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 10/15/2013

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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record reviews the facility delayed a Hospice consultation for Resident#3. This was evident in 1 of 1 resident in the sample reviewed for Hospice care. Findings included: Review of Resident#3 ' s physician order dated 9/19/13 revealed an order for a Hospice consultation due to end stage dementia. Interview on 10/14/13 at 1:50 pm with (SW)Social Worker#1 revealed she sent a fax to ----______ (name of Hospice program) on 9/19/13 for consultation. SW#1 indicated that she learned the Hospice program may not have received the initial fax and a re-fax was done on 10/2/13. SW#1 indicated " I do not have the initial faxed confirmation. " SW#1 indicated she had not noticed at the time of the initial fax whether the fax was sent without a problem. Continued interview with SW#1 revealed Nurse#12 informed her (SW # 1 was not sure of the date) that the Hospice evaluation had not been done. Interview on 10/14/13 at 2:10 pm with Nurse#12	F 309	Maple Grove acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor is that any deficiency accurate. Further, Maple Grove reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. F309 The Social Worker re-faxed a copy of the order for Hospice services to the hospice company for Resident #3 on October 2, 2013. Hospice services for this resident were initiated on October 4, 2013. A 100% audit of Hospice orders to ensure that Hospice services had been initiated, including Resident #3, was completed on October 14, 2013. This audit was expanded, including Resident #3, to include all physician orders for resident services and was completed on October 30, 2013. These audits were conducted by the Director of Nursing, the Assistant Directors of Nursing, the Quality Improvement Nurse, and both social workers to ensure all orders, to include hospice orders, have been carried out timely. Areas identified in the Hospice order audit as needing correction or follow-up were corrected by October 18, 2013; and other areas identified in the expanded audit were corrected	10/2/13 10/14/13 10/30/13 10/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra N. Pate
TITLE: Administrator
(X6) DATE: 11/8/13

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 309	Continued From page 1 revealed she informed SW#1 and SW#2 on 10/2/13 that the Hospice consultation had not been done. Interview on 10/14/13 at 2:23 pm with SW#2 revealed she was informed on 10/2/13 that the consultation had not been done. " I re-faxed over to the Hospice program the request " since SW#1 would not be available the entire day. Review of the confirmation fax page dated 10/2/13 at 12:25pm revealed SW#2 re-faxed the physician ' s order for the Hospice consultation. Review of the Hospice form revealed Resident#3 was initially evaluated and started participation into the Hospice program on 10/4/13. Interview on 10/15/13 at 2:15 pm with the administrator, director of nurses and corporate representative was held. The administrator indicated that she thought that the resident was enrolled in the Hospice program prior to 10/4/13 because the resident was discussed in stand -up meetings. The director of nurses revealed she expected the resident to be evaluated by Hospice within 5 days of the physician order.	F 309	by October 31, 2013. The corrections were made by the Director of Nursing, the Assistant Directors of Nursing, and/or the Quality Improvement Nurse. An in-service was completed on November 12, 2013 with all licensed nurses regarding Hospice orders including the need to put the pink copy of the doctor's Hospice order in the Quality Improvement Nurse's box on each nursing station to initiate quality improvement monitoring. This in-service was given by the Director of Nursing and Staff Facilitator/Staff Development Coordinator. All newly hired license nurses will be in serviced regarding Hospice orders during orientation by the Staff Facilitator/Staff Development Nurse. The Social Workers along with the Director of Nursing, Assistant Directors of Nursing, and the Quality Improvement Nurse were in-serviced regarding expectations that Hospice services are initiated within five business days (this was changed to 2 business days on October 22, 2013 after discussion at the Executive Quality Improvement Meeting) and tasks required when	10/31/13 11/12/13 10/22/13
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	implementing requests and orders for Hospice services. Social Worker tasks are to fax a copy of the signed doctor's order to Hospice and then call Hospice by telephone to ensure that the order was received with information needed to contact the resident/family. This will be documented by the Social Workers in their progress note. This in-service was given on October 14, 2013 by the Administrator. Communication regarding need for Hospice Services and Hospice doctor's orders will be	10/14/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 2	F 323		

This REQUIREMENT is not met as evidenced by:
Based on record review, interview with the nurse practitioner, and staff interviews, the facility failed to use a mechanical lift to transfer Resident #1, who subsequently sustained a left femur fracture. This was evident for one of three residents reviewed for accidents, who required a mechanical lift for transfer. The facility failed to provide one on one staff supervision as developed in the plan of care for 2 of 3 (resident #2 and resident #4) residents identified at risk for falls.

Findings included:

Record review indicated Resident #1 was initially admitted to the facility on 09/18/12 with cumulative diagnoses of late effective cerebrovascular disease with left sided hemiparesis.

