STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification/complaint investigation survey was conducted on 10/14/19 through 10/17/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# DKEV11.	E 000		
F 000	INITIAL COMMENTS A recertification/complaint investigation survey was conducted. 3 of 13 complaint allegations were substantiated with deficiency, and 1 of 13 complaint allegations was substantiated without deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		11/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/08/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain living areas in good repair on 3 of 6 halls observed for environment. Findings included: During an observation of the 200, 300 and 400 hall on 10/14/19 the following environmental findings were noted: 1. Resident room #212: The resident ' s toilet was not attached to the floor and was easily rocked. 2. Resident room # ' s 303, 304, 305, 306, 308 and 309: Were noted to have approximately 5 feet of missing trim from above the residents ' closets. The lack of trim allowed for exposed wood, sheetrock and or the closet track with obvious nail holes to be visible.	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F584 1. For the resident's affected, the following corrective action was taken. 1. Room # 212, toilet was repaired by the Maintenance Director on 10/17/19. 2. Rooms # 303,304, 305, 306, 308, 309, trim over closet doors repaired by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 3. Resident room #305: The closet door had a large hole about 3 inches in size in the lower right side of the door. The corner of the closet was noted to have significant paint peeling and damage to the wall base molding. The wall behind bed #2 was noted to have various size scrapes and gouges. 4. Resident room #305: The bathroom wall was noted to have a large hole measuring about 6 - 8 inches in the sheetrock. 5. Resident room # ' s 313B, 316A: Noted to have extensively damaged flooring exposing the subfloor under the wheels of Residents ' beds. 6. Resident room #313: Noted to have 2 large holes measuring about 4 inches wide in the sheetrock where the safety bar had been located. The safety bar was present in a lowered location, but the holes had not been repaired. 7. Resident room # 401: Noted to have large areas with significant scrapes and gouges - one located behind bed #2 and the second behind the chair along the wall. An interview was conducted with the Maintenance Director (MD) on 10/17/19 at 9:50 AM. The MD was shown all of the concerns listed above. The MD reported he was aware of the missing trim over the closets, but he did not realize there were so many missing. Additionally, he stated, he was not aware of the hole in room #305 ' s closet, but he was aware of the hole in the bathroom of room #305. The MD stated he was not aware of the holes in room #313 ' s bathroom where the safety bar had been or the scraped/gauged walls behind	F 584	Maintenance Director on 10/23/19. 3. Room # 305, closet and wall repaired by the Maintenance Director on 10/22/19. 4. Room # 305, hole in bathroom wall repaired by the Maintenance Director on 10/24/19. 5 Room # 313 B, 316 A, floors were patched by Maintenance Director on 11/8/19. The Maintenance Director contacted a contractor for floor replacement on 10/21/19, and floors scheduled for replacement on 11/25/19 (the earliest available). 6. Room # 313, holes in wall repaired by the Maintenance Director on 10/22/19. 7. Room # 401, wall was repaired by the Maintenance Director on 11/07/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents' rooms have the potential to be affected by the alleged deficient practice. Beginning on 11/4/19, the Maintenance Director audited all resident rooms in the facility for trim over closet doors, closet doors, holes in walls and floors. Any areas identified requiring correction will be repaired by 11/14/19. 3. Systemic changes In-service education was provided to the Maintenance Director by the Administrator: • On a weekly basis, the Maintenance Director will make focused facility rounds to identify areas of repair needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 the beds of room #305 and #401. The MD stated he was aware of the damaged flooring where the subflooring was exposed under the wheels of the beds and stated the facility was working on getting the floors repaired. The MD was shown room 212 where the toilet was not attached to the floor and he stated he was not aware of the unattached toilet and made the observation that the toilet was not secured to the floor and it rocked easily. The MD reported the staff made him aware of any repairs that needed to be done by submitting a work order slip. The MD stated the staff would fill the slip out and leave it in the designated box on the wall at each nurse ' s station. The MD stated he would pick up the slips daily and check the box throughout the day for any new slips. The MD reported most of the time, the staff would call him and report that something needed repair and he would take care of it right then. The MD reported he did not keep a log of the repairs he had completed. An interview was conducted with the Administrator on 10/17/19 at 2:00 PM. The Administrator stated his expectations of the maintenance staff was to be aware of the surroundings in the facility and to recognize any concerns that may need attending to and be repaired timely.	F 584	Identified maintenance issues will be discussed with the facility Administrator to determine an appropriate timeline for completion. This information will be integrated into the standard orientation training for all Maintenance Personnel and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor timeliness of maintenance repair task. Audit will be completed weekly x 2 weeks them monthly x 3 months. Audit will be completed by reviewing submitted work request tickets and auditing the area of concern for completion of repair work. