PRINTED: 09/29/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245040	D WING			l	С
		345218	B. WING _			08	/18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER			12	TREET ADDRESS, CITY, STATE, ZIP CODE  O SOUTHWOOD DRIVE BOX 379  LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 SS=D	(a)(1) A facility must a resident in a manner promotes maintenancher quality of life recoindividuality. The faci promote the rights of This REQUIREMENT by: Based on observation resident and staff intensure a privacy bag residents with a urina Resident #218 and R  Findings included:  1. Resident #12 was facility on 06/19/13 were tention of urine and re-admitted to the facility on 06/19/13 were tention of urine and re-admitted to the facility on 06/19/13 were tention of urine and re-admitted to the facility on 06/19/13 were tention of urine and re-admitted to the facility on 06/19/13 were tention of urine and tention of urine and the complex of the extensive mobility, toileting and MDS indicated Resident Assessment (CAA), or Resident #12 had an due to hydronephrosion under the care of a under the care of a union of the care	the resident.  T is not met as evidenced  ans, record review, and erviews, the facility failed to was utilized for 3 of 3 ary catheter (Resident #12, esident #87).  as originally admitted to the eith diagnoses which included I hydronephrosis. She was cility on 08/08/17 with the Tract Infection (UTI).  #12's annual Minimum Data 101/17, revealed Resident gnitively impaired and e assistance of staff for bed personal hygiene. The ent #12 had an indwelling  #12's Care Area dated 07/01/17, indicated indwelling urinary catheter s of her right kidney and was	F 2	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 Federand 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  Corrective Action for Resident Affected Residents #12, # 218 and # 87 had the urinary catheter bags immediately covered for privacy on 8/16/17 by licen nurses.  Corrective Action for Resident Potentia Affected	al n	9/15/17
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	 DE		TITLE		(X6) DATE

**Electronically Signed** 09/08/2017

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	
						(	c
		345218	B. WING			08/	18/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		TREET ADDRESS, CITY, STATE, ZIP CODE		
MARVCR	AN NURSING CENTER			12	20 SOUTHWOOD DRIVE BOX 379		
WARTGR	AN NURSING 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	X (EACH CORRECTIVE ACTION SHOULD BE COME			(X5) COMPLETION DATE
F 241	catheter bag should be to promote her dignity. During an observation 08/16/17 at 9:47 a.m. her bed. The urine condition in the clear side entrance to the room. did not have a privacy. During an interview we 2:10 p.m., Nurse #3 sto the facility on 08/08 having been at the hostated she assessed completed the admissistated she recalled lo collection bag. Nurse her shift and she was stated she probably juurine collection bag we During an interview we (DON) on 08/16/17 at it was her expectation bag in place for all resurinary catheters.  2. Resident #218 we 07/21/17 with diagnos prostatic hypertrophy	dicated Resident #12's urine be kept adequately covered of the covered of the second part of the bag facing the the urine collection bag of facing the the urine collection bag of flap or a cloth cover.  The urine collection bag of flap or a cloth cover.  The urine the trip on the side of her the urine collection bag of flap or a cloth cover.  The urine the urine the trip of the trip of the bag facing the of the bag facing the of the urine the stated Resident #12 returned the solution of the urine in the the trip of the urine in the the trip of the urine in the trip of the urine in the trip of the urine the trip of the urine the trip of the urine the urine the urine the trip of the urine	F	241	On 8/16/17 licensed nurses assessed current residents with urinary catheters ensure they had privacy covered draina bags. 3 out of 18 were found to not have covered urinary catheter bags.  On 8/16/17, 3 urinary catheters were covered with privacy covers by licensed nurses.  Systemic Changes  On 8/16/17 the Director of Nursing and Staff Development Coordinator initiated servicing FT, PT and PRN nurses, nurse assistants, medication aides and medication techs on the following:  ¿ All urinary catheter drainage bags must be covered for resident privacy in skilled facilities;  ¿ When residents are admitted or readmitted it is important to assess the urinary drainage bags to ensure that a privacy cover is on the urinary drainage bags;  ¿ Nursing Assistants, Med Techs and Med Aides educated on why urinary drainage bags are to be covered for privacy and to report if they identify any uncovered urinary drainage bags.  ¿ All clinical staff were educated when	s to age ve  d  d in sing	
	Data Set (MDS), date Resident #218 was se	#218's Admission Minimum			the privacy urinary drainage bag covers are located  Any staff not receiving the education, volume to be permitted to work until receiving	vill	

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		345218	B. WING _			l	C 18/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2017
MADV CD	AN NURSING CENTER			12	20 SOUTHWOOD DRIVE BOX 379		
MAKI GK	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	FIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 241	Continued From page	e 2	F2	241			
	MDS indicated Residurinary catheter, BPH	DS indicated Resident #218			the education by September 15, 2017.		
		//040L-0			Quality Assurance		
	Resident #218 was o facility on 07/13/17. If facility on 07/21/17 af and severe sepsis. T #218 had an indwellir urine retention.  A review of Resident updated on 08/16/17, urinary catheter bag scovered to promote h During an observation 08/15/17 at 10:42 a.m. in an armchair in his in near his chair. Resid bag was attached to I flap or cloth cover. T	lated 07/28/17, indicated riginally admitted to the He was re-admitted to the fer a hospitalization for UTI The CAA indicated Residenting urinary catheter due to #218's Care Plan, last indicated Resident #218's should be kept adequately			The Staff Development Coordinator/Licensed Nurse will monitor using the QA Catheter Audit Tool to ensure all urinary catheter drainage based are covered for privacy by assessing firms residents weekly. This audit will be performed weekly for four weeks, then monthly for 2 months, including weekends. Reports will be presented to the weekly QA committee by the Administrator/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 DON, MDS Coordinator, Unit Manager, Support Nurse, Rehab Director, HIM, Dietary Manager and the Administrator.	gs ve o ored d at iA	
	2:38 p.m., Nurse #4 s returned to the facility with an indwelling uril stated she recalled charinary catheter and t stated she honestly d the urine collection be was an "old-school" n	with Nurse #4 on 08/18/17 at stated when Resident #218 on 07/21/17, he returned hary catheter. Nurse #4 necking the size of the he color of his urine but id not think about changing ag. Nurse #4 stated she nurse and she was taught not is it was necessary. Nurse			Compliance date: September 15, 2017		