Review of the annual Minimum Data Set (MDS) with an assessment reference date of 08/15/13 indicated the resident had moderately impaired cognition and was totally dependent on staff for transfers which required two plus person physical assistance.

Review of the care plan dated 08/26/13, indicated Resident #1 required assistance for transfers from one position to another related to lack of strength and status post cerebrovascular accident with left sided weakness. The care plan goals indicated Resident #1 would receive necessary physical assistance to transfer through the next review. Interventions included: Transfers with two persons provided for physical assist with a mechanical lifting device. Resident #1 was to

Provider's Plan of Correction (F 323):

discussed in the daily Monday – Friday Morning Meeting starts October 16, 2013. The goal is to ensure that residents receive Hospice services in a timely manner for their well-being. If there are issues that might impact being able to implement Hospice services within two business days of the order that this information is shared and closely problem-solved with days monitored by the Administrator and/or Director of Nursing. This meeting is attended by the department managers including the Administrator, Director of Nursing, Assistant Directors of Nursing, Minimum Data Set Nurses, Social Workers and bookkeepers. The Morning Meeting Agenda was revised on October 14, 2013 to facilitate discussion regarding residents needing or requesting Hospice Services; and Hospice orders pending, days pending, and any issues or follow-up information. — 10/16/13; 10/14/13

The Quality Improvement Nurse and/or Assistant Director of Nurses will receive the pink copy of the doctor's order for Hospice services and will audit all of the doctors' orders for Hospice services to ensure that Hospice orders are initiated timely utilizing a Hospice QI Audit Tool weekly for 4 weeks, then monthly for 4 months. All identified areas of concern will immediately be corrected by the Quality Improvement nurse, Assistant Directors of Nurses, and/or Social Worker.

A Quality Improvement Meeting was held on October 14, 2013 to discuss expectations and tasks needed to insure that residents receive Hospice services timely. Expectations and duties — 10/14/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 3 be monitored for safety awareness. Review of the current undated resident care guide for Resident #1 indicated, " Handling/ /Movement: Non-ambulatory, mechanical (lifting device) medium sling, Aid of 2 persons. " Interview with MDS Nurse #2 conducted on 10/14/13 at 11:58 AM indicated, " The resident ' s care plan from admission has always reflected use of a lift for transfers. I changed the care plan for transfers on 04/9/13 to indicate ' Provide two persons for physical assist with mechanical aid (named brand Lift). ' The aides were already using a lift and it was already on (Resident #1 ' s) care guide to use the lift as part of their training. " Review of the nursing notes dated 09/09/13 at 1:05 PM read: The resident is alert and oriented to self and able to communicate needs to staff. The resident complains of pain to the left hip. The resident reports he heard something pop when he was being put to bed. The physician was made aware and ordered an x-ray to the left hip. As needed pain medication was given for pain. Review of the physician ' s orders dated 09/09/13 read: X-Ray to the left hip, related to edema. Vicodin 5/500 milligram tablet, give 1 by mouth every 8 hours times 3 days, then give Vicodin 5/500 milligram tablet, 1 by mouth every 8 hours as needed for pain. Review of the radiology report dated 09/09/13 read, " Exam: Hip Unilateral Complete, Minimal 2V (2 views), Left. Results: Hip series. Findings: There is no acute fracture or dislocation. Narrowing of the hip joint space is noted which suggests arthritis. Conclusion: No acute fracture	F 323	of social workers and nurses when a Hospice order is written were discussed. Results to date of the 100% audit and the action plan for correction were discussed at the Executive Quality Improvement Committee Meeting during the week starting October 22, 2013. The next Quality Improvement Committee meeting will be held during the week starting November 11, 2013 to discuss audit results for 4 weeks; and the Executive Quality Improvement Committee will meet during the week starting on November 25, 2013 to discuss identification of any potential trends to determine the need for action and/or frequency of continued monitoring. F323 The MD was notified of Resident #1 complaint of pain on September 9, 2013. An x-ray of Resident #1's hip was taken on September 9, 2013. A second x-ray was taken on September 10, 2013 to include Resident #1's leg. Resident # 1 was transferred to the hospital on September 10, 2013 following communication of resident injury. The Administrator initiated an investigation of injury of unknown origin and submitted a 24-hour report to the State on September 10, 2013, when the injury was identified; and a 5 day report was submitted on September 16, 2013. NA# 3, NA # 4 and NA #5 were in-serviced regarding reading the resident care guide for transfer prior to transfers and safe handling by the Staff Facilitator/Staff Development Nurse. Resident #2 and Resident # 4 were placed on 24-hour one to one monitoring beginning October 22, 2013. A 100% audit was completed of all residents' care guides, including Resident #1, for accuracy to include the transfer section by the Director of	Week of 11/11/13 week of 11/25/13 9/9/13 9/9/13 9/10/13 9/10/13 9/10/13 9/16/13 10/22/13

