQUIREMENT by: Based on record revious resident according to the resident standard pressure reset according to the resident standard pressure reset according to the resident standard pressure resident standard pressure resident standard pressure resident pres	re ulcers. hensive assessment of a nust ensure that- c care, consistent with sof practice, to prevent loes not develop pressure vidual's clinical condition beywere unavoidable; and essure ulcers receives and services, consistent udards of practice, to vent infection and prevent loping. The is not met as evidenced ew, observations, and staff			F686 Treatment/Services to Prevent/H Pressure Ulcer On 1/25/23 The Treatment Nurse adjusted the air mattress settings for Resident #80 to the ordered range of weight 90-150 lbs, Medium Firm with 10-minute cycle time, alternate.	eal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			C 1/27/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		1/2//2023	
				308 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	Continued From page	e 30	F 6	86			
	11/08/22 with diagnorinfarction (stroke) and ulcer. Resident #80's active an order dated 12/18 pressure air mattress check setting every of	to the bed. Nursing to lay and night shift. Settings:		On 2/14/23 The Corporate Director reviewed all reside air mattress and updated the require the nurse/treatment off on the EMAR the mattrescorrect settings. On 2/15/23, The Director on Nursing/Assistant Director Manager the initiated an in-	ents' orders on ne order to t nurse to sign ess was at the f of Nursing/Unit		
	Weight 90-150lbs, Medium firm, 10 minutes cycle time, Alternate. Review of Significant Change Minimum Data Set (MDS) assessment, dated 01/13/23, revealed Resident #80's cognition was severely impaired, one stage 4 pressure ulcer, one Deep Tissue Injury (DTI), and a pressure reducing device to the bed. Resident #80's weight on 1/2/2023 was 133.0 pounds (lbs). Review of Resident #80's care plan dated			nurses and treatment nurse mattress setting, and docur the EMAR. In-services will by 3/6/23. After 3/6/23, any include agency and contract not received the in-service in-serviced prior to next scl shift. All newly hired nurses contract staff will be in-servicentation regarding air materials.	mentation on be completed nurses to et staff who has will be neduled work s, agency and viced during attress settings		
	focus area that read; admit at risk for skin breakd further pressure ulce pressure ulcer. One of to place resident on p such as pressure reli at 90-150 pounds (lb minutes cycle, and cl appropriate.			On 2/20/23 DON/ADON/UN residents with air mattress mattress is set at the correweekly x 4 weeks, then 1-ti months. The DON/ADON a address all concerns identiaudit to include additional enurse/treatment nurse. The DON will forward the resolution of the	to ensure the ct setting 1 x's ime monthly x 2 and UM will fied during the education of		
	revealed ongoing wo coccyx pressure ulce	#80's medical record und care was provided to a er since 11/08/22 and to a DTI) to the right outer arch of		Audit Tool to the Quality As Performance Improvement (QAPI) monthly x 2 months Committee will meet month and review the Audit Tool to trends and / or issues that	Committee S. The QAPI Ily x 2 months determine		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				SURVEY
		345448	B. WING				C 27/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017.	2112023
				3	08 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		G	GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 31	F 6	386			
	pressure level of the	onal manual for the s mattress indicated the air mattress was according fessional recommendations.			further interventions put into place and determine the need for further and / or frequency of monitoring. Date of alleged compliance 3/6/23		
	Record (MAR) reveal	edication Administration ed nursing staff had been rnating pressure air mattress erly.			σ σ γ γ		
	01/23/23 at 11:14 AM						
	01/23/23 at 03:40 PM her eyes closed. The	red of Resident #80 on I. She was lying in bed with alternating pressure was set on "firm" and to					
	01/23/23 at 03:50 PM with her eyes open. T reducing air mattress cycle every 15 minute conducted with Nurse mattress was set on '15 minutes and the n pressure settings and She stated she would clarify the ordered se	e #5. She confirmed the air Ifirm" and was cycling every urses are to check the air I cycling time every shift. I have to look at the order to ttings.					
	conducted with the D She	AM an interview was irector of Nursing (DON). s not have a wound Nurse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			l	C 27/2023	
	ROVIDER OR SUPPLIER ROVE HEALTH AND RE	HABILITATION CENTER		STREET ADDRESS, CIT 308 WEST MEADOWN GREENSBORO, NO	VIEW ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 686	Continued From pag	e 32	F	86				
F 729 SS=D	time. She also stated the facility Wound Ca Friday. She further stalternating pressure to be set according to the stated on the machine. On 01/25/23 at 10:10 conducted with the Wair mattress settings during rounds and she had id wound care. preformed wound can not checked the setting conducted with the A expectation was for the according to what the	O AM an interview was Vound Nurse. She stated the were checked by the nurses he checked them when She indicated she had not re yet therefore she had higs of the air mattress. B AM an interview was dministrator. He stated his he air mattress to be set he order reads Verification, Retraining	F	29			3/6/23	
	aide, a facility must r that the individual ha requirements unless- (i) The individual is a training and compete approved by the Stat (ii)The individual can recently successfully competency evaluati evaluation program a has not yet been incl	dividual to serve as a nurse eceive registry verification s met competency evaluation full-time employee in a ency evaluation program te; or prove that he or she has completed a training and on program or competency approved by the State and						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345448	B. WING			1	27/2022
NAME OF PE	ROVIDER OR SUPPLIER	0.01.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/2	27/2023
TVAIVIL OF T	TOVIDEN ON OUT FIELD				08 WEST MEADOWVIEW ROAD		
MAPLE GI	ROVE HEALTH AND RE	HABILITATION CENTER			REENSBORO, NC 27406		
					<u>·</u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 729	Continued From page	je 33	F 7	729			
	individual actually be	ecomes registered.					
	Before allowing an ir aide, a facility must State registry establi (2)(A) or 1919(e)(2)(State registry verification. Individual to serve as a nurse seek information from every ished under sections 1819(e) A) of the Act that the facility information on the individual.					
	§483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced						
	Aide Registry forms facility failed to verify Nurse Aide Registry (NA#12) certification reviewed (NA#12). The findings include NA#12 was hired by work with residents in	the facility on 7/20/2010 to			F729 Nurse Aide Registry Verification Retraining On 1/26/23 all certified nursing assista (CNA) currently employed with the facilitate have had their employee files audited the Administrator and Director of Nursi (DON) for current certification status to ensure that their certification is not expired and is currently active. The Administrator/ DON will address all concerns identified during the audit.	nce ility by ng	
	indicated that NA #1 had expired on 11/20 A review of the staffi	2's Nurse Aide Certification 0/2022. ng schedule sheet from to January 23, 2023,			On 1/26/23 an in-service conducted by Administrator was completed with the facility receptionist and payroll manage on completing monthly verification of the facility staff nurse aide and agency nur	er ne	

