STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Maple Leaf	**1101 Maple Care Lane , Statesville, North Carolina, 28625**

(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
F0000	INITIAL COMMENTS A complaint investigation survey was conducted on 12/18/25. Additional information was collected offsite through 12/22/25 therefore, the exit date was changed to 12/22/25. The following intake was investigated: 2681213. Event ID #1DEEB2-H1. One of the one complaint allegation resulted in a deficiency.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and interviews with staff, Nurse Practitioner (NP) and Medical Director, the facility failed to provide care in a safe manner when Resident #1 rolled out of her bed and hit the floor during incontinence care. Resident #1 was sent to the Emergency Department (ED) and diagnosed with an occult (subtle hip bone break often in older adults that often does not show up on imagining but causes pain, tenderness, and difficulty walking) nondisplaced (the bone breaks but maintains it proper alignment) left hip fracture, distal left femur fracture (fracture of the lower portion of the thighbone near the knee joint) and a left side scalp hematoma (bruise that occurs when blood pools outside blood vessels). The deficient practice occurred for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1).	F0689	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0689 SS = G	Continued from page 1 The findings included: Resident #1 was admitted to the facility on 08/28/24 with diagnoses that included coronary artery disease and dementia with agitation. Review of Resident #1's physician orders revealed an order dated 08/28/24 for clopidogrel bisulfate (antiplatelet) 75 milligrams (mg) one tablet by mouth one time a day. Antiplatelet medications can increase the risk of bleeding. The quarterly Minimum Data Set (MDS) assessment dated 11/10/25 revealed Resident #1 had severe cognitive impairment, required substantial assistance from staff for bed mobility and positioning and had no functional limitations on either side. The MDS also indicated that the Resident had no falls since the previous review and was not on an anticoagulant. The care plan last reviewed on 11/10/25 revealed Resident #1 had a self-care performance deficit in her activities of daily living (ADL) related to disease processes and was at risk for a decline in physical function related to limited mobility and dementia. The goal that Resident #1 would improve her current level of function would be attained by utilizing interventions such as encouraging the Resident to fully participate with each interaction, allowing for increased support as necessary and encouraging participation in skilled therapies when provided. Review of an Incident Report dated 11/24/25 at 10:30 AM and written by Nurse #2 revealed Nurse Aide (NA) #1 was in the process of cleaning Resident #1 up for the day when the Resident was asked to roll over. Resident #1 was asked to roll back over to NA #1 after the NA placed a pad onto the bed. The Resident was on her side facing the opposite direction. The Resident then rolled out of the bed and onto the floor instead of back towards the NA. Resident #1 stated, "I rolled over like she asked me to". The Report continued to explain that Resident #1 was assessed by the Nurse Practitioner (NP) who determined that due to a head injury the Resident needed to be evaluated at the hospital. Resident #1's left leg appeared to be shorter than her right leg. Resident #1 remained on the floor until the emergency medical services (EMS) arrived. An interview was conducted with NA #1 on 12/18/25 at 10:10 AM. The NA explained that she was providing incontinent care for Resident #1 on 11/24/25 and after she put the brief and incontinent pad under the Resident, she asked Resident #1 to roll back over	F0689		

