

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER The Greens at Maple Leaf		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to maintain sanitary conditions in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer, and 1 of 1 dry storage area. These practices had the potential to affect food served to residents. The findings Included:a. During the initial tour of the kitchen with the Dietary Manager on 07/28/2026 at 10:50AM, the following was observed in the walk'in cooler:-Six (6) single serve ice cream cups observed on the floor underneath the shelving unit,-Several pieces of used plastic cling wrap observed underneath the shelving unit,-Other unidentified debris was scattered throughout the walk-in cooler floor and underneath the shelving unit,-A dark brownish/ grayish/ blackish substance was observed scattered across an extended area of the left wall of the walk-in cooler,-A dark brownish/ grayish/ blackish substance was observed across several areas of the shelving unit (this shelving unit was positioned directly in front of the wall at the entrance door of the walk-in cooler),-A plastic container was observed with dark brownish/ grayish/ blackish substance scattered across the container and rim of the container located on the top shelf of the shelving unit. The plastic container contained the following items: (2) ketchup bottles, (2) mustard bottles, (3) strawberry syrup bottles, (1) chocolate syrup bottle, and (1) liquid creamer container; all of which were observed with dark brownish/ grayish/ blackish substance on the bottles/ containers.-Water was observed leaking from the ceiling fan from condensation that had accumulated along the rim of the ceiling fan vent.On 07/28/2026 at 10:55AM an interview with the Dietary Manager was completed. She explained the ceiling fan ventilation seals had been leaking for 2-3 months and Maintenance was aware. The Dietary Manager stated Maintenance had repaired the ceiling fan ventilation seals in the past (March 2026), but it began to leak again. Further interview with the Dietary Manager stated the leaking walk-in cooler ceiling fan was an ongoing issue that worsened during heavy rains. The Dietary Manager explained she had verbally informed the Maintenance Director for several months about the presence of a dark brownish/ grayish/ blackish substance on the left wall of the walk-in cooler during the morning department head meeting. The Dietary Manager also stated she had reported the issues to her Director of Operations for dietary services. The Dietary Manager could not recall the exact time she had reported the issue to her Director of Operations for dietary services. b. On observation of the walk-in freezer was completed on 07/28/2026 at 11:00AM which revealed the following:-Fallen food debris and unidentified debris scattered beneath the bottom shelving units,-An accumulation of ice on the walk-in freezer floor beneath the bottom of the shelving unit,-Ice accumulation along the walk-in freezer door threshold and the lower edges of the walk-in freezer door,An interview was completed with the Dietary Manager on 07/28/2026 at 11:06AM who stated there was no definitive cleaning schedule for the walk-in freezer. The Dietary Manager stated she was not certain as to why there was ice build up on the floor or underneath the shelving unit. c. On observation of the dry storage was completed on 07/28/2026 at 11:10AM which revealed the (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following: -(1) Fallen package of crackers, crumbs, and unidentified debris scattered throughout the floor beneath the bottom shelving units, -(1) Fallen condiment package observed underneath the shelving unit. An interview with the Dietary Manager on 07/28/2026 at 11:15AM. The Dietary Manager further stated there was no definitive cleaning schedule for the dry storage area. An interview with the Maintenance Director on 07/30/2026 at 3:23PM confirmed that staff identified daily repair needs by completing the facility's maintenance clipboard located at the nursing station. He stated a second clipboard was located in the kitchen. The Maintenance Director stated he seldom reviewed it unless someone informed him of an important issue. He preferred the Dietary Manager notify him directly of needed kitchen concerns. The Maintenance Director explained that when he became aware of a repair need, he consulted with the Dietary Manager and the Administrator to begin the process of submitting the requests to the corporate office. The Maintenance Director stated that there had not been an issue with the walk-in cooler ceiling fan leaking or producing condensation because there has been very little rain. Due to recent heavy rain this caused a backup of standing water on the rooftop. He explained that water had gotten in the condenser and produced moisture inside the walk-in cooler. The Maintenance Director stated he was not aware of the dark brownish/ grayish/ blackish substance on the left wall and shelving unit in the walk-in cooler until yesterday (07/29/2026), when the Director of Operations for dietary services instructed the dietary staff to remove the walk-in cooler equipment and clean. He confirmed that the dark brownish/ grayish/ blackish substance had resulted from moisture and from staff opening the cooler door, which allowed warm air to enter. The Maintenance Director stated he was not aware there was ice buildup on the floor at the threshold of the walk-in freezer door opening. He stated the kitchen staff had not reported the issue to maintenance. He stated