		AND HUMAN SERVICES		046.28 K	13:15		APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES					10/		. 0938-039 <sup>2</sup>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE S COMPLE	ETED
!			B. WING	ì			С
		345448				05/1	1/2011
NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY,			
MAPLE	GROVE HEALTH AND	REHABILITATION CENTER	!	308 WEST MEADOWY GREENSBORO, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECT CTIVE ACTION SHOUND TO THE APPROPRICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241 SS=D	INDIVIDUALITY  The facility must premanner and in an elenhances each research research recognition of head of the second of the	comote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.  The is not met as evidenced tion and staff interviews, the intain dignity for 1 of 1 resident moving a soiled linen bag lor; from the resident's e resident was eating.  Imitted to the facility on inoses that included ed Fracture of Ankle, to of Multiple sites and Disorder. The annual completed on 4/21/11 ent was cognitively intact. PM, Resident #4 was inch in bed in her room. The mental Services was observed comforter tied in a plastic bag and a stool odor was present, was still eating her lunch in 1/10/11 at 1:55 PM, with the inf Nursing (ADON) she making rounds this morning 0:00 AM and smelled a mild oming from Resident #4's cated she observed the inen bag in the bathroom. The prought a family member was	F 24	Britthaven acknown Statement of De this Plan of Corthe summary of correct and in o compliance with provisions of the residents. The submitted as a vector of De Correction does with the Statement of De Correction does with the Statement of the Deficient Britthaven reservof the Deficient Dispute Resolut procedures and administrative of the Statement of the Deficient Dispute Resolut procedures and administrative of the Statement of the Deficient Dispute Resolut procedures and administrative of the Statement of the Statement of the Deficient of the	rection to the exterior to maintain happlicable rules e quality of care of Plan of Correction written allegation written allegation it thaven's responsificiencies and Plan of Deficiencies and Plan of Deficiencies and Plan of Deficiencies and Plan of Hamber of Deficiencies and Plan of Grant denote agree ent of Deficiencies and Plan of Hamber of	oposes ent that ally and of is of se to this an of ment es nor curther, efute any mal al g. ified on bedspread coom 139 vas tray on blated 44.  I ealed no the	5/10/11
		nought a family member was	MYLIDE		1) Daily rounds a	ıd	(X6) DATE
LABUKATURY	LDIKECTOK'S OK PROVIL	ER/SUPPLIER REPRESENTATIVE'S SIGN	₩ I UKE	TITLE	-	_	MOUNTE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing 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.

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PRINTED: 05/24/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDE			A. BUILDING  B. WING			C 05/11/2011	
NAME OF D	POVIDER OR SUPPLIER	345448		·	EET ADDRESS, CITY, STATE, ZIP CODE	05/11	/2011
NAME OF PROVIDER OR SUPPLIER  MAPLE GROVE HEALTH AND REHABILITATION CENTER				30	08 WEST MEADOWVIEW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX 3	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL		F	241		rs and ed er was elling ers and ed elling ers and ed elling ers and ed ellistaff eey the are trash ed ellistaff. Nursing. eetings 5/20/22, 23 ectober results repeated	5/31/11 5/25/11 5/26/11 5/26/11 6/2/11
	Aide (MA) #1 reve	11 at 10:30 AM, with Medication aled on 5/7/11 (Saturday) the edium amount of darkish-black indicated "I put the comforter					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345448	B. WING			C 05/11/2011			
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETION DATE			
F 241 F 252 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 in a plastic bag and tied it up (after incontinent care for stool was provided). I placed the comforter in the bathroom under the sink, as directed by the family member. I asked the family member if she wanted me to wash it but she indicated she wanted the administrator to see it." MA #1 confirmed she observed the soiled comforter located in Resident #4's bathroom, underneath the sink on 5/8/11 (Sunday) between 9:00 AM-9:30 AM.  Interview on 5/11/11 at 12:05 PM, with the Director of Environmental Services and the administrator; he indicated he wanted to re-clarify his previous interview from 5/10/11 that the odor he smelled was that of an acidity odor that came from the toilet. He stated that happened from time to time throughout the building. He indicated, "I took the back of the toilet tank lid off, adjusted the water valve to apply pressure; due to the toilet was not flushing all the way (Did not indicate stool was present in the toilet). At that point, I flushed the toilet and put the lid back on. The linen bag (soiled comforter) located in the bathroom was taken to the soiled utility room and when I took the comforter out of the bag, is when I first smelled feces."  483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.			F 252  F252  The source of the odor was in 5/10/11 by the Asst. Nursing during her morning rounds a from a soiled bedspread in a the bathroom of Room 139 in Environmental Services was of the bag and it was remove found. This was an isolated		ector ming bag in 1. le aware nen it was			
	This REQUIREMEN	NT is not met as evidenced			found. This was an isolated incic affecting Room 139 North.	lent only			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2011 FORM APPROVED OMB NO. 0938-0391

