PRINTED: 10/03/2017 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345218	B. WING _		01	C 08/18/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		3.13.23.11	
(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 CORREC ((EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 241 SS=D	resident in a manner apromotes maintenance her quality of life recoindividuality. The facil promote the rights of This REQUIREMENT by: Based on observation resident and staff interensure a privacy bag residents with a urina Resident #218 and Resident #218 and Resident #218 and Resident #218 and Resident #12 was facility on 06/19/13 wiretention of urine and re-admitted to the fact diagnosis of Urinary The Areview of Resident Set (MDS), dated 07/412 was severely cogrequired the extensive mobility, toileting and MDS indicated Resideurinary catheter. A review of Resident Assessment (CAA), desident #12 had and due to hydronephrosis under the care of a urinary of Resident and the care of a urinary of Resident a	reat and care for each and in an environment that the or enhancement of his or gnizing each resident's ity must protect and the resident. It is not met as evidenced the resident and the resident and the resident. It is not met as evidenced the resident and the	F 2	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 F and State Regulations the facility between taken or will take the actions set for this Plan of Correction. The Plan Correction constitutes the facility's allegation of compliance such that alleged deficiencies cited have bewill be corrected by the date or daindicated. F 241 Corrective Action for Resident Affer Residents #12, # 218 and # 87 ha urinary catheter bags immediately covered for privacy on 8/16/17 by nurses. Corrective Action for Resident Pot Affected	and do ne ederal nas orth in of all en or res cted d their	9/15/17 (X6) DATE	

09/08/2017 **Electronically Signed**

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		TE SURVEY MPLETED	
							С	
		345218	B. WING _			0	8/18/2017	
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE			
				12	20 SOUTHWOOD DRIVE BOX 379			
MARY GR	AN NURSING CENTER			С	LINTON, NC 28328			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 241	Continued From pag	ge 1	F 2	241				
	updated 06/30/17, in	idicated Resident #12's urine			On 8/16/17 licensed nurses assessed	18		
	catheter bag should	be kept adequately covered			current residents with urinary catheters	s to		
	to promote her dignit	ty.			ensure they had privacy covered drain	age		
					bags. 3 out of 18 were found to not ha	ve		
		on of Resident #12 on			covered urinary catheter bags.			
		n., Resident #12 was lying in						
	her bed. The urine of	S .			On 8/16/17, 3 urinary catheters were			
	indwelling urinary catheter hung on the side of her bed with the clear side of the bag facing the entrance to the room. The urine collection bag				covered with privacy covers by license	a		
					nurses.			
did not have a privacy flap or a cloth cover.								
	did not have a privacy hap of a cloth cover.				Systemic Changes			
	During an interview	with Nurse #3 on 08/17/17 at			Systemic Smanges			
		stated Resident #12 returned			On 8/16/17 the Director of Nursing and	t		
		08/17 at 6:37 p.m. after			Staff Development Coordinator initiate			
	having been at the h	ospital for a UTI. Nurse #3			servicing FT, PT and PRN nurses, nur	sing		
	stated she assessed	Resident #12 and			assistants, medication aides and			
		ssion process. Nurse #3			medication techs on the following:			
		ooking at the urine in the						
	_	se #3 stated it was the end of			¿ All urinary catheter drainage bags			
		s wrapping things up and			must be covered for resident privacy in	1		
		just forgot to replace the			skilled facilities			
	urine collection bag	with one that has a flap on it.			¿ When residents are admitted or readmitted it is important to assess the			
	During an interview v	with the Director of Nursing			urinary drainage bags to ensure that a			
		at 12:56 p.m., the DON stated			privacy cover is on the urinary drainag			
	1 -	on nursing staff have a dignity			bag	J		
		esidents with indwelling			¿ Nursing Assistants, Med Techs an	ıd		
	urinary catheters.	3			Med Aides educated on why urinary			
	_				drainage bags are to be covered for			
		was admitted to the facility on			privacy and to report if they identify an	y		
		oses which included benign			uncovered urinary drainage bags			
		y (BPH), chronic kidney			¿ All clinical staff were educated wh			
	disease and urinary	tract infection (UTI).			the privacy urinary drainage bag cover are located	S		
	A review of Resident	t #218's Admission Minimum			a. 5 . 564.64			
	Data Set (MDS), dat	ed 07/28/17, revealed						
		severely cognitively impaired			Any staff not receiving the education,			
	and required the extensive assistance of staff for				not be permitted to work until receiving	ı		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
		345218	B. WING			C 08/18/2017
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	DE	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 241	Continued From pag		F 24		45 0047	
	MDS indicated Residurinary catheter, BPF	DS indicated Resident #218		the education by September	15, 2017.	
		//040L O		Quality Assurance		
	Resident #218 was of facility on 07/13/17. facility on 07/21/17 a and severe sepsis. #218 had an indwelli urine retention. A review of Resident updated on 08/16/17 urinary catheter bag covered to promote had buring an observation 08/15/17 at 10:42 a.r. in an armchair in his near his chair. Resident bag was attached to flap or cloth cover. To	dated 07/28/17, indicated briginally admitted to the He was re-admitted to the fter 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 of using the QA Catheter Audit of ensure all urinary catheter drawing are covered for privacy by associated to performed weekly. This audit of performed weekly for four we monthly for 2 months, including weekends. Reports will be put the weekly QA committee by Administrator/Director of Nursensure corrective action initial appropriate. Compliance will and ongoing auditing program the weekly QA Meeting. The Meeting is attended by the DC Coordinator, Unit Manager, SNurse, Rehab Director, HIM, Manager and the Administrator.	Fool to ainage bags sessing five vill be eks, then ng resented to the sing to ted as be monitored in reviewed at weekly QA ON, MDS support Dietary	
	room. During an interview v 2:38 p.m., Nurse #4: returned to the facility with an indwelling uri stated she recalled c urinary catheter and stated she honestly of the urine collection b was an "old-school" in	vith Nurse #4 on 08/18/17 at stated when Resident #218 y on 07/21/17, he returned nary catheter. Nurse #4 hecking the size of the the color of his urine but did not think about changing ag. Nurse #4 stated she nurse and she was taught not si t was necessary. Nurse		Compliance date: September	15, 2017	