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F0689 SS = G	Continued from page 2 towards her, but the Resident rolled away from her instead and rolled off the bed onto the floor. The NA continued to explain that she had both of her hands under Resident #1 to hold the brief and pad down, but the Resident rolled over so fast that she did not have enough time to grab her before she fell off the bed. She reported that she went to Resident #1 who had landed halfway on her front and her left side between the two beds and asked her if she was hurt and the Resident stated her left arm hurt. The NA stated she immediately went and found Nurse #1 and asked him to come to Resident #1's room because she had fallen off the bed. She explained that when they returned to the Resident's room the Resident had blood coming from her head. The NA reported that the NP entered Resident #1's room within seconds after she and Nurse #1 arrived and started assessing the Resident for injuries. She stated Resident #1 was sent to the hospital for evaluation of her injuries. The NA explained that Resident #1 was a one person assist because she was able to roll herself over and hold onto the bed while incontinence care was being provided and she did not know why the Resident decided to roll in the opposite direction. An interview conducted with Nurse #1 on 12/18/25 at 10:40 AM. The Nurse explained that he was at the nurses' station when he was called to Resident #1's room by NA #1 who reported that the Resident rolled out of bed. He continued to explain that when he entered the Resident's room, he observed her lying between her left side and her front side on the floor between the beds with her left leg and right arm underneath her. The Nurse reported that the NP was seconds behind him and entered the room and immediately started to assess the Resident after which the NP and Nurse #1 rolled Resident #1 over onto her back. Nurse #1 stated that there was blood coming from the left side of the Resident's forehead, so they obtained some gauze while the NP rendered first aid and continued to assess Resident #1 for further injuries while Nurse #1 called 911. Review of a Progress Note written by Nurse #2 dated 11/24/25 at 10:33 AM revealed Resident #1 was in the middle of being cleaned up for the day when she was asked to roll over by NA #1. The Resident rolled over and continued to roll out of bed onto the floor. Resident #1 does not have bed rails on her bed. The NP was onsite and assessed Resident #1. The Resident presented with a large hematoma to the left scalp. The Resident's left leg appeared to be shorter than the right leg. Resident #1 was being sent out to the hospital to be evaluated per NP.	F0689		

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F0689 SS = G	Continued from page 3 Review of a Progress Noted written by Nurse #2 dated 11/24/25 at 10:30 AM revealed Resident #1 was being sent to the hospital for evaluation for post fall and possible fracture per the NP. Review of Resident #1's Emergency Department report dated 11/24/25 revealed a Computed Tomography (CT) of the pelvis that showed severe bone demineralization and a non-displaced left hip fracture and a distal left femur fracture. The CT scan of the skull showed no midline shifts of structures, no subarachnoid hemorrhage and no fractures. The scan showed hemorrhage (bleeding) in the frontoparietal scalp. The report indicated that orthopedics was consulted and Resident #1's family opted for no surgical intervention, so a knee immobilizer was placed. There was no orthopedic follow-up ordered for the Resident. Resident #1 was discharged back to the facility on 12/03/25 with orders for acetaminophen 500 mg by mouth four times a day for pain and tramadol 50 mg by mouth every six hours as needed for pain. Review of Resident #1's physician orders dated 12/04/25 revealed: wear immobilizer as Resident allowed. Review of Resident #1's Medication Administration Record for from 12/03/25 through 12/18/25 revealed the Resident received acetaminophen 500 mg by mouth four times a day routinely for pain. There was also an order for tramadol 50 mg by mouth every six hours as needed for pain dated 12/05/25. The tramadol had been given 4 times for extra coverage for pain. An observation and interview were conducted with Resident #1 on 12/18/25 at 9:30 AM. The Resident was lying on her back in bed with the head of her bed slightly raised. The bed had a concaved mattress (a mattress with raised sides) and no side rails. She had green and yellow bruising on her left forehead and face that appeared to be fading, and she wore an immobilizer on her left leg. Both legs were resting on a pillow. When Resident #1 was asked if she remembered falling, she replied in a low voice, "No" and when she was asked if she was in pain she pointed to her left leg. A sitter who stayed with Resident #1 reported that the Resident had recently received her pain medication. An interview was conducted with the Nurse Practitioner on 12/18/25 at 10:55 AM. The NP explained that she was summonsed to Resident #1's room by Nurse #1 when NA #1 informed Nurse #1 that the Resident had fallen off the bed. The NP went to the room to find Resident #1 lying on her abdomen and her left side and the Resident had a large hematoma on the left side of her forehead that	F0689		