Facility ID: 923329

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		345218	B. WING		,	C 98/18/2017	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		10/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241	could be placed in buit.  During an interview of (DON) on 08/16/17 at it was her expectation bag in place for all resurring catheters.  Resident #87 was 7/20/17 with diagnost Kidney Disease, Atrice Syndrome, Hypertent A review of Resident Data Set (MDS), date Resident #87 was seand was totally dependently, toileting, an MDS indicated Resident Assessment (CAA), Resident #87 was or on 7/20/17. Resident #87 was or on 7/20/17. Resident #87 was or on 7/20/17. Resident #87 was or on 7/20/17, induring the facility on 8/1/17 after returned to the facility for comfort care related A review of Resident updated 8/16/17, induring an observation at 2:30 p.m., Resident urine collection bag in the facility of the facility o	with the Director of Nursing at 12:56 p.m., the DON stated in nursing staff have a dignity esidents with indwelling admitted to the facility on es which included Chronic al Fibrillation, Irritable Bowel sion and Diabetes.  #87 Admission Minimum ed 7/27/17, revealed everely cognitively impaired indent of staff for bed dipersonal hygiene. The dent #87 was always and bladder.  #87's Care Area dated 7/27/17, indicated iginally admitted to the facility at #87 was re-admitted to the ir a hospitalization and y with an indwelling catheter ted to a terminal illness.  #87's Care Plan, last icated Resident #87's should be covered	F 2	41			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, 50.25	_		(	С
		345218	B. WING			08/	18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE BOX 379 :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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	have a privacy flap or During an interview w 2:31 p.m., Nurse #7 s returned to the facility with an indwelling urir stated she recalled chaize, color of urine in the bag, but she did no bag or changing the body the hospital were different with the hospital were different was her expectation bag in place for all resurinary catheters.  483.20(g)-(j) ASSESS ACCURACY/COORD (g) Accuracy of Assess must accurately reflect (h) Coordination A registered nurse must be accurated to the assessment with participation of health (i) Certification (1) A registered nurse the assessment is conducted.	e collection bag did not a cloth cover.  with Nurse #7 on 8/17/17 at tated when Resident #87 on 8/1/17, she returned hary catheter. Nurse #7 hecking the urinary catheter the bag, amount of urine in not think about covering the bag because the bags from because the		2241			9/15/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 08/18/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	<b>,</b>	30/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	(j) Penalty for Falsific (1) Under Medicare a who willfully and kno (i) Certifies a materia resident assessment penalty of not more trassessment; or (ii) Causes another in and false statement subject to a civil more \$5,000 for each asses (2) Clinical disagreer material and false statement is subject to a civil more \$5,000 for each asses (2) Clinical disagreer material and false statement is subject to a civil more \$5,000 for each asses (2) Clinical disagreer material and false statement is subject to a civil more statement in the Minimum Data Source of the Minimum Data Source of the Source of the Source of the Source of Source of the Source of Sour	cation and Medicaid, an individual wingly- al and false statement in a is subject to a civil money han \$1,000 for each addividual to certify a material in a resident assessment is a resident assessment as resident assessment as resident as resident assessment as resident as resi	F 2	The statements made on this F Correction are not an admission not constitute an agreement wit alleged deficiencies.  To remain in compliance with all and State Regulations the facilitaken or will take the actions set this Plan of Correction. The Placorrection constitutes the facilitallegation of compliance such the alleged deficiencies cited have will be corrected by the date or indicated.  F 278  Correction for Affected Resident MDS for resident # 152 with idea.	n to and do th the  II Federal ty has et forth in an of ty's hat all been or dates	

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		345218	B. WING _			l	C 18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328			10,2011
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		D BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	slough and/or eschar  During an interview w 12:22 p.m., Nurse #5 she coded Resident # having pressure ulcer instead of having dial  During an interview w 08/18/17 at 3:35 p.m. was his expectation t MDS be coded accur  2. Resident #44 was 07/18/14. Resident # peripheral vascular d type 2 and stage 4 pr and right lower leg.  A review of Resident 06/18/17, indicated R having a stage 1 or g having no unhealed p higher. The MDS wa which required the nu Stage 3 and Stage 4  During an interview w 12:22 p.m., Nurse #5 the MDS was inaccur	with Nurse #5 on 08/18/17 at stated due to human error, #152's MDS to reflect him rs on his left and right foot petic foot ulcers.  With the Administrator on the Administrator stated it he ately.  admitted to the facility on each of the administrator stated it he ately.  admitted to the facility on each of the ately.  admitted to the facility on each of the ately.  admitted to the facility on each of the sease, diabetes mellitus essure ulcers on right heel  #44's quarterly MDS, dated each each each each of the sections are ater pressure ulcer and as pressure ulcers at Stage 1 or so left blank for the sections amber of Stage 1, Stage 2, pressure ulcers.  With Nurse #5 on 08/18/17 at stated due to human error, each of the Administrator on the Administrator stated it	F2	278	coding error was modified and coding corrected and resubmitted by MDSC of 8/16/17.  Identification of Other Potentially Affect Residents:  All residents who had documented skir ulcers were reviewed to ensure accurated coding in section M of current or most recent MDS assessment were reviewed by MDSC on 8/17/17.  All MDSs with coding errors identified through audit were modified and correct on 8/17/17 by MDSC. One MDS out of twenty was identified to be coded inaccurately and was modified on 8/17/18 and resubmitted by the MDSC. Systemic Changes:  MDSC and MDS Assistant were provided ucation on how to accurately code Section M of the MDS. This education was provided by the Regional MDS Consultant on 8/17/17 and 8/18/17. Quality Assurance:  The most recent MDS for 5 residents whave had documented skin ulcer(s) durithe past 90 days will be audited to ensuaccurate coding of Section M. These 5 residents will be chosen by running an Assessment History report from Point Click Care that will include all Weekly Pressure Ulcer Reviews and Weekly Wound Reviews (non-pressure) that we completed during the past 90 days. If there are not 5 residents who have or skin ulcer(s) present during their MDS	ed te d tred tring ure	

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		345218	B. WING			l	C
NAME OF PI	ROVIDER OR SUPPLIER	040210	1		REET ADDRESS, CITY, STATE, ZIP CODE  0 SOUTHWOOD DRIVE BOX 379	1 08/	18/2017
MARY GR	AN NURSING CENTER				LINTON, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279 SS=D	Continued From page 483.20(d);483.21(b)(1 COMPREHENSIVE C	) DEVELOP	F2		assessment period, then 5 random residents who have had an MDS completed within the past 30 days will be reviewed to ensure accurate coding of Section M. This audit will be completed by the MDS Consultant or Nurse Consultant weekly x 4, and then month 2 or until compliance is achieved and sustained. Any concerns identified will addressed immediately. This audit will reviewed weekly by the QA committee, consisting of the DON, Social Worker, Dietary Manager, Business Office Manager, Lead Support Nurses, Activit Director, Rehab Director and NHA.  Compliance Date: September 15, 2017	d lly x be be	9/15/17
	assessments completed months in the resident results of the assessment results of the assessment revise the resident plan.  483.21 (b) Comprehensive Comprehensive personal resident, consists set forth at §483.10(c) includes measurable	est maintain all resident red within the previous 15 t's active record and use the ments to develop, review nt's comprehensive care  are Plans  evelop and implement a n-centered care plan for tent with the resident rights (2) and §483.10(c)(3), that objectives and timeframes nedical, nursing, and mental					

