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 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 000	INITIAL COMMENTS The survey team entered the facility on 8/5/21 to 8/6/21 for an unannounced complaint survey and follow-up survey. The survey team returned on 8/13/21 to conduct an additional unannounced complaint survey and to validate the credible allegation. Additional information was obtained offsite through 8/18/21. Therefore, the exit date was 8/18/21. Immediate Jeopardy was identified at 483.90 at tag F919 at a scope / severity of an L. Immediate Jeopardy began on 8/6/21 and was removed on 8/12/21. 10 of 21 complaint allegations were substantiated. Event ID CZ7T11	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		9/30/21

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

Electronically Signed | 09/11/2021

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interview, the facility failed to notify a resident's legal representative of the resident's hospitalization. This occurred for 1 of 1 resident (Resident #28) reviewed for notification of change. Findings included: Resident was admitted to the facility on 1-7-20 with multiple diagnoses that included end stage renal disease, diabetes and dependence on renal	F 580	Maple Grove Nursing 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 to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Nursing and Rehabilitation Center s response to this Statement of Deficiencies	

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F 580	Continued From page 2 dialysis. The quarterly Minimum Data Set (MDS) dated 7-9-21 revealed Resident #28 was severely cognitively impaired. Legal documentation in Resident #28's medical record revealed Resident #28 was assigned a legal representative and guardian on 5-21-21. The facility physician's admission documentation was reviewed on 1-7-20 revealed an order for Resident #28 to attend dialysis treatments 3 times a week. A telephone interview was conducted with a family member of Resident #28 on 8-13-21 at 11:50am. The family member discussed Resident #28 had been transferred from the dialysis center to the hospital on 8-7-21 around 3:00pm without her knowledge. She further stated she was not informed of the transfer until she had received a telephone call from the hospital at 9:00pm on 8-7-21. On 8-16-21 at 4:36pm Nurse #3 was interviewed by telephone. Nurse #3 discussed Resident #28 attending dialysis treatment the morning of 8-7-21. He explained the resident left the facility for the dialysis center around 10:00am. The nurse stated when Resident #28 did not return from the dialysis center by 5:30pm, he had informed a nursing assistant that Resident #28 had not returned from dialysis and he said the nursing assistant informed him she had heard the resident was sent to a hospital from the dialysis center. Nurse #3 stated he called the dialysis center to clarify what had happened to Resident #28 but said no one answered the phone at the	F 580	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 other administrative or legal proceedings. F 580 Notify of Changes Resident #28 continues to be transferred to dialysis safely three times weekly. Resident #28 has not had any additional transfers to the hospital. Resident #28 responsible party has been notified of changes to Resident #28 treatment/medication regimen and incidents by nursing staff. All residents have the potential to be affected by alleged deficient practice. On 09/02/2021 the social worker, admissions coordinator, and/or assigned project nurse completed a review of all discharges/transfers from the facility in the last 30 days to ensure that the residents□ representative has been notified of a resident□s hospitalization, accident, significant change in the resident□s condition, a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility. On 8/27/2021, the interim administrator	

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F 580	Continued From page 3	F 580		

dialysis center. He further said he did not call the legal representative or inform any member of management that Resident #28 had not returned from dialysis.

Nurse #4 was interviewed by telephone on 8-16-21 at 4:15pm. Nurse #4 explained she worked 7:00pm to 7:00am the evening of 8-7-21. She further explained Nurse #3 had informed her Resident #28 had been transferred to the hospital from dialysis but did not know what hospital. The nurse acknowledged she had not notified the interim Director of Nursing, Administrator or the resident's legal representative.

The facility's receptionist was interviewed by telephone on 8-17-21 at 4:25pm. The receptionist stated she had received a call from the dialysis center informing her Resident #28 was transferred to the hospital. She explained she transferred the call to the nursing station on east hall but did not know if anyone had answered the call. The receptionist acknowledged she did not inform the interim Director of Nursing, Administrator or a staff member. She also stated she had not informed the residents legal representative and she stated that it was not her job to call a resident's legal representative.

On 8-17-21 at 4:34pm NA #8 was interviewed by telephone. NA #8 discussed escorting Resident #28 to the dialysis center on 8-7-21. She explained the dialysis center had decided to send the resident to the emergency room due to chest pain. NA #8 stated, when she returned from the dialysis center, she did not report to any staff members, interim Director of Nursing or the Administrator that Resident #28 had been transferred to the hospital. She also said she did

completed education with facility receptionist on the requirement; if he/she (the receptionist) forwards a telephone call to the hall nurse and the hall nurse does not answer the telephone call, the receptionist will forward the telephone call to the unit manager, assistant director of nursing, director of nursing, or the (interim) administrator for follow up.

On 8/24/2021 the interim administrator, interim director of nursing (DON), staff development and/or assigned project nurse in serviced facility staff of the requirement to notify the assigned resident□s nurse of resident not returning to the facility from an outside vendor, the resident is involved in a hospitalization, accident, a significant change in the resident□s condition, a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility. This in-service also included ensuring the resident□s assigned nurse□s responsibility to notify the resident□s responsible party of resident□s change in condition and/or need to transfer/discharge the resident. On 8/27/2021 the staff development coordinator mailed a letter of this in-service to any facility staff member and contracted agency staff not in attendance for this in-service. All newly hired facility staff or agency contracted staff will be educated on notification of resident changes/discharges/transfers during orientation to facility. No staff will be eligible to work until he she has been educated on this process.

