STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/17/15 through 8/20/15 a complaint investigation survey was conducted. There were no deficiencies as a result of the complaint investigation. Event #4PG911.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, and record reviews the facility failed to honor the choice for 1 of 3 sampled residents to receive showers as scheduled by the facility. Resident #190. Findings included: Resident #190 was originally admitted to the facility on 5/13/15 with diagnoses which included: cerebrovascular accident with left sided hemiparesis, secondary Parkinsonism, anxiety state, muscle weakness, dementia with behavioral disturbances, hyperlipidemia, epilepsy, cataract, hypertension, and psychosis. A review of the most recent quarterly MDS (Minimum Data Set) dated 6/18/15, indicated	F 242	F242 Resident # 190 received a shower on August 20, 2015. Resident is scheduled 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 resident #190s wife and was informed by wife that resident is receiving shower twice a week and 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 week	9/9/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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F 242	Continued From page 1 Resident #190 was severely cognitively impaired with no behaviors and was totally dependent on staff for his personal hygiene and bathing. The resident's Care Plan revealed he required assistance with the potential to restore or maintain maximum function of self-sufficiency for bathing related to his cognitive impairment, impaired mobility. Interventions included: approach in calm, patient manner; break tasks into segments, give steps one at a time to avoid overwhelming the resident. Review of the facility's records revealed Resident #190 was scheduled to receive his showers during second shift on Mondays and Thursdays. Review of the ADL (Activities of Daily Living) Flow sheets for Resident #190 dated from 7/21/15 through 8/19/15 indicated Resident #190 did not receive a shower as scheduled on: 7/23/15, 8/6/15, 8/10/15, and 8/17/15. Facility records revealed Resident #190 was out of the facility on Leave with family on 7/25/15-7/28/15 and 8/2/15-8/4/15. Further review of the ADL Flow sheets revealed Resident #190 received a shower on Tuesday, 7/21/15 and Sunday, 7/30/15; but received a full bath on Monday, 8/10/15. There was no documentation in the resident ' s clinical record or the facility ' s records indicating the resident refused a shower or a bath during the reviewed time period (7/21/15-8/19/15). On 8/18/15 at 10:30am, Resident #190 was observed in a wheelchair in front of nursing station. The resident appeared clean and well groomed, dressed for the day. The resident was nonverbal and calm.	F 242	and as needed per the shower schedule unless a specific schedule had been developed for them. 2) If a resident refuses a shower the primary nurse must be notified immediately. 3) The type of bath and any refusals must be documented in POC and on shower schedule. The reeducation was completed on 9/7/15. A Shower Schedule Audit Tool was initiated on September 3, 2015 to monitor that showers are being given per shower schedule and documentation is complete in POC. The Shower Schedule Audit Tool will be completed for 10% of residents by the DON, ADON, and staff facilitator 4 x week x 4 weeks, then 2 x week x 8 weeks, then 1 x week x 12 weeks. On September 3, 2015 the administrator in-serviced DON, ADON, and staff facilitator on completing the Shower Schedule Audit Tool. The QI committee consist of administrator, DON, ADON, and staff facilitator will meet weekly x 8 weeks, then every other week x 8 weeks, then monthly x 2 months. Any inconsistencies will be immediately reported to the administrator for possible modification of quality improvement monitoring process. The Executive Committee will meet quarterly x 2 quarters to discuss quality improvement process and evaluate effectiveness of residents receiving showers twice a week. Recommendations to continue, alter or modify will be discussed at this time. The	

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F 242	Continued From page 2 During an interview on 8/18/15 at 1:52pm, the resident's RP (Responsible Party) stated that her routine was to arrive at the facility everyday close to Resident #190's lunch time; leave the facility between 2:00p-2:30p; then return to the facility close to the resident's dinnertime, and stay with the resident until 8:00pm. The RP revealed the resident was to receive a minimum of two showers every week; in the evenings, every Monday and Thursday. The RP stated the nursing assistants frequently failed to give the resident his scheduled shower unless she (RP) made the request. During an interview on 8/19/15 at 10:28am, SN#1 (Staff Nurse) confirmed that Resident #190's scheduled shower days were Mondays and Thursdays during second shift. After reviewing the "NA (nursing assistant) Book" where the NA daily assignments and shower schedule sheets were maintained, SN#1 acknowledged that there were only shower sheets for the following days in August 2015 for Resident #190: 8/3/15, 8/13/15, and 8/17/15 which were incomplete, indicating the resident did not receive a shower. During a follow-up interview on 8/19/15 at 2:03pm, The RP revealed that prior to his admission to the facility, Resident #190 preferred taking a shower every day; but, would sometimes take a bath.	F 242	Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		9/9/15