(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 323	Continued From page 4 or dislocation. Degenerative changes of the hip. " The nursing notes of 09/09/13 at 3:47 PM read: The x-ray report was received and it showed no fracture or any dislocation noted. The nursing notes dated 09/10/13 at 3:37 AM read: The resident continues to have swelling to the left knee and lower leg. (The resident) complained of pain and received pain medication. The pain medication was effective. The nursing notes dated 09/10/13 at 9:55 AM read: Resident continues to complain of pain to left knee. The on call (referring to the physician) was notified and ordered an x-ray to the left knee. The resident was given pain medication. The physician ' s orders dated 09/10/13 read: X-Ray to the left knee stat. (immediately) related to edema and pain. (Apply) an ice pack to the left thigh every 4 hours for edema. Change Vicodin (pain medication) to every 4 hours scheduled. Morphine (pain medication) 2 milligrams, was ordered to be given intramuscularly prior to the resident ' s transfer via Emergency Medical Services. The patient was to be moved to the local hospital. Review of the radiology report dated 09/10/13 read: " Exam: Knee Exam 3V (views), Left. Results: The distal femoral shaft has an acute fracture with lateral displacement. Conclusion: Acute distal femur fracture. " The nursing notes of 09/10/13 at 1:48 PM read: The resident ' s x-ray showed a Distal Femur Fracture. The Nurse Practitioner ordered for resident to be sent to the local hospital. The	F 323	Nursing, Assistant Directors of Nursing and the Quality Improvement Nurse was initiated on September 10, 2013 and completed by November 12, 2013. Resident care plan areas identified as needing correction were immediately updated by Director of Nursing, Assistant Directors of Nursing and the Quality Improvement Nurse. 100% transfer observation was completed, on all nursing staff to include licensed nurses, nursing assistants, and NA#3, NA #4, and NA #5, to ensure proper transfer technique is being utilized per the resident care guides by the Director of Nursing, Assistant Directors of Nursing, the Quality Improvement Nurse and the Staff Development Facilitator/Staff Development Nurse. Retraining was immediately completed with licensed nurses and nursing assistants for any identified areas of concerns by the Director of Nursing, Assistant Directors of Nursing, the Quality Improvement Nurse and/or the Staff Facilitator/Staff Development Nurse. A 100% audit was also completed on October 22, 2013 by the Quality Improvement Nurse for all residents identified at risk for falls, including Resident #2 and Resident #4, within the last 180 days to ensure appropriate interventions were in place. Any identified areas of concern were addressed by the Quality Improvement Nurse with initiation of appropriate interventions and documentation in the Quality Improvement progress notes; including 24-hour, one to one monitoring which was put into place on October 22, 2013, An in-service was initiated on September 11, 2013 by the Staff Facilitator/Staff Development Nurse with all nursing assistants, including NA	9/10/13-11/12/13 10/22/13 10/22/13 9/11/13

