PRINTED: 04/08/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		' '	(X3) DATE SURVEY COMPLETED C			
		345448	B. WING _			03/06/2024
	ROVIDER OR SUPPLIER  ROVE HEALTH AND RE	CHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000		
F 000	to conduct a Recerti survey. The survey through and 02/29/2 obtained offsite on 0 date was changed to found in compliance	tered the facility on 02/26/24 fication and Complaint team was onsite 02/26/24 4. Additional information was 3/06/24. Therefore, the exit o 03/06/24. The facility was with the requirement CFR Preparedness. Event ID#	FC	000		
	to conduct a recertificinvestigation. The s 02/26/24 through 02 information was obtated Therefore, the exit description of Event ID# SOH411. investigated NC00210649, NC002106499, NC002106499, NC002106499, NC002106499, NC0021064999, NC0021064999999999999999999999999999999999999	tered the facility on 02/26/24 cation survey and complaint urvey team was onsite //29/24. Additional ained offsite on 03/06/24. The following intakes were 12844, NC00213878, 212034, NC00211315, 210414, and NC00209566.				
F 637 SS=D	Comprehensive Ass CFR(s): 483.20(b)(2) §483.20(b)(2)(ii) Wi determines, or shoul there has been a sig resident's physical o purpose of this secti means a major decli resident's status that itself without further implementing standards.	essment After Signifcant Chg )(ii)  thin 14 days after the facility d have determined, that inificant change in the r mental condition. (For on, a "significant change" ne or improvement in the t will not normally resolve intervention by staff or by ard disease-related clinical as an impact on more than	Fé	537		4/2/24
AROBATORY	I NIPECTOR'S OR PROVINER	/SLIPPLIER REPRESENTATIVE'S SIGNATUR	) PE	TITI F		(X6) DATE

Electronically Signed 03/28/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345448	B. WING		C 03/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2024
				308 WEST MEADOWVIEW ROAD	
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406	
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F 637	Continued From pag	e 1	F 63	7	
	requires interdisciplir care plan, or both.)	ent's health status, and nary review or revision of the			
	Based on medical reinterviews the facility significant change in resident reviewed for (Resident #70).  Findings included:  Resident #70 was ad 4/27/23 with diagnost with eating the dated 10/18/23 reveas the supervision with eating lower body dressing assistance for oral hyputting on/taking off hygiene. Resident #7 mobility areas of roll lying to sit, sit to star Resident #70 had no	status assessment for 1 of 1 r significant change  Imitted to the facility on es of dementia.  In Minimum Data Set (MDS) aled Resident #70 required ng, upper body dressing, partial /moderate staff //giene, toileting hygiene, footwear, and personal 70 was independent in the left and right, sit to lying, d, chair and bed transfer.  Weight loss.		Maple Grove Health and Rehabilitat Center acknowledges receipt of the Statement of Deficiencies and proporthis Plan of Correction to the extent the summary of findings is factually correct and to maintain compliance applicable rules and provisions of quotient of care of residents. The Plan of Correction is submitted as a written allegation of compliance.  Maple Grove Health and Rehabilitat response to this statement of deficiencies nor does in constitute an admission that any deficiency is accurate. Further, Map Grove Health and Rehabilitation rest the right to refute any of the deficient through informal dispute resolution, appeal procedure and/or any other administrative or legal proceeding.	tion sencies  tiole terves formal
	revealed Resident #7 the following areas of hygiene, toileting, shour body taking off footwear, a area of Mobility, Ressubstantial/maximal right and was depending to sit, sit to star and tub shower trans	rly MDS dated 1/18/23 70 was dependent on staff in f mobility: eating, oral ower/bathing, upper body dressing, putting on and and personally hygiene. In the ident #70 required assistance to roll left and dent on staff for sit to lying, d, chair/bed to chair transfer, afer. Resident #70 was d weight loss and was not on		On 2/29/2024 the corrective action of residents #70 was completed by the Minimum Date Set (MDS) Nurse. Resident #70 Minimum Date Set (M for Significant Change was complet 2/29/24 to reflect the changes in the Activities of Daily living (ADL) due to decline in eating, dressing, personal hygiene, chair and bed transfers and weight loss.	ed on eir

