PRINTED: 09/21/2015 FORM APPROVED OMB NO. 0938-0391

AND DIAN OF CORRECTION IN INDENTIFICATION NUMBER:		` '	, , ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345448	B. WING		C 08/20/2015	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2010	
MAPLE GI	ROVE HEALTH AND REF	ABILITATION CENTER		308 WEST MEADOWVIEW ROAD 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	INITIAL COMMENTS		F 000			
F 242 SS=D	no deficiencies as a r investigation. Event #	vas conducted. There were esult of the complaint	F 242		9/9/15	
	schedules, and health her interests, assessr interact with members inside and outside the	right to choose activities, in care consistent with his or ments, and plans of care; is of the community both a facility; and make choices or her life in the facility that resident.				
	by: Based on family and reviews the facility fai choice for 1 of 3 samples same same same same same same same sa	riginally admitted to the diagnoses which included: dent with left sided ary Parkinsonism, anxiety ess, dementia with es, hyperlipidemia, epilepsy, n, and psychosis.		F242 Resident # 190 received a shower on August 20, 2015. Resident is schedule to receive a minimum of two showers every week; in the evenings, every Monday and Thursday. On Monday August 24,2015 and Monday August 31,2015 administrator met with resider #190s wife and was informed by wife the resident is receiving shower twice a weand is pleased with care resident is receiving at the facility. On 8/20/2015 the DON began reeducating nursing staff to include: licenses nurses, C.N.As and medication aides on the following: 1) Residents should be receiving showers twice a weather the state of the second state of the second showers the s	t nat eek	
ADODATORY		Dated 6/18/15, Indicated SUPPLIER REPRESENTATIVE'S SIGNATURE	=	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

09/09/2015

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:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345448	B. WING _			0;	8/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				30	08 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER		G	REENSBORO, NC 27406			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 242	Continued From p	page 1	F 2	242				
	Resident #190 wa	as severely cognitively impaired			and as needed per the shower schedu	le		
	with no behaviors	and was totally dependent on			unless a specific schedule had been			
	staff for his perso	nal hygiene and bathing. The			developed for them. 2) If a resident			
	resident's Care P	an revealed he required			refuses a shower the primary nurse mi	ust		
	assistance with th	e potential to restore or			be notified immediately. 3) The type of	:		
	maintain maximui	m function of self-sufficiency for			bath and any refusals must be			
	bathing related to	his cognitive impairment,			documented in POC and on shower			
		Interventions included:			schedule. The reeducation was			
	1	, patient manner; break tasks			completed on 9/7/15.			
		ve steps one at a time to avoid						
	overwhelming the	resident.			A Shower Schedule Audit Tool was			
					initiated on September 3, 2015 to mon			
		ility's records revealed Resident			that showers are being given per show			
		led to receive his showers			schedule and documentation is comple			
	during second shi	ft on Mondays and Thursdays.			in POC. The Shower Schedule Audit			
		. /A (* ''			will be completed for 10% of residents			
		L (Activities of Daily Living) Flow			the DON, ADON, and staff facilitator 4	Х		
		nt #190 dated from 7/21/15			week x 4 weeks, then 2 x week x 8			
	_	ndicated Resident #190 did not			weeks, then 1 x week x 12 weeks. On	ı		
		as scheduled on: 7/23/15,			September 3, 2015 the administrator in-serviced DON, ADON, and staff			
	8/6/15, 8/10/15, a	110 0/17/13.			facilitator on completing the Shower			
	Facility records re	evealed Resident #190 was out			Schedule Audit Tool. The QI committ	100		
		eave with family on			consist of administrator, DON, ADON,	,00		
	1	nd 8/2/15-8/4/15. Further			and staff facilitator will meet weekly x 8	8		
		Flow sheets revealed Resident			weeks, then every other week x 8 wee			
		shower on Tuesday, 7/21/15 and			then monthly x 2 months. Any	ito,		
		but received a full bath on			inconsistencies will be immediately			
		There was no documentation in			reported to the administrator for possib	ole		
		nical record or the facility 's			modification of quality improvement	_		
		the resident refused a shower			monitoring process.			
	_	ne reviewed time period			.			
	(7/21/15-8/19/15)	·			The Executive Committee will meet			
	,				quarterly x 2 quarters to discuss quality	y		
	On 8/18/15 at 10:	30am, Resident #190 was			improvement process and evaluate			
	observed in a who	eelchair in front of nursing			effectiveness of residents receiving			
	station. The resid	ent appeared clean and well			showers twice a week.			