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		11/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code medications on two Minimum Data Set (MDS) assessments for 2 of 26 sampled residents (Resident #69 and Resident #117) and failed to accurately code behaviors on one MDS assessment for 1 of 26 sampled residents (Resident #117) whose MDS assessments were reviewed. Findings included: 1. Resident #69 was admitted to the facility on 10/07/15 and had diagnoses of diabetes, chronic pain, and heart disease. a. The quarterly MDS dated 09/05/19 specified Resident #69 received seven insulin injections during the seven day look back period. Further review of this MDS revealed this section was completed by the MDS Nurse. Resident #69's Medication Administration Record (MAR) dated 8/30/19-09/05/19, which reflected the seven day look back period, revealed that Victoza 0.6 milligrams (mg) (a non-insulin injectable medication) was administered all seven days for diabetes. Resident #69 received zero insulin injections. In a telephone interview on 10/17/19 at 1:11 PM the MDS Nurse stated that when she filled out the medication section on the MDS she reviewed the resident's MAR to see what medications they received during the look back period. When asked about the insulin injections, the MDS Nurse	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 Accuracy of Assessments Corrective Action: Resident # 69 Resident Minimum Data Set (MDS) assessment (Quarterly Assessment) with Assessment /Reference Date (ARD) [9/5/2019] was modified with a Corrective Attestation Date of 11/5/2019. The assessment was submitted to the state QIES system on 11/07/2019 and was accepted on 11/07/2019 in Batch #1353. Resident # 117 Resident Minimum Data Set (MDS) assessment (Admission Assessment) with Assessment /Reference Date (ARD) [7/19/2019] was modified with a Corrective Attestation Date of 11/5/2019. The assessment was submitted to the state QIES system on 11/07/2019 and was accepted on 11/07/2019 in Batch #1353. Identification of other residents who may	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 reviewed Resident #69's MAR and indicated that she had seen the Victoza and had mistakenly documented it as insulin. The MDS Nurse expressed that the medication section of the MDS needed to be correct because it monitored high risk medications and served as a snapshot of what the resident received during the look back period. In an interview on 10/17/19 at 2:55 PM the Director of Nursing (DON) stated that the MDS should be coded completely and accurately to reflect the resident's status. b. The quarterly MDS dated 09/05/19 specified Resident #69 received zero anticoagulant medications during the seven day look back period. Further review of this MDS revealed this section was completed by the MDS Nurse. Resident #69's MAR dated 8/30/19-09/05/19, which reflected the seven day look back period, revealed that Xarelto, (an anticoagulant) 20 mg was administered all seven days of the look back period for anticoagulation. In a telephone interview on 10/17/19 at 1:11 PM the MDS Nurse stated that when she filled out the medication section on the MDS she reviewed the resident's MAR to see what medications they received during the look back period. When asked about anticoagulants that Resident #69 received the MDS Nurse reviewed Resident #69's MAR and indicated that Resident #69 received Xarelto for all days of the look back period. The MDS Nurse indicated that although Xarelto was an anticoagulant she did not need to code it on the MDS because the medication did not need laboratory tests for monitoring. The MDS Nurse	F 641	be involved with this practice: All current residents on anticoagulants, Victoza and who have noted moods or behaviors have the potential to be affected by the alleged practice. On 11/1/2019 through 11/7/2019 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who use anticoagulants have Section N0410E: Anticoagulant coded accurately. On 11/1/2019 through 11/7/2019 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who use Victoza have Section N0350: Insulin coded accurately. On 11/1/2019 through 11/7/2019 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who have noted moods or behaviors have Section E: Behaviors coded accurately. This was completed on 11/7/2019. Any MDS assessments identified with inaccurate coding were modified and corrected by the facility Minimum Data Set Nurse on 11/07/19. Audit Results: 28 MDS assessments of 48 that were reviewed were identified as having coding inaccuracies. These MDS assessments were modified and corrected by the Minimum Data Set Nurse on 11/07/19 and were re-submitted to and accepted by the state database in (13 of the corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6 expressed that the medication section of the MDS needed to be correct because it monitored high risk medications and served as a snapshot of what the resident received during the look back period. In an interview on 10/17/19 at 2:11 PM the Regional Nurse Consultant stated that the MDS Nurse had only held that position for about one year. She expressed that there may have been some miscommunication in how to code anticoagulants on the MDS and the need for laboratory testing. In an interview on 10/17/19 at 2:55 PM the DON stated that the MDS should be coded completely and accurately to reflect the resident's status. 2. Resident #117 was admitted to the facility on 07/16/19 with diagnoses that included long term use of anticoagulants, hypertensive heart disease with heart failure and nonrheumatic aortic valve stenosis. She was discharged to the hospital on 07/18/19. a. Physician orders for July 2019 included the anticoagulant Xarelto 20mg. The Medication Administration Record for July 2019 documented the resident had received the medication during her stay at the facility on 07/17/19 and 07/18/19. The Minimum Data Set (MDS) admission assessment dated 07/19/19 documented in Section N0410 (E) that Resident #117 had received zero anticoagulants during her stay at the facility. In an interview conducted with the MDS Nurse on	F 641	assessments) Batch #1353 on 11/07/19 and (15 of the corrected assessments) in Batch #1354 which was accepted on 11/08/19. Systemic Changes: On 11/5/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident's status. Section N0350: Insulin. Insulin is a medication used to treat diabetes. Victoza is not insulin. Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received. N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. The items in section E: Behavior identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7	F 641		