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F 580	Continued From page 4 not know if the resident's legal representative had been notified of the transfer because notification was the responsibility of the nurse. On 8-18-21 at 2:12pm the Administrator was interviewed by telephone. The Administrator explained, when staff are aware of a resident that had been transferred to the hospital, the staff should contact the resident's legal representative, Director of Nursing and the Administrator.	F 580	Beginning 09/10/2021 the social worker, admissions coordinator, (interim) administrator, and/or assigned project nurse will audit resident medical records weekly to ensure the residents representative has been notified of a resident's hospitalization, accident, significant change in the resident s condition, a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility weekly for 3 months. The audit will be documented on the F580 Notify of Changes audit tool. Beginning 09/10/2021 the (interim) Director of Nursing/Assistant Director of Nursing will review results of the audits during the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring to maintain regulatory compliance.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff, resident and physician interviews, the facility failed to send medication with a resident who left the facility for	F 760	F760 Residents are Free of Significant Med Errors Resident #16 continues to remain in the	9/30/21

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F 760	Continued From page 5 the weekend including medications for hypertension and pain management. This occurred for 1 of 3 residents (Resident #16) reviewed for medication error. Findings included: Resident #16 was admitted to the facility on 7-31-20 with multiple diagnoses that included heart failure, arthritis and dementia. The annual Minimum Data Set (MDS) dated 7-15-21 revealed Resident #16 was cognitively intact. Resident #16's care plan dated 7-27-21 revealed a goal that she would verbalize a reduction in pain after administration of medication. The interventions for the goal were in part; administer pain medication as ordered, encourage resident and or family to request pain medication before pain becomes severe. A review of the physician's orders dated July 2021 revealed Resident #16 was prescribed the following medication: Lasix 40mg (milligrams) daily for hypertension, Prinivil 2.5mg daily for hypertension, Roxicodone 5mg twice daily as needed for pain, Tylenol 325mg three times a day and Norvasc 5mg at bedtime for hypertension. Review of Resident #16's Medication Administration Record (MAR) for the month of July 2021 revealed Resident #16 had not received any of her medication on July 3rd, 2021. Resident #16's Medical Record dated 7-4-21 revealed vital signs, including blood pressure were not obtained upon the resident's return to	F 760	facility. Resident #16 had no adverse affects from missing medications from leave of absence on July 3, 2021, and July 4, 2021, requiring additional/increased dosage of medications, treatments, or supplies. All residents have the potential to be affected by alleged deficient practice. On 9/3/2021, the (interim) director of nursing, assistant director of nursing, unit manager, (interim) administrator, and/or assigned project nurse completed an audit of active resident's charts to ensure all residents received his/her prescribed medications/treatments and are being administered per doctor's order including when resident is out of the facility. On 8/24/2021, the (interim) administrator, (interim) director of nursing (DON), staff development and/or assigned project nurse in-serviced the nursing staff regarding; it is the responsibility of the assigned nurse/medication aide/unit manager to ensure the resident has taken his/her medication (unless resident refuses) as per Doctor's order, prior to appointment or leave of absence. Residents needing to be out of the facility for a significant length of time (longer than resident next medication is due) the assigned nurse/medication aide/unit manager must send the needed medication and/or supplies with the resident and/or responsible party with instructions on medication administration and side effects. It is also the responsibility of the resident assigned	

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F 760	Continued From page 6	F 760		

the facility. On 7-5-21 the Medical Record revealed Resident #16's blood pressure was 121/71.

Nurse #1 was interviewed on 8-5-21 at 1:07pm. The nurse acknowledged she had signed Resident #16 out of the facility to family on 7-2-21. Nurse #1 stated she sent the residents bedtime medication for 7-2-21 but did not send any other medication with the family or resident because she believed the resident was returning the next morning to the facility. The nurse explained she questioned Resident #16 on how long she would be out of the facility and said the resident told her overnight. She acknowledged she did not verify the information with the family. She further said she had not received a call from the family requesting medication for Resident #16. The nurse explained the resident did not return to the facility until 7-4-21 and stated the resident nor the family member voiced any concerns of Resident #16 having pain or discomfort. She acknowledged she did not obtain a set of vitals upon the resident's return.

During an interview with Resident #16 on 8-5-21 at 2:15pm, Resident #16 explained the leave from the facility was scheduled from 7-2-21 to 7-4-21 and said, "Saturday was the day of the wedding. I wasn't coming back here and missing the wedding." The resident stated her family member attempted to call the facility to obtain her medications but had not received a return call. She further stated she had increased pain on Saturday (7-3-21) and the resident stated, "I wished I had my pain medication."

The former Director of Nursing (DON) was interviewed on 8-5-21 at 2:35pm. The former

nurse/medication aide/unit manager to contact the resident and/or resident responsible party to return to the facility for the resident's needed medication and/or supplies unless other arrangements are needed. On 8/27/2021 the staff development coordinator mailed a letter of this in-service to any facility staff member and contracted agency staff not in attendance for this in-service. All newly hired facility staff or agency contracted staff will be educated on significant medication errors to ensure residents receive prescribed medication regimen during orientation to facility. No staff will be eligible to work until he she has been educated on this process.

Beginning 9/3/2021, the (interim) director of nursing, assistant director of nursing, unit manager, (interim) administrator, and/or assigned project nurse will audit 6 resident medical records weekly for 3 months to ensure all residents have his/her prescribed medications/treatments and are being administered per doctor's order including when resident is out of the facility. The audit will be documented on the F760 Residents are Free of Significant Med Errors audit tool.

Beginning 9/10/2021, the (interim) Director of Nursing/Assistant Director of Nursing will review results of the audits during the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for

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F 760	Continued From page 7	F 760		

DON stated he had remembered fourth of July weekend and Resident #16 leaving the facility for the weekend. He explained the resident was to be out of the facility from 7-2-21 to 7-4-21 but stated he could not remember if medications were sent with the family. The former DON said it was customary if a resident was leaving for an extended stay with family, that medications were packaged by the nurse on duty and provided to the family.

During a telephone interview with the former Social Worker (SW) on 8-6-21 at 2:07pm, the former SW stated she remembered Resident #16 leaving the facility for a long weekend with her family and explained the resident was attending a wedding on Saturday (7-3-21) and was not expected back until 7-4-21. The SW further stated she had informed nursing staff of the resident's plans to include her leave date and return date but could not remember which nurse she had spoken to.

