STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 9/6/13. Event ID# LZH111.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE
	345218	A. BUILDING: _____ B. WING _____	9/6/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the residents status.

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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345218	A. BUILDING: _____ B. WING _____	9/6/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC

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 COMPLETE
	345218	A. BUILDING: _____ B. WING _____	9/6/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	Continued From Page 2 pressure ulcer would be recognized and a care plan would be completed

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 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 include: Day room is being for storage and door is not self closing(400 hall).Also rooms 407,409,411-415 being used for storage.	K 029	K029 Day room and rooms 407, 409, 411-415 are no longer being used for storage. This has the potential to affect all residents. Proper facility storage has been added to monthly maintenance rounds. Any deficient practice will be reviewed by Quality Assurance Committee.	10/21/13 10/31/13

ORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 10/11/13

ency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that uards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days e 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 wing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued articipation.

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	345218	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 42 CFR 483.70(a)	K 029	K062 Sprinkler heads are now free of corrosion. Wet/Dry system had a 3 year full flow test and 5 year obstruction test. Sprinkler heads outside of 200 hall shower room have been replaced. Resident bedroom closets have no storage within 18 inches of sprinkler head.	10/31/13
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	This has the potential to affect all residents. Proper resident storage and sprinkler head review has been added to the weekly rounds sheet. Simplex Grinnell will review Wet/Dry system yearly. Any deficient practice will be reviewed by Quality Assurance Committee.	10/31/13
	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 include: 1) per sprinkler report sprinkler heads in kitchen are not free of corrosion. 2) facility could not provide proper documentation that the dry and wet system has had : 1. 3 year full flow test.(dry only) 2. 5 year obstruction investigation test(on wet and dry). 3) Sprinkler heads outside shower room on 200 hall had paint on orifice. 4.) residents bedroom closet had storage within 18 inches of sprinkler head.		K072 All hallways have been cleared of obstructions. Hallway rounds have been added to Housekeeping Supervisor daily rounds sheet. Any deficient practice will be reviewed by Quality Assurance Committee.	10/31/13
	42 CFR 483.70(a)			
072 S=E	NFPA 101 LIFE SAFETY CODE STANDARD 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.	K 072		

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	345218	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/24/2013

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K 072	Continued From page 2 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 include: facility had wheel chair's chairs, electric fans(plugged into outlet on corridor) overhead bed tables stored on all corridors in facility . 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD 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 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	K 072	K076 Oxygen tanks are now being stored in doors. This has the potential to affect all residents. Oxygen tank storage has been added to monthly maintenance rounds. Any deficient practice will be reviewed by Quality Assurance Committee.	10/31/13
K 076 LSC E		K 076		

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K 076	Continued From page 3 include: oxygen cylinders stored outside will need to be protected from the weather. 42 CFR 483.70(a)	K 076		

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	345218	A. BUILDING 02 - BUILDING 02 B. WING	09/24/2013

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 8.1.2 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 include: residents rooms 713 and 714 are using multi power strip for TV and refrigerator to be plugged into. 42 CFR 483.70(a)	K 147	K147 Multi power strips have been removed from rooms: 713 & 714. All resident rooms have been reviewed for power strip removal. Power cord use in resident rooms will be added to monthly housekeeping rounds. Any deficient practice will be reviewed by Quality Assurance Committee.	10/31/13

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrate | (X6) DATE: 10/11/13

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