

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

PRINTED: 08/23/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 584 SS=E	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p>	F 584		8/7/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/07/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 584	<p>Continued From page 1</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interviews, staff interviews and observation the facility failed to maintain an air conditioning/heating unit, a night stand, walls, a door frame, a bathroom light fixture, a window ledge in good repair and maintain proper room temperature for 6 of 10 resident rooms reviewed for a safe, clean, comfortable and homelike environment. (Rooms 224, 232, 209, 205, 229 and 235E)</p> <p>Findings included:</p> <p>1: During an observation of room 235 on 7-20-18 at 8:10am the resident requested for his air to be turned on. While observing the unit it was noted to have a hole in the covering below the power button. An attempt was made to turn on the unit and it did not work. The resident stated, "you have to stick your finger down in the hole and turn it on." The resident was unsure how long the unit was in disrepair but stated "a while."</p> <p>The maintenance manager was brought to the room on 7-20-18 at 8:15am who stated, "the residents push too hard below the power button causing it to break." He also stated when that happened the connection no longer worked, and the unit cannot be turned on. The maintenance manager stated he was unaware of the issue. He stated he could not do anything about the brown stain because it was a stain and did not feel the writing was too faded to read.</p> <p>During an interview with the Administrator on 7-20-18 at 5:00pm she stated she expected the</p>	F 584	<p>Maple Grove Health and Rehabilitation 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 is order 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.</p> <p>Maple Grove Health and Rehabilitation 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.</p> <p>The position of Maple Grove Nursing and Rehabilitation Center regarding the process that lead to this deficiency- staff failure to notify maintenance director of concerns identified in the environment to promote a continued safe, clean environment.</p> <p>On 7/20/2018 the PTAC unit was repaired by the maintenance director. On 7/20/2018 the night stand was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 584	<p>Continued From page 2</p> <p>facility to be maintained and have a clean safe environment for the residents.</p> <p>2: During an observation of room 224 on 7-20-18 at 8:25am it was noted that the residents night stand had 3 drawers and that 2 of the drawers had broken handles. The resident stated she could not close the 2 drawers all the way because she would not be able to reopen them. The resident was unsure how long the handles on the drawers had been broken but stated "for a good bit."</p> <p>The maintenance manager was interviewed on 7-20-18 at 8:27 who stated he was unaware that there was an issue with the resident's night stand but would have it replaced.</p> <p>During an interview with the Administrator on 7-20-18 at 5:00pm she stated she expected the facility to be maintained and have a clean safe environment for the residents.</p> <p>3: During an observation of room 229 on 7-20-18 at 8:30am there were 4 large white spots and paint chipped above the headboards of both beds revealing plaster.</p> <p>The maintenance manager was interviewed on 7-20-18 at 9:20am who stated he had to repair the wall and was waiting for it to dry before he painted it. He also stated he did the repair work last week and "have not had a chance to paint it."</p> <p>During an interview with the Administrator on 7-20-18 at 5:00pm she stated she expected the facility to be maintained and have a clean safe environment for the residents.</p>	F 584	<p>removed from room 224 A south hall by the maintenance director.