A telephone interview occurred with Resident #16's physician on 8-6-21 at 6:10pm. The physician stated anytime a resident leaves the facility for an overnight stay, medications should be packaged and sent with the family. The physician explained Resident #16 had chronic pain and hypertension and her medications should have been sent with her.

A telephone interview occurred with the Administrator and interim Director of Nurses (DON) on 8-12-21 at 11:08am. The Administrator discussed the process for a resident to leave the facility with family for any length of time. The interim DON stated when Resident #16 did not return to the facility the next day, the nurse on three months to identify trends and/or need for additional monitoring to maintain regulatory compliance.

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F 760	Continued From page 8 duty should have contacted the family and provided the medication.	F 760		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, interviews, the administration and/or corporate office failed to ensure the replacement of a non-functioning call system was scheduled. The call system was in disrepair throughout the entire building affecting all residents residing in the facility. Findings included: The Assistant Maintenance Director was interviewed on 8-6-21 at 1:30pm. The Assistant Maintenance Director acknowledged the call light system had been malfunctioning since April 2021 and had stopped working 3 days ago (8-3-21). He explained in June 2021 the facility had approved	F 837	F837 Governing Body On August 6, 2021, it was brought to the attention of the Corporate Management Company; the facility administrator had not followed up with Corporate Management Company for update on contracted call light repair/instillation company estimated start date for facility call light system. On August 10, 2021, corporate maintenance department contacted facility administrator with a start date for replacing the facility call light system by the call light system repair/installation company. The start date is August 12, 2021. The completion date of the call light	9/30/21

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F 837	Continued From page 9 a contract with a company to come replace the call light system, but he stated he did not know when the system was going to be replaced. The contract between the facility and a system monitoring company was reviewed. The contract was for the call light system in the facility to be replaced. The date on the approved contract was 6-14-21. There was no start date provided for the installation of the new call bell system. The Administrator was interviewed on 8-6-21 at 3:23pm. The Administrator discussed the facility had a contract since June 2021 to have the call light system replaced but stated it was not his responsibility to follow up with the contract company for an installation date. He stated the facility's corporate maintenance staff would be responsible to follow up with the contract company. The corporate maintenance staff member was interviewed by telephone on 8-6-21 at 3:50pm. The maintenance staff member explained the facility had an old call light system that needed to be replaced. He discussed speaking with the contract company that would be replacing the facility's call light system every week but had not received a date from the contract company when the system would be installed. The maintenance staff member also said he had been in contact with his manager in the corporate office weekly updating her on the progress for the new call light system. The Manager in the corporate office was interviewed by telephone on 8-6-21 at 3:53pm. The Manger stated she had not been made aware the contract company had not begun	F 837	instillation was September 2, 2021. All residents have the potential to be affected by alleged deficient practice. Facility call light system was replaced and is functioning correctly. There are presently no other facility systems in need of repair. On August 19,2021 the present facility licensed administrator was relieved of his duties. An interim facility licensed administrator was employed by Corporate Management on August 19, 2021. On 8/19/2021, the Regional Vice President of Operations (RVPO) educated the present interim facility licensed administrator regarding notification to designated corporate office and RVP of any facility repairs needed from an outside vendor. Facility RVPO also educated interim facility licensed administrator to ensure repair is timely. It is the interim licensed facility administrator/administrator's responsibility to follow up weekly with RVP and facility corporate management to ensure facility systems are in place functioning properly to ensure safety of residents and staff. RVPO will educate the newly hired licensed facility administrator upon hire date on expected communication with corporate management on properly working facility systems. On September 2, 2021, facility Maintenance Director, assistant maintenance director, director of nursing, and facility(interim) administrator will audit all facility system during Monday – Friday	

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F 837	Continued From page 10 installing the new call light system but acknowledged the approval for the contract company was dated in June 2021.	F 837	Cardinal intradisciplinary team (IDT) meeting for any needed repair. The administrator will be notified via phone by the weekend maintenance on duty of any facility system failure in need of repair. The facility administrator will notify RVPO of repair/needed repair of any facility system failure. Beginning 9/10/2021, the Maintenance Director, assistant maintenance director will review results of the audits during the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring to maintain regulatory compliance.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		9/30/21

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 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 880	Continued From page 11	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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 08/18/2021

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F 880	Continued From page 12 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and physician interview, the facility failed to perform hand hygiene when 2 of 2 staff (Nurse Aide #1 and #2) delivered meal trays for 5 of 5 residents who resided on the quarantine isolation hall. The failure occurred during the COVID-19 pandemic. Findings included: Review of the facility's "Handwashing Policy" dated 3/10/20 revealed in part; personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice. An alcohol-based hand sanitizer may be used for handwashing unless the hands are visibly soiled. Observations of rooms 200, 201, 203, 207, and 211 on 8/5/21 at 11:50 am, revealed there were contact and droplet isolation signs on the doors. Each door displayed a caddy that contained gloves and gowns. The signs on each door read "Stop," "Droplet Precautions," and "Contact Precautions." Further review of the signs revealed in part; "Perform hand hygiene before entering and before leaving room."	F 880	F880 Infection Control & Prevention Observations noted two Certified Nursing Assistants failed to perform hand hygiene while passing resident meal trays. No residents were affected (increase/prolonged signs/symptoms of infection) by this deficient practice. All residents have the potential to be affected by alleged deficient practice. • On 8/24/2021 the facility (interim) administrator, (interim) director of nursing, staff development nurse, and unit managers educated staff on required personal protective equipment (PPE) and proper hand hygiene per Center of Disease Control, Federal and State guidelines, and facility protocol. • On 8/27/2021 the staff development coordinator mailed a letter of this in-service to any facility staff member and contracted agency staff not in attendance for this in-service. An attached letter was enclosed with the education to contact the facility (interim) administrator, (interim)	