	groomed, dressed	for the day. The resident was			Recommendations to continue, alter or	r		
	nonverbal and ca				modify will be discussed at this time.	Γhe		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345448	B. WING		C		
NAME OF DE	ROVIDER OR SUPPLIER	343440		STREET ADDRESS, CITY, STATE, ZIP CODE	08/2	0/2015	
NAME OF F	OVIDER OR SUFFLIER			308 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND REF	IABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 242	resident's RP (Respo routine was to arrive a to Resident #190's lui between 2:00p-2:30p close to the resident's the resident until 8:00 resident was to receive showers every week; Monday and Thursda assistants frequently a scheduled shower un request.	n 8/18/15 at 1:52pm, the nsible Party) stated that her at the facility everyday close nch time; leave the facility then return to the facility dinnertime, and stay with pm. The RP revealed the	F 24	Executive Committee consist of: med director, administrator, DON, pharma consultant, dietary manager, activities director and medical record director.	су		
	(Staff Nurse) confirmed #190's scheduled shot and Thursdays during reviewing the "NA (nurse) where the NA daily as schedule sheets were acknowledged that the sheets for the following Resident #190: 8/3/15	ed that Resident over days were Mondays a second shift. After rsing assistant) Book" esignments and shower emaintained, SN#1 ere were only shower g days in August 2015 for 5, 8/13/15, and 8/17/15 e, indicating the resident did					
F 248 SS=D	taking a shower every take a bath. 483.15(f)(1) ACTIVITI INTERESTS/NEEDS The facility must prov	aled that prior to his ty, Resident #190 preferred day; but, would sometimes	F 24	18	Ş	9/9/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345448	B. WING			C 8/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	0.07.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•	0/20/2015	
TO THE OT THE	NOVIDEN ON OUT FIELD			308 WEST MEADOWVIEW ROAD	<i>,</i> 552		
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 248	· ·	page 3 re assessment, the interests and tal, and psychosocial well-being	F 24	18			
	by: Based on observ interviews, and re			F- 248 Resident 150 was re assess determine need for 1:1 visits reassessed for the types of resident showed interest. At activity aide to visit and encompared and encompar	activities the rrange for courage		
	facility on 4/18/13 diagnoses which tracheostomy, chi contractures, atte kidney disease st muscle weakness Review of the Act dated 6/17/15 ind interested and pa included: Bingo, s	ivity Progress (Interests) Sheet icated Resident #150 was rticipated in Activities which cocials at times with wife in		resident to observe or designous assist resident in planning leactivities. Encourage reside leisure-t time activities. Engurous activities. Give reside reminders of activity before commencement of activity of activities for resident to surpost personal activity schedules resident is room. Provide surindependent activities of resident activities activitie	eisure- time ent to plan own lage resident in ent verbal Offer schedule elect choices. dule in upplies for sident choice cordingly.		
	and pet therapy. also provided, and activities he could The review of the (minimum data se Resident #150 ha with no behaviors assessment refer	y and friends visits; television; In-room activities/projects were d the resident assisted with I pursue independently. most recent quarterly MDS et) dated 6/19/15 indicated d moderately impaired cognition or moods. Also, for the ence period, the MDS coded amotion as activities that did not		A 100% audit was complete 21, 2015 for all residents the been affected. Updated doc and care plans completed o residents. Activities Director in service Administrator and Activities serviced by the Activities Di ensure 100% of staff partici in-service consist of all resid assessed appropriately to d	at could have cumentation on identified ed by the staff in rector to pation. The dents will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _				20/2015	
NAME OF PR	ROVIDER OR SUPPLIER	L	'	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20,2010	
				30	08 WEST MEADOWVIEW ROAD			
MAPLE GI	ROVE HEALTH AND RI	EHABILITATION CENTER			REENSBORO, 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 SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 248	indicated an alterati recreation character involvement, lack of impaired mobility, in (expressive aphasia accident, tracheostic and the resident's conterventions include leisure-time activities activities; post personactivities of resident choice in regard to I resident to activities health-related equipates the activities of resident to activities health-related equipates to the commentation #150 received one-in any group activities 8/20/15; with the exon 5/24/15. During an observation 4:28pm, Resident #150 the head of the bed The resident also he feeding tube in place resident's bed was a resident was alert a speak very softly and questions. Resident	re Plan dated 6/26/15 on in supervised/organized rized by little or no f attendance related to npaired communication a), a history of cerebrovascular omy and gastrostomy tube, hoice. The documented ed: assist resident in planning as; engage resident in group onal activity schedule in vide supplies for independent r's choice; respect resident's imited/no activities; transport a; assist in transporting any oment to activities. Vity Attendance Reports or any n indicating Resident con-one Activity or participated es from 5/25/15 through ception of a religious activity on and interview on 8/18/15 at 150 was observed in bed with up approximately 40 degrees. and a tracheostomy and e. Next to the left side of the an electric wheelchair. The and oriented; was able to and nod his head in response to a #150 indicated that no one	F 2	248	need for 1:1 visits. What determines the need for 1:1 visits; physical and medical condition, unable to be out of bed, men condition, resident choice, change in condition etc. The in service was completed on August 24, 2015 New residents will be assessed accord to regulations, other residents will be assessed quarterly and or as needed. New residents identified as requiring 1: visits will be added to the report for monitoring. A Quality Improvement tool was initiate for 1:1 attendance records to be review. The tool will be utilized bi- weekly to monitor accuracy, and compliance of 1 visits. Activities Director or designee will mon Quality Improvement tool biweekly X8 weeks, then weekly X 8 weeks, then every other week X 2 weeks, then monthly X2 and report weekly to the Quality Improvement Committee. This committee consist of Activities Director Assistant Activities Director, Dietary manager, Director of Nursing, Assistan Director of Nursing and Medical Record Director. The Quality Improvement Committee will meet weekly X8 weeks then every other week X 8 weeks, then monthly X 2 months. Any inconsistency will be immediately reported to the	ing 1 d ved. :1 itor		
	to attend any group aware of any. The re had ever visited him	ever asked him if he wanted activities and he was not esident also indicated no one in from Activities. An Activity ved on the wall located			Administrator for possible modification quality improvement monitoring proces The Executive Committee will convene quarterly X 2 quarters to discuss quality improvement process and evaluate	S.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DATE COMF	SURVEY PLETED
		345448	B. WING _			l	C 20/2015
	ROVIDER OR SUPPLIER	HABILITATION CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 08 WEST MEADOWVIEW ROAD REENSBORO, NC 27406	1 00/	20/2010
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312 SS=D	approximately two fer resident's bed. The reprint on the Activity Caccessible to him, he decision whether to a Activities. When aske (which were observed approximately 2:00pr resident replied with a "no". During an interview of Activity Director indic #150 used to receive staff; then with the rap be out of bed in his e stated that the Activity resident to encourage out of room activities. resident usually only when his wife was in resident's family visite acknowledged that the read the Activity Cale wall along the right si resident's wife prefer current location. She Therapy Group that verification. She also acknowledged that the Activity Cale wall along the right si resident's wife prefer current location. She Therapy Group that verification. She also acknown. 483.25(a)(3) ADL CADEPENDENT RESIDENT R	et from the right side of the esident indicated that if the alendar was larger and would like to make the ittend any of the group ed if the Pet Therapy group dentering the facility in that day) visited him, the a shake of his head and said in 8/20/15 at 10:50am, the attendance and that Resident one-on-one with Activity by, the resident was able to lectric wheelchair. She y staff would visit the entered that the attended group activities attendance and that the ed him everyday. She he resident was unable to ndar that was taped on his de of his bed; but the red the calendar in its' also revealed that the Pet was observed on 8/18/15 at ne-on-one visits in residents' nowledged that Resident riented, and able to make		312	effectiveness of 1:1 visits. Recommendations to continue, alter or modify will be discussed at that time. The executive Committee consist of; Medical Director, Administrator, Director of Nursing, Pharmacy consultant, Dietarnanager, activities director and medicarecord director.	or ary	9/9/15

			(X3) DATE SURVEY COMPLETED		
		345448	B. WING		08/20/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2013
				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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 312	Continued From page	e 6	F 312	2	
	and oral hygiene.				