Facility ID: 923456

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7. BOILDIN	<u> </u>		С	
		345448	B. WING		0	1/27/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MADIFGE	ROVE HEALTH AND REH	IARII ITATION CENTER		308 WEST MEADOWVIEW ROAD			
MAI LE OI	NOVE HEALITIAND NEI	ABIENATION GENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 729	Continued From page timeframe of the sche		F 72	aide certifications. On 01/26/23			
	presented the NC Nur 01/26/23 and it verifie Certification had expir Administrator indicate NC Nurse Aide Regis NA#12's certification I Administrator indicate facility had contacted she would be unable certification with the N current. On 01/27/23 at 9:05A the receptionist she wasigned the task to r Aide Registry to ensu had current certificatios stated she knew NA # facility for years, but s #12's certification info	enior Administrator, and she ree Aide Registry form dated d NA #12's Nurse Aide red on 11/20/22. The Senior of that the facility contacted try and was informed that had expired. The Senior of that on 01/26/23, the NA #12 and informed her to return to work until her lurse Aide Registry was M during an interview with erified on 01/26/23 she was nonitor and check the Nurse re the current NA's working ons on file. The Receptionist #12 had worked for the she had no knowledge of NA		in-service was completed by the Administrator with the payroll m reporting current licensure staturenewals and certification issue the Cardinal IDT meeting. On 0 certified nursing assistants and have been in-serviced by the Doresponsibility of maintaining a certification/license to remain in professional practice as outlined governing bodies. The Receptionist will monitor are all certifications/license. The Adwill review the Employee Certification/Licensure Audit Towekly x 4 weeks and 1 time months for completion and confithat all licensed nurses and certifications possess an active licental to the Quality Assurperformance Improvement Compand (QAPI) monthly x 2 months. The Committee will meet monthly x 2 and review the Audit Tool to det trends and / or issues that may	anager on is, s during 1/26/22 All nurses ON on the urrent d by their and validate lministrator of 1 time onthly x 2 firmation tified nurse ense. The results urance mittee e QAPI 2 months ermine		
				further interventions put into pla determine the need for further a frequency of monitoring. Date of alleged compliance 3/6/	and / or		
F 760 SS=E		Significant Med Errors	F 76	60		3/6/23	
	The facility must ensu	re that its-					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345448	B. WING				27/2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406			1 0172	21/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	medication errors. This REQUIREMENT by: Based on observation psychiatric nurse prathe facility failed to ach hydrochloride (an anti- eleven days as order practitioner for 1 of 5 (Resident# 27) review Findings included: Resident #27 was add 11/14/17 with diagnor depressive disorder, and bipolar disorder. The quarterly assess indicated Resident #2 impaired; had no beh antipsychotic and and 11/14/15 use of psychotic antidepressant) with of cardiac, neuronus systems related to his Interventions include and side effects of m reduction of psychotr mood/behaviors (anxions)	nts are free of any significant is not met as evidenced n, record reviews, ctitioner and staff interviews, dminister duloxetine idepressant medication) for ed by the psychiatric nurse sampled residents wed for unnecessary drugs. mitted to the facility on ses which included: major disorganized schizophrenia,	F 7	60	F760 Residents are Free of Significan Med Errors On 1/26/23 the medication order for Duloxetine Hydrochloride was correcte and resident #27 began receiving the correct medication. On 1/27/23, the Interdisciplinary Team (IDT) began auditing all residents' medication orders during the IDT meet to ensure all medication orders are transcribed correctly and the residents receiving the correct medication. On 2/17/23 The Director of Nursing (DON)/Assistant Director of Nursing (DON)/Assistant Director of Nursing (ADON) initiated an in-service with all nurses, agency and contract staff on medication transcription, and documentation on the EMAR. In-servic will be completed by 2/28/23. After 2/28/23, any nurses to include agency contract staff who has not received the in-service will be in-serviced prior to ne scheduled work shift. All newly hired nurses, agency and contract staff will be in-serviced during orientation regarding medication transcriptions and documentation on the EMAR.	d ing are es and ext	
		v Up Note dated 1/11/23 ent #27 receive a GDR on) of duloxetine			The DON/ADON/Unit Manager will aud all residents' medication orders to ensu all medication orders are transcribed		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345448	B. WING _			C 1/27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	•	172772020
MADI E 0	DOVE HEALTH AND	DELIA DII ITATIONI GENTED		308 WEST MEADOWVIEW RO	DAD	
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER		GREENSBORO, NC 27406	6	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 760	Continued From p	age 36	F 7	760		
1 700	hydrochloride from 30mg per day; and sleep, appetite, we Review of the clini was written on 1/1 practitioner for Re duloxetine hydroch particles, everyday. The review of the administration reconstruction of the same administered to Remark also revealed receiving duloxetir on 1/15/23 "pending the process of the same administered to Remark also revealed receiving duloxetir on 1/15/23 "pending the same also revealed the same also revealed receiving duloxetir on 1/15/23 "pending the same also revealed th	n 60mg (milligrams) per day to distaff to monitor the resident's eight, mood and behavior. cal records revealed an order 4/23 by the psychiatric nurse sident #27 to receive 30mg nloride capsule delayed release		correctly and the resi the correct medicatio an ongoing audit duri Interdisciplinary Tean DON/ADON and UM concerns identified di include additional edu nurse/treatment nurse The Director of Nursi forward the results of the Quality Assurance Improvement Commi x 2 months. The QAF meet monthly x 2 mo meeting Audit to dete issues that may need put into place and to	on 1 time weekly as ing the Cardinal meeting. The will address all uring the audit to ucation of se. Ing (DON) will f IDT meeting Audit to be Performance will committee (QAPI) monthly PI Committee will onths and review IDT ermine trends and/or d further interventions determine the need	
	did not receive any hydrochloride from (eleven days). On 1/23/23 at 4:07 observed sitting que himself a sandwick watching a televisialert and verbally no disruptive behasigns of pain. During a telephone a.m., the Psychiat that she had been #27's family with ta revealed she wrote	MAR indicated Resident #27 y dosage of duloxetine 1/15/23 through 1/25/23 I p.m., Resident #27 was uietly in his room feeding and drinking water while on show. The resident was bleasant. Resident #27 showed aviors and voice or showed any e interview on 1/27/23 at 9:56 ric Nurse Practitioner stated working closely with Resident apering his medications. She e an order for Resident #27's hydrochloride to be changed to		for further and/or freq		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	l ^{(X}	(3) DATE SURVEY COMPLETED
		345448	B. WING _			C 01/27/2023
	ROVIDER OR SUPPLIER ROVE HEALTH AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	· '	0.1.2.1.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	she discovered the n discontinued. The Ps stated she reported to Director of Nursing. Sthe order for the 30 n on 1/25/23 after asseconcluded the 11 day his system did not ap in a negative way. On 1/27/23 at 10:35 (DON) confirmed the Practitioner had infor discontinued Resider hydrochloride order for the An interview with Unitional Practitioner shad information of the Practitioner had information of the Practition of the Practitioner had information of the Practition of the P	an onsite visit on 1/25/23 nedication had been sychiatric Nurse Practitioner he discrepancy to the She stated that she rewrote ng duloxetine hydrochloride ressing the Resident #27. She resy without the medication in repear to affect Resident #27 a.m., the Director of Nursing resychiatric Nurse remed her someone had nt #27's duloxetine for 30mg per day on 1/15/23. It Manager #1 on 1/27/23 at the created the Psychiatric relephone order to to #27's 30mg duloxetine 4/23 and she confirmed the repending orders in the tore/Prepare/Serve-Sanitary (2) Ity requirements. The food from sources red satisfactory by federal, ties. Food items obtained directly to subject to applicable State	F 7			3/6/23