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	345448	A. BUILDING _____ B. WING _____	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 880	Continued From page 13 A continuous observation was conducted on the 200 East Hall during lunch meal pass on 8/5/21 at 11:45 am through 11:55 am. NA #1 was observed to enter room 200 without performing hand hygiene and placed a meal tray on the resident's table. NA #1 exited the room without performing hand hygiene. NA #1 proceeded to enter and exit rooms 203 and 211 without performing hand hygiene and placed meal trays on the residents' tables. He had a mask on during the observation and no other PPE was worn. During the same continuous observation on 8/5/21 at 11:47 am, NA #2 entered room 201 and did not perform hand hygiene prior to entering the room and placed a meal tray on the resident's table. She did not perform hand hygiene when she exited the room. NA #2 proceeded to enter room 207 without performing hand hygiene and placed a meal tray on the resident's table and exited without performing hand hygiene. She had a mask on during the observation and no other PPE was worn. NA #1 was interviewed on 8/5/21 at 11:57 am. When asked why he did not perform hand hygiene when he entered and exited the three rooms, NA #1 stated "I just didn't think about it." NA #1 stated he received COVID-19 infection control training which included hand hygiene within this year. NA #2 was interviewed on 8/5/21 at 12:00 pm. When asked why she did not perform hand hygiene when she entered and exited the two rooms, NA #2 stated she normally did not perform hand hygiene between entering each room unless she provided personal care. NA #2 stated she	F 880	director of nursing or facility supervisor with any questions. • All newly hired facility staff or agency contracted staff will be educated on proper hand hygiene per Center of Disease Control, Federal and State guidelines, and facility protocol during orientation to facility, annually and as needed. • No staff will be eligible to work until he she has been educated on this process. On 9/13/2021 a questionnaire/quiz was provided and reviewed with agency/facility staff to ensure understanding of required personal protective equipment (PPE) and proper hand hygiene per Center of Disease Control, Federal and State guidelines, and facility protocol. No employee will be eligible to work until this PERSONAL PROTECTIVE EQUIPMENT AND HANDWASHING QUESTIONNAIRE has been completed. This questionnaire will be added to the new hire/agency staff initial education. • Additional education will continue monthly beginning September 2021 through December 2021 to ensure compliance of COVID-19, required personal protective equipment (PPE), and proper hand hygiene per Center of Disease Control, Federal and State guidelines, and facility protocol. On 9/1/2021 additional hand washing signs were posted on isolation/quarantine resident room doors and throughout the facility by maintenance department (interim) Director of Nursing, or Infection Prevention Nurse as a reminder to staff	

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	345448	A. BUILDING _____ B. WING _____	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 880	Continued From page 14 had received COVID-19 infection control training which included hand hygiene within this year. In an interview with the Infection Preventionist Nurse on 8/5/21 at 1:38 pm, she revealed she believed the failure of the staff not following infection control procedures was due to the facility's use of too many agency nursing staff. She stated the agency nursing staff received infection control in-services prior to working an assignment and expected all staff to follow COVID-19 procedures. In an interview with the Administrator on 8/5/21 at 2:05 pm, he revealed he was unsure of why the staff did not follow infection control procedures while on the quarantine hall. The Administrator stated that staff did receive COVID-19 infection control training earlier in the year. In an interview with the Medical Director on 8/6/21 at 4:45 pm, he indicated there was potential harm when staff entered and exited the droplet isolation rooms, however there was no harm done because the staff did not provide direct care encounters. The Medical Director stated that staff should follow isolation protocols and this issue needed to be addressed by the facility.	F 880	on hand hygiene. On 9/1/2021, the facility (interim) administrator, (interim) director of nursing, infection prevention nurse, assistant director of nursing, staff development nurse, or unit managers began auditing on required PPE and hand hygiene is being performed appropriately per Center of Disease Control, Federal and State guidelines, and facility protocol on 6 random staff members each shift daily x2weeks, then 6 random staff members each shift weekly x3 months. The audit will be documented on F880 Infection Control & Prevention (hand hygiene) audit tool. Any staff member noted out of compliance with required PPE and hand hygiene will be given 1:1 education by (interim) director of nursing, infection prevention nurse, assistant director of nursing, staff development nurse, or unit managers. Beginning 9/3/2021, the (interim) Director of Nursing/Assistant Director of Nursing/Infection Prevention Nurse will review results of the audits during the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/education to maintain regulatory compliance.	
F 919 SS=L	Resident Call System CFR(s): 483.90(g)(2)	F 919		9/30/21

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 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 919	Continued From page 15 §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, physician and contractor interviews for the facility's call system, the facility failed to have a functioning call system and 12 of 14 alert and oriented residents (Resident #17, Resident #18, Resident #19, Resident #20, Resident #21, Resident #22, Resident #23, Resident #24, Resident #25, Resident #26 and Resident #27) did not have an alternate means to call for staff assistance. The call system was in disrepair throughout the entire facility causing the residents to express feelings of being scared, concerned and not cared for by the facility. Immediate Jeopardy began on 8-6-21 when it was observed resident's call lights were not working and they did not have an alternate means to call for assistance. The facility did not conduct on going monitoring which caused no means for some residents to call for staff assistance. This was likely to cause serious injury, serious harm or death. Immediate Jeopardy was removed 8-12-21 when the facility implemented an acceptable creditable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "F" that is not Immediate Jeopardy to ensure monitoring systems put in place are effective.	F 919	F919 Resident Call System On August 6, 2021, a state surveyor identified twelve resident rooms (104, 106, 108, 110, 112, 115, 208, 215, 224, 228, 230, and 231) (Resident #17, Resident #18, Resident #19, Resident #20, Resident #21, Resident #22, Resident #23, Resident #24, Resident #25, Resident #26 and Resident #27) call systems were not properly functioning, and the resident was noted by the surveyor not to have a tap bell or wireless lanyard at this time. All residents have the potential to be affected by alleged deficient practice. Resident #17, Resident #18, Resident #19, Resident #20, Resident #21, Resident #22, Resident #23, Resident #24, Resident #25, Resident #26 and Resident #27 were assigned and educated on the appropriate alternative call light system. All residents' safety has been maintained during this alleged deficient practice. On August 6, 2021, all residents residing in the facility were assessed by nurse	