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F 248	Continued From page 3 the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to provide Activities for 1 of 1 resident with impaired mobility. Resident #150. Findings included: Resident #150 was originally admitted to the facility on 4/18/13 and re-admitted on 6/9/14 with diagnoses which included: attention to tracheostomy, chronic respiratory failure, contractures, attention to gastrostomy, chronic kidney disease stage II, pressure ulcers, and muscle weakness. Review of the Activity Progress (Interests) Sheet dated 6/17/15 indicated Resident #150 was interested and participated in Activities which included: Bingo, socials at times with wife in attendance; family and friends visits; television; and pet therapy. In-room activities/projects were also provided, and the resident assisted with activities he could pursue independently. The review of the most recent quarterly MDS (minimum data set) dated 6/19/15 indicated Resident #150 had moderately impaired cognition with no behaviors or moods. Also, for the assessment reference period, the MDS coded transfers and locomotion as activities that did not occur.	F 248	. F- 248 Resident 150 was re assessed to determine need for 1:1 visits and reassessed for the types of activities the resident showed interest. Arrange for activity aide to visit and encourage resident to observe or designate activity, assist resident in planning leisure- time activities. Encourage resident to plan own leisure-t time activities. Engage resident in group activities. Give resident verbal reminders of activity before commencement of activity. Offer schedule of activities for resident to select choices. Post personal activity schedule in resident¿s room. Provide supplies for independent activities of resident choice Care plan was modified accordingly. A 100% audit was completed on August 21, 2015 for all residents that could have been affected. Updated documentation and care plans completed on identified residents. Activities Director in serviced by the Administrator and Activities staff in serviced by the Activities Director to ensure 100% of staff participation. The in-service consist of all residents will be assessed appropriately to determine the	

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F 248	Continued From page 4 Resident #150's Care Plan dated 6/26/15 indicated an alteration in supervised/organized recreation characterized by little or no involvement, lack of attendance related to impaired mobility, impaired communication (expressive aphasia), a history of cerebrovascular accident, tracheostomy and gastrostomy tube, and the resident's choice. The documented interventions included: assist resident in planning leisure-time activities; engage resident in group activities; post personal activity schedule in resident's room; provide supplies for independent activities of resident's choice; respect resident's choice in regard to limited/no activities; transport resident to activities; assist in transporting any health-related equipment to activities. There were no Activity Attendance Reports or any other documentation indicating Resident #150 received one-on-one Activity or participated in any group activities from 5/25/15 through 8/20/15; with the exception of a religious activity on 5/24/15. During an observation and interview on 8/18/15 at 4:28pm, Resident #150 was observed in bed with the head of the bed up approximately 40 degrees. The resident also had a tracheostomy and feeding tube in place. Next to the left side of the resident's bed was an electric wheelchair. The resident was alert and oriented; was able to speak very softly and nod his head in response to questions. Resident #150 indicated that no one from the facility had ever asked him if he wanted to attend any group activities and he was not aware of any. The resident also indicated no one had ever visited him from Activities. An Activity calendar was observed on the wall located	F 248	need for 1:1 visits. What determines the need for 1:1 visits; physical and medical condition, unable to be out of bed, mental condition, resident choice, change in condition etc. The in service was completed on August 24, 2015 New residents will be assessed according to regulations, other residents will be assessed quarterly and or as needed. New residents identified as requiring 1:1 visits will be added to the report for monitoring. A Quality Improvement tool was initiated for 1:1 attendance records to be reviewed. The tool will be utilized bi- weekly to monitor accuracy, and compliance of 1:1 visits. Activities Director or designee will monitor 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, Assistant Director of Nursing and Medical Records Director. The Quality Improvement Committee will meet weekly X8 weeks then every other week X 8 weeks, then monthly X 2 months. Any inconsistencies will be immediately reported to the Administrator for possible modification of quality improvement monitoring process. The Executive Committee will convene quarterly X 2 quarters to discuss quality improvement process and evaluate	