Facility ID: 923329

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	TE SURVEY MPLETED
		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		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		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			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(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 urin stated she recalled ch size, color of urine in the bag, but she did r bag or changing the k the hospital were diffe During an interview w (DON) on 8/16/17 at it was her expectation bag in place for all re- urinary catheters. 483.20(g)-(j) ASSESS ACCURACY/COORD (g) Accuracy of Asses must accurately reflect (h) Coordination A registered nurse me each assessment with participation of health (i) Certification (1) A registered nurse the assessment is co (2) Each individual with	re collection bag did not a cloth cover. With Nurse #7 on 8/17/17 at stated 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 erent from the facility 's bag. With the Director of Nursing 12:56 p.m., the DON stated in nursing staff have a dignity sidents with indwelling SMENT DINATION/CERTIFIED esements. The assessment of the resident's status. Lust conduct or coordinate in the appropriate in professionals. Example the must sign and certify that impleted. The completes a portion of the in and certify the accuracy of		278		9/15/17	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED
		345218	B. WING			C 8/18/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/10/2017
MARYCR	AN NURSING CENTER			120 SOUTHWOOD DRIVE BOX 379		
WARTGR	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	Continued From page	e 5	F 2	78		
	(j) Penalty for Falsific (1) Under Medicare a who willfully and know	nd Medicaid, an individual				
	* *	and false statement in a is subject to a civil money nan \$1,000 for each				
	and false statement in	dividual to certify a material n a resident assessment is ey penalty or not more than ssment.				
	material and false sta	nent does not constitute a tement. is not met as evidenced				
	Based on observation interviews, the facility the Minimum Data Set Ulcers for a resident foot ulcers (Resident conflicting responses have two stage 4 present to the stage of	n, record review and staff failed to accurately code et (MDS) by coding Pressure with non-pressure chronic #152) and by coding on a resident assessed to ssure ulcers (Resident #44) viewed for Pressure Ulcers.		The statements made on this Correction are not an admission not constitute an agreement walleged deficiencies. To remain in compliance with and State Regulations the facilitaken or will take the actions sthis Plan of Correction. The Population separation peoplitudes the facilitation	on to and do with the all Federal dilty has set forth in	
	03/31/17 with the diag	s admitted to the facility on gnosis of non-pressure part of the foot, left and		Correction constitutes the faci allegation of compliance such alleged deficiencies cited have will be corrected by the date o indicated.	that all been or	
		#152's Admission MDS, ated Resident #152 had 1		F 278		
	unhealed pressure ul	cer at Stage 1 or higher, had cer and had 1 unstageable		Correction for Affected Reside	nt:	
		coverage of wound bed by		MDS for resident # 152 with id	lentified	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE S	
		345218	B. WING _			08/4	; 18/2017
	ROVIDER OR SUPPLIER AN NURSING CENTER			120 S	ET ADDRESS, CITY, STATE, ZIP CODE OUTHWOOD DRIVE BOX 379 TON, NC 28328	1 007	10/2017
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I	(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 diak During an interview w 08/18/17 at 3:35 p.m. was his expectation th MDS be coded accur 2. Resident #44 was 07/18/14. Resident # peripheral vascular di 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 are on his left and right foot petic foot ulcers. With the Administrator on the Administrator stated it he artely. admitted to the facility on wide's diagnoses included sease, diabetes mellitus essure ulcers on right heel #44's quarterly MDS, dated esident #44 was coded as reater 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, artely coded.	F 2	Id R Aucreb Athornia S Me SwCC Thithare ACP Worth	oding error was modified and coding orrected and resubmitted by MDSC of /16/17. Identification of Other Potentially Affect desidents: Ill residents who had documented skir licers were reviewed to ensure accurated or most expected by MDSC on 8/17/17. Ill MDSs with coding errors identified arough audit were modified and correct most were was identified to be coded accurately and was modified on 8/17 and resubmitted by the MDSC. Systemic Changes: IDSC and MDS Assistant were provided ducation on how to accurately code ection M of the MDS. This education was provided by the Regional MDS consultant on 8/17/17 and 8/18/17. Apuality Assurance: The most recent MDS for 5 residents were provided by the most recent MDS for 5 residents who have had documented skin ulcer(s) dure past 90 days will be audited to ensure coding of Section M. These sesidents will be chosen by running an assessment History report from Point elick Care that will include all Weekly wound Reviews (non-pressure) that we completed during the past 90 days. If there are not 5 residents who have or lickin ulcer(s) present during their MDS is a possible of their most received that we completed during the past 90 days. If there are not 5 residents who have or lickin ulcer(s) present during their MDS	ted te d te d tred /17 ed	

Facility ID: 923329

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
						С	
		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	Ē		
(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 COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 278	Continued From page			assessment period, then 5 rar residents who have had an MI completed within the past 30 creviewed to ensure accurate of Section M. This audit will be oby the MDS Consultant or Nur Consultant weekly x 4, and the 2 or until compliance is achieved sustained. Any concerns identicated addressed immediately. This areviewed weekly by the QA consisting of the DON, Social Dietary Manager, Business Of Manager, Lead Support Nurse Director, Rehab Director and I Compliance Date: September 279	DS days will be coding of completed rse en month! yed and tified will be committee, Worker, fffice es, Activity NHA.	d ly x be be	9/15/17
SS=D	483.20 (d) Use. A facility mu assessments complet months in the resident results of the assessment revise the resident plan. 483.21 (b) Comprehensive C (1) The facility must do comprehensive personal compr	care PLANS est maintain all resident ted within the previous 15 et's active record and use the ments to develop, review ent's comprehensive care					

Facility ID: 923329

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	` '	ATE SURVEY DMPLETED
		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	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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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		TE SURVEY MPLETED
		345218	B. WING			C 8/18/2017
NAME OF P	ROVIDER OR SUPPLIER	0.102.10	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0/10/2017
TVAINE OF T	TO VIDER OR OUT FEEL			120 SOUTHWOOD DRIVE BOX 379		
MARY GR	AN NURSING CENTER			CLINTON, NC 28328		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP		COMPLETION DATE
F 279	F 279 Continued From page 9		F 27	79		
	section. This REQUIREMENT	is not met as evidenced				
	by:					
		iew and staff interviews, the		The statements made on this P	-	
	_	op a comprehensive care		Correction are not an admission		
	#218).	dents reviewed (Resident		not constitute an agreement with alleged deficiencies. To remain i		
	#210 <i>)</i> .			compliance with all Federal and		
	Findings Included:			Regulations the facility has take take the actions set forth in this	n or will	
	1. Resident #218 w	as admitted to the facility on		Correction. The Plan of Correct	ion	
	_	ses which included benign		constitutes the facility's allegatio		
	prostatic hypertrophy (BPH), chronic kidney			compliance such that all alleged		
	disease and urinary re	etention.		deficiencies cited have been or vicerrected by the date or dates in		
	A review of Resident Data Set (MDS), date	#218's Admission Minimum ed 07/28/17, indicated				
	Resident #218 had ar	n indwelling urinary catheter.		F 279		
	A review of Resident	#218's Care Area		F 279		
		lated 07/28/17, indicated				
		n indwelling urinary catheter		Correction for Affected Resident	:-	
		re of a urologist due to				
	urinary retention.			The care plan for affected reside	ent #218	
				was updated to reflect that he ha		
		#218's Admission Care Plan		indwelling urinary catheter. This		
	an indwelling urinary	18 was not care planned for catheter.		completed by the MDSC on 8/16		
	During an interview w	ith the MDC Coordinator on		Identification of Other Potentially Residents:	/ Апестеа	
	_	vith the MDS Coordinator on n., the MDS Coordinator		ivesidents.		
		was originally admitted to		All residents that have urinary ca	atheters	
		7. The MDS Coordinator		have had their care plan reviewe		
	_	ischarged to the hospital		updated accordingly to ensure the		
		icility with an indwelling		accurately reflects presence of u		
	urinary catheter on 07			catheters. Three out of eighteen		
		e indwelling urinary catheter		plans were updated. This was o		
	should have been car missed it.	re planned and she just		by the MDS Nurse Consultant of 9/8/2017.	n	