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345448	B. WING			C 1/27/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	1/2//2023
				308 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 812	F 812 Continued From page 38		F 8	12		
	safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se	es not preclude residents ls not procured by the facility. prepare, distribute and ance with professional				
	by: Based on observation facility failed to ensure stacked clean and drensure the food items were dated and label names, dates and rothe snack/nourishme items served to but restored in 1 of 3 reside	ons and staff interviews, the re dishware was stored and ry; The facility also failed to so not provided by the facility led with the residents' om numbers when stored in nt refrigerators; and food refused by residents were not lents' nourishment rooms.		F 812 FOOD PROCUREMENT STORE/PREPARE/SERVE—(F) On 2/15/23, The Certified Die Manager (CDM) will educate department on sanitation incluensuring the items that have leaned are inspected for cleaproper condition prior to storings.	SANITARY tary the dietary uding been anliness and	
				On 2/15/23, Nursing and dietable educated by the CDM and food items not provided by the to be dated and labeled with names, dates and room number stored in the snack/nourishmerefrigerators; and food items presented in the snack/nourishmerefrigerators.	/or DON that e facility are residents' pers when ent	
	for use next to steam 3-sectioned/divided pone of which was als meal service trayline tins with dried food d 1-large (6"deep) stea stains stacked on the and dry pots and par removed the identifie	table. There were also plates with dried food stains, o chipped stacked on the . There were 4-large muffin ebris and greasy stains and stains and estorage rack next to clean is. The Dietary Consultant is soiled dishware and and put the soiled pans in		the facility that are served to rare refused, will be discarded placed in the nourishment roc On 2/15/23 The CDM and/or Home Administrator (NHA) was 2x/week x4 weeks and then was month to ensure items are prolabeled in the nourishment roc refrigerators and nourishment	resident, but and not oms. Nursing vill monitor veekly x1 operly om	