</p> <p>On 7/23/2018 the white spots and chipped paint in room 229 was repaired by the maintenance director.</p> <p>On 7/23/ 2018 the six small holes around the frame of the resident's bathroom door in room 232.</p> <p>On 7/20/2018 the light cover over the ceiling light was replaced by the maintenance director.</p> <p>On 7/20/2018 the thermostat was adjusted immediately and the temperature was monitored to ensure temperature did not reached 70 degrees.</p> <p>On 7/30/2018 the window sill in room in room 205 was repaired by the maintenance director.</p> <p>A 100% audit of night and in need of repair was conduct by the maintenance director on 7/24/2018. Any night stands missing or broken handles were removed from the resident care area.</p> <p>A 100% audit was conducted by the environmental supervisor and supply clerk on 7/24/2018. No additional units identified with a hole in the unit and all units in working condition.</p> <p>A 100% audit was initiated on window ledges by the maintenance director and completed on 7/25/2018 with any window ledged identified as broken was immediately repaired.</p> <p>A 100% audit was initiated on 7/23/2018 on light covers and completed on 7/25/2018 by the supply clerk and maintenance director with no light cover</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD</b> <b>GREENSBORO, NC 27406</b>		
(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 584	<p>Continued From page 3</p> <p>4: During an observation of room 232 on 7-20-18 at 8:35am there were 6 small holes around the frame of the resident's bathroom door. The resident stated she was unaware the holes were there and did not know how they could have gotten there.</p> <p>An interview with the maintenance manager occurred on 7-20-18 at 9:25am who stated it looked like something had been "tacked up" around the door but that he was unaware it had not been fixed.</p> <p>During an interview with the Administrator on 7-20-18 at 5:00pm she stated she expected the facility to be maintained and have a clean safe environment for the residents.</p> <p>5: Room 209 was observed on 7-20-18 at 8:40am and was noted to not have a light cover over the ceiling light in the bathroom. The resident was not interview able.</p> <p>The maintenance manager was interviewed on 7-20-18 at 9:30am who stated, "that is very strange" and that he did not know how that occurred and that he was not informed the light fixture in the bathroom was missing.</p> <p>During an interview with the Administrator on 7-20-18 at 5:00pm she stated she expected the facility to be maintained and have a clean safe environment for the residents.</p> <p>6: During an observation of room 205E on 7-20-18 at 8:45am the resident was sitting in his room with a coat and hat on. The resident stated he was cold and that he had no way of controlling the temperature in his room because it was</p>	F 584	<p>identified.</p> <p>A 100 % room audit on wall repairs was conducted by the maintenance director and supply clerk on 7/24/2018. Identified areas repaired as needed and completed without large white spots.</p> <p>On 7/24/2018 a 100% in service was initiated on notification of the maintenance director of nay repairs required through the facility in the available TELS programing. In servicing completed on 7/29/2018. All new hire staff will be in serviced during orientation.</p> <p>Department heads were in serviced on need to continue expected facility rounds with any needed repairs documented in TELS program system for maintenance awareness on 7/24/2018 by the administrator.</p> <p>An assistant maintenance director was hire on 7/31/2018.</p> <p>A regional maintenance director from Principle Long Term Care toured the facility on 8/1/2018 for strategies to help maintenance department with needed repairs.</p> <p>The monthly QI committee will review the results of the F584 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.</p>		