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 10/15/2013

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 323	Continued From page 5 resident was in pain when leaving. Two milligrams of Morphine (pain medication) was given per the Nurse Practitioner ' s order. Review of the facility Nurse Practitioner ' s note dated 09/10/13 read: " Chief Complaint: AV Femur Fracture. The nurse (referring to Nurse #6) reported the patient started complaining of left hip and thigh pain yesterday morning (09/09/13) and notes edema to the left thigh. (Nurse#6) denies recent fall; states patient is usually transferred from bed to chair with the lift, but was assisted back to bed via 2 person assist approximately 2 days ago (09/08/13). A hip x-ray was obtained yesterday (09/09/13) and was negative for acute fracture and dislocation. This morning, the patient reportedly continued to complain of pain and the on-call provider ordered a left knee x-ray. The conclusion of the three views revealed an Acute Distal Femur Fracture. The Patient reports feeling a " pop " when assisted back to bed 2 days ago (09/08/13). (The resident) states the left hip and thigh " hurts " and (the resident) can ' t move (the resident ' s) left leg due to the pain. " Interview with the Nurse Practitioner conducted on 10/14/13 at 11:15 AM indicated, " I had come in on Tuesday(09/10/2013), (Resident #1) was in lot of pain, and the doctor had ordered a left hip x-ray on Monday (09/09/13), which was negative for a hip fracture. On Tuesday (09/10/13), the hall Nurse (Nurse #6) showed me the x-ray report which showed a Left Distal Femur Fracture. (Resident #1) was still complaining of pain on Tuesday (09/10/13), and I sent (Resident #1) to the hospital, because of my assessment of an obvious fracture. (Resident #1) told me (Resident #1) felt something pop when the Nursing	F 323	#3, NA #4, and NA #5, and licensed nurses regarding reading the resident care guide prior to transfer of a resident, the safe handling and movement policy, and preventative interventions for all residents identified at risk for falls, to include one to one monitoring. All newly hired nursing assistants and licensed nurses will be in-serviced regarding reading the resident care guide prior to transfer of a resident, safe handling and movement policy and preventative interventions for all residents identified at risk for falls to include one to one monitoring by the Staff Facilitator/Staff Development Nurse during orientation. The Quality Improvement Nurse and/or Assistant Directors of Nursing will complete transfer observations with licensed nurses and nursing assistants, including NA #3, NA #4, and NA #5, to ensure staff are reading residents' care guides prior to transfer and use of proper transfer techniques 5 times per week for 4 weeks, then weekly for 4 weeks, then monthly for 2 months utilizing a Transfer Audit QI Tool. Staff will immediately be retrained for any identified areas of concern by the Quality Improvement Nurse, the Staff Facilitator/Staff Development Nurse and/or Assistant Directors of Nursing. The Director of Nursing and/or Assistant Directors of Nursing will review daily assignment schedules and initial her approval, prior to that day, to ensure that the schedule identifies the names of one to one staff monitors for each reasident for each shift.	completed by 11/12/13 Started 9/12/13 + ongoing Started 10/22/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 6 Assistants were putting him (Resident #1) back in the bed. (Resident #1) said it happened on Sunday (09/08/13). The Nurse (Nurse #6) told me the aides did not use the lift to transfer (Resident #1) on Sunday (09/08/13); that is what (Referring to Nurse #6) told me on Tuesday 09/10/13, while I was there. I wasn ' t there when it happened on Sunday and (Nurse #6) wasn ' t there. (Nurse #6) was told they didn ' t use the lift that day Sunday (09/08/13), to transfer (Resident #1) back to bed. "	F 323	Each resident identified as requiring one to one monitoring, including Resident #2 and Resident #4 , has been assigned an individual staff member (called staff monitor) to provide 24-hour supervision. The staff monitor will document his/her initials during his/her assigned schedule on a daily log for that resident, to include Resident #2 and Resident #4.	as of 10/22/13
	Interview with Nurse #6 was conducted on 10/14/13 at 10:10 AM. Nurse #6 indicated (Resident #1) sustained a fracture to the left leg. Nurse #6 indicated there was no documentation to indicate the resident had a fall. Nurse #6 indicated the resident was sent to the hospital on Monday (09/09/13), and on that day, Nurse #6 saw the resident ' s leg was swollen, and stated the doctor was there that day and assessed the resident. Nurse #6 indicated further that Resident #1 was complaining of left hip pain, and the doctor ordered an x-ray. The x-ray revealed no fracture of the left hip. Nurse #6 revealed on Tuesday (09/10/13), the resident was still complaining of pain at 7:00 AM when Nurse #6 arrived. Nurse #6 revealed she and the third shift (Nurse #7) decided to call the on call doctor and the doctor ordered a stat (immediate) x-ray to the left leg. The results of the x-ray showed a Distal Femur Fracture. The resident was sent immediately to the hospital on Tuesday (09/10/2013).		The Assistant Directors of Nursing and/or Quality Improvement Nurse will review and initial the daily resident monitoring logs 2 times per week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Visual audits of staff providing one to one supervision for all residents identified as requiring one to one monitoring, to include Residents #2 and #4 , will be conducted by the Assistant Directors of Nursing, the Quality Improvement Nurse, Staff Facilitator/Staff Development Nurse, licensed nurses, and/or Administrative Department Managers (i.e. Social Workers, Dietary Managers, Activities Director, Medical Records Manager, Administrator, and Supply Coordinator) providing Weekend Manager coverage utilizing a resident care audit too. The audits will include nights and weekends. These audits will be conducted 2 times per week for 4 weeks, weekly for 4 weeks, then monthly for 2 months.	started 10/22/13 started 10/22/13
	An interview was conducted on 10/14/13 at 11:00 AM with the attending physician regarding whether the physician knew how Resident #1 was transferred on Sunday (09/08/13). The attending		The Director of Nursing and/or Administrator will review the results of audits conducted on a weekly basis for 2 months. Any identified areas of concern will be immediately addressed by the Director of Nursing and/or Administrator.	started 10/22/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 7 physician was unaware of how the resident had been transferred. A direct care staff interview was conducted on10/14/13 at 12: 32 PM with Nursing Assistant (NA #3) who worked weekends only. NA #3 was asked how Resident #1 was transferred back to bed on the afternoon of Sunday (09/08/13). NA #3 revealed, " When you read the care guide it said to use two aides for transfers. I got NA #4 to help me use the lift to transfer (Resident #1) from the chair to bed. After changing (Resident #1), the resident was left to rest until dinner. After dinner I asked NA #5 to help me use the lift to transfer (Resident #1) from bed to chair. (Resident #1) did not express any pain during the transfers. " An attempt to interview NA #5 was made on 10/15/13 at 12:00 Noon was unsuccessful. A direct care staff interview was conducted 10/14/13 at 12:50 PM with NA #4 regarding the transfer conducted on Sunday (09/08/13). NA #4 revealed, " I only helped (referring to NA #3) to transfer (Resident #1) after lunch from the chair to the bed. (NA #3) already had the pad on the lift to transfer (Resident #1). I was using the remote, and I was moving the lift. (NA #3) had to be behind (Resident #1) to hold (Resident #1 ' s) legs and move (Resident #1) to the bed, while I was holding the lift. We just had to lower the lift and place (Resident #1) in the middle of the bed. " A second interview with Nurse #6 was conducted 10/14/13 at 1:20 PM regarding how the Nursing Assistants transferred Resident #1on Sunday (09/08/13). Nurse #6 ' s knowledge of the events changed from the information noted in the Nurse	F 323	The results of the transfer audit QI Tools, the daily resident monitoring logs, staff one-one monitoring observation sheets, and Resident Care Audit tools will be presented and discussed with the Executive Quality Improvement Committee on a monthly and quarterly basis to ensure identification of any potential trends, to determine the need for action, and to determine the frequency of continued monitoring.	Qtrly/monthly 10/22/13 week of 11/25/13 + ongoing monthly

