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	11/19/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with the resident's Responsible Party, staff, Nurse Practitioner (NP), Medical Director, law enforcement, and the hospital physician, the facility failed to protect Resident #1's right to be free from injury of an unknown origin. Resident # 1 sustained facial swelling, hematoma and contusion extending from the right eye to the corner of his right lip. The source of the injury to Resident #1 was not observed by anyone, the source of injury could not be explained by the resident, and the injury was suspicious. On 10/09/25, Resident #1's was observed by Nurse Aide (NA) #2 to have swelling to the residents' right side of face. The resident was transferred to the hospital via Emergency Medical Services (EMS) who noted the resident had been assaulted by a facility staff member. Observations of Resident #1 during the investigation showed swelling to the residents' right side of the face and soreness was reported by the resident. This deficient practice affected 1 of 3 residents reviewed for resident abuse/injury of unknown origin (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses which included seizures, bipolar disease, major depressive disorder, anxiety disorder, osteoarthritis, schizophrenia, cognitive communication deficit, alcoholic hepatitis without ascites, chronic pancreatitis, convulsions, and psychosis not due to a substance or unknown physiological condition. Review of physician order dated 10/31/23 revealed Resident #1 was ordered Eliquis (a blood thinner used to prevent and treat blood clots) 5 milligrams (mg) two times a day. Review of physician order dated 06/12/24 revealed Resident #1 was ordered Keppra 5 milligrams (mg) two times a day for seizures. Review of lab dated 06/18/25 revealed Resident #1 had received labs to monitor the residents Keppra level. The labs further revealed Resident #1's level was at 44.6 mg/ml (micrograms per milliliter). The normal range is from 10.0 mg/ml to 40. 0 mg/ml.Review of Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired. The MDS further revealed Resident #1 had impaired range of motion of the upper extremity on his left side. The MDS further revealed Resident #1 was not coded for any behaviors. Review of Resident #1's care plan revised on 09/16/25 revealed Resident #1 had inappropriate behaviors such as being resistive to treatment and care, refusing appointments which resulted in missed treatments, refused showers, disrobing, pulled and tore his brief, banging on the wall at night due to the residents diagnoses of bipolar, schizophrenia, psychosis, and anxiety. The goal was for Resident #1 to comply with routine care and have a decrease in behavior. Interventions included document care being resisted per facility protocol and notify physician of patterns in behavior, discuss with Resident #1 implications of not complying with therapeutic regimen, and if he refuses care, leave him and return in 5-10 minutes.A phone interview conducted with Nurse Aide (NA) #1 on 10/13/25 at 12:20 PM revealed she had worked from 3:00 PM to 11:00 PM on 10/08/25. NA #1 further revealed while providing incontinence care to Resident #1 on 10/08/25 around 7:45 PM the resident scratched NA #1 on the left side of her face with his right hand. NA #1 stated she had started on the right side of Resident #1's bed and had cleaned the resident and then rolled Resident #1 onto his back. NA #1 indicated she went to the left side and gradually raised Resident #1's hip to fasten his brief and Resident #1 took his right hand and reached across and scratched NA #1 in on the left cheek. NA #1 indicated she had told Medication Aide (MA) #1 that Resident #1 had scratched her but did not report this to the assigned Nurse. NA #1 indicated she told MA #1 that it was okay and thought she would report the resident's behaviors and her scratch. NA #1 stated Resident #1 was often aggressive and cussed staff. NA #1 revealed she had worked with Resident #1 multiple times and it was no surprise the resident had aggressive behavior towards her. NA #1 denied hitting Resident #1. A follow-up phone interview with NA #1 on 10/14/25 at 4:15 PM revealed NA #1 had worked in the facility for about a year and had been assigned to Resident #1 multiple times. NA #1 indicated Resident #1 was often could be resistive to care and at times aggressive towards staff. On 10/08/25 NA #1 worked 2nd shift from 3:00 PM until 11:00 PM and was assigned Resident #1. NA #1 revealed around 7:30 PM she provided incontinence care to Resident #1 and she had started on the left side of the resident and rolled Resident #1 to clean him and place his brief under him. NA #1 stated she went to the right side to fasten his brief she gently raised the resident's right hip to fasten the brief and Resident #1 struck out with his right hand and scratched her on the left cheek. NA #1 indicated she stated to Resident #1 ouch.you shouldn't do that. NA #1 revealed she fastened Resident #1's brief and pulled the bed cover over up on the resident. NA #1 she returned to Resident #1's room around 10:00 PM and indicated Resident #1 had no behaviors and she was able to check the resident's brief. NA #1