10/17/19 at 1:10 PM she stated she had not coded the MDS assessment correctly. She indicated that she only coded anticoagulant medication if the medication required routine laboratory testing. She stated she was not aware that anticoagulants given to residents that did not require routine laboratory testing were also to be recorded.

In an interview conducted with the Corporate Nurse Consultant on 10/17/19 at 2:11 PM she stated the MDS Nurse had only been completing assessments for one year. She felt the nurse may have received some miscommunication when learning her role. She stated she would pass information up the corporate ladder that all anticoagulants were to be coded on the MDS assessments, not just those requiring laboratory testing.

b. The care plan for Resident #117 included the problem, "I have potential to demonstrate physical behaviors related to agitation and confusion." The goal was for the resident not to harm herself or others. Interventions included for staff to intervene before the agitation escalated, to guide the resident away from sources of distress, to engage the resident in calm conversation, and if the response was aggressive to walk away and return later.

Review of the MDS assessment dated 07/19/19 for Resident #117 documented she had no moods or behaviors.

A skilled nursing review dated 07/18/19 at 1:18 AM documented Resident #117 was very agitated and spent most of the night at the nurses station attempting to get out of her chair. Several

inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident himself or herself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. This section focuses on the resident's actions, not the intent of his or her behavior. Because of their interactions with residents, staff may have become used to the behavior and may underreport or minimize the resident's behavior by presuming intent (e.g., "Mr. A. doesn't really mean to hurt anyone. He's just frightened."). Resident intent should not be taken into account when coding for items in this section. Section E0200:Review the medical record for the 7-day look-back period. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. Observe the resident in a variety of situations during the 7-day look-back period. Code 0, behavior not exhibited: if the behavioral symptoms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8	F 641		

attempts had been made to reorient the resident during the shift to prevent her from falling.

A health status note written on 07/18/19 at 1:13 PM documented Resident #117 had been seen by the Nurse Practitioner due to combativeness, removing her oxygen supply and yelling at staff.

In an interview conducted with the facility Administrator 10/16/19 at 9:35 AM he stated he had viewed video of the resident sitting in a geri chair at the nurses station the last night she was at the facility. The family had stayed with her the first night. He relayed he had seen on the video the resident wiggling in the geri chair, kicking her legs, and scooting to the side of the chair with her body. He commented Resident #117 had a really tough time while at the facility because she had dementia and he felt the move from the hospital to the nursing home had caused her confusion and resistance to care to escalate. He said the family had told him the resident had been having hallucinations and had been referring to a man outside her window that was not there.

In an interview conducted with Nurse Aide #1 on 10/16/19 at 10:25 AM she stated she had taken care of Resident #117 and remembered her. She said the resident had been confused, combative and resistant to care while a resident. She commented the family stayed at the facility with her most of the time.

In an interview conducted with Nurse Aide #2 on 10/16/19 at 11:45 AM she stated she had cared for Resident #117 and remembered her. She said the resident was confused and combative during care.

were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days. Code 2, behavior of this type occurred 4-6 days, but less than daily: if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days. Code 3, behavior of this type occurred daily: if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days
This in service was completed by 11/7/2019 for the Minimum Data Set Nurse and Social Services Director(s) by the MDS Nurse Consultant. This information has been integrated into the standard orientation training for new MDS Coordinators and Social Services Directors.