Facility ID: 923329

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(>	(3) 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)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
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 the plans a	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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345218	B. WING _			C 08/18/2017
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	E	00/10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	80 Continued From page 11		F 2	280		
	including the right to be included in the plarequest meetings and revisions to the personal content of	ipate in establishing the putcomes of care, the type, and duration of care, and any to the effectiveness of the ve the services and/or items of care. The care plan, including the nificant changes to the plan will inform the resident of the his or her treatment and dent in this right. The structure is significant of the resident and/or ve. The sident's personal and an developing goals of care.				
	(2) / Completionsive	oaro pian maor bo-				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	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 CO 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	•	00/10/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From page	e 12	F 2	280		
	(i) Developed within 7 the comprehensive as	days after completion of ssessment.				
	(ii) Prepared by an inincludes but is not lim	terdisciplinary team, that ited to				
	(A) The attending phy	vsician.				
	(B) A registered nurse resident.	e with responsibility for the				
	(C) A nurse aide with resident.	responsibility for the				
	(D) A member of food	I and nutrition services staff.				
	the resident and the r An explanation must medical record if the	cticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the				
		staff or professionals in inded by the resident's needs e resident.				
	team after each asse comprehensive and cassessments.	vised by the interdisciplinary ssment, including both the quarterly review is not met as evidenced				
	Based on staff and fa reviews the facility fai care plan meeting for	amily interviews and record led to invite the resident to a 1 of 29 sampled residents failed to revise a care plan		The statements made on the Correction are not an admiss not constitute an agreement alleged deficiencies.	sion to and do	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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		345218	B. WING			08/	18/2017	
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
				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)			
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 280	Continued From page	e 13	F:	280				
		sidents Resident #87 who			To remain in compliance with all Federa	al		
		er 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	i:			allegation of compliance such that all			
					alleged deficiencies cited have been or			
		s admitted to the facility for			will be corrected by the date or dates			
		with diagnosis including			indicated.			
		haviors, Hypertension, and						
	Malnutrition.				F 000			
	In an interview with th	as reconcible party for			F 280			
		ne responsible party for I5/17 at 3:04 PM revealed			Correction for Affected Residents:			
		78 had not been invited to			Correction for Affected Nesidents.			
		e of care planning meeting to			Resident #178 has had care plan			
		d treatment objectives.			meetings held by the interdisciplinary c	are		
	_	ealed she would have			plan team as evidenced by resident			
	preferred to attend, b	out did know when the			interview. Resident stated the care plan	า		
	meeting was held.				team has met in his room and discusse			
					his therapy goals and discharge plans.			
	In an interview with S	Social Worker #1 and Social			Resident is his own responsible party a	ınd		
		7 at 2:50 PM, they revealed			has a BIMS score of 13. Resident			
		residents and/or family			interview conducted on 9/8/17 by QA			
		care planning meeting.			Nurse Consultant.			
	Information could not	•			Resident # 87 has had urinary catheter			
		ne 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 a	no sign in sneet or and/or the resident being			Resident #218 has had his care plan updated on 8/17/17 by the MDS nurse	to		
	invited and/or attendi				reflect current pressure ulcers.	10		
	meeting.	ng any care planning			rondot duriont prossure diocis.			
	, J				Identification of Other Potentially Affect	ed		
	Interviews with the Ad	dministrator on 8/18/17 at			Residents:			
	3:17 PM revealed he	had just found out the staff						
	was no longer docum	nenting an invitation to care			Thirteen out of fifty seven residents tha	t		
	planning. The expec	tation is all residents and/or			have had a care plan meeting held with	ıin		
		re invited to all care planning			the last 30 days by the interdisciplinary			
	meeting from this point forward.				care plan team. Forty four			