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F 248	Continued From page 5 approximately two feet from the right side of the resident's bed. The resident indicated that if the print on the Activity Calendar was larger and accessible to him, he would like to make the decision whether to attend any of the group Activities. When asked if the Pet Therapy group (which were observed entering the facility approximately 2:00pm that day) visited him, the resident replied with a shake of his head and said "no". During an interview on 8/20/15 at 10:50am, the Activity Director indicated that Resident #150 used to receive one-on-one with Activity staff; then with therapy, the resident was able to be out of bed in his electric wheelchair. She stated that the Activity staff would visit the resident to encourage him to attend the facility's out of room activities. She revealed that the resident usually only attended group activities when his wife was in attendance and that the resident's family visited him everyday. She acknowledged that the resident was unable to read the Activity Calendar that was taped on his wall along the right side of his bed; but the resident's wife preferred the calendar in its' current location. She also revealed that the Pet Therapy Group that was observed on 8/18/15 at 2:00pm conducted one-on-one visits in residents' rooms. She also acknowledged that Resident #150 was alert and oriented, and able to make his needs known.	F 248	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, Dietary manager, activities director and medical record director.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		9/9/15

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F 312	Continued From page 6 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, and record reviews the facility failed to provide showers and baths as scheduled to 1 of 3 sampled residents who required assistance with personal hygiene. Resident #190. Findings included: Resident #190 was originally admitted to the facility on 5/13/15 with diagnoses which included: cerebrovascular accident with left sided hemiparesis, secondary Parkinsonism, anxiety state, muscle weakness, dementia with behavioral disturbances, hyperlipidemia, epilepsy, cataract, hypertension, and psychosis. A review of the most recent quarterly MDS (Minimum Data Set) dated 6/18/15, indicated Resident #190 was severely cognitively impaired with no behaviors and was totally dependent on staff for his personal hygiene and bathing. The resident's Care Plan revealed he required assistance with the potential to restore or maintain maximum function of self-sufficiency for bathing related to his cognitive impairment, impaired mobility. Interventions included: approach in calm, patient manner; break tasks into segments, give steps one at a time to avoid overwhelming the resident. Review of the facility's records revealed Resident #190 was scheduled to receive his showers	F 312	F 312 Resident # 190 received a shower on August 20, 2015. Resident has received a shower or bed bath daily since August 20, 2015. Resident is scheduled to receive a minimum of two showers every week; in the evenings, every Monday and Thursday. If it is not a scheduled shower day, resident will receive a bed bath daily. . On August 31, 2015, the administrator met with resident #190s wife and was informed that everything was going okay, and if she had any problems she would notify the administrator. On 8/20/2015 the DON began reeducating nursing staff-licensed nurses, C.N.As and medication aides on the following: 1) Residents should be receiving showers twice a week and as needed per the shower schedule unless a specific schedule had been developed for them. 2) If a resident refuses a shower the primary nurse must be notified immediately. 3) The type of bath and any refusals must be documented in POC and on shower schedule. 4) Personal grooming is important for a positive self-image and every effort should be made to encourage and assist residents to maintain a pleasing and attractive appearance. The reeducation was completed on 9-7-15. On 9-2-2015	