the current process of communicating needed repairs worked well for the facility and did not believe changes were necessary. However, he preferred that staff communicated more consistently, provided clearer information, and take greater responsibility for cleaning. An interview with the Director of Operations for dietary services was completed on 07/30/2026 at 11:50AM revealed she was aware of the dark brownish/ grayish/ blackish substance in the walk-in cooler. She was also aware of the walk-in cooler leaking ceiling fan. She stated she expected the Dietary Manager to submit a maintenance request using the facility's maintenance clipboard located in the kitchen hanging on the wall outside the Dietary Manager's office to initiate the repair process for the leaking ceiling fan and other necessities. She further stated she expected the identified repairs to be completed promptly by the facility to maintain a safe and sanitary work environment. During a follow up interview with the Dietary Manager on 07/31/2026 at 7:50AM she stated she had not entered additional requests on the maintenance log for the dark brownish/ grayish/ blackish substance because she had already informed Maintenance several times during the department head morning meeting. The Dietary Manager reported that Maintenance had not come to the kitchen to assess the dark brownish/ grayish/ blackish substance, although administration was aware of the concern. In an interview with the Administrator on 07/31/2026 at 11:18AM she stated she expected improved communication between the Dietary Manager and the Maintenance Director. The Administrator stated the facility leadership and staff have shared a long-standing good work environment, and they share strong relationships with one another. She stated that once she became aware of the dark brownish/ grayish/ blackish substance, she instructed the Dietary Manager to discard the contents of the cooler and disinfect the area. The Administrator explained that she believed because the reach-in refrigerator had been out of service, its contents were moved to the walk-in cooler, which increased the traffic in and out of the cooler and caused irregular temperature fluctuations, which created conditions favorable to the dark brownish/ grayish/ blackish substance (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	growth. The Administrator stated if she had known sooner, the matter would have been addressed. The Administrator further stated it was the Dietary Manager's responsibility to clean the dark brownish/ grayish/ blackish substance in the walk-in cooler. The Administrator expressed she was unaware of the dark brownish/ grayish/ blackish substance in the walk-in cooler until 07/28/2026.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observation and staff interviews, the facility failed to remove expired medications from 1 of 4 medication carts reviewed for medication storage (100 Hall Medication Cart). The findings included: An observation of the medication cart for the 100 Hall was conducted on 7/30/2026 at 3:50 PM in the presence of Nurse #1. The observation revealed the following expired medications: -Nine (9) benzonatate 100 milligrams (mg) capsules (medication used to treat cough) with an expiration date of 6/8/2026. Nurse #1 confirmed the expiration date by reading aloud the date printed on the medication card. -Six (6) metoclopramide 5 mg tablets (medication used to treat nausea, vomiting, and delayed stomach emptying) with an expiration date of 5/18/2026. Nurse #1 confirmed the expiration date by reading aloud the date printed on the medication card. -Sixteen (16) ondansetron 4 mg tablets (medication used to prevent and treat nausea and vomiting) with an expiration date of 6/13/2026. Nurse #1 confirmed the expiration date by reading aloud the date printed on the medication card. An interview with Nurse #1 was conducted on 7/30/2026 at 3:58 PM. Nurse #1 stated she was a as needed (PRN) employee and was working her second shift at the facility. Nurse #1 stated she did not check the medication cart for expired medications that day and only verified expiration dates on medications she administered. She indicated medication carts should be checked weekly and all medications on the cart, including PRN medications, should be within their expiration dates. An interview with Unit Coordinator #1 was conducted on 7/31/2026 at 10:54 AM. The Unit Coordinator stated every nurse and medication aide were instructed to inspect their medication cart at the beginning of each shift and again at the end of the shift. Unit Coordinator #1 stated nurses and medication aides were educated to routinely check their medication carts for expired medications. During an interview on 7/31/2026 at 12:16 PM, the Director of Nursing (DON) stated nurses and medication aides were educated and instructed to inspect medication carts for expired medications daily and again prior to medication administration. The DON stated Unit Coordinators conducted weekly medication cart inspections and reported the medication cart was inspected the previous week. She further stated pharmacy conducted monthly medication cart inspections and the most recent inspection, completed on 6/26/2026, documented no expired medications on the cart. The DON indicated she was unsure how the expired medications were subsequently found on the medication cart. She stated expired medications should not be administered and should be removed from the medication cart, returned to the pharmacy, and reordered if needed.