Facility ID: 923329

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345218	B. WING _			C 08/18/2017	
ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, Z	IP CODE	00/10/2011	
MARY GRAN NURSING CENTER			120 SOUTHWOOD DRIVE BOX 3' CLINTON, NC 28328	79		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
2. Resident #87 was cumulative diagnose Atrial Fibrillation, Irrit Hypertension and Di A review of Resident Data Set (MDS), dat Resident #87 was se and was totally depensibility, toileting, an MDS indicated Residincontinent for bowel A review of Resident Assessment (CAA), Resident #87 was or on 7/20/17. Resident facility on 8/1/17 after returned to the facilit for comfort care relation an unstageable president.	s admitted 7/20/17 with s of Chronic Kidney Disease, able Bowel Syndrome, abetes. #87 Admission Minimum ed 7/27/17, revealed everely cognitively impaired ndent of staff for bed d personal hygiene. The lent #87 was always and bladder. #87's Care Area dated 7/27/17, indicated iginally admitted to the facility t #87 was re-admitted to the r a hospitalization and y with an indwelling catheter led to a terminal illness and sure ulcer.	F 2	residents/resident reprethe fifty seven residents that they have not had a care plan team meeting days. An interdisciplinar meeting invitation will be for these forty four residents that have used have had their care plan updated accordingly to accurately reflects presect the plans were updated. The by the MDS Nurse Consecutives were reviewed to care plans reflected the pressure ulcer(s). This recompleted on 8/17/17 by	sentative out of have reported an interdisciplinary in the last 90 y care plan team extended/mailed lents by arinary catheters in reviewed and ensure that it ence of urinary eighteen care his was completed sultant on the last their presence of eview was y the MDSC. 9 of		
focus of an indwelling condition and unstage sacrum was initiated. During an interview of Administrator stated. Coordinator should a resident and the Carreflect the needs of the In an interview on 8/ Minimum Data Set (I was no care plan upon sacrum in the condition of the cond	g catheter related to terminal eable pressure ulcer on on 8/16/17. on 8/17/17 at 11:24 AM, the his expectation was the MDS accurately assess each e Plan should accurately each resident. 17/17 at 2:10 PM, the MDS) Nurse stated that there dated and/or revised for the		appropriately care plant plans were updated on a MDSC. Systemic Changes: Interdisciplinary Care plant receive education regard and resident representation invited and included in the conference at a minimum quarterly and reviewing/	an team will ding the resident tive's right to be he care planning m of once /updating care		
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag 2. Resident #87 was cumulative diagnose Atrial Fibrillation, Irrit Hypertension and Dial A review of Resident Data Set (MDS), date Resident #87 was se and was totally deperior mobility, toileting, and MDS indicated Residincontinent for bowel A review of Resident Assessment (CAA), Resident #87 was or on 7/20/17. Resident facility on 8/1/17 after terurned to the facility for comfort care related an unstageable president and unstageable president was initiated. A review of Resident focus of an indwelling condition and unstage sacrum was initiated. During an interview of Administrator stated. Coordinator should a resident and the Carreflect the needs of each of the care plan upon indwelling catheter for the c	TORRECTION IDENTIFICATION NUMBER: 345218 ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 2. Resident #87 was admitted 7/20/17 with cumulative diagnoses of Chronic Kidney Disease, Atrial Fibrillation, Irritable Bowel Syndrome, Hypertension and Diabetes. A review of Resident #87 Admission Minimum Data Set (MDS), dated 7/27/17, revealed Resident #87 was severely cognitively impaired and was totally dependent of staff for bed mobility, toileting, and personal hygiene. The MDS indicated Resident #87's Care Area Assessment (CAA), dated 7/27/17, indicated Resident #87 was originally admitted to the facility on 7/20/17. Resident #87 was re-admitted to the facility on 8/1/17 after a hospitalization and returned to the facility with an indwelling catheter for comfort care related to a terminal illness and an unstageable pressure ulcer. A review of Resident #87's Care Plan revealed a focus of an indwelling catheter related to terminal condition and unstageable pressure ulcer on sacrum was initiated on 8/16/17. During an interview on 8/17/17 at 11:24 AM, the Administrator stated his expectation was the MDS Coordinator should accurately assess each resident and the Care Plan should accurately reflect the needs of each resident. In an interview on 8/17/17 at 2:10 PM, the Minimum Data Set (MDS) Nurse stated that there was no care plan updated and/or revised for the indwelling catheter for Resident #87 on her	ROVIDER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 2. Resident #87 was admitted 7/20/17 with cumulative diagnoses of Chronic Kidney Disease, Atrial Fibrillation, Irritable Bowel Syndrome, Hypertension and Diabetes. A review of Resident #87 admission Minimum Data Set (MDS), dated 7/27/17, revealed Resident #87 was severely cognitively impaired and was totally dependent of staff for bed mobility, toileting, and personal hygiene. The MDS indicated Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17, Resident #87 was re-admitted to the facility on 7/20/17 and unstageable pressure ulcer. A review of Resident #87's Care Plan revealed a focus of an indwelling catheter related to terminal condition and unstageable pressure ulcer on sacrum was initiated on 8/16/17. During an interview on 8/17/17 at 11:24 AM, the Administrator stated his expectation was the MDS Coordinator should accurately assess each resident and the Care Plan should accurately reflect the needs of each resident. In an interview on 8/17/17 at 2:10 PM, the Minimum Data Set (MDS) Nurse stated that there was no care plan updated and/or revised for the indwelling catheter for Resident #87 on her	A BUILDING 345218 345218 345218 STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC. 28328 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCIES) (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 2. Resident #87 was admitted 7/20/17 with cumulative diagnoses of Chronic Kidney Disease, Artrial Fibrillation, Irritable Bowel Syndrome, Hypertension and Diabetes. A review of Resident #87 Admission Minimum Data Set (MDS), dated 7/27/17, revealed Resident #87 was severely cognitively impaired and was totally dependent of staff for bed mobility, folieting, and personal hygiene. The MDS Indicated Resident #87* Care Area Assessment (CAA), dated 7/27/17, indicated Resident #87 was originally admitted to the facility on 7/20/17. Resident #87 was re-admitted to the facility on 8/1/17 after a hospitalization and returned to the facility with an indiveiling catheter related to terminal condition and unstageable pressure ulcer. A review of Resident #87* Care Plan revealed a focus of an indiveiling catheter related to terminal condition and unstageable pressure ulcer on sacrum was initiated on 8/16/17. During an interview on 8/17/17 at 11:24 AM, the Administrator stated his expectation was the MDS Coordinator should accurately sesses each resident and the Care Plan should accurately reflect the needs of each resident. In an interview on 8/17/17 at 2:10 PM, the Minimum Data Set (MDS) Nurse stated that there was no care plan updated and/or revised for the indwelling catheter for Resident #87 on her 10 STREET ADDRESS, CITY, STATE, 2IP CODE 12 SOUTHWOOD DRIVE DOR CACHOCON 14 Fersion Cach consecution of Cach corons Factorion (Each Corons Factori	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345218	B. WING		C 08/18/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 280		e 15 n updating the care plans and	F 280	provided by the MDS Nurse Consult 9/15/17.	ant by	
	(DON) on 8/18/17 at was her expectation as situations arises of 3. Resident #218 was facility 7/13/17 with or Disease, Coronary A Fracture of Left Fem A review of Resident Data Set (MDS), da	as initially admitted to the diagnoses of Chronic Kidney artery Disease, Closed ur, and Atrial Fibrillation. #218 Admission Minimum ed 7/29/17, revealed cognitively impaired and esistance and one person ed mobility, toileting, and the MDS indicated Resident incontinent for bowel and #218's Care Area dated 7/29/17, indicated originally admitted to the		An audit of 5 residents and/or their resident representative will be interv to ensure that they have been invite participated in the care planning processes. This audit will be conduct weekly x 4 and then monthly x 2. The audit will be completed by the Social Worker or Activity Director weekly x then monthly x 2 or until sustained compliance is achieved. Any concertidentified will be addressed immediated This audit will be reviewed weekly by QA committee, consisting of the DO Social Worker, Dietary Manager, Business Office Manager, Lead Sup Nurses, Activity Director, Rehab Director and NHA. Compliance Date: September 15, 2	d and sted is I 4 and ns stely. y the N, pport ector	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING _				C 1 18/2017
	ROVIDER OR SUPPLIER AN NURSING CENTER			12	REET ADDRESS, CITY, STATE, ZIP CODE 0 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 PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Administrator stated h	e 16 n 8/17/17 at 11:24 AM, the nis expectation was the MDS ocurately assess each	F 2	280			
	resident and the Care reflect the needs of earling an interview on 8/1 Minimum Data Set (Mass no care plan upd pressure ulcer for Research readmission to the factorist resident and the care resident	Plan should accurately ach resident. 7/17 at 2:10 PM, the IDS) Nurse stated that there ated and/or revised for the					
F 282 SS=G	(DON) on 8/18/17 at was her expectation f as situations arises for 483.21(b)(3)(ii) SERV PERSONS/PER CAR (b)(3) Comprehensive The services provided	ICES BY QUALIFIED E PLAN	F2	282			9/8/17
	(ii) Be provided by qu accordance with each care. This REQUIREMENT by: Based on record revi and staff interviews th care plan for use of a while transferring a re- resulting in a subarac	alified persons in a resident's written plan of a resident's written plan of a since is not met as evidenced ew, observation, Physician he facility failed to follow the medium pad and 2 people he is ident with a use of a lift, hnoid hemorrhage (bleeding the brain and the thin tissues			Past noncompliance: no plan of correction required.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(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	Y, STATE, ZIP CODE IVE BOX 379		
(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	(Resident # 125) The findings included Resident # 125 was a 3/23/2017 with diagnory hypernatremia, acute metabolic encephalory mental status, dehydromental status, dehydromenta	for 1 of 1 sampled resident. admitted to the facility on oses which included acute kidney injury, acute oathy, agitation, altered ration, generalized ntia. plan dated 5/24/2017 nt has an Activities of Daily re performance deficit." The regoal as "I will maintain on in bed mobility and next 90 days." The care plan duse of full mechanical lift a medium pad and assist	F 28	32			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	COMPLETED	(X3) DATE SURVEY 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	1 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 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 herevealed 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 pad the resident p	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		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NO _		، ا	C	
		345218	B. WING				18/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MARYCE	AN NUDSING CENTED			1:	20 SOUTHWOOD DRIVE BOX 379			
WARTGR	AN NURSING CENTER			С	ELINTON, 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 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 chect the NA#1 failed to ustransfer, resulting in a NA#1 reenacted the to the Administrator informed at the time of intervied did not have another lift use and NA#1 stated does, but the sitter was acceptable as the sitter was accep	is 1. The doctor was notified sined to send the patient for a investigation headline the expression resident was assessed to differ transfers. The resident's correct lift pad to be used. The process of reviewing the ring care and transfers. The king care and transfers. The king care and transfers. The king care and transfers. The lift transfer by demonstrating the following: NA enactment of lifting the lift pad with the Maxi-move of demonstrated incorrectly a straps to the lift bar difference the private sitter were ensfer. The NA # 1 was asked with by Administrator why she staff member present during the ted, "That she normally as in the room". In the transfer was not a trained the received recent lift training that the strain with the strain in the room with the strain in	F	282				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		L. , IDENTIFICATION NITIMBED:		PLE CONSTRUCTION IG	· ,	(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 8/18/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER	0.02.0		STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		0/10/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(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 transferre resident fell on the floshe 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 resident was indicated since the resident closely for a her health. The doctowas not a candidate further mentioned the evaluated by the new 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 obstresident from the whused assigned pad securement the prop	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 at #125's room by NA #1 who do the resident alone and the cor. Nurse #1 also reported sident and she found the by the side of the head. She fied the Physician who do be sent to the emergency her added the resident came do same day with the hhoid hemorrhage. With the Physician on M, the Physician reported he had immediately after the fall doing remarkably well. He desident's fall on 7/24/2017, continuing to monitor the entry changes in cognition or for also reported the resident for surgery due to age. He de resident will continue to be a resident will continue to the r	F 2	82			