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F 312	Continued From page 7 during second shift on Mondays and Thursdays. Review of the ADL (Activities of Daily Living) Flow sheets for Resident #190 dated from 7/21/15 through 8/19/15 indicated Resident #190 did not receive a shower as scheduled on 7/23/15, 8/6/15, 8/10/15, and 8/17/15. The Flow sheets also indicated the resident did not receive a bath on 7/22/15, 7/29/15, 8/1/15, 8/2/15, 8/7/15, 8/15/15, and 8/16/15. Facility records revealed Resident #190 was out of the facility on Leave with family on 7/25/15-7/28/15 and 8/2/15-8/4/15. Further review of the ADL Flow sheets revealed Resident #190 received a shower on Tuesday, 7/21/15 and Sunday, 7/30/15; but received a full bath on Monday, 8/10/15. There was no documentation in the resident's clinical record or the facility's records indicating the resident refused a shower or a bath during the reviewed time period (7/21/15-8/19/15). There was no documentation indicating a reason for a change in bathing type. On 8/18/15 at 10:30am, Resident #190 was observed in a wheelchair in front of nursing station. The resident appeared clean and well groomed, dressed for the day. The resident was nonverbal and calm. During an interview on 8/18/15 at 1:52pm, the resident's RP (Responsible Party) stated that her routine was to arrive at the facility everyday close to Resident #190 ' s lunch time; leave the facility between 2:00p-2:30p; then return to the facility close to the resident's dinnertime, and stay with the resident until 8:00pm. The RP revealed the	F 312	ADON began reeducating nursing staff on the following: 1) All residents including dependent residents should receive a bed bath at least daily, if it is not a scheduled shower day. 2) If the resident refuses an ADL task the primary nurse must be notified immediately. 3) A resident that is unable to carry out assistance with ADLs, including eating, grooming, bathing, and personal/oral hygiene a staff member must assist resident to complete the ADL task. The reeducation was completed on 9-7-14 with 100% of nursing staff. On 9-2-15 a 100% audit was completed on all dependent residents using the ¿ADL Care Audit Tool for Dependent Residents. All negative findings corrected immediately. A Shower Schedule Audit Tool was initiated on September 3, 2015 to monitor that showers are being given per shower schedule and documentation is complete in POC. The Shower Schedule Audit Tool will be completed for 10% of residents by the DON, ADON, and staff facilitator 4 x week x 4 weeks, then 2 x week x 8 weeks, then 1 x week x 12 weeks. An ADL Care Audit Tool for Dependent Residents was initiated on September 3, 2015 to monitor that dependent residents will receive ADL care to maintain good nutrition, grooming and personal and oral hygiene. On September 3, 2015 the administrator in-serviced DON, ADON, and staff facilitator on completing the ¿Shower Schedule Audit Tool and the ADL Care Audit Tool for Dependent Residents. The ADL Care Audit Tool for Dependent	

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F 312	Continued From page 8 resident was to receive a minimum of two showers every week; in the evenings, every Monday and Thursday. The RP stated the nursing assistants frequently failed to give the resident his scheduled shower unless she (RP) made the request. The RP revealed that she has discussed her concerns with Resident #190's ADL care during the resident's Care Plan Meeting. During an interview on 8/19/15 at 10:28am, SN#1 (Staff Nurse) confirmed that Resident #190's scheduled shower days were Mondays and Thursdays during second shift. After reviewing the "NA (nursing assistant) Book" where the NA daily assignments and shower schedule sheets were maintained, SN#1 acknowledged that there were only shower sheets for the following days in August 2015 for Resident #190: 8/3/15, 8/13/15, and 8/17/15 which were incomplete, indicating the resident did not receive a shower. SN#1 revealed that at the beginning of each shift the facility's Charge Nurses would give the nursing assistants their "Daily Assignment" sheets with a copy of the "Shower Schedule" sheet. The nursing assistants were responsible for completing their assigned shower sheets. If a resident refused a shower, the nursing assistant was to immediately notify the Charge Nurse, who would also document the refusal on his/her copy of the "Shower Schedule" sheet. During an interview on 8/19/15 at 3:00pm, NA#1 (nursing assistant) stated that Resident #190 required total assistance of one person with bathing. She revealed that the resident received a full bed bath which she (NA#1) documented as part of his ADL care.	F 312	Residents will be completed for 2 dependent residents on each hall by the DON, ADON, and staff facilitator 4 x week x 4 weeks, then 2 x week x 8 weeks, then 1 x week x 12 weeks. The QI committee consist of administrator, DON, ADON, and staff facilitator will meet weekly x 8 weeks, then every other week x 8 weeks, then monthly x 2 months. Any inconsistencies will be immediately reported to the administrator for possible modification of quality	

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F 312	Continued From page 9	F 312		

