STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345292	B. WING		08/11/2016	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
				290 KEEL ROAD		
GRANTSBROOK NURSING AND REHABILITATION CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 412 SS=D	483.55(b) ROUTIN SERVICES IN NFS	E/EMERGENCY DENTAL	F 41:	2	8/17/16	
	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.					
	by: Based on record re facility failed to provi inspection and rout residents reviewed #9). The findings in Resident #9 was ad and had a diagnosi mellitus. The most recent Mi Assessment (Annu- resident had moder no dental issues no The Care Area Asse for Cognitive Status resident had some dementia. The resident 's Car noted the resident 's dentures. Review of the clinic information regardin	dmitted to the facility on 7/1/14 s of dementia and diabetes inimum Data Set (MDS) al) dated 6/17/16 revealed the rate cognitive impairment and ited. essment (CAA) dated 6/17/16 s/Dementia revealed the difficulty with recall due to re Plan updated on 8/9/16 was edentulous and used al record revealed no		F 412: Routine/Emergency Dental Services in NFS Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposi- this Plan of Correction to the extent the the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residen The Plan of Correction is submitted as written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that an deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any	es at ts. s a on of ent ny	

08/17/2016

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.

**Electronically Signed** 

		MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345292			A. BUILDING	COMPLETED		
		B. WING	08/11/2016			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	OVIDER'S PLAN OF CORRECTION (X I CORRECTIVE ACTION SHOULD BE COMPL REFERENCED TO THE APPROPRIATE DA DEFICIENCY)	
F 412	Continued From pag	e 1	F 41	2		
	contract with a dentist for routine dental care for residents on Medicaid. On 8/11/16 at 8:27 PM the Administrator stated in an interview they did not have a contract with a dentist and did not have a dentist see the residents annually.			Deficiencies through Inform Resolution, formal appeal p and/or any other administra proceeding.	procedure	
				Resident #9 will be seen at dental provider for dental s denture repair on 8/23/16. A 100% audit of all current	ervices and	
				include resident #9, was in Director of Nursing and wa 8/11/16 to ensure all reside no dental issues using the	itiated by the s completed on ents have had	
				census. There were no issu the Director of Nursing at the	nat time.	
				On 8/16/16, the Administra Director of Nursing was in- Facility Nurse Consultant re facility must ensure that se	serviced by the egarding: The	
				available for residents to p employing a staff dentist or contract service for routine	rovide either by through a	
				A contract arrangement wi dental company was made provide in-house Dental Se Administrator.	on 8/15/16 to	
				On 8/15/16, an inservice of the Administrator and a rep the contracted dental comp license nurses, regarding to services provided by the co	presentative for pany, with all he dental	
				company. Any licensed nu attend the inservice, will be prior to their next schedule new licensed nurse oriente	rse that did not inserviced d work day. All	

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CENTERS FOR MEDICARE & MEDICAID SERVICES         TATEMENT OF DEFICIENCIES         ND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345292		. ,	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 08/11/2016	
		A. BUILDING		
		B. WING		
NAME OF PROVIDER OR SUPPLIER				
			290 KEEL ROAD GRANTSBORO, NC 28529	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
Continued From page	ge 2	F 412	<ul> <li>by Long Term Care Professional Associates, Incorporated during orientation.</li> <li>The Director of Nursing will audit the dental consultations for all residents include resident #9,by the contracte dental company, or any other outsid dental services, and utilize the Dent Services QI Tool for any recommendations of needed service weekly X's 4 then monthly X's 2 mo ensure all recommendations have b addressed. The Administrator will re the Dental Services QI Tool weekly 1 then monthly X's 2 months for comp and to ensure all areas of concern v addressed.</li> <li>The Quality Improvement Executive Committee will review all Dental Ser QI Tool results monthly x 3 months for recommendations, take action as appropriate, and to monitor for conti compliance.</li> </ul>	s, to d le ral es nths to been eview X's 4 oletion vere ervices for any
	CORRECTION ROVIDER OR SUPPLIER BROOK NURSING AND SUMMARY S (EACH DEFICIEN REGULATORY OF	CORRECTION  IDENTIFICATION NUMBER:  IDENTIFICATION NUMBER: IDENTIFICATION NUMBER:  IDENTIFICATION NUMBER:	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345292       B. WING	IDENTIFICATION NUMBER:       A BUILDING         345292       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SROOK NURSING AND REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       ID         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         TAG       PREFIX         Continued From page 2       F 412         by Long Term Care Professional Associates, Incorporated during orientation.         The Director of Nursing will audit the dental consultations for all residents include resident #9, by the contracte dental company, or any other outsid dental services, and utilize the Dental Services QI Tool for any recommendations of needed service weekly X's 4 then monthly X's 2 months for company and to ensure all areas of concern v addressed.         The Quality Improvement Executive Committee will review all Dental Services QI Tool weekly X's 3 months for company and to ensure all areas of concern v addressed.

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Facility ID: 923031

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