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		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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION 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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 08/18/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		30710/2017	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From pag	ne 22	F 2	82			
	incorrectly criss- cros	device). She demonstrated ssing the leg straps to the lift e and the private sitter were					
	Administrator why sh member present dur "That she normally d room". Administrator acceptable as the sit employee. NA # 1 ha regarding having 2 s	need at time of interview by the did not have another staff ing lift use and NA # 1 stated, loes, but the sitter was in the informed her this was not atter was not a trained and received recent lift training staff members with 0/25/16 and 5/29/17.					
	identified, the root ca -NA# 1 failed to revie -NA # 1 used incorred -NA# 1 attached leg incorrectly	straps to the cradle re second trained staff					
	provider was notified Pain was also asses notified by Nurse # 1 11:55 AM. The resid- hospital at 12:05 PM Corrective Action for Residents All lift slings on 7/24/ all/any issues correct from service immediate	mediately assessed and the I by Nurse # 1 at 11:50 AM. sed. Responsible Party was on 7/24/17 at approximately. ent was transferred to the I. Potentially Affected //2017 were inspected with ted or equipment removed ately. All nursing staff					

PRINTED: 10/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	` '	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		071072017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT 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 282	executing proper trafacility lifts. Education will be prothe following: -Using the Kardex to sling size -Appropriate proces number of staff requal All nurses and CNA' demonstration for lift Systematic Changes Education provided Assistants on the utiand using the correct transfers. Education Development coording will be included in not and CNAs. Return demonstration the staff showing convention will be included in not and CNAs. Return demonstration the staff showing convention is completed to the staff showing convention is completed. PNs, RNs, Nursing Aides/Techs Were in of checking resident transfers in order to transfer technique is	nsfers using all types of povided to all clinical staff on povided is staff and ses of lift usage, including ired s will perform return t usage. s to all Nurses and Nurse clization of resident Kardexes ct lift for safe resident will be provided by the Staff nator (SDC). This education ew hire orientation for nurses on to validate competency of rrect usage of the lift pads	F 24	32		
	and in the required if or all employees an Quality Assurance F change has been su completion date on a	tandard orientation training n-service refresher courses d will be reviewed by the Process to verify that the Instained. The education				

Facility ID: 923329

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345218	B. WING _			C 08/18/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	DE	00/10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
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 in the were reeducated on lift and making sure with correct lift on the were observed durin 125. The 2 staff appresident by making sure field with correct lift on the were observed durin 125. The 2 staff appresident by making sure field with field in the weeled a nurse sup observed 5 random of mechanical lift who nurses' aides. The aid were identified for the Quality Assurance of the correct lift of of the correct li	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 be weekly Quality of Life- QA ctive action initiated as ality of Life committee tor of Nursing, Administrator, coordinator, Unit Managers, bund Nurse, Minimal Data and Health Information eets weekly. Ion on 8/17/2017 at 3:30 PM, rection was reviewed ws with staff related to the liew with the Nurses' Aides howledge in checking the difful following the interventions transfer a resident. The staff as asfe transfer with use of a the correct lift pad is used a correct resident. 2 staffing a transfer of Resident # copriately transferred the ure the correct lift. Review of appropriate use of lift pervisor on each unit residents who required a use the being transferred by 2 audit revealed no concerns	F2	282		