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

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F 919	Continued From page 16 Findings included: Resident #23 was admitted to the facility on 5-27-21 The quarterly Minimum Data Set (MDS) dated 7-8-21 revealed Resident #23 was cognitively intact. During an interview with Resident #23 on 8-6-21 at 9:25am, the resident commented that his call light had not been working for approximately 3 days. Resident #23 voiced concern regarding what he would do if he needed assistance from staff. He further explained he had informed the Director of Nursing the day the call light system was not working (8-3-21) and stated the Director of Nursing informed him the facility was trying to get the call light system fixed. Resident #23 said he was not provided an alternate means to call for staff assistants. An observation was made of resident rooms on 8-6-21 at 9:30am. The observation revealed rooms 104, 106, 108, 110, 112, 115, 208, 215, 224, 228, 230 and 231 did not have a working call light system and the residents in those rooms did not have an alternative means of call for assistance. Resident #18 was admitted to the facility on 10-6-20 The residents quarterly Minimum Data Set revealed Resident #18 was cognitively intact. Resident #18 was interviewed on 8-6-21 at 2:30pm. The resident discussed not having a call	F 919	management (interim Director of Nursing and 4-unit managers) for the use of wireless call bell lanyards, tap bells or 30-minute safety/needs rounds. A list of residents residing in the facility has been placed at each nursing station for nurse and CNA staff to reference for identified resident alternative call light system. This list will be updated daily as needed by the unit managers, the interim DON and/or the administrator. On August 6, 2021, the facility administrator educated all department heads. The interim DON and Staff Development Coordinator educated nurses, certified nursing assistants (CNAs), housekeeping staff, therapy staff, maintenance staff, dietary staff, and agency staff working. This education was completed on August 10, 2021. The education regarding the resident call system covered: • Staff educated on the wireless call bell lanyards and tap bell at bedside & in bathroom and 30-minute safety/needs rounds now and at the beginning of each shift until call bell system is replaced. • The nursing assistants, nurses, agency staff, unit managers, interim director of nursing (DON) role is, during routine care rounds, nursing staff will ensure residents have lanyards in place and functioning/battery is not dead, (if battery is dead the nurse or unit manager will replace the battery. Extra batteries will be kept in medication rooms on each unit) and tap bells are within reach and 30-minute safety/needs are being met. During routine care rounds the nursing	

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	345448	A. BUILDING _____ B. WING _____	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 17 light, bell or lanyard since April 2021. He stated, "it's been a little scary because I can't call for help unless I yell and even then, they cannot hear me because they are in another resident room." The resident said he had not had any accidents such as falls but did have to wait an hour or longer to be provided incontinence care and stated, "I just had to wait until someone came to check on me." Resident #18 clarified that staff would check on him every 30 minutes to an hour. Resident #27 was admitted to the facility on 8-16-14. Resident #27's annual Minimum Data Set revealed he was cognitively intact. Resident #27 was interviewed on 8-6-21 at 2:40pm. The resident discussed the call light system had been malfunctioning since April but said, "sometimes it worked and sometimes it did not and for the past few days it has not worked at all." The resident discussed receiving a bell yesterday (8-5-21) but stated, "I don't feel it is adequate because staff cannot hear the ding. It's scary, you have people falling and getting sick and there is no way to get them help but to yell." Resident #21 was admitted to the facility on 2-26-14. The quarterly Minimum Data Set dated 6-23-21 revealed Resident #21 was cognitively intact and required supervision with one person for toileting. During an interview with Resident #21 on 8-6-21 at 2:45pm, the resident discussed having a bell on his table but stated when he was in the bathroom there was no way to call for assistance	F 919	assistants, nurses, agency staff, unit managers, interim director of nursing will also check the wireless lanyards central monitor for low power symbol indicating that battery is low. The nursing assistants, nurses, agency staff, unit managers, interim director will replace batteries of the identified lanyard to ensure optimal power is maintained. • All cognitive residents were educated on August 6, 2021, on when and how to use the tap bells and wireless lanyard call system by the unit managers, the interim DON and/or the administrator. • All cognitive residents will continue to be educated on the use of tap bells and lanyard wireless call system as needed by the assigned nurse, assigned CNA or unit managers, the interim DON and/or the administrator. • Any concerns of tap bells or wireless lanyard not working/appropriate for any resident will be reported to the administrator immediately for any changes needed. Any safety or resident needs not being met due to the call light system will be reported to the administrator immediately and corrected to ensure each individual resident safety and needs are met. On August 10, 2021, corporate maintenance department contacted Maple Grove Health and Rehabilitation Center administrator with a start date for replacing the facility call light system by the call light system repair/installation company. The start date is August 12, 2021. The completion date of the call light instillation was September 2, 2021.	