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		345218	B. WING _			C <b>08/18/2017</b>	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	<u> </u>	00/10/2017	
(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 CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279	comprehensive assecare plan must descrive plan must descrive in the residence of maintain the residence physical, mental, and required under §483.  (ii) Any services that under §483.24, §483 provided due to the runder §483.10, include treatment under §483.  (iii) Any specialized sere in the residence of the provide as a result of recommendations. If findings of the PASA rationale in the residence in the resident's representational in the resident's representational in the resident's profuture discharge. Fact whether the resident's community was asselucal contact agencie entities, for this purportion, as appropriate,	eds that are identified in the ssment. The comprehensive libe the following -  are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6).  Are revices or specialized as the nursing facility will a facility disagrees with the RR, it must indicate its ent's medical record.  At the resident and the tive (s)-  als for admission and  eference and potential for collities must document as desire to return to the seed and any referrals to the send/or other appropriate	F 2	79			

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		345218	B. WING		0	8/18/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
MADY OD	AN NURCING CENTER			120 SOUTHWOOD DRIVE BOX 379			
WARTGR	AN NURSING CENTER			CLINTON, NC 28328			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETION DATE	
F 279	Continued From pa	ge 9	F 27	79			
	section.	<b>5</b>					
	This REQUIREMEN	NT is not met as evidenced					
	by: Based on record re	eview and staff interviews, the		The statements made on the	his Plan of		
		elop a comprehensive care		Correction are not an admis			
		sidents reviewed (Resident		not constitute an agreemen			
	#218 ).	,		alleged deficiencies. To ren			
				compliance with all Federal	and State		
	Findings Included:			Regulations the facility has			
				take the actions set forth in			
		was admitted to the facility on		Correction. The Plan of Co			
	_	oses which included benign		constitutes the facility's alle compliance such that all all	-		
	disease and urinary	ny (BPH), chronic kidney		deficiencies cited have bee			
	discuse and annary	retention.		corrected by the date or da			
	A review of Resider	nt #218's Admission Minimum		, , , , , , , , , , , , , , , , , , , ,			
	Data Set (MDS), da	ited 07/28/17, indicated					
	Resident #218 had	an indwelling urinary catheter.					
				F 279			
	A review of Resider						
		dated 07/28/17, indicated an indwelling urinary catheter		Correction for Affected Res	idont:		
		care of a urologist due to		Correction for Affected Res	ident.		
	urinary retention.	care of a diologist due to		The care plan for affected r	esident #218		
				was updated to reflect that			
	A review of Resider	nt #218's Admission Care Plan		indwelling urinary catheter.			
	revealed Resident #	#218 was not care planned for		completed by the MDSC or	ı 8/16/17.		
	an indwelling urinar	y catheter.					
				Identification of Other Poter	ntially Affected		
	_	with the MDS Coordinator on		Residents:			
		.m., the MDS Coordinator		All regidents that have using	ary cathotors		
		18 was originally admitted to //17. The MDS Coordinator		All residents that have uring have had their care plan rev			
	,	discharged to the hospital		updated accordingly to ens			
		facility with an indwelling		accurately reflects presence			
		07/21/17. The MDS		catheters. Three out of eigh	-		
		the indwelling urinary catheter		plans were updated. This v			
		are planned and she just		by the MDS Nurse Consulta	ant on		
	missed it.			9/8/2017.			