Facility ID: 923456

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			l	27/2023
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	017	2112025
					8 WEST MEADOWVIEW ROAD		
MAPLE GI	ROVE HEALTH AND REF	IABILITATION CENTER			REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 812	2 Continued From page 39		F 8	12			
	the 3-compartment si	nk.			that inappropriate food items are not stored The CDM and/or NHA will monit 2x/week x4 weeks and then weekly x1	or	
	2. On 1/25/23 at 12:1	5 p.m., accompanied by the			month to ensure proper		
		nager, the 100/200 hall			cleaning/sanitation of washed items an	d	
		s observed. The refrigerator			no chips in wares to be used for service		
) resealed bottle of soda			Any issues identified will be addressed	at	
	·	ounce container of organic			the time of discovery. in the nourishment room/refrigerator. A	l mi r	
		not labeled with a resident's rage. Also, stored in the top			issues identified will be addressed at the	•	
		k in the nourishment were			time of discovery.	ic	
	5(.75oz) sealed single				amo or discovery.		
	Manager revealed the the refrigerator was n dietary services. He a department did not structure nourishment rooms, or residents' meal trays	ereals were only served on during breakfast. He er of organic milk and the			The CDM/NHA will forward the results of Dietary Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months The QAPI Committee will meet monthly 2 months and review the Dietary Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring	/ X s or	
					The allegation of compliance date for a action items is 3/6/23	II	
	Dispose Garbage and CFR(s): 483.60(i)(4)	l Refuse Properly	F8	14	donom nomo io ororzo		3/6/23
	properly.	e of garbage and refuse					
	the facility failed to en	ation and staff interviews, sure the area surrounding 1 remained free from standing			F 814 DISPOSE GARBAGE AND REFUSE PROPERLY		
		ese unsanitary practices had the environment of the			The Nursing Home Administrator will ensure that the area surrounding the tracompactor remains free from standing	ash	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345448	B. WING				C 27/2023
	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 08 WEST MEADOWVIEW ROAD REENSBORO, NC 27406	<u> U17.</u>	2112023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 814	Dietary Manager (DM there was a mattress floating on top, lying of trash compactor. Also standing water and les surrounding the trash. On 1/23/23 at 10:06 a leaves should have be trash compactor so the DM indicated she had mattress was placed compactor. During an interview of Administrator stated to the facility's environment of the standard ensure the standard	n, accompanied by the) on 1/23/23 at 10:05 a.m., with puddles of water on the ground next to the o, there was a large pool of aves beneath and compactor. a.m., the DM stated the een raked from beneath the are rainwater could drain. The d no knowledge why a on the ground next to the n 1/27/23 at 11:10 a.m., the hat his expectation was for ental and dietary staff to trash compactor and the e free from debris when	F	814	water and refuse. On 2/15/23, The CDM and/or NHA will educate the dietary department and environmental managers regarding ensuring proper drain flow on the exter of the facility and keeping the trash compactor area free from refuse. On 2/15/23, The CDM and/or NHA will initiate an audit of the exterior drains at trash areas 3x/week x4 weeks and thei weekly x1 month to ensure no standing water and no trash outside of the trash receptacle. Any issues will be address at the time of discovery. The CDM/NHA will forward the results Garbage and Refuse Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) month x 2 months. The QAPI Committee will meet monthly x 2 months and review th Garbage and Refuse Audit Tool to determine trends and / or issues that m need further interventions put into place and to determine the need for further a / or frequency of monitoring. The allegation of compliance date for a	nd n g ed of nly ne nay e nd	
F 847 SS=E	CFR(s): 483.70(n)(2) §483.70(n) Binding A If a facility chooses to representative to enter		F	847	action items is 3/6/23		3/6/23