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 8 Practitioner ' s notes. Nurse #6 indicated, " According to my notes, all I wrote was (referring to Resident #1) heard something pop when (Resident #1) was being transferred. I was not there at the time, and I do not know how (Resident #1) was transferred. They (referring to the NA ' S) are supposed to transfer (Resident #1) with 2 person assist using a lift, according to (Resident #1 ' s) care guide. " An interview conducted on 10/15/13 at 10:40 AM with the Director of Nurses (DON) and Nurse #6 revealed, " The resident told us that two people put (referring to Resident #1) back to bed without a lift. " The DON indicated, " That is when we started the investigation on 09/10/13. " Resident #1 was in the hospital at the time of the survey, and was unavailable for an interview. An interview with the Administrator conducted on 10/15/13 at 11:45 AM, revealed, " I could not figure out how the fracture happened. We could not identify how the fracture occurred. I didn ' t have the Nurse Practitioner ' s note dated 09/10/13 when we did the investigation. " An Administrative staff interview with the Director of Nurses (DON) was conducted on 10/15/13 at 1:00 PM. When asked about the DON ' S expectations related to transfers for Resident #1, the DON indicated, " My expectation is that we would follow (the resident ' s) care guide and we would use the lift for transfers. " An Interview with the Administrator was conducted on 10/15/13 at 1:25 PM regarding expectations of the staff for transfers of Resident #1. The Administrator indicated, " I would expect	F 323		