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 05/11/2011	
NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AN	ID REHABILITATION CENTER		30	EET ADDRESS, CITY, STATE, ZIP CODE 88 WEST MEADOWVIEW ROAD REENSBORO, NC 27406		
PREFIX (EACH DEFICIENT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMP	
interview and staff maintain a bathrodue to soiled liner bathrooms (RM # Findings included Observation on 5/ revealed a mild st #139. When the bathroom revealed by the bathroom was conducted by the bathroom to the	ations, record review, family f interviews, the facility failed to om that was free of foul odor, of for 1 of 1 observed resident's 139).  10/11 at 10:00 AM (during tour) ool odor upon entry into room athroom door was opened a fused from the bathroom, sident's room. Observation of ealed a comforter in a tied under the sink in the bathroom. erved in the bathroom toilet. epartment Head Rounds Sheet) shift) revealed a departmental eted on 5/9/11 (Monday) at 4:55 from was documented as clean, 11 at 10:30 AM, a family present in room #139 indicated er was placed in the bathroom ay) by Medication Aide (MA) #1. et as the informed Nurse #1 and rector of Nursing) on call 5/7/11 et comforter had stool on it and to take it home to wash it. 10/11 at 12:00 Noon, the soiled ed to be in the bathroom had tied in a plastic bag. 10/11 at 1:53 PM, the Director Services removed the soiled at plastic bag from the bathroom	F 2	252	A facility-wide inspection by the Administrator and Environmental Services Director on 5/10/11 revother foul odors that would have potential to be a dignity issue.  Measures put into place to elimin potential for dignity issues arising foul odors include: 1) Daily roun housekeeping inspections made in building (rooms, bathrooms and lithe Housekeeping, Nursing and Management staff to identify odo treat/eliminate them, implemente 5/13/11 and is on-going. 2) Lette sent to families who do laundry to them to purchase closed lid hamp pick up dirty laundry often, mail 5/25/11, and 3) An in-service to a was given on what to do when the encounter bm/urine soiled clothing/personal belongings and timely removal of incontinence carelated trash/linen from the reside room, completed 5/26/11.  Results of daily rounds will be revely the Administrator, Environmer Services Director and Director of Weekly Quality Improvement Mewill be held for 4 weeks (5/13/11, 5/26/11 and 6/2/11), monthly for months (June, July and August 2011) and quarterly (July 2011, Oc 2011 and ongoing) to discuss the roof rounds to identify any trends, deficient areas and successfulness interventions.	ate the g from ds and a the halls) by rs and ed er was celling ers and ed ell staff ey the are ent viewed hall Nursing. eetings 5/20/22, 3 ctober results repeated	5/10/11 5/26/11 5/26/11 6/2/11