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345448	B. WING _			C 01/27/2023
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	DDE	0112112020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 847	resident or his or he agreement for bindi admission to, or as receive care at, the inform the resident his or her right not to condition of admission continue to receive \$483.70(n)(2) The f (i) The agreement is his or her represent that he or she under language the resider representative under (ii) The resident or hacknowledges that agreement; \$483.70(n)(3) The agrant the resident or right to rescind the adays of signing it. \$483.70(n) (4) The state that neither the representative is refor binding arbitration to, or as a requirem at, the facility. \$483.70(n) (5) The any language that president or anyone are sident or anyone.	in this section. acility must not require any er representative to sign an an arguirement to continue to facility and must explicitly or his or her representative of a sign the agreement as a ion to, or as a requirement to care at, the facility. acility must ensure that: a explained to the resident and ative in a form and manner restands, including in a ent and his or her	F	847		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345448	B. WING _			1	27/ 2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	2172020
					08 WEST MEADOWVIEW ROAD		
MAPLE GI	ROVE HEALTH AND R	EHABILITATION CENTER			REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 847	Continued From pa	nge 42	F 8	847			
		nd state surveyors, other					
		alth department employees,					
		of the Office of the State					
	•	mbudsman, in accordance					
	with §483.10(k).	mbadoman, in accordance					
	- , ,	NT is not met as evidenced					
	by:	The field met de evidenced					
	Based on record re			F847 Entering into Binding Arbitration			
	interviews and staff			Agreements			
	explain to resident			3			
	•	agreement was not a condition			On 1/30/23, For residents #89, #492,		
	•	of 3 residents who entered into			#493, the Regional Director of Busines	s	
	an Arbitration Agree	ement with the facility.			Development informed the Admissions		
	(Resident #89, Res	sident #492, and Resident			Director on the policy and procedure fo	r	
	#493).				Binding Arbitration Agreement. On 2/17	7/23	
					The Regional Director of Business		
	The findings include	ed:			Development will in-service the back-up	р	
					Admission person. The facility was not		
		Facility Arbitration Agreement, 01/22, included a statement			using the correct form.		
	that executing this	_			On 1/30/23 the Admissions Director		
	precondition of adn	nission.			updated the Binding Arbitration		
					Agreements.		
		s readmitted to the facility on			The Designal Disector of Design		
	11/17/22.				The Regional Director of Business		
	A review of Reside	nt #89's admission 12/4/22 indicated that			Development will in-service the	, n	
					Admissions Director/ Back-up Admission	ווע	
	During an interview	severe cognitive impairment.			person on the Admission policy and procedure process every 6 months x 2	to	
	-	/ with the resident /27/23 at 1:20pm she			ensure any updates to the admission	10	
	· ·	dmission coordinator			process are communicated.		
		ess of arbitration and that this			process are communicated.		
	·	ed to admit Resident #89.			The Admissions Director/Back-up		
	•	as admitted to the facility on			Admission person will review weekly x	4	
	1/16/23 with a diag				weeks the admission packets to include		
	During an interview				the Binding Arbitration Agreement to		
	-	/27/23 at 10:29am she			ensure the correct form was completed	i .	
	•	could not recall who met with			education was provided resident and	•	
		nission paperwork, but it was			resident representative that signing the		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING_		0.	C 1/27/2023	
NAME OF P	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP		1/2//2023	
				308 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND REI	ABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 847	Continued From page 43		F 8	47			
	explained as a requirement of admission.			form was not a condition	for admission.		
	1/14/23 with a diagnor During an interview we representative on 1/2 revealed that she me member filling in for a process was explained for admission. A telephone interview Admissions Coordina She indicated that she completing the admissional included the arbitration residents or resident other departments fill available. She further understood the arbitrarequired for admissions.	with the resident 7/23 at 10:27am she at with Medical Records Staff admission. The arbitration and and that it was required as was conducted with the attor on 1/27/23 at 9:58am. The is responsible for a sion paperwork which an agreements, with a representatives but that I in when she is not		The Admissions Director results of Arbitration Agre the Quality Assurance Pe Improvement Committee x 2 months. The QAPI Comeet monthly x 2 months Arbitration Agreement Autrends and or issues that further interventions put in determine the need for fu frequency of monitoring. Date of alleged compliance	ement Audit to rformance (QAPI) monthly ommittee will and review dit to determine may need nto place and to rther and /or		
F 867 SS=E	administrator on 1/27 indicated that he is at that it is his expectati agreement to explain their understanding be and it is not a require QAPI/QAA Improvem CFR(s): 483.75(c)(d) §483.75(c) Program to monitoring. A facility must establi	n interim administrator but on for the arbitration ed to the person and ensure efore signing the agreement ment for admission. ent Activities	F 8	67		3/9/23	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345448	B. WING _			C 01/27/2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 308 WEST MEADOWVIEW ROAL GREENSBORO, NC 27406	ZIP CODE	01/2//2023
(X4) ID PREFIX TAG			ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 867	adverse event monitor procedures must inclus following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representative information will be us are high risk, high volopportunities for impressed information from all dinot limited to the facility \$483.70(e) and include the systems with the facility \$483.70(e) and include the systems included the systems to identify the systems that the systems that the systems the systems the systems the systems that the systems the systems that the systems the systems the systems that the systems th	and monitoring, including bring. The policies and ude, at a minimum, the maintenance of effective duse of feedback and input other staff, residents, and wes, including how such ed to identify problems that lume, or problem-prone, and	F	367		
	and evaluation of per including the methods development, monitor §483.75(c)(4) Facility including the methods systematically identify analyze and use data adverse events in the facility will use the da prevent adverse ever §483.75(d) Program systemic action.	ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will y, report, track, investigate, a and information relating to a facility, including how the ta to develop activities to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345448	B. WING_			C 01/27/2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		11/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 867	implementing those a and track performance improvements are readimplement policies and (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to effevel to prevent qualit safety problems; and (iii) How the facility who fits performance improvements are that improvements and (iii) How the facility who fits performance improvements are that improvements are that improvements are included to problems in those and the facility of problems in those and the facility in the	e improvement and, after actions, measure its success, se to ensure that alized and sustained. cility will develop and ddressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems by of care, quality of life, or activities to ments are sustained. cility must set priorities for its ement activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. mance improvement medical errors and adverse yze their causes, and actions and mechanisms and learning throughout the at of their performance	F	367		
	improvement activitie	s, the facility must conduct improvement projects. The				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345448	B. WING_		C 01/27/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/21/2023
				308 WEST MEADOWVIEW ROAD	
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 867	conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analys (c) and (d) of this sec §483.75(g) Quality as §483.75(g)(2) The quassurance committee governing body, or defunctioning as a gover activities, including in program required und (e) of this section. The (ii) Develop and imples action to correct identicity) Regularly reviews data collected under resulting from drug reavailable data to make	lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). It is must include at least at focuses on high risk or identified through the data as described in paragraphs ation. It is sessment and assurance. It is all it is a sessment and assurance. It is a sessment and assurance are ports to the facility's esignated person(s) and person it is a plementation of the QAPI are paragraphs (a) through a committee must: It is a sessment and assurance are ports to the facility's esignated person it is a plementation of the QAPI are paragraphs (a) through a committee must: It is a service and a service and analyze data, including the QAPI program and data a gimen reviews, and act on	F 8	,	
	Based on observation interviews and record assurance (QA) proof monitor, and revise a developed for the reconsurveys dated 2/4/20 complaint survey on a sustain compliant deficiencies on a reconsultation.	3/18/21 in order to achieve ce. This was for recited		On 1/25/23, the Certified Nursing Assistant (CNA) gave resident # shower, washed his hair and cle trimmed his nails. On 1/26/23, the gave the resident a bed bath and the teeth and mouth of resident Resident #80 has passed away. 2/13/23, the Director of Nursing	g F79 a Paned and Pe CNA d cleaned #80.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	' '	E SURVEY PLETED
			A. BOILDII	NG		С	
		345448	B. WING			01	/27/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 01	12112023
					8 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER			REENSBORO, NC 27406		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 867	Continued From p	page 47	F 8	867			
	notice requiremen	nts before transfer/ discharge,			an audit of resident #342, #442 and #	80	
	Activity of Daily L	iving (ADL) care provided for			discharged to determine if the notice of	of	
	dependent reside	nts and residents free of			Bed Hold Policy was completed and g	iven	
		ation errors. The continued			to the resident and/or discussed with	:he	
	_	federal surveys of record			resident representative.		
		of the facility's inability to					
	sustain an effective	ve quality assurance program.			On 2/14/23, the DON/ADON/UM initia	ted	
					an audit of ADL care of all dependent		
	The findings inclu	ded:			residents to include nail care, mouth o		
					washing hair and showers. This audit		
	This tag is cross-	referenced to:			ensure all residents were assisted wit		
	4 F000 D	on record review and staff			ADL care to include but not limited to	nali	
				care per resident preference when			
		cility failed to provide the esponsible Party (RP) written			indicated and/or refusal of care documented in the electronic record.)n	
		reason for a hospital transfer for				_	
		eviewed for hospitalization			2/14/23, the Corporate Clinical Director and Social Worker initiated an audit of		
	(Residents #342,				residents discharged in the last 30 da		
	(11031001113 #042,	# + + 2 and # 00).			determine if the Bed Hold Policy and	,5 10	
	During the previo	us recertification and complaint			Acute Transfer notice was completed	and	
		the facility failed to provide			given to the resident and sent to the		
		n to the resident, resident's			resident representative. The Director	of	
		nd the ombudsman when a			Nursing (DON) and/or Assistant Direc		
		sferred or discharged from the			(ADON) of Nursing will address all		
	facility. This was	evident for 3 of 4 residents			concerns identified through the audits		
	reviewed for hosp	oitalization and discharge.					
					On 2/13/23, the DON/ADON/UM□s		
		d on observations, record review,			initiated an in-service with all nurses a	ınd	
		staff interview 's the facility			nursing assistants regarding ADL Care		
		showers, nail care, and mouth			with emphasis on ensuring nails are c		
		who needed extensive and/or			and trimmed per resident preference		
		on staff for Activities of Daily			mouth care is provided for all depende		
	– ` ,	s was for 2 of 2 residents			residents. On 2/13/23 The DON/ADO		
	(Resident #79 an	d #80) reviewed for ADL' s.			in-serviced the nurses to include ager	•	
	D				and contract staff on the Bed Hold Po	ісу	
		us recertification and complaint			and Acute Transfer notice is to be		
	_	2, the facility failed to provide a			completed when the resident is		
	residents reviewe	activity of daily living dependent			transferred to the hospital for an acute issue. The form must be given to the	;	
	i residents reviewe	u.		- 1	issue. The form must be given to the		1

