DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345218		8. WING			09/06/2013		
	PROVIDER OR SUPPLIER RAN NURSING CENT			120	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTHWOOD DR BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F	000			
		ficiencies cited as a result of stigation survey of 9/6/13.					
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LABORATOR)	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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.

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STATEMENT OF	ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:			
		345218	B. WING	9/6/2013			
NAME OF PROV	ADER OR SUPPLIER	STREET ADDRES	S, CITY, STATE, ZIP CODE	•			
	N NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	ccies					
F 278	483,20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED						
	The assessment must accurately reflect	the residents state	us.				
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.						
	A registered nurse must sign and certify that the assessment is completed						
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.						
	Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than\$5,000 for each assessment.						
	Clinical disagreement does not constitute a material and false statement						
	This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) for one of two residents, Resident #15, for pressure ulcers. The findings include:						
	Resident #15 was admitted on 6/17/2013 with diagnoses of Alzheimer's disease, and Diabetes Mellitus.						
	A review of the admitting and standing orders dated 6/17/13 noted an order for treatment to sacral wound Stage III.						
	The admission MDS dated 6/24/2013 indicated that Resident #15 was at risk for pressure ulcer development, and required extensive assistance for all Activities of Daily Living (ADL). The MDS did not indicate the presence of any pressure ulcers.						
	In an interview on 9/6/2013 at 4:20 PM, the MDS nurse stated that the admission MDS dated 6/24/13 indicated that the resident did not have a pressure ulcer. The MDS nurse stated that she would have looked at the admission information to determine if the resident had a pressure ulcer. When the MDS nurse saw the diagnosis on the admission of Stage III pressure ulcer, she stated that she had overlooked it.						
	In an interview on 9/6/13 at 5:40 PM, the Director of Nursing stated that her expectation would be that an accurate assessment would be done for all admissions						
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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 sfiftient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable90 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 disclosable14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:			
FOR SNFs AN	ID NFS	345218	B. WING	9/6/2013			
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES						
F 278	Continued From Page 1						
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop review and revise the resident's comprehensive						
	plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	The care plan must describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).						
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to develop a care plan for one of two sampled residents (Resident #15) with pressure ulcers. Findings include:						
	Resident #15 was admitted on 6/17/2013 with diagnoses of Alzheimer's disease, and Diabetes Mellitus. A review of orders with admitting diagnoses on 6/17/13 indicated a Stage III sacral wound.						
	A review of the nurse note on the admission date of 6/17/2013 revealed that Resident #15 had a Stage III pressure area on the sacrum. Measurements were documented, as was tunneling.						
	The admission Minimum Data Set (MDS) dated 6/24/2013 indicated that Resident #15 required extensive assistance for all Activities of Daily Living (ADL).						
	A review of the care plan dated 7/2/13 noted no plan of care for pressure ulcer.						
	On 9/6/13 at 8:45 AM, in an interview, the MDS nurse stated that there was no care plan for Resident#15 for pressure ulcer.						
	In an interview on 9/6/13 at 4:20 PM, the MDS nurse stated that when the admission MDS, dated 6/24/13, indicated that Resident #15 was at risk for pressure ulcer, a care plan should have been generated. The MDS nurse also stated that since the Care Area Assessment (CAA) triggered for pressure ulcer, a care plan should have been developed.						
	In an interview on 9/6/13 at 5:40 PM, the Director of Nursing stated that her expectation was that an existing						