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345448	B. WING _				C ( <b>06/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	00/2024
				3	08 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND REI	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 637	Continued From page	e 2 d weight loss regimen.	F 6	637	On 3/21/2024 the Interdisciplinary Tear	m.	
	A review of Resident revealed a Significan Assessment had not	#70's MDS assessments t Change in Status been completed after the ity of daily living in eating, rgiene, chair and bed			IDT conducted an IDT meeting to discusing significant changes of condition of all current residents to assess for the neefor a Significant Change Status Assessment to be completed by the Minurses with oversight by the Regional MDS consultant.	d	
	Nurse #1 stated that Status Assessment s there is a change in t improvement or decli revealed that a Signif should have been co- assessment and mus An interview on 2/29/ Administrator revealed	ne. MDS Nurse #1 further icant Change in Assessment			On 3/22/2024 the corrective action for residents having the potential to be affected was an initial audit of all MDS Assessments for capturing of resident that have assessed as having a signific change of condition in the past 90 days reviewing the ADL significant change report and weight measurements performed by the MDS nurses with oversight by the Regional MDS Consultant and corrections were made needed.	⊒s cant s by	
	guidollilos.				On 3/21/2024 the Regional MDS Consultant re-educated the Administra and MDS Nurses on completing a significant change assessment when the IDT team determines that the significant change guidelines are met per the RAI manual. New MDS nurses will receive orientation upon hire on completing significant change assessments by the Regional MDS Consultant.  Director of Nursing, Assistant Director Nursing, or Administrator will complete audits for capturing of significant change weekly for 4 weeks, and then monthly to 2 months. Results of audit will be share with the Quality Assurance Performance	ne nt of ges for	

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION ( G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	I	03/00/2024
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F 637	Continued From page	e 3	F 6	Improvement (QAPI) member months or until a time determ QAPI members for sustained The Director of Nursing is resulted the Plan of Correction and the Administrator is responsible from the compliance	nined by the d compliand sponsible for the	ce. or
F 641 SS=B	resident's status. This REQUIREMENT		F 6			4/2/24
	facility failed to accur. Data Set (MDS) assesspeech and vision for communication. (Resonance of the findings included Resident #96 was ad 4/5/23 with diagnosis A review of Resident record (EMR) include Comprehensive Assessing 11/9/23. This assessmedical condition of search Nurse Practition in this note that Resident fearing, and the hearing. Resident #96's most	: mitted to the facility on		Maple Grove Health and Recenter acknowledges receipt Statement of Deficiencies and this Plan of Correction to the the summary of findings is fa correct and to maintain compapplicable rules and provision of care of residents. The Plan Correction is submitted as a allegation of compliance.  Maple Grove Health and Refresponse to this statement of does not denote agreement of the statement of deficiencies nor constitute an admission that deficiency is accurate. Further Grove Health and Rehabilitate the right to refute any of the of through informal dispute rescappeal procedure and/or any administrative or legal process.	t of the ad proposes extent that actually obliance with ns of quality of written mabilitation deficiencies it any er, Maple tion reserved deficiencies oblition, formatical of the cother of the cothe	s t t n ty 's es es s

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X	(3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	03/00/2024
MADLEC	DOVE HEALTH AND DE	THARM ITATION CENTER		308 WEST MEADOWVIEW ROA	AD	
WAPLE G	ROVE REALITIAND RE	HABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 641	Resident #96's care MDS Nurse #1 rever to express emotion, auditory alteration/ddecreased lack of hedeficit, uses hearing included use of pock. An interview was coon 02/28/24 11:08 A completed this asse Resident #96 could indicated that she dipreviously assessed at the time of the assof having access to talker. MDS Nurse # was the MDS Nurse # was the MDS Nurse plan on 12/14/23 wh #96 had a hearing different indicated that is section incorrectly.	plan revised on 12/14/23 by aled a focus area for inability listen and share information; eficit characterized by earing related to hearing amplifier. The interventions set talker to hear.  Inducted with MDS nurse #1  M. She revealed that she essment, and she thought hear adequately. She further d not realize he had been to have hearing impairment esessment nor was she aware hearing amplifier/pocket that revised the hearing care iich indicated that Resident eficit and the intervention of amplifier. The MDS Nurse #1 he might have coded this	F	On 3/22/2024 the corr resident #96 was according Minimum Date Set (Minimum Date Set (Minimum Date Set) (Mini	rective action for omplished by the DS) Nurse modified MDS for identified aving a hearing and residents having ected was an initial estend to be resight from the litant on 3/22/2024 made as needed. The complete MDS all provided to S Coordinators by litant on 3/21/2024. The receive orientation coding of the literature of the litant Director of diministrator will	
	Administrator reveal	0/24 at 1:19 PM with the ed that Resident #96's ssessed per MDS guidelines.		complete audits of MD hearing devices week then monthly for 2 mo audit will be shared wi Assurance Performan (QAPI) members for 3 time determined by the for sustained compliar Nursing is responsible Correction and the Ad responsible for sustain	ly for 4 weeks, and nths. Results of ith the Quality ce Improvement months or until a e QAPI members nce. The Director of the for the Plan of ministrator is	