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 10/15/2013

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 323	Continued From page 9 the staff to use the lift for transfers, and use the correct lift pad. " 2. A. Resident #4 was admitted to the facility on 05/18/13 and had cumulative diagnoses that included Alzheimer ' s, Chronic Obstructive Pulmonary Disease (COPD), Dementia without behaviors, Diabetes, hypertension and history of falls. The most recently revised care plan dated 09/24/13 identified the resident as a risk for recurrent falls with interventions that included the following: four wheeled walker for ambulation, assist during transfer and mobility, one to one monitoring, low bed, non skid strips at bedside and assist to bathroom as needed. Observation of the care card on 10/14/13 at 12:05pm indicated resident required one person assist for activities of daily living (ADL), cane/walker for ambulation, feeds self, wheelchair as needed, falls risk, diabetes, wanders, resident swings, hits, and kicks others and attempts to leave facility unsupervised. Record review on 10/14/13 for resident #4 revealed the resident ' s current medications included Buspar, Ativan, Zoloft, Seroquel and Novolog. Record review of the progress notes on 10/14/13 at 11:00am revealed the following: On 09/20/13 at 10:33pm resident had to be reminded to use walker. On 09/21/13 resident continued to ambulate without the use of her walker.	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 10 On 09/22/13 at 1:03pm resident was noted to ambulate without the use of her walker. On 09/24/13 at 5:09 the resident was reviewed by the Quality review committee and a family meeting was held. The meeting revealed the resident had a history of falls at home and would get worse in the afternoon. Resident used a hemi walker at home versus a rolling walker. The resident ' s responsible party (RP) brought in a new pair of non-skid soles/socks. Therapy will try to evaluate resident with a meri-walker if applicable. Resident on 1:1 supervision. On 09/28/13 resident was attempting to get out of bed and sustained a fall. Resident stated she was trying to get out of bed and slid on the floor. No injuries noted. RP was notified and a note was left for the MD. Bed in lowest position. Resident complained of pain and was given Tylenol, with no further complaints of pain. Record review on 10/14/13 at 11:00am did not show that one to one supervision was being done at the time of the fall on 09/24/13 as indicated in the care plan nor was the care plan updated to reflect the fall/changes to resident ' s care. 2. B: Resident #2 was admitted to the facility on 07/30/13 and had cumulative diagnoses that included altered mental status, cerebral vascular accident (CVA), cognitive communication deficit and dementia without behaviors Review of the most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/07/13 revealed resident #2 was extensive assist requiring 1 person assist with the following:	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 11 bed mobility, transfers, walking on unit, toileting and hygiene. No behaviors were documented during this assessment period. The most recently revised care plan dated 08/21/13 identified the resident as a wanderer with interventions that included the following: administer medications as ordered, allow resident to wander and check resident daily to ensure resident has an alarm bracelet on and is functioning properly. The most recently revised care plan dated 10/14/13 identified the resident as at risk for recurrent falls with interventions that included the following: keep bed in lowest position, monitor effectiveness of medications and provide one to one monitoring. Observation of the care card on 10/14/13 at 12:00pm identified resident as needing 1 person assistance, assist with feeding, at risk for falls, needs bed in low position, uses wheelchair and has no behaviors. Record review for resident #2 revealed the resident ' s current medications included Lasix, Namenda, Aricept, Trazadone and Ativan. Record review of the progress notes on 10/14/13 at 10:30am revealed the following: Upon admission to the facility on 07/30/13 resident #2 was admitted to the East unit and was immediately transferred to the Sparks unit due to fairly aggressive wandering. Record review of progress note dated 09/24/13 indicated resident sustained a fall without injury	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 12 on 09/24/13. Resident was noted with swinging behaviors and wandering. Record review of progress note dated 10/08/13 at 9:32am revealed resident was noted walking and pacing the floor. Resident was reworked to her chair several times. Resident was placed on 1:1 supervision. Resident then began to walk in and out of resident rooms removing things. Resident yelled and gritted teeth at the nurse and told her to leave her alone. Nurse attempted to redirect resident to the hall and resident yelled stop. Resident was given Ativan. On 10/12/13 at 11:38am nurse noted resident had made several attempts to get up and ambulate. Resident was able to ambulate for short distances with hands on assistance from staff. Review of the Master Schedule for the Sparks unit revealed the following: September 17, 2013 through September 30, 2013 there were 5 aides scheduled for one to one supervision on first shift, 3.5 aides scheduled for one to one supervision on second shift and 1 aide scheduled for one to one supervision on third shift. This left a total of 29.5 shifts unaccounted for 1:1 supervision for resident #4 during this time period. October 1, 2013 through October 15, 2013 there were 12 aides scheduled for one to one supervision on first shift, 13 aides scheduled for one to one on second shift and no aides scheduled for third shift for one to one supervision. Resident #4 was scheduled for 1:1 supervision for 45 consecutive shifts during this time period while resident #2 was scheduled for	F 323		

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 10/15/2013

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 323	Continued From page 13 24 consecutive shifts during this time period. During this time period the Master Schedule does not indicate two staff assigned to 1:1 supervision at any time during this time frame to cover 1:1 supervision for resident #2 and resident#4 simultaneously. Review of the aide daily assignment sheets revealed the following: September 17, 2013 through September 30, 2013 there were 4 aides assigned for one to one supervision on first shift, 4 aides assigned for one to one supervision on second shift and 2 aides assigned for one to one supervision on third shift for resident #4. Resident #2 was identified as having 1:1 supervision on 3 shifts during this time period. Review of the 24 hour report sheets revealed the following: September 18, 2013 - resident #4 was documented as having a fall with injury to her left facial area, one to one noted. There is no documentation noted for one to one supervision on second or third shift. October 1, 2013 through October 15, 2013 there were 3 aides assigned for one to one supervision on first shift, 8.5 aides assigned for one to one supervision on second shift and no aides assigned for one to one supervision on third shift. Resident #4 was designated 1:1 supervision for 9 of the 11.5 shifts identified. Resident #2 was designated 1:1 supervision for 2 of the 11.5 shifts identified. Interview on 10/14/13 at 10:20am with nurse #1	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 14	F 323		

indicated there are two residents who currently require one to one supervision. Nurse #1 identified those residents as resident #2 and resident #4. Nurse #1 revealed both residents were on one to one supervision on all three shifts.

Observation of resident #2 and resident #4 on 10/14/13 at 10:20am revealed both residents in an activity in the activity room. Both residents had a staff member sitting with them at the time of the observation.