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
			A. BUILDING:	COMPLETE:			
- Or outset	~	345218	B. WING	9/6/2013			
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 CLINTON, NC					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	ENCIES					
F 279	Continued From Page 2 pressure ulcer would be recognized and a care plan would be completed						
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	Nov. 15. 2013 3:50PM		No. 3726 P. 2	•
DEPA	RTMENT OF HEALTH AND HUMAN SERVICES	: 4	NOV 1 5 2013 - PRINTED: 09/30	1/20148
<u>ĈE</u> NTI	ERS FOR MEDICARE & MEDICAID SERVICES	4	FORM APPR	OVED .
TATEME	NT OF DEFICIENCIES! IN PROVIDED CUIDO CENTAL	1360 41111	L OMB NO 1938.	<u>-0391</u>
NO PLAN	OF CORRECTION : IDENTIFICATION NUMBER!	(X2) MULTI	GONGGIRUGION SECTION (X3) DATE SURV	EY .
•	\$**	A. BUILUIN	G 01 - MAIN BUILDING 01 COMPLETED	' 1
	345218	B. WING_	; e .	·
NAME OF	PROVIDER OR SUPPLIER	1	9YPET ADDRESS OF STATE OF STAT	13
MARY	FRAN NURSING CENTER .		SYREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379	1
	t		CLINTON, NG 28328	1.
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	T . 10		l·
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTION (AS COMPLIED OF COMPLIED	n ETION
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		 	DAI JOENST	
K 000	INITIAL COMMENTS	K 000		.
	Carming	1000	The statements made on this plan of correction	
	Surveyor: 27871		are not an admission to and do not constitute	
į	This Life Safety Code(LSC) survey was		an agreement with the alleged deficiencies To	
	conducted as per The Code of Federal Register		remain in compliance with all federal and state regulations the facility has taken or will take	(
	at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced	·	the actions set forth in this plan of correction.	
	publications. This building is Type III(211)		The plan of correction constitutes the facility's	,
ſ	construction, one story, with a complete.	1	allegation of compliance such that all alleged	5
1	automatic sprinkler system:		deficiencies cited have been or will be	
1	The adaptive of		corrected by the date or dates indicated.	
	The deficiencles determined during the survey are as follows:		K029	
	NFPA 101 LIFE SAFETY CODE STANDARD		<u> </u>	
SS=E	TO THE COMPANY OF THE STANDARD	K 029	Day room and rooms 407, 409, 411-415 are no	
	One hour fire rated construction (with % hour	+	longer being used for storage.	5/2 1
. 11	ire-rated doors) or an approved automatic fire	, ,	1 100	7P .
19	extinguishing system in accordance with 8.4.1		his has the potential to affect all residents.	,;
f	ind/or 19.3.5.4 protects hazardous areas. When he approved automatic fire extinguishing system		Rioper facility storage has been added to	1
l o	ption is used, the areas are separated from	ĺ	pionthly maintenance rounds.	1
10	iner spaces by smoke resisting partitions and	ĺ	18/3/	1/3
- 4 Q	COIS. LOOFS are self-closing and non-rated or	۱; ا	Any deficient practice will be reviewed by	/3
[11	ald-applied protective plates that do not exceed		Quality Assurance Committee.	
2	B inches from the bottom of the door are emitted, 19,3,2,1]	,	
l b.	THE STATE OF THE S		The charge of the second of th	
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TL	NO STANDADD I	j		
. 8	ils STANDARD is not met as evidenced by:			'
	sed on observations and staff interview at			
l ap	proximately 9:30 am onward, the following			1
lte:	ms were noncompliance, specific findings	1	19 19 19 19 19 19 19 19 19 19 19 19 19 1	
inc	lude: Day room is being for storage and door is		:	1.
40	self closing(400 hall). Also rooms 7,409,411-415 being used for storage,			·
	treature and and the smith stands.			
1000				1
UKY DIRI	CTOR'S OB PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNAT	URE	TITLE (X0) DATE	٠.
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lency stat	ement ending with an astorick (") denotes a deficiency which revises sufficient protection to the patients. (See instructions.)	nolluliten en		_ ·
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wing the	fate these documents are made available to the facility. If def	ursing homes Iclencies are	reing homes, the findings:stated above are disclosable 80 days, the above findings and plans of correction are disclosable 14-	
រគពេល ់ឯមា រ	on.			: 1

i-2567(02-99) Provious Versions Obsofule

Event ID: LZH121

Facility ID: 923329

Nov. 15. 2013 3:50PM PRINTED: 09/30/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDERVSUPPLIERVOLIA TATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION : (X3) DATE SURVEY NO PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345218 B. WING 09/24/2013 VAME OF PROVIDER: OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE. 120 SOUTHWOOD DR BOX 379 **VIARY GRAN NURSING CENTER** *4 "CLINTON, NC 28328 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID lD PROVIDER'S PLAN OF CORRECTION (X6) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EAGH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY K062 K 029 Continued From page 1 K 029 Sprinkler heads are now free of corrosion. 42 CFR 483.70(a) Wet/Dry system had a 3 year full flow test and NFPA 101 LIFE SAFETY CODE STANDARD K 062 K 062 5 year obstruction test. Sprinkler heads outside SS=E of 200 hall shower room have been replaced Required automatic sprinkler systems are Resident bedroom closets have no storage continuously maintained in reliable operating within 18 inches of sprinkler head. 4.5 condition and are inspected and tested. periodically.....19.7.6, 4.8.13, NEPA.13, NEPA This has the potential to affect all residents 25, 9,7,5 Proper resident storage and sprinkler head review has been added to the weekly rounds shock Simplex Grinnell will review Wet/Dry This STANDARD is not met as evidenced by: system yearly. Surveyor: 27871 Based on observations and staff interview at ... Any deficient practice will be reviewed by approximately 9:30 am onwald, the following... « Quality Assurance Committee. Items were noncompliance, specific findings. If include: 1) per sprinkler report sprinklighheads in kitchen are not free of corrosion. 2) facility could not provide proper documentation All hallways have been cleared of obstructions that the dry and wet system has had? Hallway rounds have been added to Housekeeping 1. 3 year full flow test.(dry only) Supervisor daily rounds sheet. 2. 5 year obstruction investigation teat(on wet Any deficient practice will be reviewed by Quality and dry). Assurance Committee. Sprinkler heads outside shower room on 200....
hall had paint on orifice. Commence the state of the state hall had paint on orifice." 4.) residents bedroom closet had storage within 18 inches of sprinkler head. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD 272 K 072 ì≍E Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. IS-2607(02-99) Previous Versions Obsolete Event ID: LZH121 Facility ID; 923329 If continuation sheet Page 2 of 4