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C 08/18/2017	
	ROVIDER OR SUPPLIER AN NURSING CENTER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE BOX 379 31 SLINTON, NC 28328	1 00/	10/2017
(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 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			0/0/47
F 323 SS=G	(d) Accidents. The facility must ensure (1) The resident envir from accident hazards (2) Each resident receand assistance devices (n) - Bed Rails. The fappropriate alternative bed rail. If a bed or semust ensure correct in maintenance of bed received (1) Assess the reside from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beappropriate for the resident or the resid	onment remains as free as as is possible; and eives adequate supervision es to prevent accidents. Facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and eails, including but not limited ents. Int for risk of entrapment installation. Interpresentative and obtain or to installation.	F	323			9/8/17
	interviews the facility size (medium) and us	ew, observations, and staff failed to use designated pad e 2 people while t using a full mechanical lift,			Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	· '	DATE SURVEY COMPLETED
		345218	B. WING			C 08/18/2017
	ROVIDER OR SUPPLIER			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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	resulting in a subara in the area between that cover the brain who was care plann # 125) The findings includ The user manual in mechanical lift date. The instruction indic. Do not use a sling use with the lift. - Always check the particular patient an capacity. Resident # 125 was 3/23/2017 with diag hypernatremia, acumetabolic encephal mental status, dehy weakness and dem Resident #125's caindicated "the reside Living (ADLs) self-care plan indicated current level of functions for the current level of functions including all transfers usin with use of 2 person. The quarterly Minim 7/3/2017 indicated I cognitively impaired resident required experson for bed mobof two person for trachair. The MDS also	achnoid hemorrhage (bleeding achnoid hemorrhage (bleeding achnoid hemorrhage) for 1 of 1 sampled resident and for use of a lift. (Resident lift.) (Resident lif	F 3.	23		

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 _			C 08/18/2017
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		00/10/2011
(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 COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	falls and walking did back period. The resident's Karde care guide for direct needs at the facility) indicated the residen lift for transfers using medium pad size. A nurse note dated 7 revealed "the nurse vroom around 11:40 a When the nurse enteresident lying on the left side. NA # 1 state back with head being verbal with sitter and resident. A raised are noted and no bleedin that the resident was to wheel chair when it.	e 27 esident was not coded for not occur during the look x dated August/July 2017 (a staff identifying resident care under transfer headline t required a full mechanical 2 persons and the use of //24/2017 at 12:57 PM was called to the resident's m due to the resident's fall. red the room she noted the floor next to bed lying on her ed the resident fell on her pumped noted alert and staff NA#1 was with the eat to back of the head was g was noted. NA# 1 stated being transferred from bed a fall occurred. The doctor esponsible party was notified.	F	323		
	The patient was then room for an evaluation. A nurse note dated 7 revealed the resident facility from the emer medication but with a the use of aspirin medicated the doctors resident to a neurosure sident to a neurosure for an evaluation of the revealed the doctors resident to a neurosure.	sent out to an emergency on." /24/2017 at 5:00 PM t was admitted back to the gency room with no new on order for the facility to stop				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		· ,	E SURVEY PLETED	
345218	B. WING _		0.5	C 8/18/2017
		STREET ADDRESS, CITY, STATE, ZIP CC	•	10/2017
FR		120 SOUTHWOOD DRIVE BOX 379		
LIX		CLINTON, NC 28328		
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
nt transferred. The resident was insported back to the nursing 7/24/2017. cility's investigation report dated ed "Resident, # 125 was being urse Aide (NA) # 1 using the all mechanical lift) with a XL pad. During the transfer NA# 1 decame unhooked on 1 corner. ent sustained a hematoma to the investigation headline the ent ent investigation headline the entity in the correct lift pad to be used. The correct lift pad to be used the patient for ent in the investigation headline the entity in the process of reviewing the entity in the process of reviewing the entity in the lift transfers. The entity in the lift transfer by demonstrating the entity in the following: NA entity in the entity in the lift pad with the Maximove. She demonstrated incorrectly the leg straps to the lift bar and the private sitter were for transfer. The NA # 1 was asked entity by Administrator why she ther staff member present during a stated, "That she normally er was in the room".	F3	23		
	IDENTIFICATION NUMBER:	A. BUILDIN 345218 B. WING PRESIDENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) Page 28 Int transferred. The resident was insported back to the nursing 7/24/2017. Cility's investigation report dated led "Resident, # 125 was being urse Aide (NA) # 1 using the lill mechanical lift) with a XL pad. During the transfer NA# 1 became unhooked on 1 corner. lent sustained a hematoma to the lill. The resident was immediately se # 1. The doctor was notified obtained to send the patient for er the investigation headline the "The resident was assessed to the pad for transfers. The resident's the correct lift pad to be used. The office of the process of reviewing the legiving care and transfers. The check the care guide as a result, to use the correct lift pad for g in an improper transfer. The the lift transfer by demonstrating that the following: NA re-enactment of lifting the lex XL lift pad with the Maxi-move She demonstrated incorrectly leg straps to the lift bar e and the private sitter were of transfer. The NA # 1 was asked erview by Administrator why she ther staff member present during I stated, "That she normally er was in the room". Tormed her this was not e sitter was not a trained had received recent lift training	STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328 PAGENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) Page 28 Int transferred. The resident was insported back to the nursing 77/24/2017. Cillity's investigation report dated ed "Resident, # 125 was being urse Aide (NA) # 1 using the ill mechanical lift) with a XL pad. During the transfer NA# 1 became unhooked on 1 corner. ent sustained a hematoma to the I. The resident was assessed to t pad for transfers. The resident was assessed to t pad for transfers. The resident was assessed to the correct lift pad to be used. e of the process of reviewing the e giving care and transfers. The the lift transfer by demonstrating to the following: NA In re-enactment of lifting the e XL lift pad with the Maxi-move She demonstrated incorrectly e leg straps to the lift bar e and the private sitter were if transfer. The NA # 1 was asked erview by Administrator why she ther staff member present during I stated, "That she normally er was in the room". The resident was not e e sitter was not a trained had received recent lift training	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328 RY STATEMENT OF DEFICIENCIES DEPTICIENCY OF U.S. CIDENTIFYING INFORMATION) PAGE OF THE APPROPRIATE DEFICIENCY F 323 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) F 323 IT transferred. The resident was insported back to the nursing 772/4/2017. Cility's investigation report dated ed "Resident, # 125 was being urse Aide (NA) # 1 using the ull mechanical lift) with a XL pad. During the transfer NA# 1 became unhooked on 1 corner. ents usstained a hematoma to the L. The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for if the investigation headline the "The resident was assessed to the patient for it will be a provided by a formation of the patient for it will be a provided by a formation of the patient for its patient for it

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C 8/18/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 120 SOUTHWOOD DRIVE BOX 37 CLINTON, NC 28328	P CODE	0/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 323	During the interview 12:30 PM, she verificated size while transferring the reported on 7/24/20 transferring the resident # 125 reported she was awal located which indicate transferred using me people. NA #1 also repersons while transferred using me people. NA #1 also repersons while transferred using me people. NA #1 also repersons while transferred using me people. NA #1 also repersons while transferred using the interview at 1:00 PM, she reported to resident stated she transferred resident fell on the flushe assessed the represident had a bump (Nurse # 1) then not ordered the patient to room. Nurse # 1 furtility that the facility that the facility that the facility staff were resident closely for a her health. The doct was not a candidate	with NA #1 on 8/16/2017 at ed she did not use the correct ferring the resident and she is staff with her in the room e resident. NA #1 further 17 while in the process of lent from bed to wheelchair, of fell on the floor. NA # 1 also ware of where the Kardex was sted the resident was to be edium size pad and use of 2 deported she always used 2 derring a resident but she was one person for the transfer. with Nurse # 1 on 8/16/2017 orted that on 7/24/2017 she in the transfer with the resident alone and the coor. Nurse #1 also reported sident and she found the in by the side of the head. She effed the Physician who on be sent to the emergency ther added the resident came the same day with the	F	323		

