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 03/06/2024

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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E 000	Initial Comments The survey team entered the facility on 02/26/24 to conduct a Recertification and Complaint survey. The survey team was onsite 02/26/24 through and 02/29/24. Additional information was obtained offsite on 03/06/24. Therefore, the exit date was changed to 03/06/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# SOH411.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 02/26/24 to conduct a recertification survey and complaint investigation. The survey team was onsite 02/26/24 through 02/29/24. Additional information was obtained offsite on 03/06/24. Therefore, the exit date was changed to 03/06/24. Event ID# SOH411. The following intakes were investigated NC00212844, NC00213878, NC00212538, NC00212034, NC00211315, NC00210649, NC00210414, and NC00209566. 3 of the 22 complaint allegations resulted in deficiency.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than	F 637		4/2/24

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

Electronically Signed | 03/28/2024

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F 637	Continued From page 1 one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to complete a significant change in status assessment for 1 of 1 resident reviewed for significant change (Resident #70). Findings included: Resident #70 was admitted to the facility on 4/27/23 with diagnoses of dementia. Review of the quarterly Minimum Data Set (MDS) dated 10/18/23 revealed Resident #70 required supervision with eating, upper body dressing, lower body dressing partial /moderate staff assistance for oral hygiene, toileting hygiene, putting on/taking off footwear, and personal hygiene. Resident #70 was independent in the mobility areas of roll left and right, sit to lying, lying to sit, sit to stand, chair and bed transfer. Resident #70 had no weight loss. Review of the quarterly MDS dated 1/18/23 revealed Resident #70 was dependent on staff in the following areas of mobility: eating, oral hygiene, toileting, shower/bathing, upper body dressing, lower body dressing, putting on and taking off footwear, and personally hygiene. In the area of Mobility, Resident #70 required substantial/maximal assistance to roll left and right and was dependent on staff for sit to lying, lying to sit, sit to stand, chair/bed to chair transfer, and tub shower transfer. Resident #70 was assessed to have had weight loss and was not on	F 637	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 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 Health and Rehabilitation□s response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 2/29/2024 the corrective action for residents #70 was completed by the Minimum Date Set (MDS) Nurse. Resident #70 Minimum Date Set (MDS) for Significant Change was completed on 2/29/24 to reflect the changes in their Activities of Daily living (ADL) due to decline in eating, dressing, personal hygiene, chair and bed transfers and weight loss.	

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F 637	Continued From page 2 a physician-prescribed weight loss regimen. A review of Resident #70's MDS assessments revealed a Significant Change in Status Assessment had not been completed after the noted decline in activity of daily living in eating, dressing, personal hygiene, chair and bed transfers and weight loss. An interview on 5/17/23 at 1:30 PM the MDS Nurse #1 stated that a Significant Change in Status Assessment should be done whenever there is a change in two or more areas of improvement or decline. MDS Nurse #1 further revealed that a Significant Change in Assessment should have been completed on 1/18/23 assessment and must have been overlooked. An interview on 2/29/24 at 1:18 PM with the Administrator revealed that a Significant Change in Assessment should be completed per MDS guidelines.	F 637	On 3/21/2024 the Interdisciplinary Team, IDT conducted an IDT meeting to discuss significant changes of condition of all current residents to assess for the need for a Significant Change Status Assessment to be completed by the MDS nurses with oversight by the Regional MDS consultant. On 3/22/2024 the corrective action for all residents having the potential to be affected was an initial audit of all MDS Assessments for capturing of resident□s that have assessed as having a significant change of condition in the past 90 days by reviewing the ADL significant change report and weight measurements performed by the MDS nurses with oversight by the Regional MDS Consultant and corrections were made as needed. On 3/21/2024 the Regional MDS Consultant re-educated the Administrator and MDS Nurses on completing a significant change assessment when the IDT team determines that the significant change guidelines are met per the RAI manual. New MDS nurses will receive orientation upon hire on completing significant change assessments by the Regional MDS Consultant. Director of Nursing, Assistant Director of Nursing, or Administrator will complete audits for capturing of significant changes weekly for 4 weeks, and then monthly for 2 months. Results of audit will be shared with the Quality Assurance Performance	

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F 637	Continued From page 3	F 637	Improvement (QAPI) members for 3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area hearing, speech and vision for 1 of 1 resident reviewed for communication. (Resident #96). The findings included: Resident #96 was admitted to the facility on 4/5/23 with diagnosis of hearing deficit. A review of Resident #96's electronic medical record (EMR) included Pace of the Triad Primary Comprehensive Assessment progress note dated 11/9/23. This assessment revealed a chronic medical condition of severe hard hearing. The Pace Nurse Practitioner (Pace NP #1) indicated in this note that Resident #96's was severely hard of hearing, and the hearing loss was chronic and ongoing. Resident #96's most recent Minimum Data Set (MDS) assessment dated 12/4/23 revealed the	F 641	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 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 Health and Rehabilitation's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	4/2/24