Monitoring:
To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission , Annual or Quarterly Assessment to ensure that section N0350 Insulin, Section N0410E Anticoagulant and Section E: Behavior are coded accurately. This will be done on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 In an interview conducted with Nurse #1 on 10/16/19 at 12:00 Noon she stated she had cared for Resident #117 and remembered her. She said the resident had been very agitated so she had asked the Nurse Practitioner to see her. She said the resident kept throwing her blanket off so she had staff put the resident back to bed. She said the family was present with the resident. In an interview with Nurse Aide #3 on 10/16/19 at 2:15 PM she stated she had taken care of Resident #117 the night she was admitted to the facility. She said the resident was confused and did not recognize her family members. She commented the resident was agitated until she recognized her family then she was able to calm down and slept the remainder of the night. Interview with MDS nurse on 10/17/19 at 1:13 PM she stated when the CNA's marked behaviors on their documentation that it auto populated the behavior section on the MDS. She said if the documentation was not correct it could be changed when she completed the assessment. The normal process was to gather information from the progress notes, physician notes, therapy notes, Medication Administration Record, and test results. She said she looked at the documentation and saw that the resident had behaviors but neglected to indicate the behaviors on the MDS assessment because the resident came and went so fast. Interview with the DON on 10/17/19 at 1:40 PM she stated the MDS assessment should have been coded for and reflected that behaviors were present for Resident #117. She indicated she knew the MDS nurse had been aware the resident had behaviors during her stay at the	F 641	weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10 facility. She concluded the MDS nurse had only been doing MDS assessments for one year and was relatively new at the position.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Nurse Practitioner (NP) interview, Consultant Pharmacist interview, staff interview, and record review the facility failed to administer medications as ordered by the physician for 2 of 26 sampled residents (Resident #2 and Resident #30) whose physician orders were reviewed. Findings included: 1. Record review revealed that Resident #2 was admitted to the facility on 03/29/19, and was hospitalized from 04/01/19 until 04/04/19 due to sepsis secondary to pneumonia and an urinary tract infection. The resident's documented diagnoses included atrial fibrillation, gout, chronic obstructive pulmonary disease, and hypertension. The resident was readmitted to the facility on 04/04/19 with an order for Potassium Citrate 10 milliequivalents (MEq) twice daily (BID). Review of Resident #2's April 2019, May 2019, and June 2019 medication administration records (MARs) revealed the resident missed 19 doses of the Potassium Citrate which the physician ordered. The resident did not receive his	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 1. For the resident's affected, the following corrective action was taken. For resident #2, on 07/30/2019 the resident's medication was switched to Potassium Chloride by the Nurse Practitioner. Medication For resident #30, on 11/23/2019 the Nurse Practitioner was notified of the Nystatin cream error in scheduling. New order was received to discontinue the Nystatin Cream. 2. Corrective action for residents with the	11/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 04/27/19 5:00 PM dose and his 04/28/19 9:00 AM and 04/28/19 5:00 PM doses with the MAR documenting the medication was not available. The resident did not receive his 05/24/19 5:00 PM dose, his 9:00 AM and 5:00 PM doses on both 05/25/19 and 05/26/19, and his 5:00 PM dose on 05/27/19. The resident did not receive his 9:00 AM and 5:00 PM doses on 06/19/19, 06/20/19, 06/22/19, and 06/24/19. The resident also missed his 5:00 PM dose on 06/23/19 and his 9:00 AM dose on 06/25/19. In May 2019 and June 2019 Resident #2's MARs either documented the Potassium Citrate was not available, or it was not available with the pharmacy being aware of the problem. The resident's 04/11/19 5-day Prospective Payment System (PPS) assessment documented his cognition was intact, he exhibited no behaviors including resistance to care, and he required extensive assistance from staff with all of his activities of daily living (ADLs). A 06/19/19 Health Status Note documented Resident #2's family member had concerns about the resident with "decreased endurance with transfers (and) ability to walk lessened with unsteady gait." A 06/25/19 Nurse Practitioner Note documented she was seeking clarification about the form of potassium supplementation Resident #2 was receiving with the resident having missed ten doses of Potassium Citrate in the past week. She also documented the resident was experiencing pain in his upper arms. The resident's 07/01/19 quarterly minimum data set (MDS) assessment documented his cognition	F 658	potential to be affected by the alleged deficient practice. The Director of Nursing audited for all current residents the November Medication Administration Records (MAR) for any documentation indicating that any medication was not given due to being unavailable in the facility. This was completed on 11/08/2019. The Director of Nursing audited for all current residents the Unscheduled orders report in PCC on 11/08/2019 to identify any orders entered without a schedule to fire to the MAR or Treatment Administration Record (TAR). This was completed on 11/08/2019. 3. Systemic changes On 10/31/2019, the Staff Development Coordinator provided an in-service education to all full time, part time, and as needed nurses, Medication Aides and Medication Tech's. Topics included: • Documenting medication administration on the electronic medication administration record • Medications that are available in the emergency medication box • How to obtain medications when they are unavailable in the facility or emergency box • Obtaining hard scripts for narcotic medications and how to ensure the narcotics are received timely • How to obtain medications from the back up pharmacy • How to confirm Prescriber entered orders in PCC Education will be completed by 11/14/2019. Any staff that has not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 was intact, he exhibited no behaviors including resistance to care, and he required extensive assistance from staff with all of his ADLs. During a telephone interview with the facility's Consultant Pharmacist on 10/16/19 at 1:45 PM she stated Resident #2 was receiving Potassium Citrate in conjunction with his diuretic (Lasix). She reported the resident could be getting Potassium Citrate rather than Potassium Chloride because he was taking citrate at home or the doctor wanted him on citrate because he was not eating that well. She commented Potassium Citrate was relatively easy to obtain, and there was no reason that the resident should have missed 19 doses because it should have at least been available through the facility's back-up pharmacy. According to the Consultant Pharmacist, the facilty's pharmacy should have provided all of Resident #2's medications until the resident's Medicare Part A coverage ended. She stated, according to pharmacy records, the facilty pharmacy sent 42 Potassium Citrate tablets (lasting 21 days) for Resident #2 on 04/05/19, 04/19/19, and 05/27/19. She reported that missing 19 doses of potassium could have caused the resident to experience muscle cramps. During an interview with Medication Aide #1 on 10/16/19 at 4:04 PM she stated there was some confusion about Resident #2's medications because a family member wanted a local pharmacy to supply some of them due to reduced cost. However, she reported she thought this local pharmacy may have sent the wrong form of potassium, causing a delay in the resident getting the Potassium Citrate which had been ordered. She commented she was not sure whether the	F 658	received the in-service training by this date will not be allowed to work until it is completed. This information has been integrated into the standard orientation training for facility staff as well as Agency staff and in the required in-service refresher courses for all nurses, medication aides, and medication tech's and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor medication availability and unscheduled orders using the Order audit QA. The Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3 months. Monitoring will include auditing 100% of all medication administration documentation on the MAR for missed medications due to unavailable or due to orders not scheduled. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Completion date: 11/14/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 13	F 658		

facility attempted to get the Potassium Citrate from it's back-up pharmacy when it realized there was going to be a delay.

During an interview with Nurse Practitioner (NP) #1 on 10/17/19 at 9:25 AM she stated Resident #2 should not have missed 19 doses of a medication since the facility pharmacy delivered medications daily, and the same day as ordered if the order was received by the pharmacy before 3:00 PM - 4:00 PM. She also reported the facility should have utilized its back-up pharmacy to make sure the resident received his Potassium Citrate.

During an interview with NP #2 on 10/17/19 at 10:56 AM she stated Resident #2 was receiving the Potassium Citrate in conjunction with a diuretic but to also help with the management of his gout. She reported the facility should have made her aware of difficulty obtaining the Potassium Citrate before 06/25/19 so she could have gotten the problem corrected. She commented Resident #2's family member wanted medications obtained from a local pharmacy, and she thought the local pharmacy had problems finding the citrate form. She stated missing 19 doses of Potassium Citrate was not acceptable, and could have caused the resident's gout to worsen.