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F0689 SS = G	Continued from page 4 was bleeding. The NP reported that she and Nurse #1 log rolled Resident #1 onto her back, and she asked the Resident if she had pain and Resident #1 stated her left leg was hurting but denied head pain. The NP continued to report that she assessed the Resident and found her left leg was shorter and internally rotated. She stated she advised Nurse #1 to call 911 while she applied a pressure bandage to stop the hematoma from bleeding. The EMS arrived shortly afterwards, and Resident #1 was transported to the hospital. The NP reported that Resident #1 returned to the facility with a left side forehead hematoma with no cranial bleed or fracture and a left mid-distal femoral fracture. She stated the Resident's bones were severely demineralized. The NP reported Resident #1's pain was controlled with routine and as needed pain medication and a long leg immobilizer that stayed in place except for bathing. An interview was conducted with Nurse #2 on 12/18/25 at 9:55 AM. The Nurse explained that she was assigned to Resident #1 on 11/24/25 but was not on the hall when the Resident fell off the bed. The Nurse reported that all the nurses received a message on their phone application from the NP to go to Resident #1's room stat (immediately), and when the Nurse entered the Resident's room, the NP and Nurse #1 were already in the room and working with Resident #1. Nurse #2 continued to explain that she observed Resident #1 lying on the floor on her back between both beds with her head pointed toward the roommate's bed. The left side of her forehead was bleeding. The Nurse reported that by that time, the NP was treating the Resident's bleeding, and the EMS had already been called. She stated Resident #1 was repeating, "get me out of the floor" and when Nurse #2 asked her what happened, the Resident stated, "I rolled out of bed". Nurse #2 stated Resident #1 remained on the floor until the EMS came to transport her to the hospital which was within minutes. Review of a physician progress note dated 12/04/25 at 11:34 AM written by the Medical Director revealed Resident #1 had a fall with a head injury on 11/24/25 and was sent to the hospital and was noted to have a left mid/distal femoral shaft fracture. The Resident was seen by orthopedics, but she was non-ambulatory and family did not wish for surgery at this time. An interview was conducted with the Medical Director on 12/18/25 at 12:40 PM. The Medical Director explained that Resident #1 had a fall at the facility and was transported to the hospital where she was found to have a head injury, but the CT scan ruled out a subdural hematoma. She also sustained a fracture of the femur,	F0689		

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F0689 SS = G	Continued from page 5 but her family refused surgery. When the Medical Director was asked if he considered the Resident's injuries to be significant, he explained that he did not consider her injuries to be significant because she was not ambulatory before the fall and she was not ambulatory after the fall so he did not feel that the fracture hindered her quality of life. Multiple attempts were made to interview the ED Physician, but the attempts were unsuccessful. Interviews were conducted simultaneously with the Administrator and Director of Nursing (DON) on 12/18/25 at 2:55 PM. The DON explained that she felt like the fall was an unfortunate accident because Resident #1 was assessed to be a one person assist with incontinence care and bed mobility and she was able to roll over with little assistance and hold onto the bed frame by herself. She stated she felt that the Resident was confused when she was asked to roll back towards the NA and rolled in the opposite direction instead. The DON continued to explain that Resident #1's pain was being managed with routine acetaminophen and as needed tramadol when she would take it. She stated Resident #1 did not want to take other pain medications except for acetaminophen. The DON added that the Resident always wore the immobilizer. She continued to explain that skilled therapy orders were initiated to evaluate and treat Resident #1 when she returned to the facility. The DON added the NP will monitor Resident #1 for the healing fractures and obtain x-rays as necessary. The Administrator added that the facility has provided a sitter 24/7 for the time being until it was determined not to be necessary. The facility provided the following corrective action plan: The decision to monitor and QA incident was made on 11/25/25 at an AD HOC meeting.1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:On 11/24/2025, Resident #1 was assessed immediately following the fall out of bed during incontinent care by the Nurse Practitioner. The Nurse Practitioner placed an order on 11/24/2025 to transfer the resident to the local hospital Emergency Department for further evaluation and treatment of a possible fracture. The resident's care plan was updated on 11/24/2025 by the nursing staff to require two-person assistance for all bed mobility tasks. On 11/24/2025, the Director of Nursing completed	F0689		