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F 641	Continued From page 4 resident had moderately impaired cognition and coded the resident as not having a hearing deficit. Resident #96's care plan revised on 12/14/23 by MDS Nurse #1 revealed a focus area for inability to express emotion, listen and share information; auditory alteration/deficit characterized by decreased lack of hearing related to hearing deficit, uses hearing amplifier. The interventions included use of pocket talker to hear. An interview was conducted with MDS nurse #1 on 02/28/24 11:08 AM. She revealed that she completed this assessment, and she thought Resident #96 could hear adequately. She further indicated that she did not realize he had been previously assessed to have hearing impairment at the time of the assessment nor was she aware of having access to hearing amplifier/pocket talker. MDS Nurse #1 then confirmed that she was the MDS Nurse that revised the hearing care plan on 12/14/23 which indicated that Resident #96 had a hearing deficit and the intervention of the use of a hearing amplifier. The MDS Nurse #1 then indicated that she might have coded this section incorrectly. An interview on 2/29/24 at 1:19 PM with the Administrator revealed that Resident #96's hearing should be assessed per MDS guidelines.	F 641	On 3/22/2024 the corrective action for resident #96 was accomplished by the Minimum Date Set (MDS) Nurse modified the assessments on MDS for identified resident #96 for not having a hearing deficit. Corrective action for all residents having the potential to be affected was an initial audit of all MDS Assessments for accuracy of assessment related to hearing abilities was performed by the MDS nurses with oversight from the Regional MDS Consultant on 3/22/2024 and corrections were made as needed. Re-education of how to complete MDS assessments accurately provided to Administrator and MDS Coordinators by Regional MDS Consultant on 3/21/2024. New MDS nurses will receive orientation upon hire on accurate coding of assessments by the Regional MDS Consultant. Director of Nursing, Assistant Director of Nursing (ADON) or Administrator will complete audits of MDS assessments for hearing devices weekly for 4 weeks, and then monthly for 2 months. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.	

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F 677	Continued From page 5	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with resident and staff, the facility failed to provide nail care to a resident who needed extensive assistance from staff for Activities of Daily Living (ADL). This deficient practice affected 1 of 7 residents (Resident # 90) reviewed for ADLs. Findings included: Resident #90 was admitted to the facility on 03/18/22 with diagnoses of hemiplegia (paralysis of one side of the body). Review of the annual Minimum Data Set (MDS), dated 01/09/24, revealed Resident #90 was cognitively intact and required extensive assistance with personal hygiene. Review of Resident #90's care plan revised 01/25/24 revealed a need for Activities of Daily Living (ADL)/Personal Care with the following intervention including the resident required assistance for personal hygiene, and grooming. During observation and interview on 02/26/24 at 12:03 pm, Resident #90 was observed lying in bed with fingernails on both hands that were about ½ inch long. Resident #90 stated he wanted his nails clipped and would ask the staff.	F 677	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 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 Health and Rehabilitation's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 2/29/24, MDS Nurse #1 trimmed resident #90 nails. On 3/21/27, the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Unit Manager (UM) initiated an audit of Activities of Daily Living (ADL)	4/2/24