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 _			C 08/18/2017
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		00.10.2011
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	On 8/17/2017 at 1:30 Resident #125 in her grimacing or behavior pain and no bump or NA # 3 were also obstaced resident from the whoused assigned pad securement the propertransferring the resididentified During the interview on 8/18/2017 at 10:5 investigated the circust25's fall on 7/24/20' #1 had not followed the for the use of 2 staff the resident and had The Administrator state the NA# 1 to have footransferring a resider added that NA # 1 was needed 2 persons ar while transferring a resider and had The Administrator state NA# 1 to have footransferring a resider added that NA # 1 was needed 2 persons ar while transferring a resident in serviced on Facility provided corresident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # and the matter with the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA #1 resident # 125 was susing the Maximove the transfer NA # 1 resident # 125 was susing the Maximove th	rosurgeon and an en set up by the facility staff. DPM, observation of wheel chair revealed nowes 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 er procedure while ent. No concerns were with the facility Administrator of am, she stated she had umstances of Resident # 17 and determined that NA the care plan interventions members while transferring not used the right pad size. The Administrator also as aware the resident of the use of correct pad size esident because she had 10/25/2016 and 5/29/2017.	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	1		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	•	00/10/2011
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	((EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
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, resident using the NA # 1 demonstrated the resident using the Maxi-move (total lift incorrectly criss- crobar reporting that ship present at time of transfer that she normally croom. Administrator why she member present dur. That she normally croom. Administrator acceptable as the side employee. NA # 1 has regarding having 2 smechanical lifts on 1 After review of the inidentified, the root cannot be reviewed incorrectly. NA# 1 failed to reviewed incorrectly. NA# 1 failed to have member present dur.	ER for evaluation. This was 2017. sessed to use a medium lift e 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 ulting in an improper transfer. In the lift transfer by 1 Administrator the following: In the lift pad with the device). She demonstrated the lift pad with the device). She demonstrated sing the leg straps to the lift in the end the private sitter were insfer. Bed at time of interview by the did not have another staff ing lift use and NA # 1 stated, loes, but the sitter was in the informed her this was not atter was not a trained and received recent lift training staff members with 0/25/16 and 5/29/17. Expressigation of the event, it is auses to be as follows: EW Kardex prior to transfer cet lift sling straps to the cradle.	F3	323		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENC REGULATORY OR Continued From page obtained to send to be completed on 07/24/ The resident was as pad for transfers. The pad to be used. NA a of reviewing the Kard transfers. The NA # as a result, the NA # pad for transfer, result, the NA # pad for transfer, result he resident using the NA # 1 demonstrated the resident using the Maxi-move (total lift incorrectly criss-crobar reporting that ship present at time of transfer transfers. The NA # 1 was ask Administrator why ship member present dur "That she normally croom". Administrator acceptable as the side mployee. NA # 1 has regarding having 2 side mechanical lifts on 1 After review of the initial dentified, the root cand the context of the context	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 obtained to send to ER for evaluation. This was completed on 07/24/2017. The resident was assessed to use a medium lift pad for transfers. The Kardex listed the correct lift pad to be used. NA # 1 was aware of the process of reviewing the Kardex before giving care and transfers. The NA # 1 failed to check the Kardex as a result, the NA # 1 failed to use the correct lift pad for transfer, resulting in an improper transfer. The NA # 1 demonstrated the lift transfer by demonstrating to the Administrator the following: NA # 1 demonstrated by re-enactment of lifting the resident using the XL lift pad with the Maxi-move (total lift device). She demonstrated incorrectly criss- crossing the leg straps to the lift bar reporting that she and the private sitter were present at time of transfer. The NA # 1 was asked at time of interview by Administrator why she did not have another staff member present during lift use and NA # 1 stated, "That she normally does, but the sitter was in the room". Administrator informed her this was not acceptable as the sitter was not a trained employee. NA # 1 had received recent lift training regarding having 2 staff members with mechanical lifts on 10/25/16 and 5/29/17. After review of the investigation of the event, it is identified, the root causes to be as follows: -NA# 1 failed to review Kardex prior to transfer -NA# 1 used incorrect lift sling -NA# 1 attached leg straps to the cradle	A BUILDIN 345218 B. WING ROVIDER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 botained to send to ER for evaluation. This was completed on 07/24/2017. The resident was assessed to use a medium lift pad for transfers. The Kardex listed the correct lift pad to be used. NA # 1 was aware of the process of reviewing the Kardex before giving care and transfers. The NA # 1 failed to use the correct lift pad for transfer, resulting in an improper transfer. The NA # 1 failed to use the correct lift pad for transfer, resulting in an improper transfer. The NA # 1 reenacted the lift transfer by demonstrated by re-enactment of lifting the resident using the XL lift pad with the Maxi-move (total lift device). She demonstrated incorrectly criss- crossing the leg straps to the lift bar reporting that she and the private sitter were present at time of transfer. The NA # 1 was asked at time of interview by Administrator why she did not have another staff member present during lift use and NA # 1 stated, "That she normally does, but the sitter was in the room". Administrator informed her this was not acceptable as the sitter was not a trained employee. NA # 1 had received recent lift training regarding having 2 staff members with mechanical lifts on 10/25/16 and 5/29/17. After review of the investigation of the event, it is identified, the root causes to be as follows: -NA# 1 failed to review Kardex prior to transfer -NA # 1 used incorrect lift sling -NA# 1 attached leg straps to the cradle incorrectly -NA# 1 failed to have second trained staff member present during lift transfer Corrective Action for Affected Residents	ROVIDER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY SPULL (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 Obtained to send to ER for evaluation. This was completed on 07/24/2017. The resident was assessed to use a medium lift pad for transfers. The Kardex listed the correct lift pad for transfers. The Kardex before giving care and transfers, resulting in an improper transfer. The NA # 1 failed to check the Kardex as a result, the NA # 1 failed to check the Kardex as a result, the NA # 1 failed to the doministrator the following: NA # 1 demonstrated by re-enactment of lifting the resident using the XL lift pad with the Maxi-move (total lift device). She demonstrated incorrectly crises—crossing the leg straps to the lift bar reporting that she and the private sitter were present at time of transfer. The NA # 1 was asked at time of interview by Administrator why she did not have another staff member present during lift use and NA # 1 stated, "That she normally does, but the sitter was not acceptable as the sitter was not a trained employee. NA # 1 had received recent lift training regarding having 2 staff members with mechanical lifts on 10/25/16 and 5/29/17. After review of the investigation of the event, it is identified, the root causes to be as follows: -NA# 1 failed to review Kardex prior to transfer -NA # 1 used incorrect lift sting enhanced incorrectly -NA# 1 failed to have second trained staff member present during lift transfer Corrective Action for Affected Residents	A BUILDING 345218 A SUMPLIER 345218 BUILDING BUILDI