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				308 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 677	Continued From p	page 5	F 6	77			
F 677	· ·	ed for Dependent Residents	F 6	77		4/2/24	
SS=D						1/2/2	
	§483.24(a)(2) A re	esident who is unable to carry					
	out activities of da	ily living receives the necessary					
		ain good nutrition, grooming, and					
	personal and oral						
		ENT is not met as evidenced					
	by:	ations, record review, and		Maple Grove Health and Reh	abilitation		
		sident and staff, the facility failed		Center acknowledges receipt			
		e to a resident who needed		Statement of Deficiencies and			
	· •	nce from staff for Activities of		this Plan of Correction to the			
	Daily Living (ADL)	). This deficient practice affected		the summary of findings is fac	tually		
		Resident # 90) reviewed for		correct and to maintain compl			
	ADLs.			applicable rules and provision	s of quality		
				of care of residents. The Plan			
	Findings included	:		Correction is submitted as a w	/ritten		
	Desident #00 was	admitted to the facility on		allegation of compliance.			
		admitted to the facility on gnoses of hemiplegia (paralysis		Maple Grove Health and Reha	abilitation's		
	of one side of the			response to this statement of			
	or one side or the	body).		does not denote agreement w			
	Review of the ann	ual Minimum Data Set (MDS),		statement of deficiencies nor			
		evealed Resident #90 was		constitute an admission that a	ıny		
	cognitively intact a	and required extensive		deficiency is accurate. Further	r, Maple		
	assistance with pe	ersonal hygiene.		Grove Health and Rehabilitation			
				the right to refute any of the de			
		nt #90's care plan revised		through informal dispute resol			
		I a need for Activities of Daily		appeal procedure and/or any			
		onal Care with the following ling the resident required		administrative or legal proceed	ung.		
		sonal hygiene, and grooming.		On 2/29/24, MDS Nurse #1 tri	mmed		
	assistance for per	oonar nygiono, and grooming.		resident #90 nails.	IIIIIOG		
	During observatio	n and interview on 02/26/24 at		l solden not mane.			
	_	nt #90 was observed lying in		On 3/21/27, the Director of Nu	ırsing		
		ls on both hands that were		(DON)/Assistant Director of N			
	about ½ inch long	. Resident #90 stated he		(ADON)/Unit Manager (UM) ir			
		lipped and would ask the staff.		audit of Activities of Daily Livir	ng (ADL)		