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F 279	08/17/17 at 11:24 a.m was his expectation the	ith the Administrator on ., the Administrator stated it ne MDS Coordinator sive care plan for a resident	F 2	Systemic Changes:  MDSC, MDS assistant and Nu Managers will receive education importance of reviewing and replans to accurately reflect urinst catheters for all re-admitted and residents. This education will by the MDS Nurse Consultant Quality Assurance:  Five residents with urinary cathe be reviewed to ensure that the plans accurately reflect the presurinary catheter. This audit will completed by the MDS Consultant weekly x 4 a monthly x 2 or until sustained of is achieved. Any concerns identified be addressed immediately. The be reviewed weekly by the QA consisting of the DON, Social Dietary Manager, Business Of Manager, Lead Support Nurse Director, Rehab Director and Note that the plans accurately reflect the presure of the plans accurately reflect units accurately reflec	on on evising care ary nd current be provide by 9/15/17  heters will eir care esence of a I be Itant or and then compliance ntified will as audit will a committee Worker, effice es, Activity	ed 7.
F 280 SS=D	PARTICIPATE PLANN 483.10 (c)(2) The right to par	3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP ticipate in the development f his or her person-centered but not limited to:	F 2	Compliance Date: Septembe	r 15, 2017	9/15/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		345218	B. WING			C 08/18/2017	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	<u> </u>	00/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 280	including the right to be included in the plarequest meetings and revisions to the personal (ii) The right to particle expected goals and comount, frequency, and other factors related plan of care.  (iv) The right to receip included in the plan of care (v) The right to see the right to sign after sign of care.  (c)(3) The facility share	pate in the planning process, identify individuals or roles to anning process, the right to d the right to request on-centered plan of care.  ipate in establishing the outcomes of care, the type, and duration of care, and any to the effectiveness of the  ve the services and/or items of care.  ne care plan, including the nificant changes to the plan	F 28	30			
	shall support the resiplanning process mu  (i) Facilitate the incluresident representati  (ii) Include an assess strengths and needs  (iii) Incorporate the resident representation in the strength in the str	sion of the resident and/or ve.  sment of the resident's  esident's personal and in developing goals of care.  Care Plans					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C <b>8/18/2017</b>	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		o, 10, <b>20</b> 11	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page	e 12	F 2	80			
	(i) Developed within 7 the comprehensive as	days after completion of ssessment.					
	(ii) Prepared by an inincludes but is not lim	terdisciplinary team, that nited to					
	(A) The attending phy	ysician.					
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	and nutrition services staff.					
	the resident and the r An explanation must medical record if the	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the					
		staff or professionals in ined by the resident's needs e resident.					
	team after each asse comprehensive and c assessments. This REQUIREMENT by: Based on staff and fa reviews the facility fai care plan meeting for	vised by the interdisciplinary ssment, including both the quarterly review  is not met as evidenced amily interviews and record iled to invite the resident to a 1 of 29 sampled residents failed to revise a care plan		The statements made on this Correction are not an admissi not constitute an agreement valleged deficiencies.	on to and do		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		C	
		345218	B. WING			08/	18/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARYCE	AN NURSING CENTER			12	20 SOUTHWOOD DRIVE BOX 379		
WART GR	AN NURSING CENTER			С	LINTON, NC 28328		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 280	Continued From page	e 13	F	280			
	for 2 of 2 sampled res	sidents Resident #87 who			To remain in compliance with all Federa	al	
	•	r after readmission and			and State Regulations the facility has		
	-	ad acquired a pressure			taken or will take the actions set forth in	1	
	ulcer.	• •			this Plan of Correction. The Plan of		
					Correction constitutes the facility's		
	The findings included	:			allegation of compliance such that all		
	•				alleged deficiencies cited have been or		
	1. Resident #178 was	admitted to the facility for			will be corrected by the date or dates		
	the first time 1/19/16	with diagnosis including			indicated.		
	Dementia without beh	naviors, Hypertension, and					
	Malnutrition.						
					F 280		
	Resident #178 on 8/1	ne responsible party for 5/17 at 3:04 PM revealed 78 had not been invited to			Correction for Affected Residents:		
	participate in any type	e of care planning meeting to			Resident #178 has had care plan		
		I treatment objectives.			meetings held by the interdisciplinary c	are	
	Further interview reve	ealed she would have			plan team as evidenced by resident		
	preferred to attend, be	ut did know when the			interview. Resident stated the care plar	1	
	meeting was held.				team has met in his room and discusse	:d	
					his therapy goals and discharge plans.		
		ocial Worker #1 and Social			Resident is his own responsible party a	ind	
		at 2:50 PM, they revealed			has a BIMS score of 13. Resident		
		esidents and/or family			interview conducted on 9/8/17 by QA		
	members about the c				Nurse Consultant.		
	Information could not	•			Resident # 87 has had urinary catheter		
		e had been invited to any			updated to her care plan on 8/16/17 by		
	care plan meeting. T				the MDS nurse.		
	explained there was r	•			Resident #218 has had his care plan		
		and/or the resident being			updated on 8/17/17 by the MDS nurse	ເປ	
	invited and/or attending	ig any care planning			reflect current pressure ulcers.		
	meeting.				Identification of Other Potentially Affact	ed	
	Interviews with the Ac	Iministrator on 8/18/17 at			Identification of Other Potentially Affect Residents:	<del>c</del> u	
		had just found out the staff			Acoucino.		
		enting an invitation to care			Thirteen out of fifty seven residents tha	t	
		tation is all residents and/or			have had a care plan meeting held with		
		re invited to all care planning			the last 30 days by the interdisciplinary		
	meeting from this poin				care plan team. Forty four		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		245040	B. WING				с
		345218	B. WING _			08/	18/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GR	AN NURSING CENTER			12	20 SOUTHWOOD DRIVE BOX 379		
IIIAI OI	AIT HOROMO GENTER			С	LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	e 14	F 2	280			
		admitted 7/20/17 with			residents/resident representative out o the fifty seven residents have reported		
	cumulative diagnoses	s of Chronic Kidney Disease,			that they have not had an interdisciplin		
	_	able Bowel Syndrome,			care plan team meeting in the last 90	<i>y</i>	
	Hypertension and Dia				days. An interdisciplinary care plan tea	m	
	, , , , , , , , , , , , , , , , , , ,				meeting invitation will be extended/mai		
	A review of Resident	#87 Admission Minimum			for these forty four residents by		
	Data Set (MDS), date	ed 7/27/17, revealed			September 15, 2017.		
	Resident #87 was se	verely cognitively impaired					
	and was totally deper	ndent of staff for bed			All residents that have urinary catheter	S	
		d personal hygiene. The			have had their care plan reviewed and		
	MDS indicated Resid				updated accordingly to ensure that it		
	incontinent for bowel	and bladder.			accurately reflects presence of urinary		
					catheters. Three out of eighteen care		
	A review of Resident				plans were updated. This was comple	ted	
		dated 7/27/17, indicated			by the MDS Nurse Consultant on		
		ginally admitted to the facility			9/8/2017.		
		t #87 was re-admitted to the			All residents that surrently have proces	ıro	
		r a hospitalization and / with an indwelling catheter			All residents that currently have pressurable ulcers were reviewed to ensure that the		
		ed to a terminal illness and			care plans reflected the presence of	EII	
	an unstageable press				pressure ulcer(s). This review was		
	an unstageable press	sure dicer.			completed on 8/17/17 by the MDSC. 9	of	
	A review of Resident	#87's Care Plan revealed a			21 residents did not have pressure ulc		
		catheter related to terminal			appropriately care planned. These 9 ca		
		eable pressure ulcer on			plans were updated on 8/17/17 by the		
	sacrum was initiated	•			MDSC.		
	_	n 8/17/17 at 11:24 AM, the					
		his expectation was the MDS			Systemic Changes:		
		ccurately assess each					
		e Plan should accurately			Interdisciplinary Care plan team will		
	reflect the needs of e	ach resident.			receive education regarding the reside		
		7/47 . 1.0.40 DM .!!			and resident representative's right to b		
	In an interview on 8/1				invited and included in the care planning	ng	
		MDS) Nurse stated that there			conference at a minimum of once		
		lated and/or revised for the			quarterly and reviewing/updating care		
		r Resident #87 on her cility. She expressed she			plans to include urinary catheters and pressure ulcers. This education will be	<del>)</del>	

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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 8/18/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		0/10/2017	
				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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 280	Continued From page	e 15	F 28	30			
	had gotten behind on had not done it.	updating the care plans and		provided by the MDS Nurse 9/15/17.	Consultant by		
	(DON) on 8/18/17 at	vith the Director of Nursing 10:15 AM, the DON stated it for care plans to be updated or every resident.		Quality Assurance:  An audit of 5 residents and/o			
	facility 7/13/17 with d Disease, Coronary A	s initially admitted to the iagnoses of Chronic Kidney tery Disease, Closed ur, and Atrial Fibrillation.		resident representative will be to ensure that they have bee participated in the care plant processes. This audit will be weekly x 4 and then monthly audit will be completed by the	en invited and ning conducted x x 2. This		
	Data Set (MDS), date Resident #218 was c required extensive as	#218 Admission Minimum ed 7/29/17, revealed ognitively impaired and esistance and one person d mobility, toileting, and		Worker or Activity Director w then monthly x 2 or until sust compliance is achieved. Any identified will be addressed in This audit will be reviewed w	tained concerns mmediately.		
	personal hygiene. Th	ne MDS indicated Resident incontinent for bowel and		QA committee, consisting of Social Worker, Dietary Mana Business Office Manager, Le Nurses, Activity Director, Re	the DON, ager, ead Support		
		dated 7/29/17, indicated riginally admitted to the		and NHA.			
	re-admitted to the factorist hospitalization for Se	ility on 7/21/17 after a vere Sepsis related to rinary Tract Infection.		Compliance Date: Septemb	er 15, 2017		
		#218's Care Plan revealed a essure ulcer development					
	dated 7/31/17 revealed heel with wound clea	#218's Physician Orders ed an order for clean right nser and apply Calcium sing every day shift for deep					