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Responsible Party, dental provider Chief Operating Officer, Medical Director, staff and hospital physician interviews, the facility failed to provide the necessary assistance to obtain dental services for 1 of 3 residents reviewed for routine and emergency dental services (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses which included seizures, osteoarthritis, and cognitive communication deficit.Review of physician order dated 10/31/23 revealed Resident #1 was ordered Eliquis (anticoagulant medication) 5mg (milligrams) twice a day.Review of the in-house dental list provided by the facility revealed 07/09/25 was the last time the dentist was in the facility. Resident #1 was not seen by the dentist on 07/09/25. Review of a notice sent by the in-house dentist office on 08/22/25 revealed the notice had been emailed to Social Worker (SW) #1 and SW #2 and indicated Resident #1 required a medical consultation for medication adjustment before he could be added back to the routine dental visits.Review of a notice sent by the in-house dentist office on 09/29/25 revealed the notice had been emailed to Social Worker (SW) #1 and SW #2 and indicated Resident #1 required a medical consultation for medication adjustment before he could be added back to the routine dental visits. The notice included the dentist had requested this since 02/05/25 and Resident # 1 would not be able to be added to the routine dental visit list on 10/22/25 because a medical consultation had not been completed. It was noted Resident #1 had teeth that needed fillings and multiple teeth that needed to be extracted. An interview with the in-house contracted dental providers Chief Operating Officer (COO) on 10/15/25 at 2:55 PM revealed Resident #1 had not been assessed by the dentist since 02/05/25 and the resident was aggravated during this routine dental visit. The COO indicated Resident #1 required a medical consultation for medication adjustment to assist with Resident #1's comfort before the resident could be seen in the future for routine visits. The COO stated they had reached out to the facility by email on 08/22/25 and 09/29/25 to Social Worker #1 and Social Worker #2 to follow up about the resident being seen but had not received any responses. The COO stated Resident #1 was overdue to be assessed by the dentist and possibly needed to have tooth extractions and tooth fillings completed. An interview with Social Worker #1 on 10/16/25 at 11:30 AM revealed the in-house dentist kept a running list of residents that needed to be seen, and the SW was able to add residents if they had experienced dental pain or requested to be seen. SW #1 indicated she was provided with a copy of who was going to be seen at each routine dental visit. SW #1 stated she was not aware of any notices being sent on 08/22/25 or 09/29/25 from the in-house dental provider for Resident #1 to receive a medical consultation for future appointments. An interview conducted with Social Worker #2 on 10/16/25 at 11:45 AM revealed she had been employed for 6 months and had received notices and the routine list from the in-house dental provider. It was further revealed she did not recall any notices or concerns from the in-house dental office regarding Resident #1. The SW did not recall receiving any emails on 08/22/25 and 09/20/25 about Resident #1. Review of Resident #1 quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired and required extensive support with one person assistance with personal hygiene care. The MDS further revealed Resident #1 did not have mouth or facial pain, discomfort, or difficulty with chewing. The MDS indicated Resident #1 had not behaviors during the look back period.Review of Resident #1's care plan revised on 09/16/25 revealed the resident had deficit pertaining to teeth or oral cavity characterized by altered oral mucous membrane, problems with teeth and gums, and other oral dental problems related to the history of carious teeth (teeth that have cavities or tooth decay). The goal was for the Resident #1 to be able to chew food sufficiently, provide appropriate oral hygiene, and to be able to eat and drink free of pain. Interventions included coordinating arrangements for dental care, dietary referral as needed for chewing or swallowing, ensure resident is tolerating current diet consistency, and observe for and notify physician of signs and symptoms of oral or dental problems needing attention or possible evaluation such as pain, abscess, debris in mouth, cracked or bleeding lips, missing, loose, broken, eroded, decayed teeth; black or white coated tongue, ulcers of mouth, and lesions.Review of hospital records dated 10/9/25 revealed Resident #1 was brought in by Emergency Medical Services (EMS) from the facility, and it was reported he was assaulted by a staff member who punched him in the face, and he had right facial pain. It was documented Resident #1 had traumatic injuries to his face which appeared to be superficial. The records indicated the resident's face showed soft tissue swelling of the pre-[NAME] (transitional teeth located between the canine and molar teeth) and peri mandibular (lower jaw) areas but no