Observation on 10/14/13 at 12:00pm revealed resident #2 and resident #4 in bingo activity in the dining room. Both residents had a staff member sitting with them at the time of the observation.

Observation on 10/15/13 at 9:10am revealed resident #4 lying in bed asleep with a sitter at the bedside.

Observation on 10/15/13 at 9:15am revealed resident #2 sitting in the dining room eating breakfast and her assigned aide passing out trays to other residents in the dining room. Aide #2 was passing out trays to other residents in the dining room and when asked if she was assigned to resident #2 she replied " yes " .

Interview on 10/15/13 at 9:45am with the DON revealed the master schedule identifies which staff are working on a particular day and is posted daily. The DON revealed the scheduler is responsible for completing the master schedule. The DON further indicated the charge nurse makes the assignment for the aides on a daily basis. When asked where on the master schedule would the assignment for one to one supervision be identified she stated " it should

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 15 have been written under the extra assignment/duty section. " The DON stated that both resident #2 and resident #4 were on one to one supervision for first and second shifts only. When asked what her expectation of one to one supervision means, she stated " usually we try lots of interventions before we go to one to one. Usually I speak with the administrator and therapy as well. The nurse documents in the nurses ' notes that we are going to put a resident on one to one and monitor that. " When asked if the nurse will document the exact shifts the resident is to have one to one supervision in her notes she stated " the nurse will not document exact shifts in her note, she will document that on the 24 hour report sheet. " The DON indicated there is no MD order written when a resident is placed on one to one supervision. When asked about the staffing for the residents who require one to one supervision the DON stated " sometimes the scheduler does not get someone to work the one to one assignment so when I get here I will pull someone and if it is on nights the night shift coordinator will pull someone. Sometimes the nurse does the one to one and when she has to give her meds one of the aides will take them until she (nurse) can take them back. " October 8, 2013 - resident #2 was documented as having prn (as needed) ativan and one to one supervision noted. Second shift resident was documented as having a skin tear and no documentation noted for third shift. Interview on 10/15/13 at 10:15am with nurse #2 indicated the management staff has a daily morning meeting to discuss residents that are on one to one supervision and falls. Nurse #2 revealed the QI nurse monitors falls and will	F 323		

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 10/15/2013

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 323	Continued From page 16	F 323		

update the care plans as needed. Nurse #2 was asked what one to one supervision means to her and she stated " one CNA to one patient, usually for safety and it is around the clock on all three shifts. It is usually for safety or for a multitude of reasons such as a resident that has pulled out a g-tube and falls. There are many reasons why residents are on one to one. When asked how she would document on the care plan if a resident was on one to one supervision for only one shift she stated " I haven ' t seen it for just one shift. I would think I would put that on the care plan. "

Interview on 10/15/13 at 10:20am with the scheduler indicated she completed the master schedule for all three shifts. When asked how she is informed if a resident requires one to one supervision she stated " the nurse supervisor (DON) will let me know if there is a one to one. " The scheduler indicated she uses GCA ' s on first shift and will give aides the opportunity to sign up for a one to one assignment. She further revealed that in the event the aides do not sign up then she will use GCA ' s. The scheduler stated " the nurse usually does the one to one on the weekends in the unit when I cannot find coverage. " When asked what one to one supervision means to her she stated " it means someone is with them at all times. The one to one shadows, walks with them. I try to put an extra person when I can. It varies how often I can do that. I always give them (staff) an opportunity to sign up. I put sign up sheets in the dining room for the aides to sign up for one to one ' s. "

Interview on 10/15/13 at 10:35am with aide #2 revealed her title is geriatric care aide (GCA). When asked what one to one supervision means to her she stated " I ' m gonna be with her