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY BUILDING COMPLETED		
		345448	B. WING			C
	20,4252.02.01221.52	343446	D. WING_		01/	/27/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD		
				GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 867	Continued From page	e 48	F 8	67		
	psychiatric nurse prathe facility failed to achydrochloride (an anteleven days as order practitioner for 1 of 5 (Resident# 27) review. During the previous of the facility failed to seresident who left the including medications management. This or reviewed for medications and the administrator was assurance interview. An interview with the assisting in the surve at 1:49 PM. The Mob Quality Assurance (Compared to a series of the surve at 1:49 PM. The Mob Quality Assurance (Compared to a series of the facility failed to achieve the failed th	idepressant medication) for ed by the psychiatric nurse sampled residents wed for unnecessary drugs. complaint survey on 8/18/21, end medication with a facility for the weekend for hypertension and pain occurred for 1 of 3 residents ion error.		resident and discussed with the resident is transferred to an acute care hospital floor nurse will be responsible for githe resident the bed hold and Busin Office Manager will discuss with the family. The in-service will be complete 3/6//23. After 3/6/23, any nurses, agand contract staff who have not wor received the in-service will be in-service to next scheduled work shift. A newly hired nurses, nursing assistant agency and contract staff will be in-serviced during orientation regard the Bed Hold Policy and Acute Trannotice. After 3/6/23, any nurse or nuassistant to include agency and constaff who has not received the in-serviced work shift. All newly hired nurses ar nursing assistants, agency and constaff will be in-serviced during orient regarding ADL Care, Bed Hold and Transfer.	ted by ency ked or viced ll ats, ring sfer rect rvice duled d ract ation	
	that plan and 4) discuchange and addition needed to resolve the Administrator further repeated deficiencies area of concern woul old plan would be rewhere the failures, ar happened. The root onew interventions, me in place. Audit / educineeded. The team wo	a plan, audits, and monitors uses the outcome. System task would put in place as a issue. The Mobile stated that if there were that were identified then the decome a focus area. The risited and analyzed to see and where the breakdown cause would be revisited and onitoring tools would be put action would be completed as ould continuously monitor a concerns have been		The DON/ADON/UM□s will review of Click Care (PCC) documentation to ensure bath/showers, nail care, and mouth care are being completed as assigned. Resident observation will performed by the DON/ADON/UM and Administrator to include resident #7 (resident #80 is no longer in the fact weekly x 4 weeks then monthly x 1 utilizing the Audit Tool. This audit is ensure all residents were assisted when ADL care to include but not limited to care, shower/bath and mouth care particular to the care include the care includes the care include the care includes the care include the care includes the c	be nd), lity) month to vith o nail	

Facility ID: 923456

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345448	B. WING _			01/2	; ?7/2023
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STA	TE. ZIP CODE	1 01/2	11/2023
				308 WEST MEADOWVIEW R			
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTION CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 49	F8	resident preference refusal of care docu electronic record. The will address all concent the audit. The Direct review the ADL Audit x 4 weeks then monensure all concerns. The DON/ADON will x 4 weeks, 1-time mutilizing the Transfer Audit Tool. This aud resident transferred hospital are given the Notice From and it is representative. The concerns identified of include re-training of On 2/16/23 The Directon (ADON) initiated an nurses, agency and medication transcript documentation on the will be completed by 2/28/23, any nurses contract staff who has in-service will be inscheduled work shift nurses, agency and in-serviced during of medication transcript documentation on the The DON/ADON/Unall resident's medication orders all medication orders.	mented in the ne DON/ADON/UM terns identified duritor of Nursing will it Tool 5 times weel thly x 1 month to were addressed. I audit 1 times wee onthly x 2 months r/Discharge/Bed Hoti is to ensure all or discharged to the Acute Discharge is sent to the reside a DON will addressed during the audit to finurses. The Edit of Nursing in-service with all contract staff on the EMAR. In-service include agency as not received the serviced prior to near the Acute Discharge in-service with all contract staff on the EMAR. In-service include agency as not received the serviced prior to near the All newly hired contract staff will be rientation regarding the EMAR.	kly kly bld ne ent all	