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 08/18/2021

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 919	Continued From page 18 if he needed it. Resident #21 stated he had received the bell yesterday (8-5-21) because the call light system was not working but said, "What am I supposed to do in the bathroom? I am scared if I fall in there no one will know." Observation of Resident #21's bathroom revealed the call light system was pulled out of the wall exposing the wires and there was no other means available for the resident to call for assistance. Resident #17 was admitted to the facility on 12-21-20. The residents quarterly Minimum Data Set dated 3-30-21 revealed Resident #17 was cognitively intact and required supervision with one person for toileting. Resident #17 was interviewed on 8-6-21 at 2:50pm. The resident discussed if he needed help, he would use his call light system. Resident #17 said, "I did not know it was not working. What about the bathroom?" The resident stated when he came back to his room this afternoon (8-6-21), he saw a bell on his table but did not know what it was for. He further said, "Oh they will know if I need help. I can yell loud, but it does bother me I would have to yell." The Interim Director of Nursing (DON) was interviewed on 8-6-21 at 9:40am. The DON discussed being aware the call light system had not been working in the entire facility for the past 3 days but explained each resident had been provided a bell to be able to call for staff assistance. She observed rooms 104, 106, 108, 110, 112, 115, 208, 215, 224, 228, 230 and 231 and found no bell or alternate means for the	F 919	On September 2, 2021, facility Maintenance Director, assistant maintenance director, director of nursing, and facility(interim) administrator will audit the call bell system in every room daily for 1 week, then 20 periodic rooms twice weekly for 3 weeks, then 10 periodic rooms twice weekly for 2 months. The facility Maintenance Director, assistant maintenance director, director of nursing, and/or facility(interim) administrator will put an alternate call light system in place for any call light in need of repair immediately to ensure resident safety. The administrator will be notified via phone by the weekend maintenance on duty of any call light system failure in need of repair. Beginning 9/10/2021, the Maintenance Director, assistant maintenance director will review results of the audits during the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring to maintain regulatory compliance.	

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	345448	A. BUILDING _____ B. WING _____	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 919	Continued From page 19	F 919		

residents to call for assistance. The DON stated she did not know why the rooms did not have a bell and explained the nursing staff was responsible for monitoring each resident to assure they had means to call for assistance.

During an interview with the Administrator on 8-6-21 at 10:05am, the Administrator discussed having a plan of correction (POC) in place for the call light system. He explained in April 2021, management had become aware the facility's call light system was malfunctioning and had placed a bell or a wireless lanyard in each resident room. The Administrator stated an audit had been completed to assure each resident had a bell or lanyard present to call for staff assistance and did not know why the rooms that were observed to did not have a bell or lanyard present. He further said the nursing staff was responsible for monitoring the resident rooms to assure each resident had a bell or lanyard present.

A review of the facility's POC dated 4-28-21, listed the problem identified was "call lights in rooms not functioning properly." The action taken on the POC was "all call lights have been tested for proper function." The plan section for the POC read "call light service has been contacted. Staff have been communicated on select call lights not functioning. Alternate manual bells have been provided to residents. Staff will conduct 15-minute checks on all rooms with nonfunctioning call light." The POC's monitoring was "call light rounds check will be reviewed daily in cardinal meeting. All call lights will be tested weekly. Daily concern rounds to monitor the call light." The resolution date in the POC was "Until the call light system for the rooms is fixed."

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 08/18/2021

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 919	Continued From page 20	F 919		

A nursing assistant (NA) #3 was interviewed on 8-6-21 at 1:15pm. The NA stated she had been checking on the residents every 30-45 minutes. She discussed being aware the call light system had not been functioning but was not aware she was to check on the residents every 15 minutes. The NA further stated she was not aware if the residents assigned to her had a bell/lanyard to call for assistance and said she would ask the residents during her rounds if they needed anything.

NA #4 was interviewed on 8-6-21 at 1:20pm. The NA explained she was aware the call light system was not functioning and said she had been checking on her residents every 30 minutes to see if they needed assistance. NA #4 discussed not being aware she was to check on the residents every 15 minutes and stated it was not possible to check on the residents every 15 minutes due to the volume of residents she was assigned. She further said she was not aware if each of her residents had a bell/lanyard to call for assistance.

During an interview with NA #5 on 8-6-21 at 1:25pm, the NA stated she was aware the call light system was not functioning and did not know if her residents had a bell/lanyard in their room to call for assistance. The NA further stated she could not check on her residents every 15 minutes because she was usually in a resident room for 30 minutes at a time and she was not aware that she was to be checking on her residents every 15 minutes. She said when she checked on her residents, she would ask them if they needed anything.

The Assistant Maintenance Director was

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 08/18/2021

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 919	Continued From page 21	F 919		

interviewed on 8-6-21 at 1:30pm. The Assistant Maintenance Director stated he had not been testing the call light system weekly and was not aware he was supposed to test the call light system weekly. He further stated when a resident or staff member informed him a call light was not working, he would attempt to repair that call light. The Assistant Maintenance Director acknowledged the call light system had not been working consistently since April and had stopped working 3 days ago. He explained the facility had a contract with a company to come replace the call light system since June 2021 but did not know when the system was to be replaced.

The contract between the facility and a system monitoring company was reviewed. The contract was for the call light system in the facility to be replaced. The date on the approved contract was 6-14-21.

The Administrator and DON were interviewed on 8-6-21 at 3:23pm. The Administrator discussed not being aware the residents were not wearing their lanyards and the monitoring system in the facility's April 2021 POC was not being followed. The DON discussed reviewing the staffing but stated the facility used agency staff and often there were call outs. The Administrator discussed the facility having a contract to have the call light system replaced but stated it was not his responsibility to follow up with the contract company for an installation date. He stated the facility's corporate maintenance staff would be responsible to follow up with the contract company.

The corporate maintenance staff member was interviewed by telephone on 8-6-21 at 3:50pm.

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 08/18/2021

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 919	Continued From page 22	F 919		

The maintenance staff member explained the facility had an old call light system that needed to be replaced. He discussed speaking with the contract company that would be replacing the facility's call light system every week but had not received a date when the system would be installed from the contract company. The maintenance staff member said he had also been in contact with his manager in the corporate office weekly updating her on the progress for the new call light system.

The Manager in the corporate office was interviewed on 8-6-21 at 3:53pm. The Manger stated she had not been made aware the contract company had not begun installing the new call light system but acknowledged the approval for the contract company was dated 6-14-21.

