STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	07/03/2025

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

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E 000	Initial Comments An unannounced recertification investigation was conducted on 06/30/25 through 07/03/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness Event ID #4IZL11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 06/30/25 through 07/03/25. Event ID#4IZL11	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than	F 641		7/10/25

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

Electronically Signed | 07/10/2025

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F 641	Continued From page 1 $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 5 residents reviewed for unnecessary medications (Resident #1) and 1 of 1 resident (Resident #22) reviewed for anticoagulant medication. The findings included: 1. Resident #1 was admitted to the facility on 05/08/23 with diagnoses that included diabetes mellitus. Review of Resident #1's physician orders revealed orders dated 05/15/23 for gabapentin (an anticonvulsant) 100 milligrams (mg) by mouth twice a day for diabetic neuropathy (nerve damage) and metformin (a hypoglycemic) 500 mg by mouth once a day for diabetes mellitus dated 05/09/23. Review of Resident #1's Medication Administration Record for 04/01/25 through 04/30/25 revealed the Resident received gabapentin 100 mg by mouth twice a day and metformin 500 mg by mouth once a day as ordered. Review of Resident #1's quarterly MDS assessment dated 04/15/25 revealed the MDS was not coded as receiving an anticonvulsant or a hypoglycemic medication. On 07/03/25 at 10:08 AM an interview was	F 641	F 641 1. On 7/3/25 Minimum Data Set(MDS) Assessment Nurse corrected and resubmitted assessments for Residents #1 and #22. 2. The MDS Assessment Nurse audited last completed MDS for all current residents to ensure coding accuracy in section N related to anticoagulants, hypoglycemics and anticonvulsants. Additional findings noted on 7/8/25. Corrections made to assessments identified as reflecting inaccurate coding in section N on 7/8/25. 3. The Regional MDS Coordinator educated the MDS Assessment Nurses on 7/8/25 about MDS coding accuracy specifically Section N. Newly hired MDS team members will be educated on this process by the Regional MDS Coordinator upon hire. 4. The Regional MDS Coordinator or designee will audit section N of the MDS on 5 residents weekly for accuracy of medication coding for 8 weeks to ensure ongoing compliance with medication coding accuracy. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 7/10/25	

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F 641	Continued From page 2	F 641		

conducted with MDS Nurse #1 who reviewed Resident #1's quarterly MDS dated 04/15/25 and acknowledged the MDS was coded as not receiving an anticonvulsant or a hypoglycemic medication and stated she did not know why she miscoded the MDS but agreed the MDS was coded in error.

On 07/03/25 at 11:00 AM an interview was conducted with the Administrator who stated she expected the MDS assessments to be completed accurately.

2. Resident #22 was admitted to the facility on 08/31/22 with diagnoses that included atrial fibrillation.

Review of Resident #22's physician orders for 06/10/25 revealed the Resident was not prescribed an anticoagulant (blood thinner) medication.

Review of Resident #22's Medication Administration Record for 06/01/25 through 06/30/25 revealed the Resident did not receive an anticoagulant medication.

Review of Resident #22's quarterly MDS assessment dated 06/15/25 revealed the MDS was coded as receiving an anticoagulant medication.

On 07/03/25 at 10:08 AM an interview was conducted with MDS Nurse #2 who reviewed Resident #22's 06/15/25 quarterly MDS and acknowledged the MDS was miscoded as receiving an anticoagulant medication and stated she coded the MDS in error.

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F 641	Continued From page 3 On 07/03/25 at 11:00 AM an interview was conducted with the Administrator who stated she expected the MDS assessments to be completed accurately.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645		7/10/25

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F 645	Continued From page 4 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for an evaluation for an updated Preadmission Screening and Resident Review (PASRR) determination for a	F 645	F645 1. On 7/8/2025 the Social Worker submitted a request for a Preadmission Screening and Resident Review(PASRR)	

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F 645	Continued From page 5 resident who was admitted to the facility with mental health disorders for 1 of 2 residents reviewed for PASRR (Resident #33). Findings included: A PASRR Determination Notification letter dated 09/23/20 revealed Resident #33 had a Level I PASRR with no expiration date. Resident #33 was admitted to the facility on 04/28/25 with diagnoses that included bipolar disorder, anxiety disorder and dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Review of Resident 33's electronic medical record revealed the following active physician orders: *04/28/25: Quetiapine fumarate (antipsychotic) 100 milligrams (mg) in the evening for bipolar disorder. *04/28/25: Sertraline (antidepressant) 100 mg at bedtime for bipolar/depression. *04/28/25: Trazodone (antidepressant) 100 mg at bedtime for restlessness. The admission Minimum Data Set (MDS) assessment dated 05/05/25 revealed Resident #33 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #33 received antipsychotic and antidepressant medications during the MDS assessment period. A North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document provided by the facility on 07/02/25 revealed Resident #33 had a Level I PASRR effective 09/30/20. There	F 645	reevaluation for Resident # 33. 2. On 7/8/25 the Administrator conducted an audit of all current resident medical diagnosis and current PASRR level. Findings noted for residents with significant mental health diagnoses without appropriate PASRR level and were submitted for PASRR reevaluation by 7/9/25. 3. Education was completed on 7/8/25 by the Administrator for the Social Worker and Admission Coordinators. This education included screening new admissions for significant mental health diagnosis and the requirement to ensure facility identifies residents requiring PASRR review. Newly hired team members who will participate in the PASRR review process will be educated on this process by the administrator or social service director upon hire. 4. Social Worker or Designee will audit all new admissions and current residents weekly for 8 weeks for identification of significant mental illness diagnosis and the need for PASRR review. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance 7/10/25	