			(3) DATE SURVEY COMPLETED				
		345448	B. WING				
NAME OF D	ROVIDER OR SUPPLIER	0.107.10	1	STDE	EET ADDRESS, CITY, STATE, ZIP CODE	U17.	27/2023
NAME OF T	NOVIDER OR SOLT EIER				WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REP	HABILITATION CENTER			ENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	÷ 50	F	the second of th	correctly and the residents are receiving the correct medication 1 time weekly as an ongoing audit during the Cardinal Interdisciplinary Team meeting. The DON/ADON and UM will address all concerns identified during the audit to include additional education of nurse/treatment nurse. The Director of Nursing (DON) will conver the results of IDT meeting Audit the Quality Assurance Performance improvement Committee (QAPI) months and review ID meeting Audit to determine trends and/sisues that may need further interventional into place and to determine the need for further and/or frequency of monitorial into place and to determine the need for further and/or frequency of monitorial into place and to determine the need for further and/or frequency of monitorial into place and the facility Quality Assurance Performance Improvement QAPI) monthly meetings, to ensure the acility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director is eview the minutes, and the Performan mprovement Plans once a month for 2 months. The Administrator will hold monthly Quality Assurance Performance a month for 2 months. The Administrator will hold monthly Quality Assurance Performance in the QAPI committee (QAPI) meeting agenda will include review of all Performance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL Berformance Improvement Plans (PIP) include the PIP for ADL	t to lly OT or ons ed or ons eal e / will ce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345448	B. WING			C 01/27/2	2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		01/2//2	2023
MADLEC	DOVE HEALTH AND DEL	LABILITATION CENTED		308 WEST MEADOWVIEW ROAD			
WAPLE	ROVE HEALTH AND REF	IABILITATION CENTER		GREENSBORO, NC 27406			
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F 867	Continued From page		F 80	notice. The Audit Tools will be monthly to determine trends an issues that may need further in put into place and to determine for further and / or frequency of monitoring. Date of Alleged Compliance 3/6	nd / or terventice the nee f	ons d	(00
F 883 SS=E	S483.80(d) Influenza immunizations §483.80(d) (1) Influenza immunizations §483.80(d)(1) Influenza policies and procedur (i) Before offering the each resident or the receives education repotential side effects (ii) Each resident is or immunization Octobe annually, unless the incontraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's medocumentation that in following: (A) That the resident was provided educati and potential side effeimmunization; and (B) That the resident immunization or did not the immunization or did not seem to see the seem to	and pneumococcal za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically e resident has already been as time period; e resident's representative or refuse immunization; and dical record includes dicates, at a minimum, the	F 8	33		3/6/	/23

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345448	B. WING _			C 01/27/2023
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	,	STREET ADDRESS, CITY, STA 308 WEST MEADOWVIEW R GREENSBORO, NC 2740	OAD	01/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	(X5) COMPLETION DATE
F 883	must develop policic that- (i) Before offering the immunization, each representative receiveness and potential immunization; (ii) Each resident is immunization, unless medically contraind already been immunicated been immunication that following: (A) That the resident was provided educated and potential side expression immunication; and (B) That the resider pneumococcal immunication or inthis REQUIREMENTED by: Based on staff interfacility failed to offer (pneumonia) vaccin (Resident #69) reviews.	mococcal disease. The facility es and procedures to ensure he pneumococcal resident or the resident's ives education regarding the fall side effects of the he offered a pneumococcal sist the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and hedical record includes indicates, at a minimum, the hat or resident's representative ation regarding the benefits ffects of pneumococcal hat either received the funization or did not receive mmunization due to medical refusal. It is not met as evidenced reviews and record review, the repneumococcal effort of 5 residents ewed for immunizations.	F	F883 Influenza and Immunizations On 1/26/23 and 2/15 refused the Pneumo On 2/20/23, an audit	5/23 Resident # 69 coccal Immunization	
	08/02/21. Review of the Quar	dmitted to the facility on terly Minimum Data Set 22 revealed Resident #69 was		have consented to the Pneumococcal Immulinitiated by the ADO residents requesting have received them.	unizations was N/UM to ensure all the immunizations	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345448	B. WING _				C 27/2023
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				30	08 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER			REENSBORO, NC 27406		
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F 883	Continued From page	e 53	F	883			
	revealed the MDS co	mpaired. Further review ded the pneumonia vaccine that the pneumonia vaccine			completed by 2/24/23. The Assistant Director of Nursing/Unit Managers will address all concerns identified during taudit.	he	
	Guidelines, which har read in part; There are (Pneumonia) vaccines. These vaccines are to 13 vaccine (PCV 13) polysaccharide 23 vaccine recommendate Centers for Disease and Advisory Committee (ACIP). Pneumonia vadmission unless conthe consent/release of the consent of the c	s recommended for adults. The pneumococcal conjugate and the pneumococcal ccine (PPSV23). These actions are established by the and Control (CDC) and the conform Immunization Practices accines are given on atraindicated was noted on form. #69's medical record to documentation to indicate are every dependent of the pneumococcal and by family on 6/21/22 at #69's electronic medical arm or nursing note revealing ducted on 01/26/23 at 10:02 Control at Director of Nursing ted if a resident refused a			On 2/15/23, the Regional Nurse Consultant initiated an in-service with the Director of Nursing/Assistant Director of Nursing(IP nurse)/Unit Managers on the policy and procedure for offering reside the Pneumococcal Immunizations on admission and on the resident and resident representative receiving education regarding the benefits and potential side effects of each immunization. On 2/20/23 The Director of Nursing/Assistant	of e ents Unit to	
		ducted on 01/27/23 at 11:35 of Nursing (DON). She			The Assistant Director of Nursing/Unit Managers will forward the results of Au	dit	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	1	PLETED
		345448	B. WING				C (27/2022
	ROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 8 WEST MEADOWVIEW ROAD REENSBORO, NC 27406	j U 17	27/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	stated if a resident or receive a vaccine but expected nursing to c consent/refusal in the stated a new consent out and filled in chart administration of a va	iginally consented/refused to later refused/consulted, she locument the nursing notes. She also large filled she further stated the	F 8	383	to the Quality Assurance Performance Improvement Committee (QAPI) month x 2 months. The QAPI Committee will meet monthly x 2 months and review Immunization Audit to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 3/6/23	•	
F 887 SS=D	CFR(s): 483.80(d)(3) §483.80(d) (3) COVID LTC facility must developed and procedures to endition (i) When COVID-19 vacility, each resident is offered the COVID-immunization is meditaresident or staff memitaresident or the resident receives education registes and potential sident covided with current of the covided with current or the resident representative provided with current or the covided vibration of	ci)-(vii) D-19 immunizations. The elop and implement policies sure all the following: raccine is available to the and staff member -19 vaccine unless the cally contraindicated or the ber has already been DVID-19 vaccine, all staff of with education and risks and potential side the vaccine; DVID-19 vaccine, each intrepresentative agarding the benefits and de effects associated with e; re COVID-19 vaccination es, the resident, ve, or staff member is information regarding those uding any changes in the	F 8	887			3/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED			
		345448	B. WING _		0,	C I/27/2023
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
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F 887	requesting conser additional doses; (v) The resident, remember has the control of the resident's documentation that the following: (A) That the resident was provided edual benefits and poter COVID-19 vaccing (B) Each dose of to the resident; or (C) If the resident vaccine due to make contraindications (vii) The facility make to staff COVID-19 includes at a minimal (A) That staff were the benefits and passociated with Country (B) Staff were offer information on object (C) The COVID-19 related information Disease Control and Healthcare Safety This REQUIREMED by: Based on record the facility failed to refusal or if contrained covid-19 for 2 of the covid-	e COVID-19 vaccine, before at for administration of any esident representative, or staff opportunity to accept or refuse a se, and change their decision; medical record includes at indicates, at a minimum, ent or resident representative cation regarding the atial risks associated with se; and COVID-19 vaccine administered did not receive the COVID-19 edical for refusal; and aintains documentation related vaccination that mum, the following: e provided education regarding otential risks	F	F877 COVID-19 Immunization On 1/25/23 Resident #44 and offered and refused the COV Immunization, it was docume immunizations record on the chart in Point Click Care.	d #242 were /ID-19 entated on the	

PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391

			ATE SURVEY DMPLETED				
		345448	B. WING				27/2022
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NAME OF FI	NOVIDER OR SUFFLIER				, - , ,		
MAPLE G	ROVE HEALTH AND REI	ABILITATION CENTER			8 WEST MEADOWVIEW ROAD		
				G	REENSBORO, NC 27406		
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F 887	Continued From page	e 56	F8	887			
	Findings included:						
	Review of the policy, Guidelines, last revise	ed 10/2022, revealed in part, couraged to remain up to			On 2/15/23, ADON/UM will audit all residents to ensure they have been offered the COVID-19 immunizations, i refused it will be documented as refuse Point Click Care (PCC) Immunizations section. The audit will be completed by 2/17/23. The Assistant Director of	al in	
	04/14/16. Review of Resident #	admitted to the facility on 44's medical records atation that the COVID-19	2/17/23. The Assistant Director of Nursing/Unit Managers will address all concerns identified during the audit. Signed Consent Forms were placed in resident chart and the immunizations were recorded in the resident chart in				
	vaccine was contraine refused.	dicated, administered, or			Point Click Care. On 2/15/23, the Regional Nurse		
	AM with the Infection Preventionist/Assistar (ICP/ADON). She sta vaccine she would ac immunizations in the stated that the facility	nt Director of Nursing ted if a resident refused a			Consultant initiated an in-service with t Director of Nursing/Assistant Director of Nursing(IP nurse)/Unit Managers on th policy and procedure for offering reside the COVID-19 immunization, documen consent or refusal of the immunizations under the immunizations tab in the resident chart and the resident and resident representative have received	of e ents ting	
	AM with the Director of stated a new consent out and filed in the restated the administrated documented on the MRecord (MAR). 2. Resident #242 was 07/08/20.	ducted on 01/27/23 at 11:35 of Nursing (DON). She /refusal form should be filled sident 's chart. She also tion of a vaccine should be fledication Administration admitted to the facility on 242's medical records			education regarding the benefits and potential side effects of the immunization. On 2/15/23 The Director of Nursing/Assistant Director of Nursing/Assistan	Unit s to ss t or	
	revealed no documer				x 2 months. The ADON/UM will addres all concerns identified during the audit	s	

Facility ID: 923456

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345448	B. WING _			01/2	27/2023	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE			
MADIECD	OVE HEALTH AND DEL	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD)			
WAPLE GR	OVE REALTH AND REI	HABILITATION CENTER		GREENSBORO, NC 27406				
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	AM with the Infection Preventionist/Assista (ICP/ADON). She sta vaccine she would actimmunizations in the stated that the facility consent/refusal form An interview was con AM with the Director stated a consent/refu and filed in the reside the administration of	ducted on 01/26/23 at 10:02 Control nt Director of Nursing Ited if a resident refused a Id "refused" under electronic record. She also does not currently have a for the COVID-19 vaccine. ducted on 01/27/23 at 11:35 of Nursing (DON). She sal form should be filled out ent's chart. She also stated	F 8	include additional educational formation and the educational educa	of Nursing/Unit the results of Aute Performance (QAPI) month Committee will as and review etermine trends or need further ace and to further and / or .	dit		