	by: Based on family and reviews the facility fa	r is not met as evidenced staff interviews, and record iled to provide showers and o 1 of 3 sampled residents		F 312 Resident # 190 received a shower or	
		nce with personal hygiene.		August 20, 2015. Resident has recei a shower or bed bath daily since Aug 20, 2015. Resident is scheduled to	ved ust
	Findings included:			receive a minimum of two showers every week; in the evenings, every Monday Thursday. If it is not a scheduled shows the state of the st	and
	facility on 5/13/15 wit cerebrovascular acci- hemiparesis, second state, muscle weakne	ary Parkinsonism, anxiety ess, dementia with ces, hyperlipidemia, epilepsy,		day, resident will receive a bed bath of a confidence of the confi	ator s kay, ıld
	(Minimum Data Set) Resident #190 was s with no behaviors an staff for his personal resident's Care Plan	•		reeducating nursing staff-licensed nu C.N.As and medication aides on the following: 1) Residents should be receiving showers twice a week and a needed per the shower schedule unless specific schedule had been developed them. 2) If a resident refuses a shower the primary purse must be petified.	as ess a d for
	bathing related to his impaired mobility. Int approach in calm, pa into segments, give s overwhelming the res	unction of self-sufficiency for cognitive impairment, erventions included: tient manner; break tasks steps one at a time to avoid sident.		the primary nurse must be notified immediately. 3) The type of bath and refusals must be documented in POC on shower schedule. 4) Personal grooming is important for a positive self-image and every effort should be made to encourage and assist reside to maintain a pleasing and attractive	Cand
	-	s records revealed Resident to receive his showers		appearance. The reeducation was completed on 9-7-15. On 9-2-20	15

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	I' '		E SURVEY IPLETED
		345448	B. WING		01	C 3/20/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		720/2010
				308 WEST MEADOWVIEW ROAD		
MAPLE G	ROVE HEALTH AND RE	EHABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 312	Continued From pag	ge 7	F 3	12		
		on Mondays and Thursdays.		ADON began reeducating nurs	sing staff on	
		, ,		the following: 1) All residents		
	Review of the ADL (Activities of Daily Living) Flow		dependent residents should re	-	
		#190 dated from 7/21/15		bath at least daily, if it is not a		
	through 8/19/15 indi	cated Resident #190 did not		shower day. 2) If the resident	refuses an	
		scheduled on 7/23/15,		ADL task the primary nurse mu		
		8/17/15. The Flow sheets		notified immediately. 3) A res		
		esident did not receive a bath		unable to carry out assistance		
		, 8/1/15, 8/2/15, 8/7/15, -		including eating, grooming, ba		
	8/15/15, and 8/16/1	D.		personal/oral hygiene a staff m		
	Facility records rove	soled Desident #100 was out		must assist resident to comple		
	of the facility on Lea	ealed Resident #190 was out		task. The reeducation was co	•	
	•	1 8/2/15-8/4/15. Further		9-7-14 With 100% of hursing si	laii.	
		low sheets revealed Resident		On 9-2-15 a 100% audit was o	ompleted:	
		ower on Tuesday, 7/21/15 and		on all dependent residents usi	-	
		it received a full bath on		¿ADL Care Audit Tool for Depe	•	
	Monday, 8/10/15.			Residents. All negative finding immediately.		