NAME OF PROVIDER OR SUPPLIER  MAPLE GROVE HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 677 Continued From page 6  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MEADOWVIEW ROAD  GREENSBORO, NC 27406  ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETIVE ACTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  MAPLE GROVE HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 677  Continued From page 6  An observation was conducted on 02/27/24 at 12:41 pm of Resident #90 lying in bed and his nails remained long. Resident #90 stated he did not ask to have his nails clipped and would ask his nurse today.  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MEADOW/IEW ROAD  GREENSBORO, NC 27406  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 677  Care of all dependent residents to include nail care, skin, and foot assessments. This audit is to ensure all residents were assisted with ADL care and in the event of refusal of care, it's documented in the electronic record. The DON/ADON/UM will address all concerns identified during		
MAPLE GROVE HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 677  Continued From page 6  An observation was conducted on 02/27/24 at 12:41 pm of Resident #90 lying in bed and his nails remained long. Resident #90 stated he did not ask to have his nails clipped and would ask his nurse today.  STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWIEW ROAD GREENSBORO, NC 27406  B PROVIDER'S PLAN OF CORRECTION FOR CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 677  Care of all dependent residents to include nail care, skin, and foot assessments. This audit is to ensure all residents were assisted with ADL care and in the event of refusal of care, it's documented in the electronic record. The DON/ADON/UM will address all concerns identified during		
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his nurse today.  electronic record. The DON/ADON/UM will address all concerns identified during		
will address all concerns identified during		
On 02/28/24 at 10:25 am an observation was the audit to include assisting dependent		
made of Resident #90 and his nails remained residents with ADL care and education of		
long on both hands. Resident #90 stated he had staff. Audit completed 3/22/27.		
asked the Nurse to clip his nails on 02/27/24,		
however he did not remember what nurse he had  On 2/29/24, the DON/ADON/UMs initiated		
asked. an in-service with all nurses and nursing		
assistants regarding ADL Care with		
An interview was conducted on 02/28/24 at 10:59 emphasis on ensuring nails are clean and		
am with the MDS Nurse and she indicated trimmed per resident preference for all		
residents' nails were usually clipped when the dependent residents. In-services will be		
Nursing Assistant (NA) provided ADL care, unless completed by 4/2/2024. any nurse or		
they had diabetes. The MDS Nurse was in the nursing assistant to include agency and		
room and verified with Resident #90 he asked to contract staff who has not received the		
have his fingernails clipped on 02/27/24 by the in-service will be in-service prior to the		
nurse, and the nurse he asked said okay, but next scheduled work shift. All newly hired		
never clipped them. nurses and nursing assistants, agency		
and contract staff will be in service during		
A review of Resident #90's Activities of Daily orientation regarding ADL Care.		
Living documentation from December 2023 to		
present revealed no documentation that showers  The DON/ADON/UM's will review nail		
had been provided and no refusals noted.  Attempt to contact NAs who were assigned to  care assessment sheets to ensure nail care is being completed as assigned.		
Attempt to contact NAs who were assigned to care is being completed as assigned.  work with Resident #90 on 02/26/24 and 02/27/24 Resident observation will be performed		
was unsuccessful.  Nurse and C.N.A to include resident #90,		
was unsuccessiui.  Nuise and C.N.A to include resident #90,  weekly x 4 weeks then monthly x 2		
An interview was conducted 02/29/24 at 11:16 am months utilizing the nail care assessment		
with the Nurse (Nurse #2) who was assigned to sheets. This audit is to ensure all		
Resident #90 on 02/26/24 and 02/27/24 and she dependent residents were assisted with		
indicated the Resident did not request to have his  ADL care and refusals of care		
nails clipped. She indicated staff had not informed documented in the electronic record. The		
her Resident needed his nails clipped. Nurse #2  DON/ADON/UM will address all concerns		
stated she did not notice Resident #90 needed identified during the audit. The DON will		

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		345448	B. WING _			l	C 06/2024
NAME OF PE	ROVIDER OR SUPPLIER	L		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	, 33,	
MADIFO	DOVE HEALTH AND DEL	LABILITATION CENTER		30	8 WEST MEADOWVIEW ROAD		
MAPLE GI	ROVE HEALTH AND REI	ABILITATION CENTER		G	REENSBORO, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 7	F 6	677			
	An interview was con Administrator and Dir 02/29/24 at 3:08 pm. Resident #90's finger	ector of Nursing (DON) on The DON indicated nails were clipped on s should be clipped if he			review the nail care assessment sheets audit tool weekly x 4 weeks then month x 2 months to ensure all concerns are addressed.  The DON will forward the results of naicare assessment sheets 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 the nail care assessment sheets to determ trends and / or issues that may need further interventions put into place and determine the need for further and / or frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator is	l lee ly ne ine to	
F 685 SS=G	S483.25(a) Vision and To ensure that reside and assistive devices hearing abilities, the frassist the resident-  §483.25(a)(1) In make \$483.25(a)(2) By array and from the office of the treatment of vision the office of a profess provision of vision or	•	F	685	responsible for sustained compliance.		4/2/24
	Based on observatio	n, record review and			Maple Grove Health and Rehabilitation	1	