The contract company was interviewed by telephone on 8-6-21 at 5:25pm. The contractor stated he had spoken with the facility's corporate office and explained why he was not able to provide a start date to install the new call light system. The contractor said the facility did not have an electronic copy of the facility's layout so, he was having to draw the blueprints by hand and then the blueprints had to be accepted by the engineers. He said the company was actively working on getting the project approved but still could not provide a start date.

The facility's Medical Director was interviewed on 8-6-21 at 4:19pm. The Medical director discussed being aware the call light system was not working but was unaware there were several residents without means to call for assistance. He said there was a safety concern if the residents were not able to call for assistants and if the facility had

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 08/18/2021

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 919	Continued From page 23	F 919		

a call light system for the residents it needed to be functional.

A telephone interview occurred with the interim DON on 8-9-21 at 9:10am. The interim DON discussed all residents having a bell or lanyard on Friday (8-6-21) but she had not completed an audit today (8-9-21) or over the weekend to assure all residents had an alternate communication devise accessible to them. She further stated she had instructed the staff to check on the residents every 2 hours.

The Administrator was notified of Immediate Jeopardy on 8-9-21 at 4:45pm.

The facility provided a credible allegation of Immediate Jeopardy removal dated 8-12-21. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the non-compliance.

On April 28, 2021, Maple Grove Health and Rehabilitation Center administrator was made aware of facility call light system (combination of resident rooms on North, South and West Halls, not the entire halls) not functioning properly during a facility tour.

On April 28, 2021, a call light audit was conducted by facility maintenance director to ensure all call lights in the facility were functioning. This audit revealed 22 rooms/55 beds/ 19 residents had call lights that were not functioning properly. On April 28, 2021, a combination of a wireless call light system lanyard (to keep on resident person) or a tap bell (at bedside) as appropriate were placed in resident rooms to ensure resident safety for the identified resident rooms where call lights were

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 08/18/2021

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 919	Continued From page 24 noted not functioning properly. On April 28, 2021, a facility Plan of Improvement was put in place to ensure resident safety. " All call lights have been tested for proper functioning. " Call light system repair company has been notified. " Staff have been informed on select call lights not functioning properly. " Alternate manual bells have been provided to residents. " Staff will conduct 15-minute checks on all rooms with non-functioning call lights. " Call light rounds will be reviewed in the daily Cardinal Meeting. " All call lights will be tested weekly. Resolution to call lights malfunctioning Plan of Improvement resolved due to wireless lanyard call light systems in place. No other audits were performed for call lights functioning properly. On April 28, 2021, Maple Grove Health and Rehabilitation Center administrator held an impromptu meeting with facility department heads to inform them of facility call light system not functioning properly. On April 28, 2021, facility maintenance director contacted corporate maintenance consultant of facility call bell system not functioning properly. Corporate maintenance consultant came to facility and installed two wireless lanyard call light systems. The wireless lanyard call light system has a receiver box that is plugged into a wall outlet and a battery-operated lanyard is given to the resident to use as the resident would use a call light. The receiver box has a screen that reflects the room that the lanyard was activated in	F 919		

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 08/18/2021

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 919	Continued From page 25	F 919		

as well as a speaker with an alarm to notify staff.

On May 5, 2021, after several visits to repair Maple Grove Health and Rehabilitation Center call light system, the repair/installation company notified corporate maintenance consultant that Maple Grove Health and Rehabilitation Center call light system could not be repaired. The call light system repair/installation company did not convey to Maple Grove Health and Rehabilitation Center, nor to corporate maintenance department, to anticipate additional call lights malfunctioning. Therefore, Maple Grove Health and Rehabilitation Center staff did not resume facility call light audits to ensure proper functioning. Corporate maintenance department requested a quote from the call light system, the repair/installation company.

On June 10, 2021, corporate maintenance department received a quote from the call light system, the repair/installation company for replacement of Maple Grove Health and Rehabilitation Center facility call light system.

On June 16, 2021, corporate approved the call light system, the repair/installation company quote to replace Maple Grove Health and Rehabilitation Center call light system.

On June 29, 2021, corporate maintenance department approved Maple Grove Health and Rehabilitation Center request to replace the facility call light system.

Multiple attempts were made from corporate maintenance department to the call light repair/instillation company via phone for an estimated instillation date from June 29, 2021,

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 08/18/2021

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 919	Continued From page 26	F 919		

through August 6, 2021.

On August 6, 2021, a state surveyor identified twelve resident rooms (104, 106, 108, 110, 112, 115, 208, 215, 224, 228, 230, and 231) call systems were not properly functioning, and the resident was noted by the surveyor not to have a tap bell or lanyard at this time. These rooms were not identified on the initial call light audit on April 28, 2021, as not functioning properly nor had anyone reported any call light malfunctions in these rooms.

On August 6, 2021, Maple Grove Health and Rehabilitation Center administrator held an impromptu Quality Assurance Performance Improvement meeting with facility department heads to inform them of facility call light system not functioning properly. Facility department heads agreed to initiating a substitution call light system using a wireless lanyard call system (to be kept on resident person who demonstrated the ability to understand the use of the lanyard system) or tap bells (placed at bedside for residents that understood and had the ability to use a tap bell and in bathrooms of residents that used bathroom) to maintain resident safety. Any resident that does not have the cognitive and/or physical ability to use the lanyard system or tap bell has been identified. Staff were notified by the administrator, interim DON and nurse managers of residents that will require at least every 30-minute rounds. The administrator, interim DON and nurse managers will monitor the rounds daily to ensure, wireless lanyards are in place and functioning, tap bells are in place at bedside and in bathrooms and at least every 30-minute rounds are being completed by the assigned CNA/nurse daily.