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F0689 SS = G	Continued from page 6 one-on-one education and a competency review with the Nurse Aide #1 involved in the incident regarding safe turning and positioning techniques. The resident's family and facility Nurse Practitioner were notified of the incident and the transfer to the hospital on 11/24/2025. The family was notified of the incident by Nurse #2. The Facility NP was notified of incident by Nurse #1. Completion Date: 11/25/2025 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 11/24/2025, the Assistant Director of Nursing reviewed all resident falls that occurred within the past 30 days to identify any incidents related to staff assistance with bed mobility. No additional concerns were identified during this review of falls. On 11/24/2025, the Minimum Data Set (MDS) Coordinator and Therapy Program Manager audited each resident's GG assessment Section (GG0170), care plan and resident care summaries for bed mobility to ensure accuracy and presence on the resident care summary for nursing staff reference. No additional negative findings were identified during the GG assessment, care plan and resident care summary audit. Completion Date: 11/25/20253. Address what measures will be put into place or systemic changes were made to ensure that the deficient practice will not recur:Beginning on 11/24/2025, the Director of Nursing provided in-service education to the nursing staff regarding the facility policy and procedure for turning and repositioning residents in bed. The education completed on 11/25/2025 included instruction to ensure staff are aware of the residents' bed mobility status listed on the resident care summary and to use the correct assistance level, such as one or two-person assistance. Staff were educated to be cautious when asking confused residents to follow commands during turning and positioning. Staff were instructed that it is acceptable to use more assistance if needed, but never less than what is documented on the resident care summary. On 11/24/25 Nurse Managers were educated by the Director of Nursing that newly hired and/or absent nursing staff will be educated by a Nurse Manager on these policies prior to accepting patient assignments. Care summaries are located on the inside of the door of	F0689		

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F0689 SS = G	Continued from page 7 the resident's closet. The care summary is updated daily by the MDS Nurse if any new changes are made. Staff are instructed to check the care summary every day/shift that they care for a resident since sheets may have been updated. On 11/25/25 the MDS Nurse was notified by the Director of Nursing of their responsibility to update the residents' care summary every day if changes have been made to their care summaries. Completion Date: 11/25/2025 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or Designee will audit all falls out of bed to ensure no falls occurred because of improper turning and repositioning staff. These audits will be conducted five days a week for four weeks, then three days a week for four weeks as determined at the Ad HOC QAPI meeting on 11/25/25. The Director of Nursing or Designee will conduct the Skills Checklist for Bed Mobility/Positioning on Side with nursing staff across all shifts to ensure proper technique is utilized. The Nursing Assistant Clinical Skills Checklist and Competency Evaluation will be completed with five Certified Nursing Assistants per week for eight weeks across all shifts. Nurse Manager will observe all Certified Nursing Assistants to ensure they are turning and repositioning the resident correctly by utilizing the Nursing Assistant Clinical Skills Checklist and Competency Evaluation. The Nurse Managers were notified by the Director of Nursing on 11/25/25 to complete competency evaluations with staff and to review the amount of assistance that was needed prior to allowing staff to perform tasks. The Nurse Manager reviewed the amount of assistance that was needed prior to allowing staff to perform tasks. The Administrator or Designee will review the results of these audits and the plan during the monthly Quality Assurance and Performance Improvement (QAPI) meeting. The audits will continue at the discretion of the Quality Assurance and Performance Improvement committee based on compliance results. Date of Compliance: 11/26/2025 The facility's plan of correction was validated on 12/18/25 that included reviews of Resident #1's care plan to require a two person assist with bed mobility and turning, audits of falls within the past 30 days	F0689		

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F0689 SS = G	Continued from page 8 that occurred with staff assistance to ensure there were no issues and reviewed audits to ensure residents mobility assessments and care plans matched to the amount of assistance required. The review also included how education was provided with nursing staff through verbal instruction and return demonstration of the education. Interviews were obtained to verify the Nurse Managers were conducting the observations during their daily rounds of staff utilizing proper bed mobility and turning techniques and making sure the correct bed mobility assistance reflected the residents' care summary. The facility's compliance date of 11/26/25 was validated.	F0689		