PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			l	C / 15/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			113/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 241 SS=D			F2	241	The statements made on this plan of correction are not an admission to and 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. F 241 A corrective action for affected resident For resident #8, the nursing assistant provided incontinent care to the resider	d.	3/13/17	
AROBATORY	A review of Resident resident had the pote development and a s Activities of Daily Livi extensive staff assista	#8's Care Plan indicated the ntial for pressure ulcer elf-care deficit with her ng (ADLs) and required ance.	F		All current incontinent residents have the potential to be affected by the alleged deficient practice. All current residents were assessed by nurse management team for incontinent needs. This audit was completed by reviewing Point of Care documentation	the ice	(X6) DATE	

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

Electronically Signed

03/10/2017

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		، ا		
		345218	B. WING			1	15/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, <u>v=</u> ,	10/2011	
				12	20 SOUTHWOOD DRIVE BOX 379			
MARY GR	AN NURSING CENTER			С	LINTON, NC 28328			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 241	Continued From page	e 1	 F:	241				
	· -	vith Resident #8 on 02/14/17			continence over the last 14 days.			
		ent #8 stated she had a			Residents identified as having			
		continent episode around			incontinence had their care plan review	ed		
		e. Resident #8 stated she			by the MDS Nurse to ensure their care			
	had always been able	e to wash her upper body but			plan was current with their incontinent			
	required assistance for	or her lower body. Resident			care needs. This review will be comple	ted		
		d her call light at the time of			by 03/13/2017.			
		de and her assigned Nursing						
	Assistant (NA) #1 came to her room and				Systemic changes made were:			
		S she would return in a						
		stated she waited until 11:00			In-service education began on 03/06/2			
	-	call light again. Resident #8			by the Staff Development Coordinator			
		d to her room and set up the rning care and left the room.			all RNs, LPNs, Med Tech's, Med Aides and CNAs, FT, PT, and PRN. The	,		
		ne washed her upper body			in-service topics included: Resident rig	hts		
		to return to her room to			and dignity was discussed and meeting			
		continent care. Resident #8			residents request timely.	'		
	•	d to her room at lunchtime						
	and provided the rem	naining ADL and incontinent			The facility specific in-service was sent	to		
	care.	•			Hospice Providers whose employees g			
					residents care in the facility to provide			
	_	vith NA #1 on 02/14/17 at			training for staff prior to returning to the			
		ated she had been aware			facility to provide care. Agencies that a	re		
		call light on and she went to			used for staffing needs were sent the			
		ed she was working with			facility specific in-service and instructed			
		would be back in a few			provide training for staff prior to assigni	ng		
		ed she and another nursing			them to the facility for a temporary			
		Resident #8's room after the			assignment. Any in-house staff member			
	_	n the floor around 12:00 p.m. DL and incontinent care.			who did not receive in-service training 03/13/2017 will not be allowed to work	Эу		
	and completed her Ai	DE and incontinent care.			until training has been completed.			
	During an interview w	vith Resident #8 on 02/14/17			This information has been integrated in	to		
	_	nt #8 stated it felt nasty and			the standard orientation training and in			
		n her bed in a brief soiled			required in-service refresher courses for			
	•	t for such a long time.			all employees and will be reviewed by			
	Resident #8 stated it	-			Quality Assurance Process to verify that			
					the change has been sustained.			
	During an interview w	vith the Director of Nursing						
	(DON) on 02/15/17 a	t 12:50 p.m., the DON stated						