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 17 (resident) all day, every step and to the bathroom. I assist her to walk and keep an eye on her at all times, making sure nothing happens to her. " When asked if she assists other resident ' s while assigned to one to one supervision she stated " I only assist others if needed. I will try to keep my eyes on her at all times. Aide #2 indicated she does not take resident to the bathroom but she has had to take her in the past due to the resident ' s assigned aide assisting another resident at the time and the resident really needed to use the bathroom. When asked if she was aware why the resident was on one to one supervision and if she required one to one supervision on all three shifts she stated " she is on one to one because she fell and damaged her face pretty good. She has one to one on all three shifts. " Interview on 10/15/13 at 10:40am with aide #1 revealed her title is GCA and that her normal assignment is to assist with facility transports but she had been pulled to provide one to one supervision for resident #2. When asked what one to one supervision means to her she stated " I stay with her at all times unless therapy has her. I go with her to the bathroom; she can pull her pants down herself. I go to activities with her. At lunch I will set resident up first but then I will help others. If I see that she tries to get up I stop and go help her. " When asked if she knew why resident #2 required one to one supervision she stated " she isn ' t able to stand long. They have tried different wheelchairs for her, one was too tall, one was too wide and then when they found one to fit she wouldn ' t stay in the wheelchair. She has to be monitored to sit in the wheelchair because she will try to get up. " Aide #1 indicated she did not know if resident required one to one supervision on all three	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 18 shifts. Aide #1 stated " I report off to the aide that gets here first. I don ' t know who has her but I tell the aide that she is a one to one. " Interview on 10/15/13 at 10:45am with nurse #1 revealed resident #2 and resident #4 are on one to one supervision for all three shifts. Nurse #1 indicated she looks at the daily nursing schedule to identify the aides assigned to work in the unit and makes out the assignment stating which aide is assigned to each resident as needed if the master schedule has not already identified the assignment of each aide. Nurse #1 stated " I am not sure how they do the assignments on 3rd shift. They might pull an aide from west hall or the scheduler will find someone. " Nurse #1 indicated that each aide assigned to a one to one supervision assignment has to wait until his/her relief arrives to take over the one to one supervision before they can leave for their assigned shift. When asked what one to one supervision means to her, nurse #1 stated " one resident to one staff member ratio. The assigned staff stays with that resident at all times and other staff assist them as needed. If a GCA (geriatric care aide) is sitting with the resident, the CNA assigned to the resident gives the care and the GCA stays with them while the CNA gives the care. " Nurse #1 indicated the GCA does not provide ADL (activities of daily living) care to any residents that all ADL care is provided by an aide. Nurse #1 indicated on first shift the one to one supervision is provided by sitters and on second and third shifts the one to one supervision is provided by aides. Nurse #1 indicated the unit is staffed with three aides on first and second shift and one medication aide and two aides on third shift.	F 323		

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 10/15/2013

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 323	Continued From page 19 A phone interview was attempted with nurse #5 on 10/15/13 at 12:00pm. Message left for nurse to return the call. A phone interview was conducted on 10/15/13 at 12:10pm with medication aide #1 that indicated she worked on the Sparks unit and assisted living hall on third shift. When asked if there were any resident ' s that required one to one supervision currently she indicated resident #2 and resident #4 were on one to one on third shift. Med aide #1 indicated she makes out the assignment for one to one ' s for her shift. She revealed all three staff assigned to the unit does the one to one assignments. She stated " If there are only two aides working, then when they do rounds herself or the other aide will watch the resident that requires one to one supervision. When asked med aide #1 about the staffing assignment on 09/28/13 and who was assigned to the one to one where the schedule indicated that herself and one aide were assigned to the unit she indicated she could not remember. Interview on 10/15/13 at 12:20pm with the Administrator revealed her expectation of a resident on one to one supervision means the resident should be in an environment that they are receiving attention by someone that does not have a regular assignment. The administrator stated " this person can be the nurse or med aide. " When asked how a nurse can give medications and provide one to one supervision the administrator stated " they can take the person (resident) with them while they give their meds or they can be pushed up to the nurses ' desk with them. " The administrator revealed when the assigned staff providing the one to one needs a break, the nurse or med aide will cover	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/15/2013

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 323	Continued From page 20 the one to one supervision. When asked who covers one to one supervision on 3rd shift (11:00pm - 7:00am) the administrator revealed a staff member would be pulled to cover the one to one and would not be given an additional assignment. Interview on 10/15/13 at 1:15pm with nurse #3 revealed that is a resident was placed on one to one staff supervision as needed, the care plan would read " as needed " and if the supervision was at all times the care plan would read " at all times " . Nurse #3 was asked to clarify the interpretation of resident #2 and resident #4 care plan that read as follows: provide one to one monitoring and nurse #3 stated " I would interpret this as at all times. " Interview on 10/15/13 at 1:20pm with nurse #4 revealed the DON or the QI (Quality Improvement) nurse will notify MDS (minimum data set) when to update the care plan for a resident with one to one staff supervision. Nurse #4 revealed that if the one to one supervision was identified in a fall care plan the QI nurse would update the care plan as needed. Nurse #4 further revealed when a resident is placed on one to one supervision the interventions will be revised to fit the intent for the resident in question. When asked what one to one supervision means to her, nurse #4 stated " The resident needs one to one constant supervision at all times. " Interview on 10/15/13 at 2:15pm with the administrator stated " We do not have a policy and procedure for one to one ' s. " On 10/15/13 at 2:30pm the Administrator presented a list of staff that had provided one to	F 323		

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 10/15/2013

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 323	Continued From page 21 one supervision for resident # 2 and resident #4 from October 1, 2013 through October 14, 2013 for first and second shifts only.	F 323		