Facility ID: 923329

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345218	B. WING				C / <b>18/2017</b>	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	1 00.	110/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 280	_	e 16 on 8/17/17 at 11:24 AM, the his expectation was the MDS	F	280				
	Coordinator should a resident and the Care reflect the needs of e	ccurately assess each e Plan should accurately each resident.						
	was no care plan upo pressure ulcer for Re readmission to the fa	MDS) Nurse stated that there dated and/or revised for the						
F 282 SS=G	(DON) on 8/18/17 at was her expectation as situations arises for	/ICES BY QUALIFIED	F	282			9/8/17	
		e Care Plans d or arranged by the facility, mprehensive care plan,						
	care.	alified persons in hresident's written plan of   □ is not met as evidenced						
	and staff interviews the care plan for use of a while transferring a resulting in a subaracteristic staff.	iew, observation, Physician he facility failed to follow the medium pad and 2 people esident with a use of a lift, chnoid hemorrhage (bleeding the brain and the thin tissues			Past noncompliance: no plan of correction required.			
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: 3IVP1	 1	Fa	cility ID: 923329 If continu	uation shee	et Page 17 of 37	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345218	B. WING _			C 08/18/2017	
	ROVIDER OR SUPPLIER  AN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	Resident # 125) The findings included Resident # 125 was 3/23/2017 with diagn hypernatremia, acute metabolic encephalo mental status, dehyd weakness and deme Resident #125's care indicated "the reside Living (ADLs) self-cacare plan indicated the current level of functi transfer through the interventions include for all transfers using with use of 2 persons.  The quarterly Minimu 7/3/2017 indicated R cognitively impaired. resident required ext person for bed mobil of two person for tranchair. The MDS also totally dependent on Living (ADLs). The resident required extended to the company of the company	for 1 of 1 sampled resident.  d:  admitted to the facility on oses which included acute exidney injury, acute pathy, agitation, altered ration, generalized ntia.  explan dated 5/24/2017 explan thas an Activities of Daily are performance deficit." The ne goal as "I will maintain on in bed mobility and next 90 days." The care plan d use of full mechanical lift a medium pad and assist	F2	282			
	The resident's Karde care guide for direct needs at the facility) indicated the resident lift for transfers using medium pad size.	x dated August/July 2017 (a staff identifying resident care under transfer headline t required a full mechanical 2 persons and the use of					

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED	COMPLETED	
		345218	B. WING		08/18/20	117	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328		, 00.10.2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COM	(X5) IPLETION DATE	
F 282	revealed "the nurse room around 11:40 When the nurse ent resident lying on the left side. NA # 1 state back with head bein verbal with sitter and resident. A raised an noted and no bleed that the resident was to wheel chair when was called and the room for an evaluat.  A nurse note dated revealed the resident facility from the emer medication but with the use of aspirin m.  Review of the emer 7/24/2017 indicated with subarachnoid harevealed the doctors resident to a neuros family member, but to have the patient subsequently transphome facility on 07/2 Review of the facility 7/24/2017 revealed transferred by Nurse Maxi-move lift (full reported lift pad become the patient), the resident pad reported lift pad become the resident of the resident pad reported lift pad become the resident pad reported lift pad reported lift pad become the resident pad reported lift pad	was called to the resident's am due to the resident's fall. ered the room she noted the effloor next to bed lying on her ted the resident fell on her g bumped noted alert and d staff NA#1 was with the rea to back of the head was ng was noted. NA#1 stated is being transferred from bed a fall occurred. The doctor responsible party was notified. In sent out to an emergency on."  7/24/2017 at 5:00 PM and the was admitted back to the ergency room with no new an order for the facility to stop edication.  gency room report dated the resident was diagnosed the morrhage. The report also is discussed transferring the turgical care center with the the family member declined ransferred. The resident was borted back to the nursing	F 28	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C <b>8/18/2017</b>	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	•	0/10/2017	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	and orders were obtaevaluation. Under the report indicated, "The use a medium lift pactor guide listed the NA # 1 was aware of care guide before giv NA # 1 failed to check the NA#1 failed to ustransfer, resulting in a NA#1 reenacted the to the Administrator the demonstrated by recresident using the XL (total lift device). She criss-crossing the leg reporting that she and present at time of trainat the time of intervied did not have another lift use and NA#1 standoes, but the sitter was Administrator informed acceptable as the sittle employee. NA#1 had regarding having 2 st mechanical lifts on 10 During the interview 12:30 PM, she verified pad size while transfer did not have another while transferring the reside she (Resident # 125) reported she was aware for the value of th	a.1. The doctor was notified ined to send the patient for a investigation headline the eresident was assessed to a for transfers. The resident's correct lift pad to be used. The process of reviewing the ing care and transfers. The act the care guide as a result, the the correct lift pad for an improper transfer. The lift transfer by demonstrating the following: NA enactment of lifting the elift pad with the Maxi-move demonstrated incorrectly a straps to the lift bar do the private sitter were the fer. The NA # 1 was asked to by Administrator why she staff member present during the terms as in the room. The was not a trained are received recent lift training aff members with	F 24	32			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		' '	(X3) DATE SURVEY COMPLETED				
		345218	B. WING_			C 08/18/2017	
	ROVIDER OR SUPPLIER  AN NURSING CENTER	1.000		STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328		1 00/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	people. NA #1 also repersons while transfer in a hurry and used of During the interview at 1:00 PM, she repowas called to resider stated she transferrer resident fell on the flashe assessed the resident had a bump (Nurse # 1) then notioned the patient to room. Nurse # 1 furth back to the facility the diagnosis of subaract During the interview 8/17/2017 at 11:00 A evaluated the reside and the resident was indicated since the rethe facility staff were resident closely for a her health. The doctowas not a candidate further mentioned the evaluated by the neulappointment had been on 8/17/2017 at 1:30 Resident #125 in her grimacing or behavior pain and no bump or NA # 3 were also obtained assigned pad securement the property.	dium size pad and use of 2 eported she always used 2 erring a resident but she was one person for the transfer. with Nurse # 1 on 8/16/2017 orted that on 7/24/2017 she of #125's room by NA #1 who of the resident alone and the or. Nurse #1 also reported sident and she found the by the side of the head. She fied the Physician who of be sent to the emergency of added the resident came the same day with the chnoid hemorrhage.  with the Physician on of the Physician on of the physician reported he of the immediately after the fall of doing remarkably well. He the esident's fall on 7/24/2017, continuing to monitor the of resident will continue to be of a resident will continue to be of a resident will continue to be of the head. The NA # 2 and of the head. The NA # 2 and of the head. The staff ize (medium) and lift belt	F 2	82			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING		C 08/18/2017	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328	00/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 282	on 8/18/2017 at 10: investigated the circ 125's fall on 7/24/20 #1 had not followed for the use of 2 staf the resident and har The Administrator s the NA# 1 to have for transferring a reside added that NA # 1 v needed 2 persons a while transferring a been in serviced on  Facility provided cor 8/16/2017 Description of event Resident # 125 was using the Maxi-mov the transfer NA #1 r unhooked on 1 corr sustained a hemator The resident was in # 1. The Physician v obtained to send to completed on 07/24 The resident was as pad for transfers. Th pad to be used. NA of reviewing the Kar transfers. The NA # as a result, the NA # pad for transfer, res The NA # 1reenacte demonstrating to the	with the facility Administrator 50 am, she stated she had cumstances of Resident # 017 and determined that NA the care plan interventions if members while transferring d not used the right pad size. tated his expectation was for collowed the care plan while ent. The Administrator also was aware the resident and the use of correct pad size resident because she had 10/25/2016 and 5/29/2017.  Trective action plan on  t:  Se being transferred by NA#1 the lift with a XL lift pad. During the proof of the proof of the pad of the	F 28.	2		