	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _			C <b>03/06/2024</b>	
NAME OF PR	ROVIDER OR SUPPLIER		<del> </del>	STREET ADDRESS, CITY, STATE, ZIP COD	<b></b>	00/00/2024	
				308 WEST MEADOWVIEW ROAD			
MAPLE GI	ROVE HEALTH AND REI	ABILITATION 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 685		sident and staff, the facility	F 6	Center acknowledges receipt			
	with access to a hear accommodate a hear	ing deficit. This deficient		Statement of Deficiencies and this Plan of Correction to the the summary of findings is factorial.	extent that ctually		
	accommodation of ne	1 of 1 resident reviewed for eds (Resident #96). The oncept was applied for		correct and to maintain compl applicable rules and provision of care of residents. The Plan	s of quality		
		nis inability to hear what was n. A reasonable person ation, loneliness, and		Correction is submitted as a v allegation of compliance.	vritten		
	frustration. Findings included:			Maple Grove Health and Rehamest to this statement of	deficiencies	3	
				does not denote agreement w statement of deficiencies nor	does it		
		esident #96 was admitted to the facility on '5/23 with the diagnosis of Alzheimer's disease.		constitute an admission that a deficiency is accurate. Furthe Grove Health and Rehabilitati	r, Maple	<b>S</b>	
	Minimum Data Set (M Resident #96 had mo	recent comprehensive fDS) dated 4/11/23 revealed derately impaired cognition ired hearing with the use of		the right to refute any of the d through informal dispute reso appeal procedure and/or any administrative or legal procee	lution, forma other ding.	al	
	revealed a focus area emotion, listen and sl alteration/deficit char-	plan revised on 12/14/23 a for inability to express hare information; auditory acterized by decreased lack hearing deficit, uses hearing		On 2/28/2024 the Social Work placement of the hearing amp testing for proper functioning. worker found the device to be properly with the attached hear	olifier and The Social functioning	1	
	amplifier. The interve pocket talker to hear.	ntions included use of		On 2/29/2024 assessment/ed use of device completed with #96 by MDS Nurse.			
	interview were condu was observed sitting quiet room. Resident hard time hearing and	M an observation and cted with Resident #96. He on the side of the bed in a #96 indicated that he had a d could not recall when he nearing amplifier but thought ne.		On 2/29/2024, Administrator of Activity Director #1, Social Wo Unit Manager #1, Nursing Ass Medication Aid #1 on the local hearing amplifier and how to put the hearing amplifier for resident	orker #1, sistant #1, tion of the properly use		

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MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		G	REENSBORO, NC 27406		
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F 685	Continued From page	e 9	F	685			
	,		, ,	000	On 3/4/2024, Social Worker conducted	an	
	A review of the Pace	of the Triad Primary			audit of all resident's care planned for	an	
		essment progress note dated			hearing devices to ensure that the hear	rina	
	•	hronic medical condition of			devices are accessible and properly	3	
	severe hard of hearir	ng. The Pace Nurse			functioning, listed on care guide/task fo	r	
	Practitioner (Pace NI	P #1) indicated in this note			nursing assistants, and on the resident	's	
	that Resident #96's v	vas severely hard of hearing,			care plan.		
	_	was chronic and ongoing.					
		d that Resident #96 was			On 2/29/24, the DON/ADON/UMs initia	ted	
					an in-service with all staff regarding		
					resident hearing devices with emphasis	3	
		gnificantly affect Resident nunicate and/or perform			on offering device, location of device, functionality of device, resident refusals		
	_	ing (ADL's). Pace NP #1			availability of device, and notification to		
	-	in previous notes hearing			charge nurse. In-services will be	•	
		ited however hearing loss			completed by 4/2/2024. Any staff		
		ressed using the pocket			member, to include agency and contra	ct	
	talker which Residen	t #96 tolerated well and was			staff who has not received the in-service	e	
	at his bedside for as	needed use.			will be in-service prior to the next		
					scheduled work shift. All newly hired st		
		ic note dated 1/26/24			to include agency and contract staff, w		
	•	Resident #96's treatment			be in service during orientation regardi	ng	
		d to be hard of hearing and on't know, and I can't hear			resident hearing devices.		
	you."				The Social Worker will conduct the		
					hearing device audit three times a wee		
					x4 weeks then weekly x 2 months. This		
	On 2/28/24 at 9:07 A				audit is to ensure that staff and residen	ts	
		ctivity Director. She indicated			are aware of the location and proper		
		as hard of hearing and that			function of all residents with hearing		
		oice for him to hear her. She			devices. The Director of Nursing		
		she was not aware of any vices and had not used or			(DON)/Assistant Director of Nursing (ADON)/Unit Manager (UM) will addres	e e	
		devices and had not used of			all concerns identified during the audit.	00	
	amplifier during activ				an concerns identified during the addit.		
	, 5				The Social Worker will present the		
	On 2/28/24 at 9:19 A	M an interview was			hearing device audit results to the Qua	lity	
	conducted with Nursi	ing Assistant (NA) #1, and			Assurance Performance Improvement		
	she indicated that sh	e was familiar with Resident			Committee (QAPI) monthly x 2 months		