During an interview on 8/19/15 at 3:26pm, NA#2 revealed that even though she was scheduled to work with Resident #190, she had not worked with the resident since late July 2015 because she and another nursing assistant (NA#3) switched residents (NA#3 preferred working with Resident #190). NA#2 indicated that this change in resident assignments was not usually documented on the Nursing Assistant Assignment Sheet because sometimes she and NA#3 would have different Charge Nurses. NA#2 revealed that when she worked Resident #190, part of her responsibility was giving him a shower twice a week and document each shower (she thought his shower days were Tuesday and Friday). NA#2 indicated that whenever the resident was not cooperative with transferring to the shower chair, she would give him a full bed bath instead of a shower, then report the resident's behavior to the Charge Nurse, immediately. The ADL Flow record was documented indicating the resident received the full bath; but there was no area on the Flow record to document the resident being uncooperative.

During an interview on 8/19/15 at 3:46pm, NA#3 revealed that she had been working with Resident #190 for approximately two months. NA#3 stated that the resident required total assistance with bathing and received a shower every Thursday and another day. NA#3 indicated that she gave residents their showers as scheduled on the Shower Sheet that she obtained from the Charge Nurse. NA#3 revealed that all nursing assistants were given a copy of the Shower Sheet which showed all room and bed numbers of residents that were due for a shower that shift. NA#3 also revealed that if Resident #190's muscles were

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F 312	Continued From page 10 stiff, making transferring to shower chair difficult, then she would give the resident a full bed bath per the resident's RP's request (the RP would visit with resident until 8:00pm every night). NA#3 would document the change of bathing type on the ADL Flow record, but did not record the reason for the change. NA#3 indicated that she would then report the change to the nurse.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to collect and send a urinalysis with culture and sensitivity for 1 of 1 (Resident #144) sampled residents as ordered by the physician. Findings included: Resident #144 was admitted to the facility on 07/13/15 with cumulative diagnoses of dementia, hypertrophy of the prostate without obstruction, and psychosis. Resident #144's Admission Minimum Data Set (MDS) dated 07/19/15 revealed Resident #144 had short and long term memory problems and was moderately impaired in daily decision	F 315	F 315 On August 20, 2015 resident # 144 was sent to the ED for evaluation. Urinalysis obtained at hospital. On August 26, 2015 a 100% lab audit was completed by the ADON, and phlebotomist using the daily census with no negative findings. On, September 3, 2015 the DON, ADON and staff facilitator began reeducating licensed nurses on the following: 1) When a new laboratory order has been obtained,	9/9/15

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F 315	Continued From page 11 making. Resident #144 was frequently incontinent of urine. Review of the Nursing Progress Notes dated 08/09/15 revealed Resident #144 was noted to be tired and lethargic and sleeping through meals. The Nurse Practioner (NP) was notified and laboratory (lab) work was ordered. Review of the Physician Telephone Orders dated 08/09/15 showed an order from the NP for a urinalysis with culture and sensitivity, (a test used to determine a urinary tract infection), a complete blood count, and a comprehensive metabolic panel. Review of the lab results dated 08/10/15 showed the complete blood count and comprehensive metabolic panel were completed as ordered. There were no results for the urinalysis or the culture and sensitivity that were ordered in the medical record. In an interview on 08/20/15 at 4:30 PM the administrator stated the facility had been unable to locate the results of the urinalysis and culture and sensitivity. She indicated she had placed a call to the nurse who had written the order for the lab tests but the nurse was unavailable. In an interview on 08/20/15 at 5:10 PM Medical Records Clerk #1 stated she had contacted the lab and they had no record of performing a urinalysis with culture and sensitivity for Resident #144 as requested by the order of 08/09/15. In an interview on 08/20/15 at 5:15 PM the Director of Nursing stated it was her expectation the nurse would fill out the lab request slip and send the requested samples to the lab in a timely manner.	F 315	the laboratory slip must be completed by the licensed nurse .2) Urinalysis/culture and sensitivity orders should be put on a separate laboratory sheet from A blood draw sheet to eliminate missed urinalysis / culture and sensitivity. 3) Nurses are responsible for obtaining all urinalysis / culture and sensitivity and any stat laboratory test ordered by doctor. The re education was completed 9/4/2015 MD orders will be reviewed during morning meeting using pink MD order slips to validate all labs have been obtained per MD orders. A ¿Lab Log Tool¿ was initiated on September 4, 2015 to monitor that labs are being obtained per MD orders. The ¿Lab Log Tool¿ will be completed by the DON, ADON, and/or staff facilitator 5 x week x 4 weeks, then 3 x week x 8 weeks, then 1 x week x 12 weeks. On, September 3, 2015 the administrator in-serviced the DON, ADON, staff facilitator, and phlebotomist on completing the ¿Lab Log Tool¿. The QI committee consist of administrator, DON, ADON, and staff facilitator and will meet weekly x 8 weeks, then every other week x 8 weeks, then monthly x 2 months. Any inconsistencies will be immediately reported to the administrator for possible modification of quality improvement monitoring process. The Executive Committee will meet quarterly x 2 quarters to discuss quality improvement process and evaluate effectiveness of residents receiving showers twice a week. Recommendations to continue, alter or modify will be discussed at this time. The	

