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

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

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews with staff, Nurse Practitioner (NP) and Medical Director, the facility failed to provide care in a safe manner when Resident #1 rolled out of her bed and hit the floor during incontinence care. Resident #1 was sent to the Emergency Department (ED) and diagnosed with an occult (subtle hip bone break often in older adults that often does not show up on imagining but causes pain, tenderness, and difficulty walking) nondisplaced (the bone breaks but maintains it proper alignment) left hip fracture, distal left femur fracture (fracture of the lower portion of the thighbone near the knee joint) and a left side scalp hematoma (bruise that occurs when blood pools outside blood vessels). The deficient practice occurred for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease and dementia with agitation.Review of Resident #1's physician orders revealed an order dated 08/28/24 for clopidogrel bisulfate (antiplatelet) 75 milligrams (mg) one tablet by mouth one time a day. Antiplatelet medications can increase the risk of bleeding.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had severe cognitive impairment, required substantial assistance from staff for bed mobility and positioning and had no functional limitations on either side. The MDS also indicated that the Resident had no falls since the previous review and was not on an anticoagulant. The care plan last reviewed on 11/10/25 revealed Resident #1 had a self-care performance deficit in her activities of daily living (ADL) related to disease processes and was at risk for a decline in physical function related to limited mobility and dementia. The goal that Resident #1 would improve her current level of function would be attained by utilizing interventions such as encouraging the Resident to fully participate with each interaction, allowing for increased support as necessary and encouraging participation in skilled therapies when provided.Review of an Incident Report dated 11/24/25 at 10:30 AM and written by Nurse #2 revealed Nurse Aide (NA) #1 was in the process of cleaning Resident #1 up for the day when the Resident was asked to roll over. Resident #1 was asked to roll back over to NA #1 after the NA placed a pad onto the bed. The Resident was on her side facing the opposite direction. The Resident then rolled out of the bed and onto the floor instead of back towards the NA. Resident #1 stated, I rolled over like she asked me to. The Report continued to explain that Resident #1 was assessed by the Nurse Practitioner (NP) who determined that due to a head injury the Resident needed to be evaluated at the hospital. Resident #1's left leg appeared to be shorter than her right leg. Resident #1 remained on the floor until the emergency medical services (EMS) arrived.An interview was conducted with NA #1 on 12/18/25 at 10:10 AM. The NA explained that she was providing incontinent care for Resident #1 on 11/24/25 and after she put the brief and incontinent pad under the Resident, she asked Resident #1 to roll back over towards her, but the Resident rolled away from her instead and rolled off the bed onto the floor. The NA continued to explain that she had both of her hands under Resident #1 to hold the brief and pad down, but the Resident rolled over so fast that she did not have enough time to grab her before she fell off the bed. She reported that she went to Resident #1 who had landed halfway on her front and her left side between the two beds and asked her if she was hurt and the Resident stated her left arm hurt. The NA stated she immediately went and found Nurse #1 and asked him to come to Resident #1's room because she had fallen off the bed. She explained that when they returned to the Resident's room the Resident had blood coming from her head. The NA reported that the NP entered Resident #1's room within seconds after she and Nurse #1 arrived and started assessing the Resident for injuries. She stated Resident #1 was sent to the hospital for evaluation of her injuries. The NA explained that Resident #1 was a one person assist because she was able to roll herself over and hold onto the bed while incontinence care was being provided and she did not know why the Resident decided to roll in the opposite direction.An interview conducted with Nurse #1 on 12/18/25 at 10:40 AM. The Nurse explained that he was at the nurses' station when he was called to Resident #1's room by NA #1 who reported that the Resident rolled out of bed. He continued to explain that when he entered the Resident's room, he observed her lying between her left side and her front side on the floor between the beds with her left leg and right arm underneath her. The Nurse reported that the NP was seconds behind him and entered the room and immediately started to assess the Resident after which the NP and Nurse #1 rolled Resident #1 over onto her back. Nurse #1 stated that there was blood coming from the left side of the Resident's forehead, so they obtained some gauze while the NP rendered first aid and continued to assess Resident #1 for further injuries