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345218	B. WING			l	C
	ROVIDER OR SUPPLIER AN NURSING CENTER	340Z10		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			15/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 F 242 SS=D	483.15(b) SELF-DET MAKE CHOICES The resident has the schedules, and health her interests, assessinteract with members inside and outside the	e nursing staff was to treat nity and respect. ERMINATION - RIGHT TO right to choose activities, a care consistent with his or ments, and plans of care; so of the community both a facility; and make choices or her life in the facility that		241	The facility plans to monitor its performance by: The Director of Nursing or Staff Development Coordinator will monitor to issue using the Quality Assurance for Residents Rights and Dignity. The monitoring will include observing five resident's residents weekly for incontinence needs being met timely. It tool will be completed weekly for 4 weethen monthly times 2 months. Reports to be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitor and ongoing auditing program reviewed the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	The ks will red d at	3/13/17
	by:	is not met as evidenced taff interviews and record			The statements made on this plan of		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345218	B. WING		,	C 2/15/2017		
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		STREET ADDRESS, CITY, STATE, ZIP CODE		2/15/2017		
	101.52.1.01.1.00.1.2.2.1			120 SOUTHWOOD DRIVE BOX 379	-			
MARY GR	AN NURSING CENTER			CLINTON, NC 28328				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 242	Continued From page	÷ 3	F 24	42				
	review, the facility fail scheduled for 1 of 3 s # 2) Findings included	ed to offer showers as campled resident.(Resident d:		correction are not an admissio not constitute an agreement w alleged deficiencies. To remain compliance with all federal and	ith the n in d state			
	Resident # 2 was admitted to the facility on 2/3/2017 with the diagnoses of Hypertensive Chronic Disease, end stage renal disease, dependence on renal dialysis, Anemia, peripheral vascular, Atrial fibrillation, Patient's noncompliance with other medical treatment and regiment, unqualified visual loss, both eyes and muscle weakness. The quarterly Minimum Data Set (MDS) dated 1/7/2017 indicated Resident # 2 was cognitively intact with no behaviors. She was coded as requiring extensive assistance for her hygiene and bathing. The most recent care plan revised 12/15/2016 indicated she required assistance with her Activity of daily living (ADLs) and no refusal of showers or other ADLs. In an interview on 2/14/17 at 11:51 AM, Resident # 2 stated he was not offered showers on his scheduled shower days of Mondays, Wednesdays and Fridays. Resident # 2 stated having showers was important to him.			regulations the facility has take take the actions set forth in this correction. The plan of corrections the facility's allegat compliance such that all allegates.	s plan of tion ion of ed			
				deficiencies cited have been o corrected by the date or dates				
				A corrective action for Affected has been accomplished by: Resident # 2 was interviewed	by the			
				Social Worker for his preference regarding showers on 03/07/20 preferences were determined a Coordinator updated resident a Point of Care. All current residents with show preferences not currently being the potential to be affected by	017. Once the MDS #2 task in ver g met have			
	not plan to give the re was not aware it was reported she depende about their shower da Resident # 2 did not r morning when she ga	A) # 1 stated she was of Resident # 2 and she did esident the shower since she his shower day. The NA # 1 ed on residents telling her hys. She also reported		deficient practice. On 03/07/2017, the two facility Workers began discussing with cognitively intact residents the preferences for shower scheduresidents not cognitively intact responsible party was contacted discussed shower schedule professional preferences were determined,	r Social th all ir ule. For , the ed and references. 2017. Once			