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F 315	Continued From page 12	F 315	Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. 0% lab audit was completed by the ADON, and phlebotomist using the daily census with no negative findings. MD orders will be reviewed during morning meeting using pink MD order slips to validate all labs have been obtained per MD orders. A Lab Log Tool was initiated on September 4, 2015 to monitor that labs are being obtained per MD orders. The Lab Log Tool will be completed by the DON, ADON, and/or staff facilitator 5 x week x 4 weeks, then 3 x week x 8 weeks, then 1 x week x 12 weeks. On, September 3, 2015 the administrator in-serviced the DON, ADON, staff facilitator, and phlebotomist on completing the Lab Log Tool. The QI committee consist of administrator, DON, ADON, and staff facilitator and will meet weekly x 8 weeks, then every other week x 8 weeks, then monthly x 2 months. Any inconsistencies will be immediately reported to the administrator for possible modification of quality improvement monitoring process. The Executive Committee will meet quarterly x 2 quarters to discuss quality improvement process and evaluate effectiveness of residents receiving showers twice a week. Recommendations to continue, alter or modify will be discussed at this time. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities	

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F 315	Continued From page 13	F 315	director and medical record director.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure that it was free of medication error rates of 5% or greater. Findings included: The facility had a medication error rate of 10% following the Medication Administration Observation and Reconciliation of Physician Orders. 1. Resident #108 was re-admitted to the facility on 07/24/12 with cumulative diagnoses of hemiplegia, anxiety disorder and hypertension. Resident #108's Quarterly Minimum Data Set (MDS) showed he was cognitively aware. A medication administration observation for Resident #108 by Medication Aide #2 was conducted on 08/19/15 at 9:20 AM. A medication typically used to decrease the production of stomach acid was administered during the observation. Review of the August 2015 Physician Orders revealed Resident #108 had orders for a medication typically used to decrease the production of acid in the stomach to be given on an empty stomach. In an interview on 08/19/15 at 2:00 PM Medication Aide #2 stated Resident #108 had already eaten breakfast at the time the	F 332	F 332 On August 19, 2015 resident # 108 was immediately assessed by the ADON with no negative findings. Resident # 108 did not voice any complaints of discomfort. QI report was completed for resident #108. MD notified on August 19, 2015 of medication error. On, August 19, 2015 an immediate in-service was completed by the DON with the medication aide involved regarding medication administration. The DON, and ADON began reeducating all licensed nurses and medication aides on the following: 1) Review resident¿s MAR carefully before administering medication. 2) All medications are to be administered according to physician¿s orders. 3) Any noted medication error warrants notification of physician to determine if further orders are necessary. 4) Observe the ¿Five Rights¿ of medication administration: right resident, drug, dose, route and time. The reeducation will be completed by 9-4-15. On August 25, 2015 the DON, ADON, and staff facilitator initiated medication pass	9/9/15

