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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Grove Health and Rehabilitation Center	308 West Meadowview Road Greensboro, NC 27406

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on observations, record review, and interviews with resident and staff, the facility failed to provide nail care to a resident who needed extensive assistance from staff for Activities of Daily Living (ADL). This deficient practice affected 1 of 7 residents (Resident # 90) reviewed for ADLs. Findings included: Resident #90 was admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis of one side of the body). Review of the annual Minimum Data Set (MDS), dated [DATE], revealed Resident #90 was cognitively intact and required extensive assistance with personal hygiene. Review of Resident #90's care plan revised 01/25/24 revealed a need for Activities of Daily Living (ADL)/Personal Care with the following intervention including the resident required assistance for personal hygiene, and grooming. During observation and interview on 02/26/24 at 12:03 pm, Resident #90 was observed lying in bed with fingernails on both hands that were about 1/2 inch long. Resident #90 stated he wanted his nails clipped and would ask the staff. An observation was conducted on 02/27/24 at 12:41 pm of Resident #90 lying in bed and his nails remained long. Resident #90 stated he did not ask to have his nails clipped and would ask his nurse today. On 02/28/24 at 10:25 am an observation was made of Resident #90 and his nails remained long on both hands. Resident #90 stated he had asked the Nurse to clip his nails on 02/27/24, however he did not remember what nurse he had asked. An interview was conducted on 02/28/24 at 10:59 am with the MDS Nurse and she indicated residents' nails were usually clipped when the Nursing Assistant (NA) provided ADL care, unless they had diabetes. The MDS Nurse was in the room and verified with Resident #90 he asked to have his fingernails clipped on 02/27/24 by the nurse, and the nurse he asked said okay, but never clipped them. A review of Resident #90's Activities of Daily Living documentation from December 2023 to present revealed no documentation that showers had been provided and no refusals noted. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempt to contact NAs who were assigned to work with Resident #90 on 02/26/24 and 02/27/24 was unsuccessful. An interview was conducted 02/29/24 at 11:16 am with the Nurse (Nurse #2) who was assigned to Resident #90 on 02/26/24 and 02/27/24 and she indicated the Resident did not request to have his nails clipped. She indicated staff had not informed her Resident needed his nails clipped. Nurse #2 stated she did not notice Resident #90 needed his nails clipped or she would have clipped them. An interview was conducted with the Administrator and Director of Nursing (DON) on 02/29/24 at 3:08 pm. The DON indicated Resident #90's fingernails were clipped on 02/28/24 and his nails should be clipped if he requested them to be clipped.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41579 Based on observations, resident and staff interviews and record review, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint surveys dated 1/18/22 and current survey 3/06/24 in the area of accurately coding Minimum Date Set (MDS). The facility also failed to maintain implemented procedures and monitor interventions the committee put in place following the annual recertification and complaint surveys conducted on 1/18/22, 1/27/23 and the current survey 03/06/24, in the area of Activity of Daily Living (ADL) care provided for dependent residents. The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This citation is cross referenced to: 1 F 641 Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area hearing, speech, and vision for 1 of 1 resident reviewed for communication. (Resident #96). During the previous recertification and complaint survey date 1/18/22 the facility failed to accurately code the nutrition section of the minimum data set (MDS) for 2 of 5 residents reviewed for Nutrition 2 F 677 Based on observations, record review, and interviews with resident and staff, the facility failed to provide nail care to a resident who needed extensive assistance from staff for Activities of Daily Living (ADL). This deficient practice affected 1 of 7 residents (Resident # 90) reviewed for ADLs. During the previous recertification and survey on 1/27/23 the facility failed to provide showers, nail care, and mouth care to residents who needed extensive and/or were dependent on staff for Activities of Daily Living (ADL). During the previous recertification and complaint survey on 1/18/22, the facility failed to provide a haircut (Resident #71) for 1 of 3 activity of daily living dependent residents reviewed. During an interview on 2/29/24 at 3:23 PM, the Administrator stated the Quality Assurance (QAPI)) committee, regarding the repeated deficiencies the Administrator stated the old plan of correction would be revisited and analyzed to see where the failures and breakdowns happened. This would help analyze the cause of repeat deficiency. The Administrator indicated once the plan was put in place, audits and the monitoring phase would be completed. She further indicated that sporadically monitoring and auditing throughout the year should be continued to ensure the repeated deficiencies do not recur. Repeated concerns were also discussed in QAPI meeting and the QAPI committee would see how the approach can be changed if needed. This could be education and training of staff or revision of the approach or new approach if needed.