Facility ID: 923329

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345218	B. WING_				C / 15/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 242	for the months of Dec and February 2017 in receiving bed baths. A review of the nursing present made no men refusing his showers. In an interview on 2/1 Director of Nursing (I expectation that Resi as scheduled and if so attempt to address the stated she also expen-	er schedule for Resident # 2 cember 2016, January 2017 indicated no refusals but only and notes from 2/3/2017 to intion of Resident # 2 15/17 at 9:00 AM, the DON) stated it was her ident # 2 receive his showers the refused, the staff should he reason why. The DON cted the aides to report is and the nurses and aide	F2	242	Coordinator updated each resident's tain Point of Care as indicated with their preference. This was completed by 03/13/2017. Systemic changes made were: In-service education began on 03/06/2 by the Staff Development Coordinator all RNs, LPNs, Med Tech's, Med Aides and CNAs, FT, PT, and PRN. The in-service topics included: Honoring resident preferences, facility shower schedules, how to locate resident preferred shower schedules, and how to document refusals of showers. The facility specific in-service was sent Hospice Providers whose employees gresidents care in the facility to provide training for staff prior to returning to the facility specific in-service and instructed provide training for staff prior to assignithem to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training 03/13/2017 will not be allowed to work until training has been completed. The facility plans to monitor its performance by: The Director of Nursing or Staff Development Coordinator will monitor its sue using the Quality Assurance for monitoring shower preference. The	on to ive and to angular to angul		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	343216	1	TREET ADDRESS, CITY, STATE, ZIP CODE	02/15/2017	
NAME OF PI	ROVIDER OR SUPPLIER					
MARY GR	AN NURSING CENTER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 242	Continued From page	2.5	F 242	monitoring will include observing five resident's weekly for preference being honored. The shower schedule chosen will be compared with documentation of actual showers given. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitor and ongoing auditing program reviewed the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support	e ored d at	
				Nurse, Therapy, HIM, Dietary Manager	·	
F 312 SS=D	DEPENDENT RESID A resident who is una daily living receives the		F 312	and the Administrator.	3/13/17	
	by: Based on observation resident and staff interprovide incontinent caresident until 3 hours	is not met as evidenced ns, record review, and rviews, the facility failed to are for a cognitively intact after it was requested for 1 ed receiving care (Resident		The statements made on this plan of correction are not an admission to and 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		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING			02/2	5 15/2017		
NAME OF P	ROVIDER OR SUPPLIER	0.02.0	 	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 021	15/2017		
NAME OF T	NOVIDER OR SOLT LIER								
MARY GR	AN NURSING CENTER				OUTHWOOD DRIVE BOX 379				
				CLINI	ON, NC 28328				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETION DATE		
F 312	Continued From page	. 6		10					
1 312	Continued From page		F 3						
					nstitutes the facility's allegation of				
	Resident #8 was adm	-			mpliance such that all alleged				
		ses which included pressure		I .	ficiencies cited have been or will be				
		al infarction (stroke) and		co	rrected by the date or dates indicate	d.			
	Diabetes Mellitus Typ	e 2.							
	A review of the quarte	erly Minimum Data Set		F;	312				
	(MDS) dated 12/05/16 indicated Resident #8 was								
	cognitively intact and required extensive			A	corrective action for affected residen	t:			
	assistance with bed n	nobility, transfers, dressing,							
	toileting and personal	hygiene. The MDS		Fo	or resident #8, the nursing assistant				
	indicated the resident	was always incontinent of		pro	ovided incontinent care to the reside	nt.			
	bowel and bladder an	d was at risk for developing							
	pressure ulcers.			All	current incontinent residents have t	he			
				ро	tential to be affected by the alleged				
		#8's Care Plan, last revised resident had the potential		de	ficient practice.				
	for pressure ulcer dev	elopment and had a		All	current residents were assessed by	the			
	self-care deficit with h	ner Activities of Daily Living		nu	rse management team for incontine	nce			
	(ADLs) and required	extensive staff assistance.		ne	eds. This audit was completed by				
				rev	viewing Point of Care documentation	n for			
	During an interview w	rith Resident #8 on 02/14/17		со	ntinence over the last 14 days.				
	at 12:30 p.m., Reside	nt #8 stated she had a		Re	esidents identified as having				
	bowel and bladder ind	continent episode around		ind	continence had their care plan review	ved			
	9:00 a.m. on this date	e. Resident #8 stated she		by	the MDS Nurse to ensure their care	:			
	had always been able	e to wash her upper body but		pla	an was current with their incontinent				
	required assistance for	or her lower body. Resident		ca	re needs. This review will be comple	eted			
	#8 stated she pushed	I her call light at the time of		by	03/13/2017.				
	her incontinent episod	de and stated the Nursing							
		ned to care for her, NA #1,		Sy	stemic changes made were:				
		d informed Resident #8 she							
		ute. Resident #8 stated she			service education began on 03/06/2				
		n. and pushed her call light		, ,	the Staff Development Coordinator				
		tated NA #1 returned to her		- 1	RNs, LPNs, Med Tech's, Med Aides	5 ,			
		supplies to begin morning			d CNAs, FT, PT, and PRN. The				
		n. Resident #8 stated she			service topics included: Staff will be				
		dy and waited for NA #1 to		I .	ucated on providing timely incontine				
	return to her room to	•		ca	re and meeting resident request time	ely.			
	incontinent care. Res	sident #8 stated NA #1							