During an interview with the facility's Director of Nursing (DON) on 10/17/19 at 1:05 PM she stated the bottom line was that Resident #2 should not have missed 19 doses of Potassium Citrate which could have affected his serum potassium level. She commented if there was some confusion about whether the resident should have been receiving Potassium Citrate or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 14 Potassium Chloride then a nurse should have requested clarification from a physician before the resident continued to miss doses of the potassium. Record review revealed Resident #2's potassium level remained in the lower normal range and his uric acid levels (used to identify acute episodes of gout) remained stable during the April 2019 - June 2019 time period. 2. Resident #30 was admitted to the facility on 12/6/05, with diagnoses to include; Anoxic Brain injury, Hemiplegia, Aphasia, Gastrostomy, Oxygen dependent, Epilepsy, and Bilateral Hand Contractures. Resident #30 ' s care plan dated 11/20/18 documented interventions in place for bilateral hand contractures to include the use of palm guards to both hands, and to administer medications as ordered. The Minimum Data Set (MDS) dated 8/3/19 documented Resident #30 was severely cognitively impaired. She exhibited no rejection of care. She had bilateral upper and lower extremity impairment, and required total dependent care with bed mobility, transfers, and activities of daily living (ADL ' s). A review of the physician orders for Resident #30 on 10/15/19 revealed an active order dated 11/2/18 to apply Nystatin powder (indicated to treat fungal infections) to both hands twice daily.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 15	F 658		

The Treatment Administration Record (TAR) for Resident #30 reviewed on 10/15/19 for the period of 11/2/18 through 10/15/19 revealed no record of the order written on 11/2/18 for Nystatin powder to both hands twice daily.

The Medication Administration Record (MAR) for Resident #30 reviewed on 10/15/19 for the period of 11/2/18 through 10/15/19 revealed no record of the 11/2/18 order for Nystatin powder to both hands twice daily.

In an interview on 10/15/19 at 4:38 PM with Nurse #4 she stated the order for Nystatin powder was put in the electronic medical record on 11/2/18 but an administration time was not scheduled and therefore the order did not flow over to the TAR or the MAR. Nurse #4 acknowledged that Resident #30 did not receive the physician ordered Nystatin powder to both hands twice daily for the period of 11/2/18 through 10/15/19.

In an observation on 10/15/19 at 3:25 PM Resident #30 had bilateral palm guards in place, there was no skin breakdown on her palms.

In an interview with the facility's Consultant Pharmacist on 10/16/19 at 2:06 PM, she stated Nystatin powder 60 grams was filled on 11/23/18 and was never refilled.

On 10/15/19 at 4:00 PM Nurse #8 checked the medication cart to review Resident #30 ' s medications and there was no Nystatin powder on the med cart.

