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 _____	C 12/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE 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 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide speech therapy services as ordered by the physician following readmission to the facility for 1 (Resident #1) of 2 sampled residents. The findings included: Review of Resident # 1 ' s medical record revealed the resident was initially admitted to the facility on 6/23/15 with diagnoses which included cerebrovascular accident (stroke), dysphagia (difficulty swallowing), and dysarthria (difficulty speaking related to weak mouth muscles). Review of the resident ' s June admission MDS (Minimum Data Set) revealed the resident ' s cognition was intact. Review of speech therapy documentation revealed the resident began receiving speech therapy at the facility on 8/28/15. Further review of the speech therapy notes revealed the resident ' s speech therapy ended on 9/15/15 secondary to the resident unexpectedly being transferred to the hospital. The therapist documented the resident needed to be re-evaluated when the resident returned to the facility.	F 406	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 allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. A. Resident #1 was discharged from the Facility on 10-29-2015. B. To identify other residents having potential to be affected by this practice, all admission and readmission charts for the past three months were audited by the Rehab Director, to	12/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2015

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F 406	Continued From page 1 Review of Resident #1 ' s medical record revealed the resident was hospitalized from 9/17/15 to 9/22/15 secondary to Acute Renal Failure. Upon the resident ' s readmission date of 9/22/15 the resident was ordered to receive speech therapy. A review of the resident ' s cumulative orders within the facility ' s computer system noted the order was initiated 9/22/15. The order remained active through 10/29/15 when Resident #1 was discharged from the facility. No documentation was found to indicate the resident was ever evaluated and treated by speech therapy following her return on 9/22/15. Review of the resident ' s care plan, updated 9/26/15, revealed swallowing was identified to be a problem for the resident. One of the approaches listed on the care plan was to " refer to Speech therapist for Swallowing Evaluation. " Nurse # 1 was interviewed on 12/8/15 at 12 noon and again at approximately 3:40 PM. Nurse # 1 stated the resident had swallowing problems and ate poorly. Nurse # 1 did not know why speech therapy did not treat the resident again following the readmission order of 9/22/15 to do so. The speech therapist was interviewed on 12/8/15 at 2:20 PM and 3:15 PM. The speech therapist reviewed his documentation and confirmed that the resident received treatment from the dates only of 8/28/15 through 9/15/15 and that the resident did not receive evaluation and treatment as ordered 9/22/15. The speech therapist stated during the course of treatment before the resident was discharged to the hospital he had worked with her so that her diet could be upgraded to soft food with chopped meats. The therapist stated following the upgrade it would have been his expectation the resident continue to be monitored. The therapist further stated the resident had met part of her speech therapy goals	F 406	assure that all orders for Therapy Services were implemented. Corrections were made as indicated. This was completed on December 18, 2015. C. Systemic changes made to ensure that the deficient practice will not reoccur were to reeducate the Rehab Director COTA and Rehab Tech to assure that all physician's orders are implemented. Email notification of each Admission and Readmission will be forwarded to the Rehab Director and Rehab Tech by the Admissions Director, on the day of the resident's arrival at the facility. All new admissions and readmissions Will be screened by all therapy disciplines. The resident name will by added to the Plan Of Care (POC) tracker form by the Rehab Tech when notification of admission or readmission is received. The POC Tracker Form will track screens, orders POCs, undated POCs, and extension orders. The Rehab Director or designee will audit the Plan of Care Tracker form weekly to assure all Residents have been Screened and	

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F 406	Continued From page 2 but not all of them prior to her transfer to the hospital on 9/17/15. The speech therapist explained he was not aware the resident had returned to the facility and had a speech therapy order on 9/22/15. The speech therapist did not know why the therapy department had not received the order to evaluate and treat the resident again.	F 406	physicians orders have been implemented. The computer software SMART system will alert The Rehab Director to any resident who has not been assigned a Payer source. These alerts will be monitored daily by the Rehab Director or COTA. D. To monitor this practice, The QA monitor Therapy Audit will be completed by the Administrator. This monitor will review two new admission or readmission charts to ensure therapy screens were completed by all three disciplines and if physician orders were received that they were followed through. This monitor will be completed weekly times 4 weeks, then monthly times two months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. E. December 18, 2015	