Facility ID: 923329

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345218	B. WING		02/4	; 5/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	1 02/1	3/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 312	returned to her room the remaining ADL ar During an interview w 12:45 p.m., NA #1 sta Resident #8 had her her room and explain another resident and minutes. NA #1 state best she could. NA # administration sent heat 11:00 a.m. which copick up additional resit took longer to respore it took longer to responsible to longer to longer to longer to longer to	at lunchtime and provided	F 31	The facility specific in-service wa Hospice Providers whose employ residents care in the facility to protraining for staff prior to returning facility to provide care. Agencies used for staffing needs were sen facility specific in-service and ins provide training for staff prior to a them to the facility for a temporar assignment. Any in-house staff n who did not receive in-service tra 03/13/2017 will not be allowed to until training has been completed information has been integrated is standard orientation training and required in-service refresher cou all employees and will be reviewed Quality Assurance Process to ve the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing or Staff Development Coordinator will make issue using the Quality Assurance Residents Rights and Dignity. The monitoring will include observing resident's residents weekly for incontinence needs being met tint tool will be completed weekly for incontinence needs being met tint tool will be completed weekly for then monthly times 2 months. Residents accompliance will be resulted appropriate. Compliance will be rand ongoing auditing program re	yees give ovide to the that are t the tructed to assigning ry nember aining by work d. This into the in the reses for ed by the rify that onitor this e for ne five nely. The 4 weeks eports will ity e ing to as monitored		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X	COMPLETED		
		345218	B. WING _			C 02/15/2017		
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		02/10/2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 312	Continued From page	e 8	F3	the weekly QA Meeting. The w Meeting is attended by the Dire Nursing, MDS Coordinator, Su Nurse, Therapy, HIM, Dietary M and the Administrator.	ector of pport			
F 353 SS=D	483.30(a) SUFFICIE PER CARE PLANS	NT 24-HR NURSING STAFF	F3	353		3/13/17		
	provide nursing and r maintain the highest and psychosocial we determined by reside individual plans of ca The facility must prov numbers of each of the personnel on a 24-ho care to all residents in	re. vide services by sufficient						
		under paragraph (c) of this ses and other nursing						
	section, the facility m	under paragraph (c) of this ust designate a licensed harge nurse on each tour of						
	by: Based on observation family and staff intervalent provide sufficient nurresident 's dignity by	is not met as evidenced on, record review, resident, views, the facility failed to sing staff to maintain not changing a brief soiled t for a cognitively intact		The statements made on this properties of the correction are not an admission not constitute an agreement with alleged deficiencies. To remain compliance with all federal and	n to and do th the n in			

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		345218	B. WING _			02/·	15/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GR	AN NURSING CENTER			12	20 SOUTHWOOD DRIVE BOX 379		
WAKI OK	AN NORSING CENTER			С	LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353		e 9 npled residents (Resident as scheduled for 1 of 3	F:	353	regulations the facility has taken or will take the actions set forth in this plan of		
	sampled resident (Re incontinent care for a	sident #2), and to provide cognitively intact resident			correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged		
	after it was requested for 1 of 3 residents observed receiving care (Resident #8). Findings included: 1. Cross refer F241. Based on observations, record review and resident and staff interviews, the facility failed to maintain a resident 's dignity by not changing a brief soiled with bowel movement for a cognitively intact resident until 3				deficiencies cited have been or will be corrected by the date or dates indicated	d.	
					F 353		
					A corrective action for the Affected Residents has been accomplished by:		
	hours after it was requested receiving ca	uested for 1 of 6 residents are (Resident #8).			For resident #8, the nursing assistant provided incontinent care to the resider	nt.	
		. Based on resident, staff			·		
	offer showers as sche resident. (Resident #2				Resident # 2 was interviewed by the Social Worker for his preference regarding showers on 03/07/2017. One preferences were determined the MDS		
	record review and res the facility failed to pr	Based on observations, sident and staff interviews, ovide incontinent care for a dent until 3 hours after it was			Coordinator updated resident #2 task in Point of Care.	1	
	care (Resident #8). Interview with the Dire	esidents observed receiving ector of Nursing at 2:30 PM d her expectations were the			The staff schedule was reviewed by the Director of Nursing and the Administrat on 02/15/2017 to ensure adequate staff meet patient needs.	or	
		provided as care planned			A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:		
					All current residents were assessed by nurse management team for incontiner needs. This audit was completed by reviewing Point of Care documentation	ice	

Facility ID: 923329

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C
	ROVIDER OR SUPPLIER AN NURSING CENTER	340210		STREET ADDRESS, CITY, STATE, ZIF 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		02/15/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE
F 353	Continued From page	e 10	F3	continence over the last of Residents identified as had incontinence had their cat by the MDS Nurse to ensigh plan was current with the care needs. This review with the care needs. This was consitively in the consistively interested the consistency of the consistency of the consistency of the care and the care needs. This was completed by 000 preferences were determ. Coordinator updated each in Point of Care as indicated in Point of Care as indicated preference. This was consistency of the consistency of the care and the care and the care and the care and many of the care and the car	aving are plan reviewed active their care in incontinent will be completed actility Social ag with all as their chedule. For intact, the intacted and alle preferences 3/09/2017. Oncoined, the MDS in resident's tasted with their impleted by were: an on 03/06/20 each's, Med and PRN. The collection of the incompleted by the included: Staff ding timely eeting resident	ed ee k 17 e