In an interview with the Director of Nursing on 10/16/19 at 3:32 PM she acknowledged that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 16 physician order for Nystatin powder was not administered to Resident #30. She stated the nurse who confirmed the order in the electronic medical record was expected to assign a scheduled administration time before confirming the medication order so that it would flow over to the TAR and the MAR and the medication should have been administered according to the physician order.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide activity of daily living (ADL) personal hygiene care by not cutting, trimming and cleaning 1 of 3 resident ' s (Resident #87) fingernails as ordered by the physician. Findings included: Resident #87 was admitted to the facility on 11/15/12. Diagnoses included, in part, dementia with behaviors. The Minimum Data Set quarterly assessment dated 09/20/19 revealed the resident was severely cognitively impaired and required total dependence with bed mobility, transfers and toileting with two physical staff assistance and total dependence with one staff physical assistance with dressing and personal hygiene. Resident #87 had impairments on both sides to upper and lower extremities and used a wheelchair.	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. For the resident's affected, the following corrective action was taken. On 10/16/2019, the hall nurse trimmed resident #87 fingernails. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	11/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 17 A review of the care plan revealed a plan of care for ADL self-care performance deficit related to limited mobility with hypertonicity of right hand and contracture of bilateral upper extremities with right hand noted to be fisted. Interventions included to assist with grooming and personal hygiene, inspect skin to right hand every shift and report any problems to nurse, perform gentle range of motion during bathing and daily care. A record review of the physician orders revealed there was an order written on 07/23/19 to perform nail care, cut, and trim and clean resident ' s nails every 14 days on the evening shift. A review of the October Medication Administration Record (MAR) revealed the order was in place and on 10/15/19, the task was signed off by a nurse (Nurse #3) as evidenced by a check mark and the nurse ' s initials. A review of the Kardex (care guide) revealed Resident #87 ' s fingernails should be clean, cut or trimmed and the palm guard should be applied to right hand daily. An observation of Resident #87 on 10/16/19 at 9:45 AM revealed the resident was noted to have contracted bilateral hands with long, jagged and dirty fingernails. The nails to the right index finger and thumb were noted to be long, jagged and dirty. The three other fingernails were contracted and folded into the right hand and noted to be long. There was a foul odor detected when Nurse #2 was able to slightly open the resident ' s right hand. The fingernails to the left hand were noted to be long, jagged and dirty. The left hand was noted to be contracted but the resident was able to open the hand with help and then folded	F 677	On 11/07/2019 he nurse managers audited all current residents to establish which residents were in need of nail care. Once it was determined who needed nail care, the assigned nurses and nurse aides completed the nail care. This was completed by 11/08/2019. 3. Systemic changes On 10/16/2019, the Staff Development Coordinator began an in-service education to all full time, part time, and as needed nurses, CNA's, and Medication Tech's. Topics included: • Daily nail care policy NUP-550 • How to document that nail care was given Any staff that has not received this in-service by 11/14/2019 will not be allowed to work until it is completed. This information has been integrated into the standard orientation training for facility staff as well as Agency staff and in the required in-service refresher courses for all nurses, medication aides, and medication tech's and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the nail care completion. The Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3 months. Monitoring will include auditing 10 residents' documentation and observing their nails for completion of nail care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 18 her hand back up again. An interview with Nurse #2 was conducted on 10/16/19 at 10:30 AM. Nurse #2 observed resident #87 ' s hands and she confirmed the fingernails to the right and left hands were very long, dirty and jagged and stated they needed to be cut and she would take care of it. Nurse #2 assessed the right hand and confirmed there was a foul odor noted coming from the right hand as she slightly opened the right hand. An interview was conducted with nursing assistant (NA) #7 on 10/16/19 at 10:30 AM. NA #7 confirmed the residents ' fingernails to the right and left hands were very long, dirty and jagged and stated she should have cleaned them while doing her ADL care. NA #7 stated there was an odor detected in Resident #87 ' s right hand and the hand should be cleansed during care to prevent odors. NA #7 reviewed the Kardex which revealed fingernails should be clean, cut, or trimmed and palm guard should be applied to right hand daily during ADL care. An Interview was conducted with Nurse #2 on 10/16/19 at 2:30 PM. Nurse #2 stated there was an order to cut, trim and clean resident ' s nails every 14 days on the October MAR. Nurse #2 stated if the MAR had a check mark with nurse ' s initials it meant that the task was completed as ordered. Nurse #2 stated the task dated 10/15/19 to trim, cut and clean the resident ' s fingernails was signed off by Nurse #3, but, Nurse #2 stated it could not have been carried out due to the observation that had occurred this morning on 10/16/19 which revealed the resident ' s fingernails on the left and right hand were noted to be long, jagged and dirty with foul odor	F 677	Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Completion date: 11/14/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 19 detected on the right hand. An interview was attempted via phone with Nurse #3 (agency nurse) who worked on 10/15/19 and signed the MAR on 10/15/19 during the evening shift indicating the task had been completed. Phone messages were left via voice mail for a returned call on 10/16/19 and 10/17/19. An interview was conducted with the Director of Nursing (DON) on 10/17/19 at 4:00 PM. The DON stated her expectations of the nursing staff was to perform ADL care as they were trained which included cutting, trimming and cleaning resident ' s fingernails to prevent skin breakdown and maintain personal hygiene.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		11/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 20 by: Based on observations, record review and staff interviews, the facility failed to apply a palm guard as recommended by the therapy department to prevent further contractures to 1 of 3 residents (Resident #87) observed for range of motion. Findings included: Resident #87 was admitted to the facility on 11/15/12. Diagnoses included, in part, dementia with behaviors. The Minimum Data Set quarterly assessment dated 09/20/19 revealed the resident was severely cognitively impaired and required total dependence with bed mobility, transfers and toileting with two physical staff assistance and total dependence with one staff physical assistance with dressing and personal hygiene. Resident #87 had impairments on both sides to upper and lower extremities and used a wheelchair. A review of the care plan revealed a plan of care for activity of daily living (ADL) self-care performance deficit related to limited mobility with hypertonicity of right hand and contracture of bilateral upper extremities with right hand noted to be fisted. Interventions included to assist with grooming and personal hygiene, inspect skin to right hand every shift and report any problems to the nurse, perform gentle range of motion during bathing and daily care, and to place palm guard/rolled wash cloth to right hand. An observation of Resident #87 on 10/14/19 at 1:00 PM revealed Resident #87 had bilateral contracted hands. There was no palm guard or	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F688 1. For the resident's affected, the following corrective action was taken. On 10/16/2019, the Nurse Consultant obtained a palm guard and applied it to resident #87 right hand. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 11/07/2019, the nurse managers audited all current residents to establish which residents were in need of devices such as a splint, palm guard, or hand roll. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint, palm guard, or hand roll, the nurse managers and MDS nurse ensured the device was in place, had an MD order, CNA task, and care plan. This process will be completed by 11/14/2019. 