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F 677	Continued From page 6 An observation was conducted on 02/27/24 at 12:41 pm of Resident #90 lying in bed and his nails remained long. Resident #90 stated he did not ask to have his nails clipped and would ask his nurse today. On 02/28/24 at 10:25 am an observation was made of Resident #90 and his nails remained long on both hands. Resident #90 stated he had asked the Nurse to clip his nails on 02/27/24, however he did not remember what nurse he had asked. An interview was conducted on 02/28/24 at 10:59 am with the MDS Nurse and she indicated residents' nails were usually clipped when the Nursing Assistant (NA) provided ADL care, unless they had diabetes. The MDS Nurse was in the room and verified with Resident #90 he asked to have his fingernails clipped on 02/27/24 by the nurse, and the nurse he asked said okay, but never clipped them. A review of Resident #90's Activities of Daily Living documentation from December 2023 to present revealed no documentation that showers had been provided and no refusals noted. Attempt to contact NAs who were assigned to work with Resident #90 on 02/26/24 and 02/27/24 was unsuccessful. An interview was conducted 02/29/24 at 11:16 am with the Nurse (Nurse #2) who was assigned to Resident #90 on 02/26/24 and 02/27/24 and she indicated the Resident did not request to have his nails clipped. She indicated staff had not informed her Resident needed his nails clipped. Nurse #2 stated she did not notice Resident #90 needed	F 677	care of all dependent residents to include nail care, skin, and foot assessments. This audit is to ensure all residents were assisted with ADL care and in the event of refusal of care, it's documented in the electronic record. The DON/ADON/UM will address all concerns identified during the audit to include assisting dependent residents with ADL care and education of staff. Audit completed 3/22/27. On 2/29/24, the DON/ADON/UMs initiated an in-service with all nurses and nursing assistants regarding ADL Care with emphasis on ensuring nails are clean and trimmed per resident preference for all dependent residents. In-services will be completed by 4/2/2024. any nurse or nursing assistant to include agency and contract staff who has not received the in-service will be in-service prior to the next scheduled work shift. All newly hired nurses and nursing assistants, agency and contract staff will be in service during orientation regarding ADL Care. The DON/ADON/UM's will review nail care assessment sheets to ensure nail care is being completed as assigned. Resident observation will be performed Nurse and C.N.A to include resident #90, weekly x 4 weeks then monthly x 2 months utilizing the nail care assessment sheets. This audit is to ensure all dependent residents were assisted with ADL care and refusals of care documented in the electronic record. The DON/ADON/UM will address all concerns identified during the audit. The DON will	

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F 677	Continued From page 7 his nails clipped or she would have clipped them. An interview was conducted with the Administrator and Director of Nursing (DON) on 02/29/24 at 3:08 pm. The DON indicated Resident #90's fingernails were clipped on 02/28/24 and his nails should be clipped if he requested them to be clipped.	F 677	review the nail care assessment sheets audit tool weekly x 4 weeks then monthly x 2 months to ensure all concerns are addressed. The DON will forward the results of nail care assessment sheets audit tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the nail care assessment sheets to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.	
F 685 SS=G	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 685		4/2/24

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F 685	Continued From page 8 interviews with the resident and staff, the facility failed to provide a cognitively dependent resident with access to a hearing amplifier to accommodate a hearing deficit. This deficient practice occurred for 1 of 1 resident reviewed for accommodation of needs (Resident #96). The reasonable person concept was applied for Resident #96 due to his inability to hear what was happening around him. A reasonable person would feel social isolation, loneliness, and frustration. Findings included: Resident #96 was admitted to the facility on 4/5/23 with the diagnosis of Alzheimer's disease. A review of the most recent comprehensive Minimum Data Set (MDS) dated 4/11/23 revealed Resident #96 had moderately impaired cognition and moderately impaired hearing with the use of a hearing device. Resident #96's care plan revised on 12/14/23 revealed a focus area for inability to express emotion, listen and share information; auditory alteration/deficit characterized by decreased lack of hearing related to hearing deficit, uses hearing amplifier. The interventions included use of pocket talker to hear. On 2/26/24 at 9:49 AM an observation and interview were conducted with Resident #96. He was observed sitting on the side of the bed in a quiet room. Resident #96 indicated that he had a hard time hearing and could not recall when he last had access to a hearing amplifier but thought he had one at one time.	F 685	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 Health and Rehabilitation's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 2/28/2024 the Social Worker verified placement of the hearing amplifier and testing for proper functioning. The Social worker found the device to be functioning properly with the attached headphones. On 2/29/2024 assessment/education for use of device completed with Resident #96 by MDS Nurse. On 2/29/2024, Administrator educated Activity Director #1, Social Worker #1, Unit Manager #1, Nursing Assistant #1, Medication Aid #1 on the location of the hearing amplifier and how to properly use the hearing amplifier for resident #96.	