No. 3726

Nov. 15. 2013 3:50PM DEPARTIMENT OF HEALTH AND HUMAN SERVICES No. 3726 PRINTED: 09/30/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA, IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 COMPLETED. 345218 B. WING 09/24/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 MARY GRAN NURSING CENTER CLINTON, NC 28328 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION JD. COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LEC IDENTIFYING INFORMATION) TAG DEFICIENCY K 072 | Continued From page 2 K 072 7.1.10 This STANDARD is not met as evidenced by: Surveyor. 27871.... Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings K076 include: facility had wheel chair's chairs, electric fans(plugged into outlet on corridor) overhead Oxygen tanks are now being stored in doors. bed tables stored on all corridors in facility. This has the potential to affect all residents. Oxygen tank storage has been added to monthly 42 CFR 483.70(a) maintenance rounds. 1 07e NFPA 101 LIFE SAFETY CODE STANDARD K 076 Any deficient practice will be reviewed by Quality JS≍E Assurance Committee. Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 la Programa Luga (paga Nasakawa 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings CMS-2567(02-89) Previous Versions Obsolete Event ID: LZH121 Facility ID: 923320 If continuation sheet Page 3 of 4 ŧ .

DEPARNOV. 15. 2013. 3:50PM HUMAN SERVICES No. 3726 P. 5 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 345218 B, WING 09/24/2013 NAME OF PROVIDER OR SUPPLIER 6TREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 MARY GRAN NURSING CENTER CLINTON, NC 28328 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG K 076 Continued From page 3 K 076 include: oxygen cylinders stored outside will need to be protected from the weather. 42 CFR 483.70(a) الدر المراجع المراجع المراجع المعاولات المراجع وهو والانتخاص والمراجع والمراجع والمراجع والمراجع والمراجع والم المراجع المراجع المراجع والمراجع والمراجع والمراجع المراجع والمراجع والمراجع والمراجع والمراجع والمراجع والمرا :: : . CMS-2567(02-99) Previous Versions Obsoléle Event ID: LZH121 Facility ID: 923329 If continuation sheet Page 4 of 4

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STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 02 - BUILDING 02	(X3) D	O. 0938-0391 ATE SURVEY DMPLETED
	· ·	345218	B. WING		3.	
NAME OF	PROVIDER OR SUPPLIER	y)	14: " -	STREET ADDRESS, CITY, STATE,	10	9/24/2013
MARY G	PRAN NURSING CENT	R		120 SOUTHWOOD DR BOX 37 CLINTON, NC 28328)	;
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROBS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	3	K 000			
	at 42 CFR 483.70(a) Health Care section of publications, This but	e Code of Federal Register using the 2000 Existing of the LSC and its referenced Iding is Type II (211)	:	<u>K147</u>	, kan engryffe sy fe'r rek	
	construction, one sto automatic sprinkler since the deficiencies determined to the construction of the deficiencies determined to the construction, one storage automatic sprinkler since the construction, one storage automatic sprinkler since the construction, one storage automatic sprinkler since the construction of the cons	ry, with a complete		Multi power strips: from rooms; 713 & All resident rooms power strip remove Power cord use in r	714. have been reviewed l.	i for 10/11/13
• • • • • •	ar e as t ellows:	ETY CÓDE STANDARD		added to monthly h	ousekeeping round	\$
SS=E	Electrical wiring and e	quipment is in accordance all Electrical Code, 9.1.2	, > K 147 	Any deficient pract Quality Assurance	ice will be reviewe Committee.	d by
a	Surveyor, 27871 Based on observation: approximately 9:30 an tems were noncompli nclude: residents roon	of met as evidenced by: s, and staff interview at n onward, the following, ance, specific findings ns 713 and 714 are using / and refrigerator to be	4	est original.		
	2 CFR 483.70(a)	100 (100 (100 (100 (100 (100 (100 (100			######################################	. 4. 2 1. 6 207 1202 1
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RATORY DIF	RECTOR'S OR PROVIDER/S	UPPMER REPRESENTATIVE'S SIGNAT	. URE	TITLE		6) DATE
eficiency sta feguards	atement ending with an asl provide sufficient protection of survey whether or not	erisk (*) denotes a deliciency which to the patients, (See Instructions.) plan of correction is provided. For no made available to the facility. If defi	ihe institution Except for nu	may be excused from correcting raing homes, the findings stated	providing it is delerm	Ined that
CMS-2507(02	2-99) Previous Versions Obsole	ele Event ID: LZH121	Facility	D; 923329	If continuation sheet i	Page 1 of 1