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MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER		308 WEST MEADOWVIEW ROAD			
				GREENSBORO, NC 27406		-	
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F 685	Continued From բ	page 10	F 6	85			
	#96 and that he hable to hear if she indicated that she hearing aids or a On 2/28/24 at 9:2 conducted with Remedication aide (lindicated that Resand that she had but he was able to	ad a hard time hearing but was a raised her voice. She further was not aware if he had hearing amplifier available.  7 AM an interview was esident 96's assigned Medication Aide #1) and she sident #96 was hard of hearing to raise her voice for him to hear on hear. She further revealed that all if Resident #96 had hearing		The QAPI Committee will m 2 months and review the AI determine trends and / or is need further interventions p and to determine the need / or frequency of monitoring of Nursing is responsible fo Correction and the Adminis responsible for sustained co	OL Audit Tool to sues that may ut into place for further and . The Director r the Plan of trator is		
	conducted with Sorevealed that Resand she had to rate and she did not use speaking with him conducted on 2/2 indicated that she and located a heat the drawer of his of the his of the his head to accept the had not and she had to accept the had not and she had to accept the hearing and she had to accept the had not a she had to accept the hearing and she had to accept the had the had to accept the had to accept the had the had the had to accept the had t	9 AM an interview was ocial Worker #1, and she ident #96 was hard of hearing, ise her voice for him to hear her se any hearing devices when a. A follow up interview was 8/24 at 10:06 am and she went to Resident #96's room aring amplifier in his room inside bedside table.  7 PM a follow up visit was made with Unit Manager #1 present. It is as able to locate the hearing edside table drawer and asked the using a raised voice if he is es of the hearing amplifier so in him. Resident #96 responded yes and reached hand out to the amplifier. Unit Manager #1 eadset to Resident #96, and he oward Unit manager #1 to g device but Unit Manager #1 eft earpiece of the amplifier was					

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F 685	' '		F 6	685		
	reattach it, but attemp Manager #1 explaine amplifier was broken, him a new one and he head yes.	Manager #1 attempted to ots were not successful. Unit d to Resident #96 that the and she would have to get e agreed by nodding his				
	indicated that he wou	was conducted with 9/24 at 1:56 PM and he lld like for staff to use the hat "I can hear better."				
	Pace of the Triad Med	ew was attempted with the dical Director as DNP #1 tempts to interview the Pace Director were not				
F 867 SS=D	an intervention on Recare guide but that it determine if they felt effectively communication further revealed that Unit Manager #1 that broken at that time.  QAPI/QAA Improvement	a/24 at 1:19 PM. She aring amplifier was listed as esident #96's care plan and was up to the staff to they needed the device to ate with Resident #96. She she was not made aware by the hearing amplifier was	F 8	367		4/2/24
	monitoring. A facility must establi- policies and procedur collections systems, a adverse event monitor	sh and implement written res for feedback, data and monitoring, including bring. The policies and ude, at a minimum, the				

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NAME OF PROVIDER OR SUPPLIER  MAPLE GROVE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	<b>,</b>	00/00/2024	
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F 867	systems to obtain a from direct care staresident representa information will be used high risk, high vopportunities for important of the fact of the f	ty maintenance of effective nd use of feedback and input ff, other staff, residents, and tives, including how such used to identify problems that olume, or problem-prone, and provement.  Ity maintenance of effective collect, and use data and departments, including but cility assessment required at uding how such information elop and monitor performance  Ity development, monitoring, erformance indicators, dology and frequency for such coring, and evaluation.  Ity adverse event monitoring, ds by which the facility will ify, report, track, investigate, ta and information relating to the facility, including how the lata to develop activities to the facility must take actions ce improvement and, after actions, measure its success,	F8	67			

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F 867	§483.75(d)(2) The fimplement policies at (i) How they will used determine underlyin impacting larger systii) How they will de will be designed to a level to prevent quasafety problems; and (iii) How the facility of its performance in ensure that improve §483.75(e) (1) The fiperformance improve importance improved in the facility of its performance in ensure that improved in the facility of its performance improved in the facility of its performance improved in the facility in the facility.  §483.75(e)(1) The fiperformance in the facility in the facilit	ealized and sustained.  acility will develop and addressing: a systematic approach to a systematic approach to a systems; velop corrective actions that effect change at the systems lity of care, quality of life, or d will monitor the effectiveness approvement activities to ements are sustained.  activities.  activities.  activities that focus on me, or problem-prone areas; and affect health safety, resident autonomy,	F8	67			

