STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495365	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Grove Nursing & Rehab Center	318 South East Main Street Lebanon, VA 24266

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28567 Based on staff interview, employee record review, and facility document review, the facility staff failed to follow their policy/procedures for screening of new employees for 1 of 25 new employees, new employee #15. The findings included: The facility staff failed to follow their policy for screening of new employees. The facility staff failed to provide evidence of screening for new employee #15. New employee #15 was identified as the Medical Director and had a hire date of [DATE]. The Administrator provided the surveyor with a copy of their policy titled, Abuse, Neglect and Exploitation. This policy read in part, .Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred . During the employee record review the surveyor requested evidence of screening of new hires. New hire #15's employee record did not include a criminal background check or reference checks. The license in the employee file expired on [DATE]. The facility staff were able to pull a current license with an expiration date of 2026. The Administrator stated they were trying to obtain the screenings from a third-party company. On [DATE] at 11:40 a.m., during a team meeting with the Administrator, Director of Nursing, Regional Director of Clinical Services, and Area Director of Social Services, the issue with the missing screening/credentials regarding new employee #15 was reviewed. On [DATE] at 9:44 a.m., the Administrator stated they had contacted the Regional Medical Director and left messages with the Human Resource department. The Administrator stated when new employee #15 was hired they were licensed in the Commonwealth of Virginia a background check, and fingerprints had been completed and accepted by the previous company. They were currently merging with another company and that company was in the process of completing background checks. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to the exit conference on [DATE] the Administrator provided the survey team with a sworn statement and a copy of a Virginia State Police Background check that had been obtained on [DATE] the status read NO IDENTIFIABLE RECORD(S). No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28567 Based on staff interview and clinical record review, the facility staff failed to ensure accurate Minimum Data Set (MDS) assessments for 3 of 20 residents, Residents #29, #57, and #4. The findings included: 1. For Resident #29, the facility staff failed to code the residents dialysis status on an annual MDS assessment. Resident #29's diagnoses included end stage renal disease and dependence on renal dialysis. Section C (cognitive patterns) of Resident #29's annual MDS assessment with an assessment reference date (ARD) of 08/08/24 included a brief interview for mental status (BIMS) score of 4 out of a possible 15 points. Per the MDS manual a score of 4=severe impairment in cognitive skills for daily decision making. Section O (special treatments/procedures/programs) was not coded to indicate this resident was receiving dialysis services. On 10/15/24, during initial tour of the facility the facility staff identified this resident as being out of the building for a dialysis treatment. Resident #29's comprehensive care plan included the focus area requires hemodialysis. Resident #29's clinical record included a provider order for Hemodialysis three times a week for kidney failure. The date of the order was documented as 12/20/23. On 10/15/24 at 1:16 p.m., the Administrator was made aware of the inaccurate MDS assessment and stated this resident had been on dialysis since they had been at the facility, and they would have the staff complete a modification MDS. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #57, the facility staff coded the residents discharge MDS assessment as they had discharged to a short-term general hospital when in fact they were discharged home. Resident #57's diagnoses included pleural effusion and atrial fibrillation. Section C (cognitive patterns) of Resident #57's discharge MDS assessment with an assessment reference date (ARD) of 08/30/24 included a brief interview for mental status (BIMS) score of 11 out of a possible 15 points. Per the MDS manual a score of 11=moderately impaired in cognitive skills for daily decision making. Section A (identification information) was coded to indicate this was a planned discharged , return not anticipated, and was coded to indicate Resident #57 was discharged to a short-term general hospital. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #57's clinical record included a progress note dated 08/30/24 that read in part, .requested to be d/c'd (discharged) today with days remaining . On 10/16/24 at 11:40 a.m., during a meeting with the Administrator, Director of Nursing, Regional Director of Clinical Services, and the Area Director of Social Services the issue with the inaccurate coding of the discharge MDS assessment was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 49622 3. For Resident #4, the facility staff coded the resident as having an indwelling catheter on the 7/18/24 minimum data set (MDS) assessment, however, the resident's catheter had been discontinued on 7/8/24. Resident #4's diagnosis list indicated diagnoses, which included, but not limited to, Alzheimer's Disease, Atrial Fibrillation, Diabetes Mellitus Type 2 (two), Neuromuscular Dysfunction of Bladder, Bipolar Disorder, and Chronic Viral Hepatitis C. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/18/24 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident had severe impairment in cognitive abilities. Surveyor observed Resident #4 on 10/15/24 at 12:55 PM and no indwelling catheter was present at the time of the observation. Review of the comprehensive person-centered care plan included a focus area that read in part, .resident requires a catheter . On 10/15/24 at 3:44 PM, surveyor interviewed licensed practical nurse #2 (LPN#2). LPN#2 informed surveyor that Resident #4 did not have a catheter, and it had been discontinued. LPN#4 reviewed the electronic health record and informed surveyor the resident had been in the hospital in July 2024 and the catheter had been discontinued on 7/8/24. A review of the medical provider's orders confirmed the indwelling catheter had been discontinued on 7/8/24. Further review of the clinical record revealed the most recent MDS dated [DATE] had Section H-Bladder & Bowel, being coded in section H0100-Appliances with; A. Indwelling Catheter. This concern was discussed at the end of day meeting on 10/15/24 at 4:31 PM with the administrator, director of nursing, social worker, and assistant director of nursing and again on 10/16/24 at 11:40 AM with the regional director of clinical services, area social worker, director of nursing, and administrator. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was informed by the administrator that the facility utilizes the RAI (Resident Assessment Instrument) manual for MDS guidelines. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 with a revision date of October 2023, read in part, .Section 1.4 Problem Identification Using the RAI . on page 10, .a. Assessment-Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident .) . No further information regarding this concern was presented to the survey team prior to the exit conference on 10/17/24.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49622 Based on observation, staff interview, family interview, and clinical record review, the facility staff failed to develop and/or implement a person-centered, comprehensive dietary care plan for 1 of 17 sampled residents, (Resident #6). The findings included: For Resident #6 the facility staff failed to develop and implement a comprehensive person-centered dietary care plan to address the resident's medical needs and/or preferences of being lactose intolerant. Resident #6's diagnosis list indicated diagnoses that included, but were not limited to, Arteriosclerotic Heart Disease, Hypertension, Old Myocardial Infarction, Atrial Fibrillation, Dementia, Age-Related Osteoporosis, Gastro-Esophageal Reflux Disease, and Diabetes Mellitus Type 2 (two). The most recent minimum data set (MDS) with an assessment reference date (ARD) of 9/20/24 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident had severe impairment in cognitive abilities. Surveyor interviewed resident's daughter via phone conversation on 10/15/24 at 7:06 PM. Daughter informed surveyor Resident #6 was lactose intolerant, and that facility continued to send milk on resident's tray at times after she had informed them of resident being lactose intolerant on several occasions. A review of the progress notes revealed a Social Services note dated 7/2/24 that read in part, .Care plan meeting w (with) resident's daughter and IDT (interdisciplinary team) .Discussed diet . A review of the comprehensive person-centered dietary care plan revealed no indication that Resident #6 was lactose intolerant. On 10/16/24 at 8:15 AM, surveyor interviewed dietary manager #1 (DM#1) and requested and received a copy of Resident #6's tray ticket dated 10/16/24 that read in part, .Allergies .Lactose .Milk . On 10/16/24 at 1:09 PM, surveyor interviewed dietary manager #1 (DM#1) and he stated he does resident preferences, and he does not do the care plans, the registered dietician does the care plans. On 10/16/24 at 1:16 PM, surveyor attempted to contact registered dietician via phone call and left a voice message. At 3:58 PM, the administrator informed surveyor the dietician does not update the care plan, the MDS nurse does the updates for care plans. This concern was discussed on 10/16/24 at 11:40 AM with the regional director of clinical services, area social worker, director of nursing, and administrator. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested but did not receive a care plan policy and was informed by the administrator that the facility utilizes the RAI (Resident Assessment Instrument) manual for care planning guidelines. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 with a revision date of October 2023, read in part on page 10, .d. Care Planning-Establishing a course of action with input from the resident (resident's family .) .that moves a resident toward resident-specific goals .e. Implementation-Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) . No further information regarding this concern was presented to the survey team prior to the exit conference on 10/17/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49622 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team for one (1) of 17 sampled residents, (Resident #4). The findings included: For Resident #4, the facility staff failed to review and revise the resident's comprehensive person-centered care plan to discontinue the focus for indwelling catheter that had been discontinued on 7/8/24. Resident #4's diagnosis list indicated diagnoses, which included, but not limited to, Alzheimer's Disease, Atrial Fibrillation, Diabetes Mellitus Type 2 (two), Neuromuscular Dysfunction of Bladder, Bipolar Disorder, and Chronic Viral Hepatitis C. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/18/24 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident had severe impairment in cognitive abilities. Surveyor observed Resident #4 on 10/15/24 at 12:55 PM and no indwelling catheter was present at the time of the observation. Review of the comprehensive person-centered care plan included a focus area that read in part, .resident requires a catheter . with a revision date of 8/8/24. On 10/15/24 at 3:44 PM, surveyor interviewed licensed practical nurse #2 (LPN#2). LPN#2 informed surveyor that Resident #4 did not have a catheter, and it had been discontinued. LPN#4 reviewed the electronic health record and informed surveyor the resident had been in the hospital in July 2024 and the catheter had been discontinued on 7/8/24. A review of the medical provider's orders confirmed the indwelling catheter had been discontinued on 7/8/24. This concern was discussed at the end of day meeting on 10/15/24 at 4:31 PM with the administrator, director of nursing, social worker, and assistant director of nursing and again on 10/16/24 at 11:40 AM with the regional director of clinical services, area social worker, director of nursing, and administrator. Surveyor requested but did not receive a care plan policy and was informed by the administrator that the facility utilizes the RAI (Resident Assessment Instrument) manual for care planning guidelines. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 with a revision date of October 2023, read in part on page 10, .f. Evaluation-Critically reviewing individualized care plan goals, interventions and implementation .assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in a resident's status, goals, or improvement or decline . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 10/17/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47299 Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to obtain a physician's order for oxygen for one of 17 residents in the survey sample, resident # 23. The findings included: Resident # 23's diagnoses included but were not limited to chronic obstructive pulmonary disease (COPD), morbid obesity, heart failure and hypertension. The minimum data set (MDS) assessment with an assessment reference date of 8/29/24 assigned the resident a brief interview for mental status (BIMS) score of 15 out 15, indication intact cognition. On 10/15/24 This surveyor observed resident # 23 in their room. They were using oxygen via nasal cannula and the setting was 4 liters per minute (LPM). When asked if they knew how much oxygen they were getting they stated, Two (2) I believe. When asked if they needed the oxygen all the time or just sometimes they stated, I use it all the time. During a review of the clinical record an order that read, C-PAP on at QHS (every hour of sleep) and off in the AM with settings- IP-18, EP-5, back up rate-10 and PRN (as needed) during the day with oxygen at 2 LPM bleed in two times a day related to chronic respiratory failure. The order was dated 8/15/24. There was no order in the record for resident to have oxygen during the day at 4 LPM. On 10/15/24 at 4:06 PM this surveyor interviewed Registered Nurse (RN) # 2. They stated they knew that resident used oxygen but was unsure of the order and needed to look it up. They were unable to locate an order for resident to have oxygen at 4 LPM via nasal cannula. They stated they would check with charge nurse who was more familiar with the resident. On 10/15/24 at 4:10 PM this surveyor interviewed Licensed Practical Nurse (LPN) # 2. They stated, I feel like he did have an order but it was prn (as needed). He's been back and forth to the hospital so that is probably what happened. I don't think he has ever had an order for 4 liters. He doesn't need it all the time. I checked his O 2 sat and it was 92% so I called the provided and got an order for oxygen at 2 LPM PRN. I already put it in the record. This surveyor reviewed the policy entitled, Medical Gas (Oxygen) with an implementation date of 1/1/24, that read in part, 1. Oxygen is administered under orders of a physician, except in the case of an emergency. On 10/15/24 at 4:35 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing and the Admissions Director. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47299 Based on observation, staff interview, and facility document review, the facility staff failed to ensure the safe and secure storage of medications and biologicals for 2 of 2 facility medication carts. The findings were: During a medication pass and pour observation on 10/16/24 at 8:03 AM, this surveyor observed Licensed Practical Nurse (LPN) # 1 leave the medication cart unattended with a vial of DuoNeb (ipratromium/albuterol liquid medication that is inhaled as a mist through a nebulizer machine). LPN # 1 left the cart on the A hall while they went to the medication room to look for another medication. During a medication pass and pour observation on 10/16/24 at 8:45 AM, this surveyor observed Registered Nurse (RN) # 1 leave a cup of Miramax (powdered laxative) mixed with 3 ounces of water on the medication cart unattended while they went to the medication room to look for another medication. When asked if leaving medication on the cart is acceptable, they stated, What should I have done? The policy entitled, Medication Storage with a revised date of 8/28/24 was reviewed and read in part, 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. On 10/16/24 at 11:40 AM the survey team met with the Director of Nursing, Administrator, and the Regional Director of Clinical Services. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299 Based on observation and staff interview, the facility staff failed to ensure proper disposal and/or containment of the facility's garbage/waste. The findings included: On 10/15/24 at 11:47 AM this surveyor employee # 1 made an observation of the facility's garbage disposal area located outside the facility but on the campus. There was one dumpster noted. All of the doors on the dumpster were shut. However, there was a large pile of debris beside the dumpster that included 5 computer screens and key boards, at least 5 wooden pallets, multiple wet, decorative [NAME] of hay, a case of outdated chicken noodle soup, two nightstands, multiple drinking straws, medication cups, drinking cups and surgical masks. Employee # 1 stated, They came and emptied it this morning, I don't know why they didn't pick this stuff up too. We couldn't put it in there because it was too full so we had to put it here. On 10/15/24 at 4:35 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing and the Admission's Coordinator. This concern was discussed. The Administrator stated, We had to have our dumpster switched out because it had holes in it and they replaced it with that smaller one. They are coming back to pour a concrete pad and I am going to tell them to bring me the bigger size back. No further information was presented to the survey team prior to the exit conference.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47299 Based on observation, staff interview, facility document review, and during the course of a medication pass and pour observation, the facility staff failed to maintain processes to prevent the spread of infection and disease, and to ensure that Point of Care Devices are utilized safely, when used on multiple residents, by properly cleaning a glucose monitor between residents. The findings included: On 10/16/24 at 8:24 AM this surveyor observed Licensed Practical Nurse (LPN) # 1 during a medication pass, obtain a blood sugar level on a resident. They returned to the medication cart and used two alcohol prep pads to clean the glucometer they had used. When asked what the facility policy is for cleaning glucometers they stated, We use alcohol pads, that's what we've always done. We clean them before and after each patient. On 10/16/24 AT 9:06 AM this surveyor interviewed the Assistant Director of Nursing. When asked what the policy for cleaning glucometers was, they stated, We clean them with alcohol preps before and after we use them. Surveyor asked for the policy and the manufacturers recommendations. When they returned with the policy they stated, We've already started the education with all the nurses. This surveyor reviewed the booklet EvenCare Blood Glucose Monitoring System User's Guide. On page 45, the booklet read in part, EvenCare G 2 Meters and lancing device are validated to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. The following products are validated for disinfecting the EvenCare G 2 meter and lancing device: Dispatch Hospital Cleaner Disinfectant Towels with Bleach (EPA registration Number: 56392-8), Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning Wipes with alcohol (EPA Registration Number: 59894-10), Clorox Healthcare Bleach Germicidal Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12), Medline Micro-Kill Bleach Germicidal Bleach Wipes (EPA Registration Number: 37549-1). The policy entitled, Glucometer Disinfection with a revised date of 9/2/24 was reviewed. The policy read in part, 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 2. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected then the meter will not be used for multiple residents. 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. On 10/16/24 at 11:40 AM the survey team met with the Director of Nursing, Regional Director of Clinical Services and the Administrator. This concern was discussed. The Director of Nursing stated, I think they were doing that because it is what we did during COVID, alcohol kills the virus. No further information was provided to the survey team prior to the exit conference.