Facility ID: 923329

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		· /	(X3) DATE SURVEY COMPLETED				
		345218	B. WING		١ ,	C <b>8/18/2017</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	1 0	33/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 282	the resident using the Maxi-move (total lift incorrectly criss- cross bar reporting that she present at time of trail.  The NA # 1 was asked Administrator why shember present dur "That she normally do room". Administrator acceptable as the sittle employee. NA # 1 haregarding having 2 semechanical lifts on 1  After review of the initidentified, the root cannown and the resident of the incorrectly and the resident was improvider was notified pain was also assess notified by Nurse # 1 11:55 AM. The residents All lift slings on 7/24/all/any issues correctly all/any iss	e XL lift pad with the device). She demonstrated sing the leg straps to the lift e and the private sitter were insfer.  ed at time of interview by the did not have another staffing lift use and NA # 1 stated, oes, but the sitter was in the informed her this was not atter was not a trained and received recent lift training taff members with 0/25/16 and 5/29/17.  Evestigation of the event, it is also to be as follows:  Eve Kardex prior to transfer at lift sling straps to the cradle  Eves escond trained staffing lift transfer  Affected Residents mediately assessed and the by Nurse # 1 at 11:50 AM.  Eved. Responsible Party was on 7/24/17 at approximately. Event was transferred to the control of the equipment removed at left. All nursing staff	F 2	82			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		345218	B. WING_			C 08/18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	<u> </u>	00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	facility lifts. Education will be prothe following: -Using the Kardex to sling size -Appropriate process number of staff requal nurses and CNA' demonstration for lift Systematic Changes Education provided: Assistants on the utiliand using the correct transfers. Education Development coording will be included in not and CNAs. Return demonstration the staff showing convict will be included in not and CNAs. Return demonstration the staff showing convict will be particulated in staff being removed education is completed LPNs, RNs, Nursing Aides/Techs Were in of checking resident transfers in order to transfer technique is initiated on 7/24/17. Coordinator. This in integrated into the stand in the required in for all employees and Quality Assurance Particulars.	ovided to all clinical staff on obtained to all clinical staff on obtained to all clinical staff on obtained to all sees of lift usage, including ired is will perform return to usage.  So to all Nurses and Nurse lization of resident Kardexes of lift for safe resident will be provided by the Staff mator (SDC). This education of the whire orientation for nurses on to validate competency of the rect usage of the lift pads performed.  Sompleted on 8/7/17 will result of the different the schedule until the All nursing staff including:  Managers, CNAs and Med.  In serviced on the importance of Kardex prior to initiating any the staff Development of the staff Development formation has been the standard orientation training on-service refresher courses of will be reviewed by the process to verify that the stained. The education	F 2	82		
	HOW THE FACILITY	Y PLANS TO MONITOR				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345218	B. WING		08/18/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328	1 00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIO
F 282	a Safe Transfer/Lift of weekly x 4 and then correct lift pad is being the correct resident. It is present findings to the committee and correct appropriate. The Quaconsists of the Direct Staff Development of Dietary Manager, Wound Assessments Nurse Management and more and the entire plan of correct lift. Interviews of the lift is an abefore using a lift to were reeducated on lift and making sure with correct lift on the were observed durin 125. The 2 staff appresident by making sure fidentially was upon of the facility's Audit revealed a nurse supobserved 5 random of mechanical lift who nurses' aides. The aid were identified for the Quality Assurance of	icensed nurse will complete Quality Assurance (QA) Audit monthly x 2 making sure the ng used with correct lift on The Director of Nursing will ne weekly Quality of Life- QA active action initiated as ality of Life committee tor of Nursing, Administrator, coordinator, Unit Managers, ound Nurse, Minimal Data and Health Information eets weekly.  Icion on 8/17/2017 at 3:30 PM, rection was reviewed was with staff related to the liew with the Nurses' Aides nowledge in checking the d following the interventions transfer a resident. The staff a safe transfer with use of a the correct lift pad is used be correct resident. 2 staff g a transfer of Resident # ropriately transferred the sure the correct lift. Review of appropriate use of lift bervisor on each unit residents who required a use ile being transferred by 2 udit revealed no concerns	F 28	2	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 50.25.			(	c
		345218	B. WING			08/	18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE BOX 379 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Review of the monitor facility had completed 8/7/2017.	25/2017 until 8/11/2017. ring tools revealed that the I the 100% in-service on		282			0.044
F 323 SS=G	483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensu		F	323			9/8/17
	(1) The resident envir from accident hazards	onment remains as free s as is possible; and					
		eives adequate supervision es to prevent accidents.					
	appropriate alternative bed rail. If a bed or simust ensure correct in	ails, including but not limited					
	(1) Assess the reside from bed rails prior to	nt for risk of entrapment installation.					
		and benefits of bed rails with nt representative and obtain or to installation.					
	This REQUIREMENT by: Based on record revi interviews the facility size (medium) and us	sident's size and weight. is not met as evidenced ew, observations, and staff failed to use designated pad			Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345218	B. WING		08/18/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328	1 00/10/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 323	resulting in a subara in the area between that cover the brain, who was care plann # 125)  The findings included the instruction indicated the particular patient and capacity.  Resident # 125 was 3/23/2017 with diag hypernatremia, acut metabolic encephalmental status, dehy weakness and demore Resident # 125's car indicated "the resided Living (ADLs) self-care plan indicated current level of functional transfer through the interventions include for all transfers usin with use of 2 person.  The quarterly Minim 7/3/2017 indicated for cognitively impaired resident required experson for bed mob of two person for transformal transfer through the interventions included for all transfers usin with use of 2 person.	achnoid hemorrhage (bleeding the brain and the thin tissues of for 1 of 1 sampled resident led for use of a lift. (Resident led:  Struction manual for use of the discrete discrete the following:  unless it is recommended for led is of the correct size and led is of the correct s	F 32	23	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345218	B. WING	<del> </del>		8/18/2017	
	ROVIDER OR SUPPLIER  AN NURSING CENTER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	•	0/10/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From pag	ne 27	F 32	23			
	,	esident was not coded for not occur during the look					
	care guide for direct needs at the facility) indicated the resider	ex dated August/July 2017 (a staff identifying resident care under transfer headline nt required a full mechanical g 2 persons and the use of					
	revealed "the nurse room around 11:40 a When the nurse enteresident lying on the left side. NA # 1 stat back with head being verbal with sitter and resident. A raised arnoted and no bleeding that the resident was to wheel chair when was called and the resident and the resident was called and the resident was	was called to the resident's am due to the resident's fall. ered the room she noted the floor next to bed lying on her ed the resident fell on her g bumped noted alert and I staff NA#1 was with the ea to back of the head was ng was noted. NA# 1 stated is being transferred from bed a fall occurred. The doctor esponsible party was notified. In sent out to an emergency on."					
	revealed the resident facility from the eme	7/24/2017 at 5:00 PM t was admitted back to the rgency room with no new an order for the facility to stop edication.					
	7/24/2017 indicated with subarachnoid h revealed the doctors resident to a neuros	gency room report dated the resident was diagnosed emorrhage. The report also discussed transferring the urgical care center with the the family member declined					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		OATE SURVEY COMPLETED
		345218	B. WING			C 08/18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328	I	00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	subsequently transphome facility on 7/24 Review of the facility 7/24/2017 revealed transferred by Nurse Maxi-move lift (full n (Extra Large) lift pad reported lift pad beconitially, the resident back of her head. The assessed by Nurse and orders were obtevaluation. Under the	ransferred. The resident was ported back to the nursing	F 32	,		
	use a medium lift particle care guide listed the NA # 1 was aware of care guide before gith NA # 1 failed to cheet the NA#1 failed to utransfer, resulting in NA#1 reenacted the to the Administrator demonstrated by reresident using the X (total lift device). She criss-crossing the lereporting that she aid present at time of traat the time of intervidid not have anothe lift use and NA#1 stadoes, but the sitter vadministrator informacceptable as the si	In the process of reviewing the ving care and transfers. The ck the care guide as a result, see the correct lift pad for an improper transfer. The lift transfer by demonstrating the following: NA enactment of lifting the L lift pad with the Maxi-move e demonstrated incorrectly g straps to the lift bar and the private sitter were ensfer. The NA # 1 was asked ew by Administrator why she is staff member present during eated, "That she normally was in the room".				

NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328  ID PROVIDER'S PLAN OF CORRECTION	)	
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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		
	(X5) COMPLETION DATE	
mechanical lifts on 10/25/16 and 5/29/17."  During the interview with NA #1 on 8/16/2017 at 12:30 PM, she verified she did not use the correct pad size while transferring the resident and she did not have another staff with her in the room while transferring the resident. NA #1 further reported on 7/24/2017 while in the process of transferring the resident. NA #1 further reported on 7/24/2017 while in the process of transferring the resident from bed to wheelchair, she (Resident # 125) fell on the floor. NA #1 also reported she was aware of where the Kardex was located which incidated the resident was to be transferred using medium size pad and use of 2 people. NA #1 also reported she always used 2 persons while transferring a resident but she was in a hurry and used one person for the transfer.  During the interview with Nurse #1 on 8/16/2017 at 1:00 PM, she reported that on 7/24/2017 she was called to resident #125's room by NA #1 who stated she transferred the resident alone and the resident fell on the floor. Nurse #1 also reported she assessed the resident as he found the resident had a bump by the side of the head. She (Nurse #1) then notified the Physician who ordered the patient to be sent to the emergency room. Nurse #1 further added the resident came back to the facility the same day with the diagnosis of subarachnoid hemorrhage.  During the interview with the Physician on 8/17/2017 at 11:00 AM, the Physician reported he evaluated the resident immediately after the fall and the resident was doing remarkably well. He indicated since the resident's fall on 7/24/2017, the facility staff were continuing to monitor the resident closely for any changes in cognition or her health. The doctor also reported the resident was not a candidate for surgery due to age. He		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		345218	B. WING			C 08/18/2017
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		·				
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE
F 323	evaluated by the neu- appointment had been on 8/17/2017 at 1:30. Resident #125 in her grimacing or behavior pain and no bump or NA # 3 were also obsertesident from the whoused assigned pad is securement the proportion that the proportion of the use of 2 staff the resident and had the Administrator state the NA# 1 to have foot transferring a resider added that NA # 1 woneeded 2 persons ar while transferring a resider and had 1 to have foot transferring a resider and had 2 persons ar while transferring a resider and had 2 persons ar while transferring a resider and had 2 persons ar while transferring a resider and that NA # 1 woneeded 2 persons ar while transferring a resider and had 2 persons ar while transferring a resider and the second of the sec	or nosurgeon and an en set up by the facility staff.  O PM, observation of wheel chair revealed nowers to indicate she was in the head. The NA # 2 and served transferring the eel chair to bed. The staff ize (medium) and lift belt	F 3.	23		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		345218	B. WING			C 08/18/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	<u> </u>	00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	obtained to send to completed on 07/24 The resident was as pad for transfers. The pad to be used. NA of reviewing the Kartransfers. The NA # as a result, the NA # pad for transfer, res. The NA # 1 reenacted demonstrating to the NA # 1 demonstrate the resident using the Maxi-move (total lift incorrectly criss-crobar reporting that she present at time of transfer why seember present dure that the transfer why seember present dure the maxi-move (total lift incorrectly criss-crobar reporting that she present at time of transfer why seember present dure that the transfer why seember present dure that the side of the	ER for evaluation. This was /2017.  Is sessed to use a medium lift the Kardex listed the correct lift # 1 was aware of the process dex before giving care and 1 failed to check the Kardex # 1 failed to use the correct lift culting in an improper transfer. In the lift transfer by the Administrator the following: the Administrator the following: the Administrator the following: the Lift pad with the device). She demonstrated sing the leg straps to the lift the and the private sitter were cansfer.  In the did not have another staffing lift use and NA # 1 stated, the does, but the sitter was in the reinformed her this was not the received recent lift training staff members with 10/25/16 and 5/29/17.  Investigation of the event, it is auses to be as follows:  The week ardex prior to transfer cot lift sling straps to the cradle are second trained staffing lift transfer.	F 3:	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING				2
NAME OF P	ROVIDER OR SUPPLIER	343210	D. Wille		TREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	18/2017
	AN NURSING CENTER			1	20 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Pain was also assess notified by Nurse # 1 11:55 AM. The reside hospital at 12:05 PM. Corrective Action for I Residents All lift slings on 7/24/2 all/any issues correct from service immedia received in-service ed demonstration for acc executing proper tranfacility lifts. Education will be provided to sling size -Appropriate processe number of staff requir All nurses and CNA's demonstration for lift Systematic Changes Education provided to Assistants on the utili and using the correct transfers. Education volume and CNAs.  Return demonstration the staff showing correct with the lifts will be performed and control of the staff showing correct with the lifts will be performed and control of the staff showing correct with the lifts will be performed and control of the staff showing correct transfers. Education not control to the staff showing correct transfers in complete education is complete education is complete.	by Nurse # 1 at 11:50 AM.  sed. Responsible Party was on 7/24/17 at approximately. Int was transferred to the  Potentially Affected  2017 were inspected with ed or equipment removed Itely. All nursing staff ducation with return bessing the Kardex & sfers using all types of  vided to all clinical staff on identify the correct lift and les of lift usage, including led will perform return usage.  In all Nurses and Nurse lift for safe resident will be provided by the Staff ator (SDC). This education where orientation for nurses  In to validate competency of lect usage of the lift pads	F	323			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
			A. BOILD	_		(	