	There was no docur	mentation in the resident's		A Shower Schedule Audit Tool	was	
		facility's records indicating		initiated on September 3, 2015	to monitor	
		a shower or a bath during		that showers are being given p		
		eriod (7/21/15-8/19/15). There		schedule and documentation is		
		ion indicating a reason for a		in POC. The Shower Schedul		
	change in bathing ty	/pe.		will be completed for 10% of re	-	
	On 0/10/15 at 10:20	om Dooidont #100 was		the DON, ADON, and staff fac		
		am, Resident #190 was Ichair in front of nursing		week x 4 weeks, then 2 x week weeks, then 1 x week x 12 week		
		t appeared clean and well		ADL Care Audit Tool for Deper		
		or the day. The resident was		Residents was initiated on Seg		
	nonverbal and calm			2015 to monitor that depender		
				will receive ADL care to mainta		
	During an interview	on 8/18/15 at 1:52pm, the		nutrition, grooming and persor	-	
		onsible Party) stated that her		hygiene. On September 3, 20		
	routine was to arrive	e at the facility everyday close		administrator in-serviced DON	, ADON,	
	to Resident #190 's	lunch time; leave the facility		and staff facilitator on complet		
		p; then return to the facility		¿Shower Schedule Audit Tool		
		t's dinnertime, and stay with		Care Audit Tool for Dependent		
	the resident until 8:0	00pm. The RP revealed the		The ADL Care Audit Tool for D	ependent	

Facility ID: 923456

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345448	B. WING _		08	C 3/ 20/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		720/2013	
				308 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER		GREENSBORO, NC 27406			
(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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 312	showers every week Monday and Thursday. The RP strequently failed to g scheduled shower unrequest. The RP revher concerns with Reduring the resident's Meeting. During an interview of (Staff Nurse) confirms scheduled shower downward thursdays during set the "NA (nursing assignments and were maintained, SN were only shower shaugust 2015 for Resand 8/17/15 which were idented to the total the beginning Charge Nurses would their "Daily Assignments" were responsible for shower sheets. If a rethe nursing assistant	ive a minimum of two ; in the evenings, every sated the nursing assistants ive the resident his nless she (RP) made the ealed that she has discussed esident #190's ADL care	F3		ed for 2 ach hall by the cilitator 4 x week x 8 weeks, then QI committee ON, ADON, et weekly x 8 reek x 8 weeks, Any nediately		
	refusal on his/her co sheet. During an interview of (nursing assistant) s #190 required total a bathing. She revealed	py of the "Shower Schedule" on 8/19/15 at 3:00pm, NA#1 tated that Resident assistance of one person with d that the resident received a he (NA#1) documented as					

AND DI AN OF COPPECTION IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
		345448	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		8/20/2015
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 312	revealed that eve work with Resident she and another is switched resident Resident #190). In resident assign documented on the Sheet because so have different Chat when she woresponsibility was week and documented that when shower days windicated that who cooperative with its shower days windicated that who cooperative with its shower, then reported the full bath; but the record to docume uncooperative. During an interview revealed that she #190 for approximate that the resident resident residents their she shower Sheet that Nurse. NA#3 reversidents the sident reversidents their she shower Sheet that Nurse. NA#3 reversidents the resident reversidents their she shower Sheet that Nurse. NA#3 reversidents the resident reversidents their she shower Sheet that Nurse. NA#3 reversidents the residents the reversidents the reversidents the reversidents their she shower Sheet that Nurse. NA#3 reversidents the residents the reversidents the reversident the reversidents t	ew on 8/19/15 at 3:26pm, NA#2 In though she was scheduled to at #190, she had not worked since late July 2015 because nursing assistant (NA#3) Is (NA#3 preferred working with NA#2 indicated that this change ments was not usually ne Nursing Assistant Assignment ometimes she and NA#3 would arge Nurses. NA#2 revealed rked Resident #190, part of her is giving him a shower twice a cent each shower (she thought were Tuesday and Friday). NA#2 renever the resident was not transferring to the shower chair, in a full bed bath instead of a cent the resident's behavior to the smediately. The ADL Flow record indicating the resident received there was no area on the Flow int the resident being It wo on 8/19/15 at 3:46pm, NA#3 had been working with Resident nately two months. NA#3 stated required total assistance with ved a shower every Thursday NA#3 indicated that she gave owers as scheduled on the at she obtained from the Charge realed that all nursing assistants	F3	312		
	Nurse. NA#3 reve were given a copy showed all room a that were due for	•				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		COM		DATE SURVEY COMPLETED
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	HABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406	'	05/20/20 10
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making transfer she would give he resident's RF with resident und document the DL Flow record on for the changed then report the 25(d) NO CATH TORE BLADDE and on the resident who enters elling catheter is ent's clinical content and service trical content and service to a special content and service to the content and service	ring to shower chair difficult, the resident a full bed bath P's request (the RP would til 8:00pm every night). NA#3 change of bathing type on , but did not record the ge. NA#3 indicated that she e change to the nurse. ETER, PREVENT UTI, R Int's comprehensive slity must ensure that a the facility without an a not catheterized unless the indition demonstrates that in ecessary; and a resident is bladder receives appropriate es to prevent urinary tract tore as much normal bladder. T is not met as evidenced view and staff interviews, the cut and send a urinalysis with y for 1 of 1 (Resident #144) is ordered by the physician. Admitted to the facility on a cative diagnoses of dementia, rostate without obstruction, inission Minimum Data Set 15 revealed Resident #144		F 315 On August 20, 2015 resident # sent to the ED for evaluation. U obtained at hospital. On August 26, 2015 a 100% la completed by the ADON, and phlebotomist using the daily ce no negative findings. On, September 3, 2015 the DO and staff facilitator began reed	Jrinalysis b audit was ensus with DN, ADON ucating	9/9/15