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F 685	Continued From page 9 A review of the Pace of the Triad Primary Comprehensive Assessment progress note dated 11/9/23 revealed a chronic medical condition of severe hard of hearing. The Pace Nurse Practitioner (Pace NP #1) indicated in this note that Resident #96's was severely hard of hearing, and the hearing loss was chronic and ongoing. Pace NP #1 revealed that Resident #96 was examined using a pocket talker which was effective and without the pocket talker, hearing loss did appear to significantly affect Resident #96's ability to communicate and/or perform Activities of Daily Living (ADL's). Pace NP #1 further revealed that in previous notes hearing aides were not tolerated however hearing loss was adequately addressed using the pocket talker which Resident #96 tolerated well and was at his bedside for as needed use. A review of psychiatric note dated 1/26/24 indicated that during Resident #96's treatment visit he was observed to be hard of hearing and repeatedly said " I don't know, and I can't hear you." On 2/28/24 at 9:07 AM an interview was conducted with the Activity Director. She indicated that Resident #96 was hard of hearing and that she must raise her voice for him to hear her. She further revealed that she was not aware of any available hearing devices and had not used or offered any hearing devices such as a hearing amplifier during activities. On 2/28/24 at 9:19 AM an interview was conducted with Nursing Assistant (NA) #1, and she indicated that she was familiar with Resident	F 685	On 3/4/2024, Social Worker conducted an audit of all resident's care planned for hearing devices to ensure that the hearing devices are accessible and properly functioning, listed on care guide/task for nursing assistants, and on the resident's care plan. On 2/29/24, the DON/ADON/UMs initiated an in-service with all staff regarding resident hearing devices with emphasis on offering device, location of device, functionality of device, resident refusals, availability of device, and notification to charge nurse. In-services will be completed by 4/2/2024. Any staff member, to include agency and contract staff who has not received the in-service will be in-service prior to the next scheduled work shift. All newly hired staff, to include agency and contract staff, will be in service during orientation regarding resident hearing devices. The Social Worker will conduct the hearing device audit three times a week x4 weeks then weekly x 2 months. This audit is to ensure that staff and residents are aware of the location and proper function of all residents with hearing devices. The Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Unit Manager (UM) will address all concerns identified during the audit. The Social Worker will present the hearing device audit results to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months.	

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F 685	Continued From page 10 #96 and that he had a hard time hearing but was able to hear if she raised her voice. She further indicated that she was not aware if he had hearing aids or a hearing amplifier available. On 2/28/24 at 9:27 AM an interview was conducted with Resident 96's assigned medication aide (Medication Aide #1) and she indicated that Resident #96 was hard of hearing and that she had to raise her voice for him to hear but he was able to hear. She further revealed that she could not recall if Resident #96 had hearing aids or hearing amplifier available. On 2/28/24 at 9:39 AM an interview was conducted with Social Worker #1, and she revealed that Resident #96 was hard of hearing, and she had to raise her voice for him to hear her and she did not use any hearing devices when speaking with him. A follow up interview was conducted on 2/28/24 at 10:06 am and she indicated that she went to Resident #96's room and located a hearing amplifier in his room inside the drawer of his bedside table. On 2/28/24 at 3:27 PM a follow up visit was made to Resident #96 with Unit Manager #1 present. Unit Manger #1 was able to locate the hearing amplifier in the bedside table drawer and asked Resident #96 while using a raised voice if he would allow the use of the hearing amplifier so she could talk with him. Resident #96 responded by nodding head yes and reached hand out to hold the base of the amplifier. Unit Manager #1 then offered the headset to Resident #96, and he leaned his head toward Unit manager #1 to accept the hearing device but Unit Manager #1 realized that the left earpiece of the amplifier was	F 685	The QAPI Committee will meet monthly x 2 months and review the ADL Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.	

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F 685	Continued From page 11 dangling loose. Unit Manager #1 attempted to reattach it, but attempts were not successful. Unit Manager #1 explained to Resident #96 that the amplifier was broken, and she would have to get him a new one and he agreed by nodding his head yes. A follow up interview was conducted with Resident #96 on 1/29/24 at 1:56 PM and he indicated that he would like for staff to use the hearing amplifier so that "I can hear better." On 2/29/24 an interview was attempted with the Pace of the Triad Medical Director as DNP #1 was not available. Attempts to interview the Pace of the Triad Medical Director were not successful. An interview was conducted with the Administrator on 2/29/24 at 1:19 PM. She indicated that the hearing amplifier was listed as an intervention on Resident #96's care plan and care guide but that it was up to the staff to determine if they felt they needed the device to effectively communicate with Resident #96. She further revealed that she was not made aware by Unit Manager #1 that the hearing amplifier was broken at that time.	F 685		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the	F 867		4/2/24

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following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that

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improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and

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F 867	Continued From page 14 available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint surveys dated 1/18/22 and current survey 3/06/24 in the area of accurately coding Minimum Date Set (MDS). The facility also failed to maintain implemented procedures and monitor interventions the committee put in place following the annual recertification and complaint surveys	F 867	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 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 Health and Rehabilitation's response to this statement of deficiencies	