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on record review, observations, and staff interviews, the facility failed to keep essential equipment clean and in safe operating order for 2 of 2 dryers (dryer #1 and dryer #2) observed for safe operating conditions. The findings included: On 07/31/2026 a continuous observation beginning at 9:02 AM, was made of the laundry rooms with the Housekeeping Manager and he was asked to open the dryer lint trap access panel to be able to observe the dryer lint traps. The observation yielded dryer #1 and dryer #2 with copious amounts of lint observed in both lint traps of the two dryers and each had a visible sheet of lint hanging from the lint traps. When the Housekeeping Manager obtained a broom and removed the lint, it looked to be approximately one quarter inch thick, all one piece, and the lint covered the entire lint trap, which was approximately 16 inches wide by 20 inches long. The Housekeeping Manager removed the Dryer Lint Trap sign-off form for the month of July 2026 from a bulletin board above the trashcan in the laundry room and provided it to the surveyor and continued the interview. A review of the Dryer Lint Trap revealed the form was last signed off on 7/30/2026 at 4:00 PM. There were no initials or names in the check boxes of the Dryer Lint Trap form after 7/30/2026 at 4:00 PM. The Housekeeping Manager stated he was unaware the Dryer Lint Trap form was missing staff initials for the evening of 7/30/2026 beginning at 4:00 PM and stated the second shift laundry aide (Laundry Aide #2) worked from 4:00 PM to 9:00 PM on 7/30/26 and explained Laundry Aide #2 may have forgotten to sign the form during her shift on the evening prior. The Housekeeping Manager explained the process for checking and removing the lint from the lint traps for both dryers, dryer #1 and dryer #2, was for the laundry aides to sign the Dryer Lint Trap form using their initials in the appropriate boxes every two hours indicating they had checked and removed the lint from the lint trap. An interview was then conducted with Laundry Aide #1, who had entered the laundry room during the observation and interview with the Housekeeping Manager. Laundry Aide #1 revealed she understood the process of removing lint from the lint traps of the dryers every two hours and then sign the Dryer Lint Trap form with her initials in the appropriate box on the form indicating she had checked and removed the lint from both dryers. Laundry Aide #1 stated she started her shift at 7:00 AM on the morning of 7/31/2026 and had not yet signed off on the Dryer Lint Trap form because she had been busy. Laundry Aide #1 stated she removed the lint from the lint traps on the morning of 7/31/2026 but could not remember the exact time. She continued by saying, usually there was only a tiny amount of lint after a two-hour span and used her fingers to make a small round circle about the size of a dime to show how much lint accumulated during a two-hour span. Laundry Aide #1 stated she had washed and dried two loads of sheets and blankets that morning. The dryers were running during the interview. A phone interview was conducted with Laundry Aide #2 on 7/31/2026 at 9:32 AM. Laundry Aide #2 stated she worked on 7/30/2026 from 4:00 PM to 9:00 PM and stated no other staff would have worked in laundry until Laundry Aide #1 arrived for work on 07/31/2026 at 7:00 AM. Laundry Aide #2 stated she had forgotten to sign Dryer Lint Trap form indicating the lint was removed from both lint traps which meant there would have been blank boxes on the Lint Trap Dryer form between the hours of 4:00 PM - 9:00 PM. She stated the facility's process was to check the dryer lint traps for buildup of lint and remove all buildup of lint the lint traps every two hours and sign the Dryer Lint Form to show the task has been done. Laundry Aide #2 explained she removed the lint from the lint traps before she left at 11:00 PM on 7/30/2026. Laundry Aide #2 stated when she removed the lint from the lint trap after a two-hour period there was normally a little bit of lint to remove, but not too much, stating not enough for the lint to hang down. Laundry Aide #2 stated if the lint traps were not checked and the lint was not removed every two hours or the lint was hanging (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	down, from what she has experienced, that meant the lint traps had not been checked much that day. A second interview was conducted with the Housekeeping Manager and Laundry Aide #1 on 7/31/2026 at 11:10 AM. The Housekeeping Manager stated he did not think the lint buildup, like what was found, was a safety concern even if lint was hanging down from the lint traps. Laundry Aide #1 stated she removed the lint from lint traps on the morning of 7/31/2026, but could not remember at what time, and felt like the lint could have built up in a two-hour period due to drying sheets and blankets the dryer. Laundry Aide #1 could not explain the buildup of lint that was found. The Housekeeping Manager indicated he agreed the buildup of lint like what was found could possibly have been from drying sheets and blankets and stated if the lint traps were to produce a buildup of lint remaining like what was found, the lint traps would need to be checked more than every two hours. The Housekeeping Manager stated he did not think the amount of lint discovered was a fire safety concern. An interview with the Administrator on 7/31/2026 at 12:05 PM revealed the lint traps should be checked for buildup of lint and with instruction from the Housekeeping Manager.		