E III I I I I I I I I I I I I I I I I I	SUMMARY S' (EACH DEFICIENC REGULATORY OR inued From pag making transfer she would give he resident's RF with resident un d document the ADL Flow record on for the chang d then report the 25(d) NO CATH TORE BLADDE ed on the reside ssment, the faci lent who enters elling catheter is lent's clinical con eterization was r is incontinent of ment and service tions and to resident and service tion as possible. REQUIREMEN' ed on record revertions and to resident and sensitivity pled residents and ings included: dent #144 was and 3/15 with cumula retrophy of the proposition of the	IDENTIFICATION NUMBER: 345448 R OR SUPPLIER HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) inued From page 10 making transferring to shower chair difficult, she would give the resident a full bed bath he resident's RP's request (the RP would with resident until 8:00pm every night). NA#3 d document the change of bathing type on NDL Flow record, but did not record the on for the change. NA#3 indicated that she d then report the change to the nurse. 25(d) NO CATHETER, PREVENT UTI, TORE BLADDER and on the resident's comprehensive syment, the facility must ensure that a lent who enters the facility without an elling catheter is not catheterized unless the lent's clinical condition demonstrates that elerization was necessary; and a resident is incontinent of bladder receives appropriate ment and services to prevent urinary tract tions and to restore as much normal bladder rion as possible. REQUIREMENT is not met as evidenced ed on record review and staff interviews, the ty failed to collect and send a urinalysis with re and sensitivity for 1 of 1 (Resident #144) oled residents as ordered by the physician. Ings included: dent #144 was admitted to the facility on 3/15 with cumulative diagnoses of dementia, artrophy of the prostate without obstruction,	R OR SUPPLIER HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) inued From page 10 making transferring to shower chair difficult, she would give the resident a full bed bath he resident's RP's request (the RP would with resident until 8:00pm every night). NA#3 d document the change of bathing type on ODL Flow record, but did not record the on for the change. 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REQUIREMENT is not met as evidenced ed on record review and staff interviews, the ty failed to collect and send a urinalysis with re and sensitivity for 1 of 1 (Resident #144) oled residents as ordered by the physician. ings included: dent #144 was admitted to the facility on 3/15 with cumulative diagnoses of dementia, rtrophy of the prostate without obstruction, psychosis. dent #144's Admission Minimum Data Set S) dated 07/19/15 revealed Resident #144 short and long term memory problems and	A BUILDING 345448 R OR SUPPLIER HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Inued From page 10 making transferring to shower chair difficult, she would give the resident a full bed bath her resident's RP's request (the RP would with resident until 8:00pm every night). NA#3 d document the change of bathing type on DL Flow record, but did not record the on for the change. NA#3 indicated that she d then report the change to the nurse. 25(d) NO CATHETER, PREVENT UTI, TORE BLADDER ad on the resident's comprehensive sament, the facility without an elling catheter is not catheterized unless the tent's clinical condition demonstrates that eterization was necessary; and a resident is incontinent of bladder receives appropriate ment and services to prevent urinary tract tions and to restore as much normal bladder iton as possible. REQUIREMENT is not met as evidenced ed on record review and staff interviews, the ty falled to collect and send a urinalysis with re and sensitivity for 1 of 1 (Resident #1444) soled residents as ordered by the physician. ngs included: deet mit 444 was admitted to the facility on 3/15 with cumulative diagnoses of dementia, rtrophy of the prostate without obstruction, psychosis. On August 26, 2015 a 100% la completed by the ADON, and philebotomist using the daily ce no negative findings. On, September 3, 2015 the DC and staff facilitator began read licensed nurses on the followin	A BUILDING 345448 R OR SUPPLIER HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFOILENCY) SUMMARY STATEMENT OF DEFICIENCY FRETX FOR EACH DORPOSED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE F 312 F 312 F 312 F 312 F 315 GN ON CATHETER, PREVENT UTI, F 315 TORE BLADDER and on the resident's comprehensive sament, the facility must ensure that a entry who enters the facility without an elling catheter is not catheterized unless the ent's clinical condition demonstrates that atent who enters the facility without an elling catheter is not catheterized unless the ent's clinical condition demonstrates that atent who enters the facility without an elling catheter is not catheterized unless the ent's clinical condition demonstrates that atent who enters the facility without an elling catheter is not catheterized unless the ent's clinical condition demonstrates that atent who enters the facility without an elling catheter is not catheterized unless the ent's clinical condition demonstrates that atent who enters the facility without an elling catheter is not catheterized unless the ent's clinical condition demonstrates that atent who enters the facility without an elling catheter is not catheterized unless the ent's clinical condition demonstrates that atent who enters the facility without an elling catheter is not cathet

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F 315	Continued From page	age 11	F3	15		
F 315	making. Resident of urine. Review of the Nurse of Nurse of the Phy o8/09/15 showed a urinalysis with cult to determine a urin blood count, and a panel. Review of the lab of the complete blood metabolic panel with the complete blood metabolic panel with order of the lab of the complete blood metabolic panel with the result and sensitivity. She call to the nurse will and sensitivity. She call to the nurse will be tests but the nurse will be and they had nurinalysis with cult #144 as requested in an interview on Director of Nursing the nurse would fill	#144 was frequently incontinent sing Progress Notes dated Resident #144 was noted to be and sleeping through meals. ner (NP) was notified and	F 3	the laboratory slip must be the licensed nurse .2) Urin and sensitivity orders show separate laboratory sheet draw sheet to eliminate mi culture and sensitivity. 3) responsible for obtaining a culture and sensitivity and laboratory test ordered by education was completed. MD orders will be reviewed morning meeting using pin slips to validate all labs ha obtained per MD orders. Tool was initiated on Sep to monitor that labs are be per MD orders. The ¿Lab be completed by the DON staff facilitator 5 x week x x week x 8 weeks, then 1 x weeks. On, September 3 administrator in-serviced the ADON, staff facilitator, and on completing the ¿Lab Lo QI committee consist of ac DON, ADON, and staff facilitator, and on the weekly x 8 weeks, the mormonths. Any inconsistence immediately reported to the for possible modification of improvement monitoring possible modification of improvement process and effectiveness of residents showers twice a week. Recommendations to continudify will be discussed as	alysis/culture ald be put on a from A blood ssed urinalysis / Nurses are all urinalysis / any stat doctor. The re 9/4/2015 d during ak MD order ve been A ¿Lab Log tember 4, 2015 ing obtained Log Tool ¿ will , ADON, and/or 4 weeks, then 3 x week x 12 , 2015 the ne DON, a phlebotomist og Tool ¿. The dministrator, illitator and will en every other atthly x 2 ies will be e administrator f quality rocess. will meet scuss quality evaluate receiving inue, alter or	