3. Systemic changes On 10/16/2019, the Staff Development Coordinator began an in-service education to all full time, part time, and as needed nurses, CNA's, and Medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 21 rolled wash cloth to her right hand. An observation of Resident #87 on 10/15/19 at 9:30 AM revealed Resident #87 was lying in bed and noted to have bilateral contracted hands. There were no palm guard or rolled wash cloth to her right hand. An observation of Resident #87 on 10/15/19 at 12:45 PM revealed Resident #87 was sitting upright in her Geri chair. There was no palm guard or rolled wash cloth to her right hand. An interview was conducted with Nurse #2 on 10/16/19 at 10:30 AM. Nurse #2 revealed Resident #87 was supposed to wear a palm guard to her right hand. Nurse #2 searched the resident ' s room for the palm guard and indicated the palm guard must be in the laundry. Nurse #2 stated, again, that she knew Resident #87 needed to wear the palm guard and if the palm guard was getting washed, then a rolled wash cloth should be used. Nurse #2 reported according to the care plan, nursing staff was to apply the palm guard to the resident ' s right hand. Nurse #2 explained if a task was in the care plan to be completed by the nursing assistants (NAs), it would trigger for the NA ' s on their Kardex to apply and remove the palm guard daily when performing care. An interview was conducted with NA #7 on 10/16/19 at 10:35 AM. NA #7 stated she had seen the task for the resident to wear the palm guard on the care guide (Kardex) and stated she did not know where the (palm guard) was and had not seen it. She stated she did not put the palm guard on the resident ' s right hand all week. NA #7 revealed the task noted in the Kardex	F 688	Tech's. Topics included: • The importance for applying splints, palm guards, hand rolls as ordered by the MD. • Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown. • What to do when the device cannot be located. Any staff that has not received this in-service by 11/14/2019 will not be allowed to work until it is completed. This information has been integrated into the standard orientation training for identified facility staff as well as Agency staff and in the required in-service refresher courses for all nurses, medication aides, and medication tech's and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor for device application. The Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3 months. Monitoring will include auditing 10 residents' documentation and observing for application of the device and documentation. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 22 which read: the palm guard should be applied and removed during and after ADL care, fingernails should be clean, cut, or trimmed and palm guard should be applied to right hand daily. NA #7 stated she should have been applying the palm guard as indicated on the care guide (Kardex). An interview was conducted with the Director of Nursing (DON) on 10/17/19 at 4:00 PM. The DON reported she expected the nursing staff to ensure the palm guard was placed on the resident as indicated in the care plan. The DON reported the need for the palm guard was to prevent further contracture of the resident's hand.	F 688	weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Completion date: 11/14/2019	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		11/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 23 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 24 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility 1) failed to accurately record weights for 1 of 5 residents (Resident #318) reviewed for nutrition; and 2) inaccuratly documented nail care that was not provided by signing off on the Medication Administration Record (MAR) that the task was completed for 1 of 3 residents (Resident #87) sampled.. Findings included: 1. Resident #318 was admitted to the facility on 04/27/19 with a diagnoses that included: atrial fibrillation (a-fib), aphasia, cerebral infarction (CVA), hypertension (HTN), gout, diabetes (DM), chronic obstructive pulmonary disease (COPD), pneumonia, and dysphagia. Review of resident ' s Minimum Data Set (MDS) dated 05/12/19 revealed resident had no cognitive impairments. Resident coded as needing extensive assistance for toileting, personal hygiene, and bed mobility. On 10/15/19 at 2:30 PM, a review of Resident #318 ' s recorded weights from 04/28/19 - 05/27/19 revealed the following weight log: Week of 04/28/19 had a weight on 05/02/19 of 148 lbs. Week of 05/05/19 - no weights. Week of 05/12/19 had a note "weight not done on shift".	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 1. For the resident's affected, the following corrective action was taken. 1. Resident #318 was discharged from the facility on 05/27/2019 2. For Resident #87, on 10/16/2019, the nails were trimmed by the hall nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 11/01/2019, the Director of Nursing audited all current physician orders to identify residents with ordered daily and weekly weights and audited to ensure their weights were obtained and entered into PCC according to the MD orders. This process will be completed by 11/06/2019. On 11/07/2019 the nurse managers audited all current residents to establish	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 25 Week of 05/19/19 - no weights. Week of 05/26/19 - no weights. An electronic medication administration record (MAR) order date of 04/28/19 for Resident #318 revealed weekly weights time 4 weeks, then monthly and as needed every day shift for 7 days(s) for 28 days. A nursing note dated 05/19/19 at 1:57 AM revealed Resident #318 did not requires daily weights. W 148.0 lbs. - 5/2/2019. A nursing note dated 05/21/19 at 12:43 PM revealed Resident #318's weight was 148.0 lbs. on 5/2/2019 at 2:56 PM via scale using a mechanical lift. An interview on 10/15/19 at 2:13 PM with Nursing Aide (NA) #11 and NA #12 (Restorative Aides) revealed Resident #318 had one admission documented weight dated 05/02/19 weight of 148 lbs. A review of the weight logs for April/2019 and May/2019 with the two restorative aides who were responsible for facility weights revealed only one weight documented for Resident #318 dated 05/02/19 of 148 lbs. Both aides said Resident #318 refused to be weighed the weeks of 04/28/19, 05/05/19, 05/12/19, 05/19/19, and 05/26/19. The NAs said they let the nursing supervisor (Nurse #1) know of Resident #318's refusal to have his weekly weights done. Both NAs said they should have entered into the weight log dates and time of the resident's refusal to be weighted, and did not. The restorative aides revealed that nurse do not do the actual weighing of residents. They reported the Restorative Aides do the weighing and log it in a paper notebook and the nurses, in turn, record the weights into	F 842	which residents were in need of nail care. Once it was determined who needed nail care, the assigned nurses and nurse aides completed the nail care. This was completed by 11/08/2019. 3. Systemic Changes On 10/16/2019, the Staff Development Coordinator provided an in-service education to all full-time, part-time, and PRN nurses, medication aides, and medication techs. Topics included: • Obtaining and documenting weights per MD order. • The importance of not documenting care provided when it was not. • Daily nail care policy NUP-550 This information has been integrated into the standard orientation training for facility staff as well as Agency staff and in the required in-service refresher courses for all nurses, medication aides, and medication tech's and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the documentation of weights and nail care. The Quality Assurance documentation tool will be completed weekly for 2 weeks then monthly for 3 months. Monitoring will include ensuring weights are obtained and entered into PCC per MD orders and Nail care is completed per facility policy. Reports will be presented to the weekly Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 26 the system. An interview on 10/15/19 at 2:30 PM with Nurse #1 revealed she could not remember NA #11 or NA #12 ever coming to her about Resident #318's refusal to have his weekly weights done. Nurse #1 said if a resident had a weight done or refused a weight, it would be documented in the resident ' s electronic medical record, medication administrator record (MAR) or in a nursing note. A review of Resident #318's electronic records with Nurse #1 revealed 2 two weight entries: one under the weight tab on 05/02/19 which had a weight of 148 lbs., and another entry under the MAR dated 05/15/19 which read to see "other nursing note", which clicked to read "weight not done on shift". Nurse #1 said there should have been weekly weight entries in one or all three weight documentation locations for Resident #318's refusals, for the three weeks prior to the resident ' s discharge, and there wasn ' t. Nurse #1 said documentation of Resident #318's weekly weight refusals should have been noted in the restorative aides ' weight book, MAR, and nurse notes by the nursing staff, and were not.. An interview on 10/16/19 at 10:14 AM with the Director of Nursing (DON) revealed it was her expectation that Resident #318 should have had weekly weights documented as done if ordered, as well as documented if refused or not done by nursing staff, and was not. An interview on 10/16/19 at 4:15 PM with the Registered Dietitian (RD) #1 revealed it was his expectation that Resident #318 should have had weekly weights documented if ordered, as well as documentation by staff, if refused or not done.	F 842	Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 27	F 842		