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MAPLE G	ROVE HEALTH AND REF	HABILITATION CENTER		GREENSBORO, NC 27406	
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F 867	67   Continued From page 14		F 86	67	
F 867	available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analysis (c) and (d) of this section (e) and (d) of this section (e) are sufficiently assurance committee governing body, or defunctioning as a governing body, or defunctioning as a governing body (e) of this section. The (ii) Develop and impleaction to correct identication (iii) Regularly review adata collected under the resulting from drug reavailable data to mak This REQUIREMENT by:  Based on observation	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 is described in paragraphs ation.  It is sessment and assurance.  It is allowed as the facility's esignated person(s) and the paragraphs (a) through the paragraphs (a) through the committee must:  It is allowed as the facility deficiencies; and analyze data, including the QAPI program and data and the paragraphs.  It is not met as evidenced ans, resident and staff areview, the facility's Quality remance Improvement.	F 86	Maple Grove Health and Rehabili Center acknowledges receipt of th Statement of Deficiencies and pro this Plan of Correction to the exter	e poses
	surveys dated 1/18/22 in the area of accurat	mittee put into place ecertification and complaint 2 and current survey 3/06/24 ely coding Minimum Date ity also failed to maintain		the summary of findings is factuall correct and to maintain compliance applicable rules and provisions of of care of residents. The Plan of Correction is submitted as a writte allegation of compliance.	e with quality
	interventions the com	mittee put in place following tion and complaint surveys		Maple Grove Health and Rehabilit response to this statement of defic	

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F 867	= 867   Continued From page 15		F 8	367			
F 867	conducted on 1/18/22 survey 03/06/24, in the Living (ADL) care proper residents. The continuity federal surveys of recifacility's inability to supprogram.  Findings included:  This citation is cross of the facility that it is cross of the facility that Minimum Data Searea hearing, speech resident reviewed for #96).  During the previous resurvey date 1/18/22 to code the nutrition section (MDS) for 2 of 5 m Nutrition  2 F 677 Based on obstand interviews with refailed to provide nail of needed extensive ass Activities of Daily Living practice affected 1 of reviewed for ADLs.  During the previous resurvey date 1/18/25.	2, 1/27/23 and the current he area of Activity of Daily wided for dependent used failure during three cord showed a pattern of the listain an effective QAPI  referenced to:  cord reviews and staff of failed to accurately code et (MDS) assessment in the equation, and vision for 1 of 1 communication. (Resident escertification and complaint the facility failed to accurately etion of the minimum data esidents reviewed for eservations, record review, esident and staff, the facility care to a resident who esistance from staff for the ing (ADL). This deficient 7 residents (Resident # 90)	F 8	867	does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reservithe right to refute any of the deficiencie through informal dispute resolution, for appeal procedure and/or any other administrative or legal proceeding.  On 2/29/24, MDS Nurse #1 trimmed resident #90 nails.  On 3/21/27, the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Unit Manager (UM) initiated ar audit of Activities of Daily Living (ADL) care of all dependent residents to inclunail care, skin, and foot assessments. This audit is to ensure all residents were assisted with ADL care and in the even refusal of care, it's documented in the electronic record. The DON/ADON/UM will address all concerns identified durithe audit to include assisting dependent residents with ADL care and education staff. Audit completed 3/22/27.  On 2/29/24, the DON/ADON/UMs initial an in-service with all nurses and nursin assistants regarding ADL Care with emphasis on ensuring nails are clean at trimmed per residents. In-services will be appealed by 4/2/2024, any purson of the additional and the proposition of the audit to the audit to presidents. In-services will be appealed by 4/2/2024, any purson of the audit to the audit to presidents. In-services will be appealed by 4/2/2024, any purson of the audit to the audit to presidents. In-services will be appealed to the audit to any purson of the audit to any purson of the audit to a purson of the audit to a purson of the audit to any purson of the audit to a purson of the audit to any purson	es mal n de re at of ng at of	
	1/27/23 the facility failed to provide showers, nail care, and mouth care to residents who needed extensive and/or were dependent on staff for Activities of Daily Living (ADL).				completed by 4/2/2024. any nurse or nursing assistant to include agency and contract staff who has not received the in-service will be in-service prior to the next scheduled work shift. All newly hir		