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F 867	Continued From page 15 conducted on 1/18/22, 1/27/23 and the current survey 03/06/24, in the area of Activity of Daily Living (ADL) care provided for dependent residents. The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This citation is cross referenced to: 1 F 641 Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area hearing, speech, and vision for 1 of 1 resident reviewed for communication. (Resident #96). During the previous recertification and complaint survey date 1/18/22 the facility failed to accurately code the nutrition section of the minimum data set (MDS) for 2 of 5 residents reviewed for Nutrition 2 F 677 Based on observations, record review, and interviews with resident and staff, the facility failed to provide nail care to a resident who needed extensive assistance from staff for Activities of Daily Living (ADL). This deficient practice affected 1 of 7 residents (Resident # 90) reviewed for ADLs. During the previous recertification and survey on 1/27/23 the facility failed to provide showers, nail care, and mouth care to residents who needed extensive and/or were dependent on staff for Activities of Daily Living (ADL).	F 867	does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 2/29/24, MDS Nurse #1 trimmed resident #90 nails. On 3/21/27, the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Unit Manager (UM) initiated an audit of Activities of Daily Living (ADL) care of all dependent residents to include nail care, skin, and foot assessments. This audit is to ensure all residents were assisted with ADL care and in the event of refusal of care, it's documented in the electronic record. The DON/ADON/UM will address all concerns identified during the audit to include assisting dependent residents with ADL care and education of staff. Audit completed 3/22/27. On 2/29/24, the DON/ADON/UMs initiated an in-service with all nurses and nursing assistants regarding ADL Care with emphasis on ensuring nails are clean and trimmed per resident preference for all dependent residents. In-services will be completed by 4/2/2024. any nurse or nursing assistant to include agency and contract staff who has not received the in-service will be in-service prior to the next scheduled work shift. All newly hired	

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F 867	Continued From page 16 During the previous recertification and complaint survey on 1/18/22, the facility failed to provide a haircut (Resident #71) for 1 of 3 activity of daily living dependent residents reviewed. During an interview on 2/29/24 at 3:23 PM, the Administrator stated the Quality Assurance (QAPI)) committee, regarding the repeated deficiencies the Administrator stated the old plan of correction would be revisited and analyzed to see where the failures and breakdowns happened. This would help analyze the cause of repeat deficiency. The Administrator indicated once the plan was put in place, audits and the monitoring phase would be completed. She further indicated that sporadically monitoring and auditing throughout the year should be continued to ensure the repeated deficiencies do not recur. Repeated concerns were also discussed in QAPI meeting and the QAPI committee would see how the approach can be changed if needed. This could be education and training of staff or revision of the approach or new approach if needed.	F 867	nurses and nursing assistants, agency and contract staff will be in service during orientation regarding ADL Care. The DON/ADON/UM's will review nail care assessment sheets to ensure nail care is being completed as assigned. Resident observation will be performed Nurse and C.N.A to include resident #90, weekly x 4 weeks then monthly x 2 months utilizing the nail care assessment sheets. This audit is to ensure all dependent residents were assisted with ADL care and refusals of care documented in the electronic record. The DON/ADON/UM will address all concerns identified during the audit. The DON will review the nail care assessment sheets audit tool weekly x 4 weeks then monthly x 2 months to ensure all concerns are addressed. On 3/22/2024 the corrective action for resident #96 was accomplished by the Minimum Date Set (MDS) Nurse modified the assessments on MDS for identified resident #96 for not having a hearing deficit. Corrective action for all residents having the potential to be affected was an initial audit of all MDS Assessments for accuracy of assessment related to hearing abilities was performed by the MDS nurses with oversight from the Regional MDS Consultant on 3/22/2024 and corrections were made as needed. Re-education of how to complete MDS	

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F 867	Continued From page 17	F 867	assessments accurately provided to Administrator and MDS Coordinators by Regional MDS Consultant on 3/21/2024. New MDS nurses will receive orientation upon hire on accurate coding of assessments by the Regional MDS Consultant. On 2/29/2024 education completed by the Facility Consultant/Corporate Clinical Director Administrator and IDT members educated on the Corporate Policy for Quality Assurance and Performance Improvement. The Facility Consultant/Corporate Clinical Director will attend the facility Quality Assurance Performance Improvement (QAPI) monthly meetings x 2 months to ensure the facility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director will review the minutes and the Performance Improvement Plans once a month for 2 months. The Administrator will hold monthly Quality Assurance Performance Improvement Committee (QAPI) meetings with the QAPI committee. The meeting agenda will include review of all Performance Improvement Plans (PIP) to include the PIP for MDS Assessment Accuracy and Coding and ADL for Dependent Residents. The Audit Tools will be reviewed monthly to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or	

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F 867	Continued From page 18	F 867	frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.	