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		345218	B. WING _			02/15/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379				
MAIN OIL	AN NOROMO CENTER			С	LINTON, NC 28328		
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F 353	Continued From page			353	Hospice Providers whose employees gresidents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that a used for staffing needs were sent the facility specific in-service and instructed provide training for staff prior to assignithem to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training to 03/13/2017 will not be allowed to work until training has been completed. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Staffing QA Tool for monitoring staffing is adequate to meet resident needs according to preferences. Round will occurs 5 times a week across various shifts weekly x 4weeks then monthly x months or until resolved by QOL/QA committee. This is measured by interviewing 5 residents 5 times a week ensure needs/preferences are being m Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monito and ongoing auditing program reviewed the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	ere d to ng er g ds us 2 c to et. / he red d at	3/13/17
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	<u>'</u>	02.10.2011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE		
F 356 SS=C	Continued From page 12 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses Licensed practical nurses or licensed vocational nurses (as defined under State law) Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.		F3					
	by: Based on observation of staff schedules, th	is not met as evidenced on, staff interview, and review e facility failed to post a on the Daily Staffing ays reviewed.		The statements made on this p correction are not an admission not constitute an agreement wit alleged deficiencies. To remain	n to and do th the			

MARY GRAN NURSING CENTER MARY GRAN NURSING MARY GRAN NURSING CENTER MARY GRAN NURSING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
MARY GRAN NURSING CENTER (X4) DISCUMENT STATEMENT OF DEFICIENCIES (ICADI DEFICIENCY MUST as PRECEDED BY FUIL REGULATORY OR LSC IDENTIFYING INFORMATION) F 356 Continued From page 13 A review of the Daily Staffing Posting for the dates of 1/17/17, 1/21/17, and 1/23/17 revealed no documentation of the registered nursing staff. An interview on 2/15/17 at 2:30 PM with the Director of Nursing was done regarding no posting of the registered nurses time sheets were provided by the Director of Nursing staff is her expectation the staff will accurately complete the Daily Staffing Posting each shift. F 356 STREET ADDRESS, CITY, STATE, ZP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NO 28328 F 356 Continued From page 13 F 356 Continued From page 13 F 356 Continued From page 13 F 356 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 sa legation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 356 A corrective action for affected resident: No specific resident was mentioned. The daily staffing records for 1/17/17, 1/21/17 and 1/23/17 more verified and corrected to include the registered nurse hours accurately. This was performed on 2/15/17 by the Director of Nursing and QA Nurse Consultant. All current residents have the potential to be affected by the alleged deficient practice. The Clinical Nurse Consultant reviewed the Daily Nursing Staff Posting Sheet from Q2/15/20/17 to 30/13/20/17 to ensure that it included the registered nursing hours correctly and all other required components, which includes: • Facility name	345218			B. WING				
120 SOUTHWOOD DRIVE BOX 378					ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2017
CLINTON, NC 28328 CLINTON, NC 28328 CAPACITO PROFICE CONTROL OF DEFICIENCIES PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE CAPACITOR SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE COMPRETENT TAG					12	0 SOUTHWOOD DRIVE BOX 379		
F356 Continued From page 13 A review of the Daily Staffing Posting for the dates of 1/17/17, 1/21/17, and 1/23/17 revealed no documentation of the registered nursing staff. An interview on 2/15/17 at 2:30 PM with the Director of Nursing was done regarding no posting of the registered nursing staff should have been completed for 1/17/17, 1/21/17 and 1/23/17. Copies of the registered nursing indicated the registered nursing was on duty. The Director of Nursing was en on duty. The Director of Nursing stated it is her expectation the staff will accurately complete the Daily Staffing Posting each shift. F 356 A review of the Daily Staffing Posting of the registered nursing was done regarding no posting of the registered nursing indicated the registered nursing was on outly. The Director of Nursing stated it is her expectation the staff will accurately complete the Daily Staffing Posting each shift. A corrective action for affected resident: The daily staffing records for 1/17/17, 1/21/17 and 1/23/17 were verified and corrected to include the registered nurse hours accurately. This was performed on 2/15/17 by the Director of Nursing and QA Nurse Consultant. All current residents have the potential to be affected by the alleged deficient practice. The Clinical Nurse Consultant reviewed the Daily Nursing Staff Posting Sheet from 02/15/2017 to 03/13/2017 to ensure that it included the registered nursing hours	MARY GR	AN NURSING CENTER						