On August 6, 2021, residents who have the

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 08/18/2021

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 919	Continued From page 27	F 919		

cognitive and/or physical ability to use the lanyard system or tap bell have been identified and staff will round on at least every 30 minutes were educated on the use of his/her alternate call light system by the administrator, interim DON and nurse managers.
On August 6, 2021, staff were educated on the alternate call light system. Staff were educated to ensure each resident had the assigned call light in place and were able to use his/her assigned call light during rounds and each additional visit to resident room to ensure resident safety. The staff was also educated on cognitively impaired or having physical inability to use the alternate call light system will be checked at least every 30 minutes to ensure safety and resident needs are met.
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:
On August 6, 2021, all residents residing in the facility were assessed by nurse management (interim Director of Nursing and 4-unit managers) for the use of wireless call bell lanyards, tap bells or 30-minute safety/needs rounds (census 119):
Lanyards were assigned to residents: 35
Tap bells were assigned to residents at bedside and in bathroom as appropriate: 84
Residents requiring 30-minute safety/needs rounds: 26
Any resident residing in the facility refusing to use any of the appropriately assigned alternate call light system will be re-assessed for an alternate appropriate call light system to meet each individual resident safety/needs.
A list of residents residing in the facility has been placed at each nursing station for nurse and CNA staff to reference for identified resident alternative

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 08/18/2021

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 919	Continued From page 28	F 919		

call light system. This list will be updated daily as needed by the unit managers, the interim DON and/or the administrator.
On August 6, 2021, at approximately 8:00p.m., Regional Maintenance consultant installed an additional wireless lanyard call system to ensure every resident room was covered by the wireless lanyard system.
On August 6, 2021, the facility administrator educated all department heads. The interim DON and Staff Development Coordinator educated nurses, certified nursing assistants (CNAs), housekeeping staff, therapy staff, maintenance staff, dietary staff, and agency staff working. The education regarding the resident call system covered:
" Staff educated on the wireless call bell lanyards and tap bell at bedside & in bathroom and 30-minute safety/needs rounds now and at the beginning of each shift until call bell system is replaced.

" The nursing assistants, nurses, agency staff, unit managers, interim director of nursing (DON) role is, during routine care rounds, nursing staff will ensure residents have lanyards in place and functioning/battery is not dead, (if battery is dead the nurse or unit manager will replace the battery. Extra batteries will be kept in medication rooms on each unit) and tap bells are within reach and 30-minute safety/needs are being met. During routine care rounds the nursing assistants, nurses, agency staff, unit managers, interim director of nursing will also check the wireless lanyards central monitor for low power symbol indicating that battery is low. The nursing assistants, nurses, agency staff, unit managers, interim director will replace batteries of the identified lanyard to ensure optimal power is

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 08/18/2021

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 919	Continued From page 29	F 919		

maintained.

" All cognitive residents were educated on August 6, 2021, on when and how to use the tap bells and wireless lanyard call system by the unit managers, the interim DON and/or the administrator.

" All cognitive residents continue to be re-educated as needed on the use of tap bells and/or the lanyard wireless call system as needed by the assigned nurse, assigned CNA or unit managers, the interim DON and/or the administrator.

" All cognitive residents will continue to be educated on the use of tap bells and lanyard wireless call system as needed by the assigned nurse, assigned CNA or unit managers, the interim DON and/or the administrator.
Any concerns of tap bells or wireless lanyard not working/appropriate for any resident will be reported to the administrator immediately for any changes needed. Any safety or resident needs not being met due to the call light system will be reported to the administrator immediately and corrected to ensure each individual resident safety and needs are met.
The in-service was started on August 6, 2021, by the administrator with all department heads. The interim DON and Staff Development Coordinator educated nurses, CNAs, and agency staff working. The education is added to all new staff and agency staff orientation. The education completion date is August 10, 2021.
By August 6, 2021, the administrator, maintenance worker, interim Director of Nursing or unit nurse manager began performing call light

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 08/18/2021

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 919	Continued From page 30	F 919		

rounds daily. The rounds include ensuring resident can use call light (tap bell or lanyard wireless call system) and staff are responding to call lights (tap bell or lanyard wireless call system) appropriately as well as staff are performing at least 30-minute safety/need rounds to ensure all resident needs are met and resident safety is maintained. These rounds will be conducted daily by unit managers, any negative findings (resident refuses to use assigned alternate call light, alternate call light not in place, alternate call light not functioning properly, resident no longer able to effectively use alternate call light due to change in cognitive/physical ability) these rounds will be reported immediately to the interim DON and/or the administrator for corrective action that will ensure all residents safety/needs are met.
On August 10, 2021, corporate maintenance department contracted with a different call light instillation company for Maple Grove Health and Rehabilitation Center new call instillation. This different company was contracted due to previous company stating multiple times to corporate maintenance department via phone the instillation company has been unable to obtain the needed parts nor does the company have the staff.
On August 10, 2021, corporate maintenance department contacted Maple Grove Health and Rehabilitation Center administrator with a start date for replacing the facility call light system by the call light system repair/installation company. The start date is August 12, 2021. The estimated completion date of the call light instillation is September 3, 2021.
The Administrator is responsible for ensuring this plan is followed.
Maple Grove Health and Rehabilitation Center IJ removal August 12, 2021.

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 08/18/2021

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 919	Continued From page 31 Validation of the facility's credible allegation occurred on 8-13-21 and was evidenced by staff interviews, record reviews, observation, facility training that included staff ensuring the residents had a tap bell or a wireless lanyard within reach and a tap bell located in the bathroom, staff is to check that the lanyards are on the residents person or the tap bell is within reach of the resident during staff rounds and staff is to check the wireless monitoring system during rounds for any low battery detection and replace the lanyard battery if needed. Observation of hall 100 revealed residents had a tap bell or a lanyard present and within reach with all lanyards functioning properly. Observation of hall 200 revealed a new call light system had been installed in each resident room and bathroom. The new call light system was observed to be functioning properly.	F 919		