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F 645	Continued From page 6 were no requests for a PASRR reevaluation submitted or completed since 09/30/20. During an interview on 07/02/25 at 3:02 PM, the Social Worker (SW) revealed Resident #33's request for a PASRR reevaluation was overlooked. The SW explained she was not always informed when a resident admitted with mental health diagnoses and had she been aware, she would have submitted a request for a Level II PASRR reevaluation for Resident #33. During an interview on 07/03/25 at 8:07 AM, the Administrator revealed the SW was responsible for submitting PASRR reevaluation requests when needed. The Administrator stated she had completed a PASRR audit on 04/16/25 that was reviewed with the SW to determine if there were any PASRR reevaluation requests that needed to be submitted. The Administrator explained that a request for a Level II PASRR reevaluation should have been submitted for Resident #33 but hers was overlooked due to her admitting to the facility after the PASRR audit had been completed.	F 645		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		7/10/25

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F 761	Continued From page 7 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on manufacturer guidelines, observations and staff interviews, the facility failed to remove loose and unsecured pills of various shapes, sizes and colors from 2 of 6 medication carts (100 and 200 Hall) and failed to label DuoNeb solution (inhalation breathing solution) with a open date and store DuoNeb solution according to the manufacturer's guidelines for 1 of 6 medication carts (200 Hall) reviewed for medication storage. The findings included: 1a. An observation was made of the 100 hall medication cart on 07/02/25 at 10:45 AM accompanied by Medication Aide (MA) #1. The cart yielded 20 loose pills of various shapes, colors and sizes in the bottom of the medication cart drawers. An interview conducted with MA #1 on 07/02/25 at 10:45 AM. The MA explained that it was every MA's responsibility to keep the carts clean, but he	F 761	F 761 1. Director of Nursing and Unit Managers removed and discarded loose medications from the 100 and 200 Hall Medication Carts on 7/2/25. DuoNeb solution not stored in foil package was discarded from the 200 hall medication cart on 7/2/25. 2. Director of Nursing, Assistant Director of Nursing, and Unit Managers completed an audit of all medication carts for presences of loose pills as well as nebulizer solution not stored in dated foil package on 7/4/25. Additional findings noted, all medications identified were removed from medication cart and discarded on 7/4/25. 3. Director of Nursing educated all Licensed nurse and Medication aides on 7/5/25 regarding storage of medications, including that loose pills may not be present on medication cart and must be discarded upon discovery and that nebulizer solution must be stored foil	

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F 761	Continued From page 8 did not know if it was a rule or not. b. An observation was made of the 200 hall medication cart on 07/02/25 at 10:55 AM accompanied by MA #2. The cart yielded 41 loose pills of various shapes, colors and sizes in the bottom of the medication cart drawers. An interview was conducted with MA #2 on 07/02/25 at 10:55 AM. The MA explained that it was the MA's responsibility to keep the medication carts clean and orderly, but she did it most of the time. On 07/02/25 at 12:00 PM an interview was conducted with the Unit Manager who explained that it was each MA's responsibility to keep the carts clean and orderly and at one time they had vacuums to use to clean the carts, but she did not know if they had them anymore. An interview was conducted with the Director of Nursing (DON) on 07/03/25 at 11:00 AM. The DON explained that it was the MA's responsibility to keep the medication carts clean and she had an extra nurse to work third shift on 07/01/25 with the only responsibility to clean the medication carts. The DON stated it was her expectation that the medication carts be neat, clean and orderly. 2. Review of the manufacturer's guidelines for DuoNeb solution revealed the solution should be stored in the foil pouch to protect from light. After opening the foil pouch: Individual vials of DuoNeb should be used within 7 days once removed from the foil pack. Unused vials removed from the pouch should be protected from light and used within one week.	F 761	package and dated upon opening. Newly hired licensed nurses and medication aides will be educated on this process by the Director of Nursing or designee upon hire. 4. The Director of Nursing or designee will audit 5 medication carts a week for 8 weeks to ensure no loose pills or undated or improperly stored nebulizer solutions are present. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 7/10/25	

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F 761	Continued From page 9 On 07/02/25 at 11:40 AM an observation was made of the 200 Nurse medication cart accompanied by Nurse #1. The cart yielded 5 DuoNeb inhalation vials loosely stored in a plastic cup. The vials were not in a foil package or dated when they were removed from the foil pack. An interview was conducted with Nurse #1 on 07/02/25 at 11:40 AM. The Nurse explained that she did not know who the DuoNeb solution belonged to, nor did she know how the solution should be stored. The Nurse stated that the solution should be dated when opened. On 07/02/25 at 12:00 PM an interview was conducted with the Unit Manager who explained that it was each nurse's responsibility to keep the carts clean and orderly. The Unit Manager stated the DuoNeb solution should be kept in the foil pouch and dated when opened. An interview was conducted with the Director of Nursing (DON) on 07/03/25 at 11:00 AM. The DON explained that it was the MA's responsibility to keep the medication carts clean and she had an extra nurse to work third shift on 07/01/25 with the only responsibility to clean the medication carts. The DON stated it was her expectation that the medication carts be neat, clean and orderly and the DuoNeb solution should be dated when open and stored in the foil pouch.	F 761		