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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 times each day. In an interview on 08/19/15 at 1:55 PM Medication Aide #1 stated Resident #164 had been out of the facility on a leave of absence. She indicated Resident #164 had returned to the facility on 08/17/15 but had not brought the eye drops back to the facility. Medication Aide #1 stated she had been initialing and circling the correct spaces on the Medication Administration Record to signify the drops had not been administered. She indicated she had not informed the nurse, the pharmacy, or the physician that Resident #164 had not been receiving the eye drops. In an interview on 08/20/15 at 9:54 AM Nurse #2 stated Resident #164 had been out of the facility on a leave of absence. She stated a family member brought Resident #164 back to the	F 332	audits for all licensed nurses and medication aides. Staff must have less the 5% medication error rate. If medication rate is greater than 5% the staff will not be allowed to administer medication until medication error rate is less than 5%. The medication pass audits were conducted using the QI monitoring tool Medication Pass Audit Form with close emphasis on Right Resident, Right Medication and dose, Right time and frequency and Right route with nurses and medication aides. All nurses /medication aides will be audited by the DON, ADON, and/or staff facilitator quarterly X4. All new hires will have a <5% medication error rate on a medication pass audit before being assigned to work independently on a medication cart. The QI committee consist of administrator, DON, ADON, and staff facilitator will meet weekly x 8 weeks, then every other week x 8 weeks, then monthly x 2 months to review all medication pass audits completed. Any inconsistencies will be immediately reported to the administrator for possible modification of quality improvement monitoring process. The Executive Committee will meet quarterly x 2 quarters to discuss quality improvement process and evaluate effectiveness of residents receiving showers twice a week. Recommendations to continue, alter or modify will be discussed at this time. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities	

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F 332	Continued From page 15 facility and that she checked the resident back in. Nurse #2 stated she did not notify the physician or the pharmacy as she was not aware the eye drops were not in the medication cart. She indicated the Medication Aides had not informed her the eye drops were not available. Nurse #2 indicated the eye drops were for cataracts and if not administered the condition could worsen. 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.	F 332	director and medical record director.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to ensure 148-bowls and 11-cooking pans were cleaned and stored under sanitary conditions. Findings included: During a meal tray line service in the kitchen on 8/19/15 at 12:15pm, 148-small plastic bowls were	F 371	Maple Grove Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes 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 and provisions of quality of care of residents . Maple Grove Health and Rehabilitation Center response to this Statement of	9/9/15

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F 371	Continued From page 16 observed stacked wet onto the preparation table located across from the steam table. The Cook revealed the bowls were to be used for back up only and she probably would not need them. The Dietary Manager informed the Cook that the plastic bowls should not have been stacked wet. During a kitchen observation on 8/19/15 at 12:20pm of the identified storage rack for the cleaned and dried pots and pans, the following were observed: 2 out of 5 stacked muffin pans contained brown debris; 2 of 2 stacked, large roasting pans were greasy with yellow debris; 6 out of 18 large sheet pans were wet and/or contained debris; and, 1 out of 5 small sheet pans contained white and brown dried debris. During an interview on 8/19/15 at 12:37pm, the Dietary Manager revealed that he expected all plates, bowls, pots, pans, and other dishware to be washed thoroughly and dried completely before stacking.	F 371	Deficiencies does not denote agreement with the Statement of Deficiencies¿ nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and / or any administrative or legal proceedings. 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 Dietary 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 washed and air dried in an appropriate rack. An in service for 100% of the dietary staff was 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 110 degrees with detergent: water will be changed frequently: rinse water clear and hot at 120-140 degrees: sanitize sink with solution pan to submerge for at least 60 s seconds: check for cleanliness re sanitize in 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 rack.	

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F 371	Continued From page 17	F 371	No wet nesting. A quality improvement monitoring tool was initiate to assess all pans for possible debris. A quality improvement monitoring tool was initiated to assess all bowl before meal service. Dietary manager in serviced staff on the function of the quality improvement tool. The Designee washer will initial after washing, sanitizing pans and air drying. Another employee will check for cleanliness and wet nesting process of pans. An initial will indicate the 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 or designee (cook). 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 2 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, ADON, medical records director and activity director. Any infraction will be reported to the Administrator immediately for possible modification of quality improvement monitoring process. The Executive committee will convene quarterly X3 to discuss the improvement process and evaluate effectiveness of the wet nesting of bowls and cleanliness of	

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F 371	Continued From page 18	F 371	pans. Recommendations to continue, alter or modify will be discussed at that time. The executive committee consist of the Medical director, Administrator, Director of Nursing, Pharmacy consultant, dietary manager, activity director and medical director.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide routine eye drops for 1 of 1 (Resident #164) sampled residents. Findings included:	F 425	F 425 On August 19, 2015 resident # 164 was immediately assessed by the ADON with no negative findings. Resident # 164 did	9/9/15