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

PRINTED: 08/23/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 584	Continued From page 4 controlled by a thermostat in the hall. He also stated he had asked for the temperature to be changed but the staff would not change it because other residents liked it cold. The resident's window ledge was also noted to have a large area broken off.  The maintenance manager and Administrator were interviewed on 7-20-18 at 9:40am. The Administrator stated the resident rooms were to be kept at 71 Fahrenheit (F) degrees. The maintenance manager tested the temperature in the resident's room and it was 70 Fahrenheit degrees. The maintenance manager also stated he was unaware of the residents broken window ledge. The Administrator stated she would have maintenance check the temperatures in the resident rooms throughout the day to make sure the rooms are staying at 71F degrees and that the residents are comfortable in their rooms.  During an interview with the Administrator on 7-20-18 at 5:00pm she stated she expected the facility to be maintained and have a clean safe environment for the residents.  The maintenance manager was interviewed at 9:50am on 7-20-18 and stated he was unaware of the needed room repairs that were brought to his attention during the survey. He further stated that work orders for repairs and maintenance service are requested through the computer system by staff and he checked the orders daily.	F 584	The title of the person responsible for implementing the acceptable plan of correction. The supple clerk is responsible for implementing the acceptable plan of correction.		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)  §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		8/6/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 804	Continued From page 5  §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;  §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to serve food that was palatable and at temperatures acceptable to the residents that resided in the facility. This was evident in 1 of 2 meals observed. Findings included: Observation on 7/20/18 at 7:31 AM in the kitchen revealed prepoured coffee mugs for breakfast on the steam table. By 7/20/18 at 7:50 AM the tray line started for North 1 cart and was delivered at 8:09 AM by Dietary Aide (DA) #1. Observation of the delivery cart revealed food trays were ill fitting causing the tray to not completely close for 3 residents' food trays. Continued observation revealed Nursing Assistant (NA) # 1 served the first food tray to a resident at 8:12 AM. The last food tray was served on the unit at 8:24 AM and a test tray was immediately conducted in the presence of the Food Service Manager (FSM). The coffee tasted cool without any additives such as creamer or sweetener. The pancake and French toast had a gummy texture and tasted cold. The pork sausage link tasted cool and greasy. Interview on 7/21/18 at 9:56 AM with the FSM who stated some of the tray lids were warped and the facility continued to order and replace them each month. The FSM stated she expected residents' to be served hot foods and beverages	F 804	F804  Maple Grove Health and Rehabilitation 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 is order 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 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding  The plan of correcting the specific deficiency		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 804	Continued From page 6 that were expected to be hot and cold foods and beverages that were expected to be cold. Record review of a list of interviewable residents identified by the facility and interview with the Social worker (SW) on 7/21/18 at 10 AM and again on 7/21/18 at 11:40 AM was conducted. The SW stated during the interview Resident #10 and #11 were alert and oriented. Interview on 7/21/18 at 10:25 AM with DA #1 revealed he started prepouring coffee at 7:15 AM this morning (referring to 7/21/18) but usually started 15 minutes before the tray line started. Continued interview revealed some of the lids and bottoms of the insulated food trays are warped from the dish machine. Interview on 7/21/18 at 10:45 AM with Resident #12 stated his coffee was often cold and just drinks it cold. Interview on 7/21/18 at 10:48 AM with Resident #10 stated the coffee at breakfast was always cold and staff do not offer to reheat when asked, so he stopped asking. Interview on 7/21/18 at 10:50 AM with Resident #11 stated usually the coffee and food items are served cold when they should be hot. Resident #11 stated the coffee this morning (referring to 7/21/18) was cold and the staff was too busy to reheat.	F 804	The position of Maple Grove Health and Rehabilitation is the process that lead to this deficiency- was knowledge deficit of the dietary staff to place foods on the steam table appropriately to maintain temperature throughout the service to residents.  On 7/24/2018 the dietary manager initiated an in service with dietary cooks. Coffee to be poured upon as needed to maintain temperature throughout the tray line. 100 % of the cooks were in serviced on 7/27/2018.All new hired cooks will receive in service during orientation period. On 7/24/2018 an in service was initiated for cooks by the dietary manager on ensuring the steam table wells are filled with adequate water and sufficiently heated prior to setting up steam table. Cooks shall place prepared food no earlier than 30 minutes prior to start of service into the steam table wells. Food temperatures must be taken prior to the start of service, midway and at the end of service to ensure that an acceptable temperature is consist through the entire service period. Items which decline in temperature quickly should be prepared/ served in batches. 100%c in servicing was completed on 7/27/2018 for cooks and all new hires will be in serviced during orientation period. On 7/24/2018 the administrator in serviced the dietary manager on the need to monitor foods to be at an acceptable temperature and to be palatable to the		

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

PRINTED: 08/23/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 804	Continued From page 7	F 804	<p>residents. On 7/27/2018 the auditing began by the dietary manager and the administrator and will continue weekly X 5 days for 12 weeks to ensure that the food is at an acceptable temperature and palatable to our residents.</p> <p>The Menu Audit Tool was in serviced by the administrator to the dietary manager on 7/24/2018.</p> <p>On 8/1/18, the Department Heads were in-serviced by administrator on the F-804 Monitoring Tool. Department Heads consist of Social Worker, Admission Coordinator, Minimum Data Coordinator, and Interim Director of Nursing, Medical Records Supervisor, Account Receivable Bookkeepers, Activity Director, and Assistant Activity Director. The auditing began on 8/1/2018 and will continue for 12 weeks . Two residents are to be interviewed daily X 5days in question if the food is palatable. If not ask residents would they like an alternate menu? Different residents to be identified daily X 5 days weekly. Manager on duty on weekends also to interview 2 residents and place in manager on duty book both Saturday and Sunday.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements</p> <p>The dietary manager, or administrator will observe 5 meals weekly x 12 weeks to</p>		