An interview on 10/16/19 at 4:30 PM with the Dietary Manager (DM) revealed Resident #318 should have had weekly weights documented as done, not done, or refused.

An interview on 10/17/19 at 9:15 AM with Nurse Practitioner (NP) #1 revealed if weekly weights were ordered for Resident #318, then it was her expectation that they should have been done, and documented. If weights were not done or refused by a resident, it was her expectation that a reason for a weekly weight not done to be documented in the resident ' s medical record.

An interview on 10/17/19 at 10:30 AM with Nurse Practitioner (NP) #2 revealed if weekly weights were ordered for Resident #318, then it was her expectation that they should have been done, and documented. If weights were not done or refused by a resident, it was her expectation that the reason for a weight not being done to also be documented in the resident ' s medical record.

An interview on 10/17/19 at 3:00 PM with the Administrator revealed it was his expectation that Resident #318 should have had weekly weights documented as done if ordered, as well as documented if refused or not done by nursing staff.

2. Resident #87 was admitted to the facility on 11/15/12. Diagnoses included, in part, dementia with behaviors.

The Minimum Data Set (MDS) quarterly assessment dated 09/20/19 revealed the resident was severely cognitively impaired and required total dependence with bed mobility, transfers and toileting with two physical staff assistance and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 28	F 842		

total dependence with one staff physical assistance with dressing and personal hygiene. Resident #87 had impairments on both sides to upper and lower extremities and used a wheelchair.

A review of the care plan revealed a plan of care for activity of daily living (ADL) self-care performance deficit related to limited mobility with hypertonicity of the right hand and contracture of bilateral upper extremities with right hand noted to be fisted. Interventions included to assist with grooming and personal hygiene, inspect skin to right hand every shift and report any problems to the nurse, perform gentle range of motion during bathing and daily care, and to place palm guard/rolled wash cloth to right hand daily.

A record review of the physician orders revealed there was an order written on 07/23/19 to perform nail care; cut, and trim and clean resident ' s nails every 14 days on the evening shift. A review of the October MAR revealed the order was in place and on 10/15/19, the task was signed off by a nurse (Nurse #3) as evidenced by a check mark and the nurse ' s initials.

An observation of Resident #87 on 10/16/19 at 9:45 AM revealed the resident was noted to have contracted bilateral hands with long, jagged and dirty fingernails. The nails to the right index finger and thumb were noted to be long, jagged and dirty. The three other fingernails were contracted and folded into the right hand and noted to be long. There was a foul odor detected when Nurse #2 was able to slightly open the resident ' s right hand. The fingernails to the left hand were noted to be long, jagged and dirty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 29	F 842		

An interview with Nurse #2 was conducted on 10/16/19 at 10:30 AM. Nurse #2 observed Resident #87 ' s hands and she confirmed the fingernails to the right and left hands were very long, dirty and jagged and stated they needed to be cut and she would take care of it. Nurse #2 assessed the right hand and confirmed there was a foul odor noted coming from the right hand as she slightly opened the right hand.

A review of Resident #87 ' s care guide (Kardex) revealed the resident ' s fingernails should be clean, cut, or trimmed and the palm guard should be applied to right hand daily.

An interview was conducted with nursing assistant (NA) #7 on 10/16/19 at 10:30 AM. NA #7 confirmed the residents ' fingernails to the right and left hands were very long, dirty and jagged and stated she should have cleaned them while doing her ADL care. NA #7 stated there was an odor detected in Resident #87 ' s right hand and the hand should be cleansed during care to prevent odors.

An interview was conducted with Nurse #2 on 10/16/19 at 2:30 PM. Nurse #2 stated there was an order to cut, trim and clean resident ' s nails every 14 days on the evening shift on the October MAR. Nurse #2 stated that if the MAR had a check mark with nurse ' s initials it meant the task was completed as ordered. Nurse #2 stated the task under the date 10/15/19 to trim, cut and clean the resident ' s fingernails was signed off by Nurse #3, but, Nurse #2 stated, it could not have been carried out due to the observation that had occurred this morning on 10/16/19 which revealed the resident ' s fingernails on the left and right hand were noted to be long, jagged and dirty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 30 with a foul odor detected on the right hand. An interview was attempted via phone with Nurse #3 (agency nurse) who worked on 10/15/19 and signed the MAR on 10/15/19 during the evening shift indicating the task had been completed. Phone messages were left via voice mail for a returned call on 10/16/19 and 10/17/19. An interview was conducted with the Director of Nursing (DON) on 10/17/19 at 4:00 PM. The DON stated her expectations of the nursing staff was to accurately document when a task was completed on the MAR. The DON stated by signing off the task without actually completing it was false documentation.	F 842		