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F 425	Continued From page 19 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. 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 times each day. 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 Medication Administration Record (MAR) for Resident #164 showed initialed and circled spaces for the two eye drops since his return to the facility on 08/17/15. There was no written explanation on the MAR to signify why the eye drops had not been given since Resident #164's return. In an interview on 08/19/15 at 1:55 PM Medication Aide #1 stated Resident #164 had been out of the facility on a leave of absence. She indicated Resident #164 had returned to the facility on 08/17/15 but had not brought the eye drops back to the facility. Medication Aide #1 stated she had been initialing and circling the correct spaces on the Medication Administration Record to signify the drops had not been administered. She stated she had not informed the nurse, the pharmacy, or the physician that Resident #164 had not been receiving the eye drops. In an interview on 08/19/15 at 2:14 PM the Director of Nursing stated it was her expectation that if a medication was missing and not available the nurse needed to order the medication from the pharmacy.	F 425	not voice any complaints of eye discomfort or decreased vision. QI report was completed for resident #164. MD notified on August 19, 2015 of medication error. Pharmacy was notified and 2 eye drops were received on August 19, 2015. On, August 19, 2015 an immediate in-service was completed by the ADON with the medication aide and nurse involved regarding medication availability. On, August 19, 2015 the DON, and ADON began reeducating all licensed nurses and medication aides on the following: 1) Review resident¿s MAR carefully before administering medication. 2) All medications are to be administered according to physician¿s orders. 3) Any noted medication error warrants notification of physician to determine if further orders are necessary. 4) Observe the ¿Five Rights¿ of medication administration: right resident, drug, dose, route and time. 5) Residents are not to go without their medication for any reason. 6) Anytime you don¿t have the medications for a resident you must notify the physician that the medication was not given so that the physician has the opportunity to order a different medication if it is not available for the pharmacy. 7) If you do not have a resident¿s medication you should make every effort to obtain the medication i.e.: Back up pharmacy is available 24 hours a day. 8) Every effort should be made to obtain the resident¿s medication. 9) If you have exhausted every avenue notify the DON, ADON, and administrator for further assistance. The	

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F 425	Continued From page 20 In an interview on 08/20/15 at 9:54 AM Nurse #2 indicated she oversaw the Medication Aides. She indicated if a medication was not available, the Medication Aides were supposed to notify her so the medication could be ordered from the pharmacy. The Medication Aides had not informed her the eye drops for Resident #164 were not available and were not being given. She stated since she did not know the medications were not being given she did not inform the physician or order them from the pharmacy. Nurse #2 indicated the eye drops were for cataracts and if not administered the condition could worsen.	F 425	reeducation will be completed by 9-4-15. On, September 3, 2015 the ADON and staff facilitator began re-education with licensed nurses and medication aides on the following: 1) When a medication is not available the medication aide must notify the licensed nurse immediately. 2) Licensed nurses must notify the pharmacy 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 facilitator or and/or licensed nurses. Medication addressed as not being available was ordered from pharmacy and received on August 21, 2015. On, September 8, 2015 a ¿Medication Availability Audit Tool¿ was initiated. The DON, ADON, staff facilitator will monitor medication availability utilizing the ¿Medication Availability Audit Tool,¿ 2 x week x 8 weeks, then 1 x week x 8 weeks, then every other week x 8 weeks. On September 3, 2015 the administrator in-serviced DON, ADON, and staff facilitator on completing the ¿Medication Availability Audit Tool.¿ The QI committee consist of administrator, DON, ADON, and staff facilitator will meet weekly x 8 weeks, then every other week x 8 weeks, then monthly x 2 months and review the ¿Medication Availability Audit Tool.¿ Any inconsistencies will be immediately reported to the administrator	

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MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 425	Continued From page 21	F 425	for possible modification of quality improvement monitoring process. The Executive Committee will meet quarterly x 2 quarters to discuss quality improvement process and evaluate effectiveness of residents receiving medications from pharmacy services . Recommendations to continue, alter or modify will be discussed at this time. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director.	