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, 0				GREENSBORO, NC 27406				
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F 315	Continued From page	e 12	F3	Executive Committee con director, administrator, DC consultant, dietary manag director and medical record 0% lab audit was complet ADON, and phlebotomist census with no negative fit MD orders will be reviewed morning meeting using pit slips to validate all labs has obtained per MD orders. was initiated on September monitor that labs are being MD orders. The Lab Log completed by the DON, A staff facilitator 5 x week x x week x 8 weeks, then 1 weeks. On, September 3 administrator in-serviced the ADON, staff facilitator, and on completing the Lab Log committee consist of administrator and the Lab Log committee consist of administrator weekly x 8 weeks, then ex x 8 weeks, then monthly x inconsistencies will be impreparted to the administration of quality impreparted to the admini	DN, pharmacy per, activities and director. The director will be using the dail indings. The director was been as Lab Log Ter 4, 2015 to gobtained per Tool will be DON, and/or 4 weeks, the x week x 12 and will meet the DON, and will meet wery other were a mediately where the director for possible provement are will meet the will meet the will meet the constant of the the DON, and the weeks are all the possible provement are will meet the will meet	dy Tool er n 3 st QI NN, et ek Any le		

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	ROVIDER OR SUPPLIER ROVE HEALTH AND REI	HABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 808 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406			
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F 315 F 332	Continued From page 483.25(m)(1) FREE 0 RATES OF 5% OR M	OF MEDICATION ERROR	F 315	director and medical record director.	9/9/15		
SS=D	The facility must ensi						
	by: Based on observation interviews the facility free of medication errichings included: The facility had a merfollowing the Medicate Observation and Recorders. 1. Resident #108 was on 07/24/12 with cumhemiplegia, anxiety of Resident #108's Qual (MDS) showed he was A medication administ Resident #108 by Meconducted on 08/19/1 typically used to decrestomach acid was adobservation. Review of the August revealed Resident #1 medication typically uproduction of acid in an empty stomach. In an interview on 08.	s re-admitted to the facility sulative diagnoses of isorder and hypertension. Interly Minimum Data Set as cognitively aware. Intration observation for edication Aide #2 was 15 at 9:20 AM. A medication ease the production of ministered during the 12015 Physician Orders 08 had orders for a listed to decrease the the stomach to be given on 149/15 at 2:00 PM tated Resident #108 had		F 332 On August 19, 2015 resident # 108 w immediately assessed by the ADON on negative findings. Resident # 108 not voice any complaints of discomfor QI report was completed for resident #108. MD notified on August 19, 201 medication error. On, August 19, 2015 an immediate in-service was completed by the DON the medication aide involved regardin medication administration. The DON ADON began reeducating all licensed nurses and medication aides on the following: 1) Review resident is MAR carefully before administering medica 2) All medications are to be administer according to physician is orders. 3) Anoted medication error warrants notification of physician to determine further orders are necessary. 4) Obsthe is Five Rights is of medication administration: right resident, drug, do route and time. The reeducation will completed by 9-4-15. On August 25, 2015 the DON, ADON staff facilitator initiated medication page	with did rt. 5 of I with ag , and did rt. Ition. ered Any if erve ose, be , and		

A BUILDING 345448 345448 375 AFEET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 [X41] ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG F 332 Continued From page 14 medication was administered and the medication should have been given before breakfast on an empty stomach. In an interview on 08/20/15 at 12:55 PM the Administrator stated it was her expectation that the facility medication error rate be below 5% and medications be given as ordered. 2. Resident #164 was re-admitted to the facility on 03/26/15 with cumulative diagnoses of diabetes, depression and a history of cataract extraction. Resident #164's Quarterly Minimum Data Set (MDS) showed he was cognitively aware. A medication administration observation for Resident #164 by Medication Aide #1 was conducted on 08/19/15 at 9:41 AM. No eye drops were administered to Resident #164. Review of the August 2015 Physician Orders revealed Resident #164 had orders for two different eye drops (used to treat dry eyes and corneal inflammation) to be administered four STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 RESIDENTIAL OF TABLES AND ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 REFIDENCE TO TABLE ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 REGUENSBORO, NC 27406 REGUENSBORO, NC 27406 REGUENSBORO, NC 27406 RECHNBORO REPROPRIVE CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 RECHNBORO REPROPRIVE ROTOS ADDRESS CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406 REGUENSBORO, NC 27406 REACH CORRECTIVE ACTION AND ADDRESS CITY, STATE, ZIP CODE 308 WEST MEADOWN AND ADDRESS CITY, STATE, ZIP CODE 308 WEST MEADOWN AND ADDRESS CITY, STATE, ZIP CODE 308 WEST MEADOWN AND ADDRESS CITY,
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revealed Resident #164 had orders for two different eye drops (used to treat dry eyes and before being assigned to work independently on a medication cart.
different eye drops (used to treat dry eyes and independently on a medication cart.
corneal inflammation) to be administered four The QI committee consist of
times each day. administrator, DON, ADON, and staff
In an interview on 08/19/15 at 1:55 PM facilitator will meet weekly x 8 weeks, then
Medication Aide #1 stated Resident #164 had every other week x 8 weeks, then monthly
been out of the facility on a leave of absence. She x 2 months to review all medication pass
indicated Resident #164 had returned to the audits completed. Any inconsistencies
facility on 08/17/15 but had not brought the eye will be immediately reported to the
drops back to the facility. Medication Aide #1 administrator for possible modification of
stated she had been initialing and circling the quality improvement monitoring process.