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 867 Continued From page 16  F 867	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	RED.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  MAPLE GROVE HEALTH AND REHABILITATION CENTER   STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MEADOWVIEW ROAD  GREENSBORO, NC 27406   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 867  Continued From page 16  STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MEADOWVIEW ROAD  GREENSBORO, NC 27406  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 867			345448	B. WING _				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 867 Continued From page 16  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					308	8 WEST MEADOWVIEW ROAD	1 00	00,2024
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During the previous recertification and complaint survey on 11/18/22. the facility failed to provide a haircut (Resident #71) for 1 of 3 activity of daily living dependent residents reviewed.  During an interview on 2/29/24 at 3:23 PM, the Administrator stated the Quality Assurance (QAPI)) committee, regarding the repeated deficiencies the Administrator stated the old plan of correction would be revisited and analyzed to see where the failures and breakdowns happened. This would help analyze the cause of repeat deficiency. The Administrator indicated once the plan was put in place, audits and the monitoring phase would be completed. She further indicated that sporadically monitoring and auditing throughout the year should be continued to ensure the repeated deficiencies do not recur. Repeated concerns were also discussed in QAPI meeting and the QAPI committee would see how the approach can be changed if needed. This could be education and training of staff or revision of the approach or new approach if needed.  During an interview on 2/29/24 at 3:23 PM, the Administrator indicated (QAPI) weeks the fermion this performed (Resident observation will be performed Nurse and C.N.A to include resident #90, weekly x.4 weeks then monthly x.2 months utilizing the nail care assessment sheets. This audit is to ensure all dependent residents were assisted with ADL care and refusals of care documented in the electronic record. The DON/ADON/UM will address all concerns identified during the audit. The DON will review the nail care assessment sheets audit tool weekly x.4 weeks then monthly x.2 months to ensure all concerns are addressed.  On 3/22/2024 the corrective action for resident #96 for not having a hearing deficit.  Corrective action for all residents having the potential to be affected was an initial audit of all MDS Assessment related to hearing abilities was performed by the MIDS nurses with oversight from the Regional MDS Consultant on 3/22/2024 and corrections were made as needed.	F 867	During the previous survey on 1/18/22, th haircut (Resident #7 living dependent research During an interview of Administrator stated (QAPI)) committee, and deficiencies the Admost of correction would be see where the failure happened. This wou repeat deficiency. The once the plan was promoved the plan was promoved the plan was promoved to ensure the repeat auditing throughout to ensure the repeat Repeated concerns meeting and the QA the approach can be could be education	recertification and complaint the facility failed to provide a 1) for 1 of 3 activity of daily idents reviewed.  In 2/29/24 at 3:23 PM, the the Quality Assurance regarding the repeated inistrator stated the old plan be revisited and analyzed to be and breakdowns and breakdowns and help analyze the cause of the Administrator indicated but in place, audits and the build be completed. She is sporadically monitoring and the year should be continued the deficiencies do not recur. Were also discussed in QAPI PI committee would see how a changed if needed. This and training of staff or revision	F	367	The DON/ADON/UM's will review nail care assessment sheets to ensure nail care is being completed as assigned. Resident observation will be performed Nurse and C.N.A to include resident #8 weekly x 4 weeks then monthly x 2 months utilizing the nail care assessment sheets. This audit is to ensure all dependent residents were assisted with ADL care and refusals of care documented in the electronic record. To Don/ADON/UM will address all concertion dentified during the audit. The Don with review the nail care assessment sheets audit tool weekly x 4 weeks then month x 2 months to ensure all concerns are addressed.  On 3/22/2024 the corrective action for resident #96 was accomplished by the Minimum Date Set (MDS) Nurse modified the assessments on MDS for identified resident #96 for not having a hearing deficit.  Corrective action for all residents having the potential to be affected was an initial audit of all MDS Assessments for accuracy of assessment related to hearing abilities was performed by the MDS nurses with oversight from the Regional MDS Consultant on 3/22/2024 and corrections were made as needed.	I 90, ent he rns II shily	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	1 ` ′	) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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F 867	Continued From page	ge 17	F	assessin Adminis Regional New ME upon hir assessin Consultate On 2/29 Facility (Director educate Quality / Improve  The Facility (API) in ensure to Regulate QAPI. To Clinical and the once a result of the Accurace of the Accurace Depending of the revieus and / or intervening the Medium of the control of the revieus and / or intervening the reviews and / or inter	0/2024 education completed by Consultant/Corporate Clinical Administrator and IDT membered on the Corporate Policy for Assurance and Performance	the ers ical o te s ans		

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MAPLE G	ROVE HEALTH AND REF	ABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE	
F 867	Continued From page	÷ 18	F8	frequency of monitoring. The Dir Nursing is responsible for the Pla Correction and the Administrator responsible for sustained compli	an of · is		