		345218	B. WING				18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 20 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	of checking resident of transfers in order to extransfer technique is initiated on 7/24/17 by Coordinator. This infinitegrated into the stand in the required infor all employees and Quality Assurance Prochange has been sust completion date on 8.  HOW THE FACILITY CHANGES IMPLEME  The Staff nurses or life a Safe Transfer/Lift Coweekly x 4 and then recorrect lift pad is being the correct resident. Present findings to the committee and correct staff Development Committee and correct S	serviced on the importance Kardex prior to initiating any insure that the safest used. This education was by the Staff Development cormation has been indard orientation training reservice refresher courses will be reviewed by the ocess to verify that the tained. The education (7/2017.  PLANS TO MONITOR ENTED  Censed nurse will complete regulatity Assurance (QA) Audit monthly x 2 making sure the gused with correct lift on The Director of Nursing will reweekly Quality of Life- QA retive action initiated as lity of Life committee or of Nursing, Administrator, roordinator, Unit Managers, und Nurse, Minimal Data and Health Information rets weekly.  On on 8/17/2017 at 3:30 PM, rection was reviewed ws with staff related to the fif were reeducated on a ref a lift and making sure used with correct lift on the refif were observed during a	F	323			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTI		(X3) DATE SURVEY COMPLETED	
	345218	B. WING				C 1 <b>8/2017</b>
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER			120 SOUT	DDRESS, CITY, STATE, ZIP CODE THWOOD DRIVE BOX 379 N, NC 28328		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
with correct lift. Review appropriate use of lift re on each unit observed a required a use of mechatransferred by 2 nurses no concerns were ident.  Quality Assurance commacility met daily to disculift audit beginning 7/25. Review of the monitorin facility had completed the 8/7/2017.  F 371 483.60(i)(1)-(3) FOOD IN STORE/PREPARE/SEF (i)(1) - Procure food from considered satisfactory authorities.  (i) This may include foom from local producers, such and local laws or regular (ii) This provision does facilities from using producers, subject to command growing and food-limited from consuming foods in (i)(2) - Store, prepare, discordance with profession service safety.	(medium size) was used of the facility's Audit of evealed a nurse supervisor of random residents who anical lift while being aides. The audit revealed iffied for the last 4 weeks.  In the appropriate use of 1/2017 until 8/11/2017. In the service on 1/2018 provide the new 1/2018 provide or sources approved or by federal, state or local ditems obtained directly subject to applicable State applicable of the service on 1/2018 provide the service on 1/2018 provide the service of 1/2018		371			9/15/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345218	B. WING		08/18/2017
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE BOX 379  CLINTON, NC 28328	, 00.10.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 371	Continued From page	e 35	F 37	1	
	visitors to ensure saf	dents by family and other e and sanitary storage, nption. Γ is not met as evidenced			
	resident and staff into	on, record review and erviews, the facility failed to sidents' water pitchers and f 1 resident's (Resident #76) ed.		The statements made on this Plan Correction are not an admission to not constitute an agreement with the alleged deficiencies.  To remain in compliance with all Fe and State Regulations the facility has	and do e deral
		#76's quarterly Minimum		taken or will take the actions set for this Plan of Correction. The Plan of Correction constitutes the facility's	th in f
	Resident #76 was co	ed 05/14/17, revealed gnitively intact and required to total dependence on staff ly Living.		allegation of compliance such that a alleged deficiencies cited have bee will be corrected by the date or date indicated.	n or
	#76 on 08/15/17 at 2	n and interview of Resident :10 p.m., Resident #76 was hair in her room. Resident		F 371	
	within her reach on h was observed to be of further inspection of the	ras observed to be placed er over-bed table. The straw gray-black in color. Upon the straw, an unknown g black flecks lined the		Corrective Action for Resident Affect Resident #76 received a new water pitcher with a new straw on 8/15/17 nursing assistant J.K.	
	inside of the straw. Water pitcher and stra #76 stated she did no	When asked how often her aw were washed, Resident ot know. The resident stated		Corrective Action for Resident Pote Affected	
	drinking out of a dirty			On 8/15/17, all water pitchers and s were cleaned and/or replaced by th nursing assistant staff. The facility	is to
	#1 on 08/15/17 at 2:1 residents' water pitch	vith Nursing Assistant (NA) 5 p.m., NA #1 stated the ers and straws never go to shed and sanitized. NA #1		ensure that all resident water pitche washed and sanitized on a regular per facility schedule.	l l
	stated she thought th	e 3rd shift NAs took the nent Room and rinsed them		Systemic Changes An in-service to review, educate ar	nd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
345218		B. WING			08/18/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
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	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  DEFICIENCY)  (X5)  COMPLETION DATE		
F 371	REGULATORY OR LSC IDENTIFYING INFORMATION)		F 3	provide instruction on Clean Sanitizing Water Pitchers Po conducted for all nursing state 16th 2017 by the Administration-service to provide instruct Pitchers and Disposable Struct be conducted for all dietary staff by LTC Staff Developm Coordinator by September 1 FT, PT and PRN staff will reeducation. Any staff not receducation, will not be permit until receiving the education September 15, 2017.  Quality Assurance The Dietary Services Directors will be done weekly for including weekends, and the two months. Reports will be weekly QOL/QA committees Corrective Action initiated as This regularly scheduled weekly	provide instruction on Cleaning and Sanitizing Water Pitchers Policy was conducted for all nursing staff on August 16th 2017 by the Administrator. An in-service to provide instruction on Water Pitchers and Disposable Straw Usage will be conducted for all dietary and nursing staff by LTC Staff Development Coordinator by September 15th 2017. All FT, PT and PRN staff will receive the education. Any staff not receiving the education, will not be permitted to work until receiving the education by September 15, 2017.  Quality Assurance The Dietary Services Director will monitor this issue using the Dietary QA Audit Tool. This will be done weekly for four weeks, including weekends, and then monthly for two months. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriate. This regularly scheduled weekly meeting is attended by The Administrator, Director		
	the Alterial to be was	neu anu samuzeu.		of Nursing, Dietary Services Managers, Business Office I Activity Director, and Social Compliance Date: Septemb	Director, Un Manager, Worker.		