correct spaces on the Medication Administration The Executive Committee will meet
Record to signify the drops had not been quarterly x 2 quarters to discuss quality
administered. She indicated she had not informed improvement process and evaluate
the nurse, the pharmacy, or the physician that Posident #164 had not been receiving the even
Resident #164 had not been receiving the eye showers twice a week. drops. Recommendations to continue, alter or
drops. In an interview on 08/20/15 at 9:54 AM Nurse #2 Recommendations to continue, alter or modify will be discussed at this time. The
stated Resident #164 had been out of the facility Stated Resident #164 had been out of the facility Executive Committee consist of: medical
on a leave of absence. She stated a family director, administrator, DON, pharmacy
member brought Resident #164 back to the consultant, dietary manager, activities

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345448	B. WING _				C 20/2015	
NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		08 WEST MEADOWVIEW ROAD	08/20/2015		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 371 SS=E	Nurse #2 stated she or the pharmacy as s drops were not in the indicated the Medicar her the eye drops we indicated the eye drop not administered the In an interview on 08 administrator stated it he facility medication medications be given 483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and	hecked the resident back in. did not notify the physician he was not aware the eye medication cart. She ion Aides had not informed re not available. Nurse #2 ps were for cataracts and if condition could worsen. /20/15 at 12:55 PM the t was her expectation that n error rate be below 5% and as ordered. DCURE, ERVE - SANITARY		3371	director and medical record director.		9/9/15	
	by: Based on observation facility failed to ensur pans were cleaned a conditions. Findings included: During a meal tray limited.	ris not met as evidenced ns and staff interview the e 148-bowls and 11-cooking nd stored under sanitary e service in the kitchen on 148-small plastic bowls were			Maple Grove Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propose this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules a provisions of quality of care of resident Maple Grove Health and Rehabilitation Center response to this Statement of	es at nd s .		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345448 B. WING			C 08/20/2015			
NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER				30	TREET ADDRESS, CITY, STATE, ZIP CODE 08 WEST MEADOWVIEW ROAD REENSBORO, NC 27406	1 00/	20/2010
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
F 371	located across from revealed the bowls wonly and she probab Dietary Manager inforplastic bowls should During a kitchen obs 12:20pm of the ident cleaned and dried powere observed: 2 our contained brown debroasting pans were gout of 18 large sheet contained debris; and contained white and During an interview of Dietary Manager revelocity pots, po	et onto the preparation table the steam table. The Cook were to be used for back up ly would not need them. The bring the Cook that the not have been stacked wet. ervation on 8/19/15 at ified storage rack for the bots and pans, the following t of 5 stacked muffin pans bris; 2 of 2 stacked, large greasy with yellow debris; 6 pans were wet and/or d, 1 out of 5 small sheet pans	F	371	Deficiencies does not denote agreeme with the Statement of Deficiencies; no does it constitute an admission that any deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Cent reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure are or any administrative or legal proceeding. F-371 11 cooking pans and 148 bowls were immediately assessed, removed and washed. Immediate re- education for the cook involved in stacking the bowls. Corporate Dietary Consultant and Dieta Manager did a 100% audit of all pans in the kitchen for visible debris. 6 pans were removed due to worn appearance and new pans ordered at that time. All bowls that were stacked was washe and air dried in an appropriate rack. An in service for 100% of the dietary swas conducted on the procedure. Staff to scrape off excess food particles on pots and pans: assure that pans are washed in water at a temperature of 11 degrees with detergent: water will be changed frequently: rinse water clear a hot at 120-140 degrees: sanitize sink w solution pan to submerge for at least 60 seconds: check for cleanliness re sanitin dishwasher then allow to air dry. Dishes will be pre washed, rinsed and placed in a rack. The dishes will then be ran through the dish machine. All bowls will be clean and left to air dry on the ran through the dish machine. All bowls will be clean and left to air dry on the ran through the dish machine. All bowls will be clean and left to air dry on the ran through the dish machine. All bowls will be clean and left to air dry on the ran through the dish machine. All bowls will be clean and left to air dry on the ran through the dish machine. All bowls will be clean and left to air dry on the ran through the dish machine.	er and / ngs. ne ary n staff s o nd vith o s c e s	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	010110	1	0	TREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	20/2015	
NAME OF F	ROVIDER OR SUFFLIER				08 WEST MEADOWVIEW ROAD			
MAPLE GROVE HEALTH AND REHABILITATION CENTER					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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 371	Continued From page	e 17	F3	371	No wet nesting. A quality improvement monitoring tool initiate to assess all pans for possible debris. A quality improvement monitoring tool initiated to assess all bowl before meal service. Dietary manager in serviced staff on the function of the quality improvement tool. The Design washer will initial after washing, sanitiz pans and air drying. Another employee check for cleanliness and wet nesting process of pans. An initial will indicate staff member that washed the pans and another staff member that checked for cleanliness. Quality improvement tool to be utilized by dietary manager/ assistant dietary manager will monitor Quality Improvement tool 5 days a week X 8 weeks, then 3 days a week X 4 weeks, then weekly X months then every other week X 2 months, then monthly X 2 months and report to the Quality Improvement Committee. This committee consist of Dietary manager, assistant dietary manager, activities director, DON, ADO medical records director and activity director. Any infraction will be reported the Administrator immediately for possi modification of quality improvement monitoring process. The Executive committee will convene quarterly X3 to discuss the improvement process and evaluate effectiveness of wet nesting of bowls and cleanliness of wet nesting of bowls and cleanliness.	was ee ing will the d ont ent 3.2 EDN, to ible ont the		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
	345448 B. WING			C 08/20/2015			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	00/20/20	
MAPLE G	ROVE HEALTH AND REI	HABILITATION CENTER		308 WEST MEADOWVIEW ROAD			
MAPLE GROVE HEALTH AND REHABILITATION CENTER				GREENSBORO, NC 27406			
(X4) ID PREFIX TAG			COMP	X5) PLETION ATE			
F 371	Continued From page		F 3	pans. Recommendations to or modify will be discussed The executive committee of Medical director, Administra Nursing, Pharmacy consult manager, activity director a director.	at that time. onsist of the ator, Directo ant, dietary		5
SS=D	ACCURATE PROCE The facility must providings and biologicals them under an agree §483.75(h) of this particles personnel law permits, but only supervision of a licen A facility must provide (including procedures acquiring, receiving, administering of all dithe needs of each resulting the facility must emparation and the second pharmacis.)	ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse. e pharmaceutical services to that assure the accurate dispensing, and rugs and biologicals) to meet sident. eloy or obtain the services of t who provides consultation provision of pharmacy					
	by: Based on observatio			F 425 On August 19, 2015 resider immediately assessed by the no negative findings. Residen	ne ADON wi	th	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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		345448	B. WING _			1	/20/2015	
NAME OF P	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2010	
					08 WEST MEADOWVIEW ROAD			
MAPLE G	ROVE HEALTH AND	REHABILITATION CENTER			REENSBORO, NC 27406			
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 425	Continued From p	page 19	F4	125				
	Resident #164 wa	is re-admitted to the facility on			not voice any complaints of eye			
		nulative diagnoses of diabetes,			discomfort or decreased vision. QI rep	ort		
	depression and a	history of cataract extraction.			was completed for resident #164. MD			
	Resident #164's 0	Quarterly Minimum Data Set			notified on August 19, 2015 of medica	ion		
	(MDS) showed he	was cognitively aware.			error. Pharmacy was notified and 2 ey	⁄e		
		gust 2015 Physician Orders			drops were received on August 19, 20	15.		