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

PRINTED: 08/23/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 804	Continued From page 8	F 804	<p>ensure meals including coffee are provided at acceptable temperature and food is palatable. This audit will occur on random days, at different meal times. This audit will be documented on the F804 menu audit tool.</p> <p>The department heads will interview 5% of the residents daily X 5 days and 2 residents on the weekends for 12 weeks to ensure the food is palatable and coffee is applicable is at an acceptable temperature.</p> <p>The monthly QI committee will review the results of the F804 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.</p> <p>The assistant activity director is responsible for implementing the acceptable plan of correction.</p>		
F 867 SS=E	<p>QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)</p> <p>§483.75(g) Quality assessment and assurance.</p>	F 867		8/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 867	<p>Continued From page 9</p> <p>§483.75(g)(2) The quality assessment and assurance committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the annual recertification survey of 4/6/2018. This was for one (1) recited deficiency which was originally cited during the annual recertification of 4/6/2018.</p> <p>Findings included: This tag is cross referred to: F584 Based on resident interviews, staff interviews and observation the facility failed to maintain an air conditioning/heating unit, a night stand, walls, a door frame, a bathroom light fixture, a window ledge in good repair and maintain proper room temperature for 6 of 10 resident rooms reviewed for a safe, clean, comfortable and homelike environment. (Rooms 224, 232, 209, 205, 229 and 235E)</p> <p>During the recertification dated 4/6/2018 the facility was cited for F584, for the facility failure to (1) maintain walls in resident rooms for 4 of 11 residents rooms (110N, 103E, 205S and 104N), (2) maintain the floors in residents rooms for 3 of 11 resident rooms (102E, 208S and 104N), (3) maintain a clean environment in resident rooms for 2 of 11 resident rooms (103E and 104N), (4) maintain equipment in resident rooms for 4 of 11 resident rooms (103E, 208S, 110N and 228S).</p>	F 867	<p>F 867</p> <p>Maple Grove Health and Rehabilitation 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 is order 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.</p> <p>Maple Grove Health and Rehabilitation 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other.</p> <p>The position of Maple Grove Health and Rehabilitation Center regarding the process that lead to this deficiency - failed to maintain implemented procedures and monitor interventions- was failure to follow established facility policy related to QAPI.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>		
(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 867	Continued From page 10 During an interview and record with the Administrator on 7/21/2018 at 12:30 PM stated the housekeeping services contract would be cancelled effective 9/8/18. A follow-up interview with the Administrator and Human Resources Specialist (HRS) was conducted. The Administrator stated that the facility determined a need for additional staff in the maintenance department. The HRS stated she was in the process of recruiting and hiring an additional staff member for the maintenance department.	F 867	On 7/31/2018 the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Administrator, IDON, MDS nurse, MDS Coordinator, maintenance director, Supply Clerk, Dietary Manager, Assistant Dietary Manager and Housekeeping Supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.  On 8/1/2018 the QIO Quality Advisor was consulted via email will be available for further education, resource and ongoing support.  On 8/1/2018 the administrator in-serviced the department heads related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeated deficiencies related to F584- to maintain a clean safe environment.  The Facility QAPI Committee will meet at a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns.		

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

PRINTED: 08/23/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD</b> <b>GREENSBORO, NC 27406</b>		
(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 867	Continued From page 11	F 867	<p>Corrective action has been taken for the identification of concerns related to F 584 : to maintain a clean safe environment.</p> <p>The executive QAPI committee will continue to meet at a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member.</p> <p>The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions.</p> <p>The administrator is responsible for implementation of the acceptable plan of correction.</p>		