DEPARTMENT OF HEALTH-AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE		
<del>-</del> .		345448	B. WIN	G		1	1/2011	
WAME OF PROVIDER OR SUPPLIER  MAPLE GROVE HEALTH AND REHABILITATION CENTER			,	30	EET ADDRESS, CITY, STATE, ZIP CODE 08 WEST MEADOWVIEW ROAD REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 252	Assistant Director of she expected staff area to be washed. family member did expectation was the remove soiled linen wash dirty linen appelaborated she was (5/10/11) around 10 unpleasant odor; or indicated she obserlinen bag in the batt thought a family me home to wash. She talked with houseke because she thoug cleaned. Interview on 5/10/1 of Environmental Silinen bag in the batt AM-900 AM, when and smelled an odo pleasant. He indica coming from the toi ADON why was line elaborated the liner have been left in the somebody from the have notified the enfurther stated he ob the comforter, when the plastic bag in the concluded the smeated been present on the days ago. The environment of the days ago.	ge 4  If Nursing (ADON) revealed to take soiled linen to the utility. She further indicated if a the resident's laundry, the at staff was expected to from the resident's room and propriately. The ADON amaking rounds this morning DAM and smelled a mild oming from the bathroom. She was the comforter tied in a shroom. The ADON stated she ember was going to take it concluded she went and beging (environmental director) that the bathroom needed to be a saw the proom on 5/10/11 around 8:30 the opened the bathroom door or that was mild and not ted he thought the odor was let. He stated he asked the en in the bathroom. He is (soiled comforter) should not be bathroom and that the nursing department should experted dark-brown smears on the took the comforter out of the soiled utility area. He are appeared as if they had a comforter from at least 3 commental director confirmed comforter in the plastic bag on smears and an unpleasant from the plastic bag.	F 2					

PRINTED: 05/24/2011

PRINTED: 05/24/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 345448 05/11/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD MAPLE GROVE HEALTH AND REHABILITATION CENTER GREENSBORO, NC 27406 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 252 | Continued From page 5 F 252 indicated nothing had been brought to his attention until today (5/10/11), regarding the soiled comforter. Interview on 5/10/11 at 4:15 PM, with the ADON she indicated departmental rounds were not conducted during the weekend. Interview on 5/10/11 at 4:40 PM, with the Staff Development Coordinator she stated "Soiled linen needed to be bagged and sealed and taken to the linen room and housekeeping was responsible thereafter. If family did laundry and a small amount of stool/urine was present on the item. staff should take the item to the soiled utility room in a bag, rinse and re-bag. Soiled linen should not be left in a resident's room because it will stain the garment and have an odor, due to a body fluid." Interview on 5/10/11 at 5:10 PM, with the Director of Nursing (DON) she indicated she expected the soiled linen (comforter) not to be left in the resident's room due to it was dirty. Interview on 5/11/11 at 10:30 AM, with MA #1 revealed on 5/7/11 (Saturday) the comforter had a medium amount of darkish-black stool present. She indicated "I put the comforter in a plastic bag and tied it up (after incontinent care for stool was provided). I placed the comforter in the bathroom

under the sink, as directed by the family member. I asked the family member if she wanted me to wash it but she indicated she wanted the administrator to see it." MA #1 confirmed she observed the soiled comforter located in room #139 bathroom, underneath the sink on 5/8/11

(Sunday) between 9:00 AM-9:30 AM. Interview on 5/11/11 at 12:05 PM, with the Director of Environmental Services and the administrator; he indicated he wanted to re-clarify his previous interview from 5/10/11 that the odor

## PRINTED. USIZ4IZUTT DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A, BUILDING B. WING 345448 05/11/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD MAPLE GROVE HEALTH AND REHABILITATION CENTER GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 252 Continued From page 6 F 252 he smelled was that of an acidity odor that came from the toilet. He stated that happened from time to time throughout the building. He indicated, "I took the back of the toilet tank lid off, adjusted the water valve to apply pressure; due to the toilet was not flushing all the way (Did not indicate stool was present in the toilet). At that point, I flushed the toilet and put the lid back on. The linen bag (soiled comforter) located in the bathroom was taken to the soiled utility room and when I took the comforter out of the bag, is when I first smelled feces." Interview on 5/11/11 at 12:10 PM, with the Administrator revealed she expected the bag of linen (comforter) not to be left in the bathroom due to an odor and infection control issues. She elaborated, "We are in the process of in-servicing the staff that linen with stool should be cleaned - 3-, 4 with a wet wipe and bagged up. Staff choices are to wash or take to the laundry, put in a bag, wash and put back into the dirty hamper."