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING	R WING		C	
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 volumed to Development coordin will be included in new and CNAs. Return demonstration the staff showing correct with the lifts will be performed to the staff showing correct with the lifts will be performed to the staff showing correct with the lifts will be performed to the staff showing correct transfers. Education not continuate the staff showing correct transfers in the staff showing correct trans	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			

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			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		50/10/2017
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	of checking resident transfers in order to transfer technique is initiated on 7/24/17 Coordinator. This ir integrated into the sand in the required for all employees ar Quality Assurance Fichange has been sucompletion date on HOW THE FACILIT CHANGES IMPLENT The Staff nurses or a Safe Transfer/Lift weekly x 4 and then correct lift pad is be the correct resident. The Quantities of the Direct Staff Development of Committee and correct Staff Development of Dietary Manager, Wassessments Nurse Management and management and management and management and management in the correct lift. The safe transfer with us the correct lift pad is correct resident. 2 stransfer of Resident	n serviced on the importance to Kardex prior to initiating any ensure that the safest soused. This education was by the Staff Development information has been tandard orientation training in-service refresher courses and will be reviewed by the Process to verify that the instained. The education 8/7/2017. Y PLANS TO MONITOR MENTED Ilicensed nurse will complete Quality Assurance (QA) Audit monthly x 2 making sure the ing used with correct lift on The Director of Nursing will he weekly Quality of Life- QA ective action initiated as itality of Life committee ctor of Nursing, Administrator, Coordinator, Unit Managers, Yound Nurse, Minimal Data e and Health Information neets weekly. Ition on 8/17/2017 at 3:30 PM, rrection was reviewed ews with staff related to the taff were reeducated on a se of a lift and making sure is used with correct lift on the taff were observed during a	F 32	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING						(X3) DATE SURVEY COMPLETED	
			7 11 20122	_		(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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323 F 371 SS=D	with correct lift. Revie appropriate use of lift on each unit observed required a use of med transferred by 2 nurse no concerns were ide. Quality Assurance confacility met daily to dis lift audit beginning 7/2 Review of the monitor facility had completed 8/7/2017. 483.60(i)(1)-(3) FOOD STORE/PREPARE/SI (i)(1) - Procure food from considered satisfactor authorities. (i) This may include for from local producers, and local laws or regulation of the food of t	and (medium size) was used a sew of the facility's Audit of revealed a nurse supervisor of 5 random residents who chanical lift while being as' aides. The audit revealed ntified for the last 4 weeks. Immittee report revealed the scuss the appropriate use of 25/2017 until 8/11/2017. Fing tools revealed that the 1 the 100% in-service on 10 PROCURE, ERVE - SANITARY In the sources approved or the sources applicable State allations. In the sources applicable State allations are not prohibit or prevent roduce grown in facility ompliance with applicable		3323			9/15/17

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIEICATION NI IMBED:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345218	B. WING				C	
NAME OF D	DOVIDED OD CUDDUED	343210	B. WING	· ·	TREET ADDRESS CITY STATE ZID CODE	08	/18/2017	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MARY GR	AN NURSING CENTER				20 SOUTHWOOD DRIVE BOX 379			
				С	LINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 371	Continued From page	ge 35	F:	371				
		sidents by family and other						
		ife and sanitary storage,						
	handling, and consu	· · ·						
		IT is not met as evidenced						
	1 -	ion, record review and			The statements made on this Plan of			
		terviews, the facility failed to			Correction are not an admission to and	ob b		
	wash and sanitize residents' water pitchers and				not constitute an agreement with the			
	plastic straws for 1 of 1 resident's (Resident #76)				alleged deficiencies.			
	water pitcher observ				To remain in compliance with all Feder	al		
					and State Regulations the facility has			
	Findings included:				taken or will take the actions set forth i	n		
					this Plan of Correction. The Plan of			
	A review of Resider	t #76's quarterly Minimum			Correction constitutes the facility's			
	Data Set (MDS), da	ted 05/14/17, revealed			allegation of compliance such that all			
	Resident #76 was c	ognitively intact and required			alleged deficiencies cited have been o	r		
	extensive assistanc	e to total dependence on staff			will be corrected by the date or dates			
	for her Activity of Da	aily Living.			indicated.			
	_	on and interview of Resident			F 274			
		2:10 p.m., Resident #76 was chair in her room. Resident			F 371			
		was observed to be placed			Corrective Action for Resident Affected	ı		
	-	her over-bed table. The straw			Resident #76 received a new water	1		
		gray-black in color. Upon			pitcher with a new straw on 8/15/17 by	,		
		the straw, an unknown			nursing assistant J.K.			
	-	ng black flecks lined the			Training addition to the			
		When asked how often her			Corrective Action for Resident Potentia	allv		
		raw were washed, Resident			Affected	,		
		not know. The resident stated						
		knowing she had been			On 8/15/17, all water pitchers and stra	ws		
	drinking out of a dirt	•			were cleaned and/or replaced by the			
		-			nursing assistant staff. The facility is t	0		
	During an interview	with Nursing Assistant (NA)			ensure that all resident water pitchers			
		:15 p.m., NA #1 stated the			washed and sanitized on a regular bas			
		hers and straws never go to			per facility schedule.			
		shed and sanitized. NA #1						
	stated she thought t	he 3rd shift NAs took the			Systemic Changes			
	_	ment Room and rinsed them			An in-service to review educate and			

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 CODE			
MARY GRAN NURSING CENTER				20 SOUTHWOOD DRIVE BOX 379		
				LINTON, NC 28328		
PREFIX (EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
During an interview w (DM) on 08/15/17 at 2 there was a schedule the residents' water p provided a copy of the in the Dietary Departs During an interview w 2:26 p.m., Nurse #6 s pitchers and straws d washed and sanitized would get a new water resident they became During an interview w 08/18/17 at 3:32 p.m. had not been aware t and straws were not be washed and saniti stated it is his expect for the residents' wate followed and the wate	REGULATORY OR LSC IDENTIFYING INFORMATION)		371	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 of the conducted for all dietary and nursing staff by LTC Staff Development Coordinator by September 15th 2017. 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 monithis issue using the Dietary QA Audit To This will be done weekly for four weeks including weekends, and then monthly two months. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriated This regularly scheduled weekly meeting is attended by The Administrator, Director of Nursing, Dietary Services Director, Umanagers, Business Office Manager, Activity Director, and Social Worker. Compliance Date: September 15, 2017	er will g All tor pool. for e te. ng ttor Jnit	