A review of the Daily Staffing Posting for the dates of 1/17/17, 1/21/17, and 1/23/17 revealed no documentation of the registered nursing staff. An interview on 2/15/17 at 2:30 PM with the Director of Nursing was done regarding no posting of the registered nursing staff on 1/17/17, 1/21/17 and 1/23/17. Interview revealed the registered nursing staff should have been completed for 1/17/17, 1/21/17 and 1/23/17. Copies of the registered nurses time sheets were provided by the Director of Nursing indicated the registered nursing were on duty. The Director of Nursing stated it is her expectation the staff will accurately complete the Daily Staffing Posting each shift. F 356 A corrective action for affected resident: No specific resident was mentioned. The daily staffing records for 1/17/17, 1/21/17 and 1/23/17 were verified and corrected to include the registered nurse hours accurately. This was performed on 2/15/17 by the Director of Nursing and QA Nurse Consultant. All current residents have the potential to be affected by the alleged deficient practice. The Clinical Nurse Consultant reviewed the Daily Nursing Staff Posting Sheet from 02/15/2017 to 03/13/2017 to ensure that it included the registered nursing hours correctly and all other required components, which includes: • Facility name	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	<	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per	F 356	A review of the Daily dates of 1/17/17, 1/21 no documentation of the Daily dates of 1/17/17, 1/21 no documentation of the Daily dates of 1/25/Director of Nursing was posting of the register 1/21/17 and 1/23/17. The provided for 1/17/17 Copies of the register provided by the Direct registered nursing we nursing stated it is he accurately complete the dates.	w of the Daily Staffing Posting for the f 1/17/17, 1/21/17, and 1/23/17 revealed umentation of the registered nursing staff. Tryiew on 2/15/17 at 2:30 PM with the r of Nursing was done regarding no of the registered nursing staff on 1/17/17, and 1/23/17. Interview revealed the red nursing staff should have been ted for 1/17/17, 1/21/17 and 1/23/17. of the registered nurses time sheets were d by the Director of Nursing indicated the red nursing were on duty. The Director of g stated it is her expectation the staff will ely complete the Daily Staffing Posting		F 356 compliance with all federal and state regulations the facility has taken or take the actions set forth in this plant correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indicated the daily staffing records for 1/17/1 1/21/17 and 1/23/17 were verified at corrected to include the registered in hours accurately. This was performe 2/15/17 by the Director of Nursing at Nurse Consultant. All current residents have the potent be affected by the alleged deficient practice. The Clinical Nurse Consultant reviet the Daily Nursing Staff Posting Shee 02/15/2017 to 03/13/2017 to ensure included the registered nursing hour correctly and all other required components, which includes: Facility name Current Date Total number and actual hours worked by the following categories of		d. se on QA to drom at it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
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F 356	Continued From page	÷ 14	F3	\$ 12233 • • • • • • • • • • • • • • • • • •	The required staffing information is postability in a clear and readable format. It is ocated in a prominent place readily accessible for residents and visitors. This was completed by 03/13/2017. Systemic Changes On 03/06/2017 the Staff Development Coordinator began in servicing the full time, part time and prn RN's and LPN's Administrator, and Nursing Secretary. Topics included: The daily nursing staffing data must be posted daily at the beginning of each staffing data must include the following components: Facility name Current Date Total number and actual hours worked by the following categories of idensed and unlicensed nursing staff directly responsible for resident care pershift: Registered Nurses Licensed Nurses Certified Nursing Assistants	is s, hift.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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345218			B. WING _			02/15/2017		
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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				(X5) COMPLETION DATE	
F 356	Continued From page	e 15	FS	356	daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors. Any in-house staff member who did not receive in-service training by 03/13/201 will not be allowed to work until training has been completed. This information is been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Clinical Nurse Consultant will monith is issue using the Staff Posting Surve Audit Tool. This audit will monitor the danursing staffing posting requirement for accurate staffing data weekly for 2 weethen monthly for 2 months or until resolved by the Quality Assurance Committee. Reports will be presented the weekly Quality Assurance (QA) committee by the Administrator or Director Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MI Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator	t 17 J nas at itor ey aily r eks		