	revealed Residen							
	different eye drop			On, August 19, 2015 an immediate				
		ion) to be administered four			in-service was completed by the ADOI	N		
	times each day.	inistration observation for			with the medication aide and nurse	I:4		
		inistration observation for Medication Aide #1 was			involved regarding medication available	•		
	· ·			On, August 19, 2015 the DON, and Albegan reeducating all licensed nurses				
		19/15 at 9:41 AM. No eye drops d to Resident #164.			medication aides on the following: 1)	anu		
		gust 2015 Medication			Review resident is MAR carefully before	re		
	_	cord (MAR) for Resident #164			administering medication. 2) All			
		and circled spaces for the two			medications are to be administered			
		is return to the facility on			according to physician¿s orders. 3) A	nγ		
		vas no written explanation on			noted medication error warrants	,		
		why the eye drops had not			notification of physician to determine if			
	been given since	Resident #164's return.			further orders are necessary. 4) Obse	rve		
	In an interview on	08/19/15 at 1:55 PM			the ¿Five Rights¿ of medication			
	Medication Aide #	1 stated Resident #164 had			administration: right resident, drug, do			
	been out of the fa	cility on a leave of absence. She			route and time. 5) Residents are not to			
		t #164 had returned to the			without their medication for any reason	۱.		
	· -	5 but had not brought the eye			6) Anytime you don¿t have the			
		facility. Medication Aide #1			medications for a resident you must no	-		
		en initialing and circling the			the physician that the medication was	not		
	correct spaces on the Medication Administration				given so that the physician has the	4:		
	1	the drops had not been			opportunity to order a different medica			
		e stated she had not informed			if it is not available for the pharmacy.	•		
	_	armacy, or the physician that difference of the			you do not have a resident¿s medicati you should make every effort to obtain			
	drops.	a not been receiving the eye			medication i.e.: Back up pharmacy is	uic		
		08/19/15 at 2:14 PM the			available 24 hours a day. 8) Every eff	ort		
		g stated it was her expectation			should be made to obtain the resident,			
		n was missing and not available			medication. 9) If you have exhausted	, -		
		to order the medication from			every avenue notify the DON, ADON,	and		
	the pharmacy.				administrator for further assistance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345448 B. WING				C 08/20/2015		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2015
MAPLE G	ROVE HEALTH AND RE	HABILITATION CENTER			8 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)		ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 425	In an interview on 08 indicated she oversa indicated if a medica Medication Aides we the medication could pharmacy. The Medi informed her the eye were not available ar stated since she did were not being given physician or order the Nurse #2 indicated the	/20/15 at 9:54 AM Nurse #2 w the Medication Aides. She tion was not available, the re supposed to notify her so be ordered from the	F	425	reeducation will be completed by 9-4-1 On, September 3, 2015 the ADON ar staff facilitator began re-education with licensed nurses and medication aides of the following: 1) When a medication is available the medication aide must not the licensed nurse immediately. 2) Licensed nurses must notify the pharm regarding medication and back-up pharmacy can be utilized. 3) If the medication cannot be obtained for the resident during approved time frame, the MD must be notified for further orders. On, August 21, 2015 a 100% medication availability audit was completed for all residents by DON, ADON, staff facilitation and/or licensed nurses. Medication addressed as not being available was ordered from pharmacy and received of August 21, 2015. On, September 8, 2015 a ¿Medication Availability Audit Tool ¿ was initiated. Tool, ADON, attended the ¿Medication availability utilizing the ¿Medication availability audit Tool, 2 week x 8 weeks, then 1 x week x 8 weeks, then every other week x 8 week On September 3, 2015 the administration-serviced DON, ADON, and staff facilitator on completing the ¿Medication Availability Audit Tool. ¿ The QI committee consist of administrator, DO ADON, and staff facilitator will meet weekly x 8 weeks, then every other week x 8 weeks, then every other week x 8 weeks, then monthly x 2 months ar review the ¿Medication Availability Audit Tool. ¿ Any inconsistencies will be immediately reported to the administration of the administration o	on not iffy acy ne on or on who, ek od lit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD SUDDIJED	343440		STREET ADDRESS, CITY, STATE, ZIP CODE	0	8/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,			
MAPLE G	ROVE HEALTH AND REF	IABILITATION CENTER		308 WEST MEADOWVIEW ROAD			
				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 OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 425	Continued From page	21	F 4	for possible modification of quality improvement monitoring process. The Executive Committee will me quarterly x 2 quarters to discuss of improvement process and evaluate effectiveness of residents receiving medications from pharmacy serving Recommendations to continue, a modify will be discussed at this time Executive Committee consist of director, administrator, DON, phaconsultant, dietary manager, active director and medical record director and medical record directors.	eet quality ate ng ices . Iter or me. The medical irmacy vities		