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 03/23/2023

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 survey and complaint investigation were conducted on 03/20/23 through 03/23/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # X14C11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 03/20/23 through 03/23/23. Event ID# X14C11. The following intakes were investigated: NC00196266, NC00198854, NC00192034, NC00192008, and NC00199792. 5 of the 16 complaint allegations resulted in deficiencies.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		4/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/14/2023

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 03/23/2023

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 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and Physician interviews the facility failed to notify the physician when a resident was noted to have redness and bleeding along the gumline for 1 of 1 resident reviewed for dental care (Resident #65).	F 580	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	

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 03/23/2023

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 580	Continued From page 2 The findings included: Resident #65 was admitted to the facility on 10/17/22. A review of the quarterly Minimum Data Set (MDS) dated 01/10/23 indicated that Resident #65 had severe cognitive impairment and needed total assistance with personal hygiene. Resident #65 was coded for no issues with his teeth and no pain. A nursing note dated 02/16/23 at 2:31 PM by Nurse #7 revealed Resident #65 has strong foul odor coming from mouth, redness and bleeding noted on gum line and teeth. Resident has verbalized that there is pain in her mouth on several occasions. There was not any documentation of a physician being notified. A nursing note dated 02/23/23 at 7:08 PM by Nurse #1 revealed Resident #65 remains in bed today, denies any pain. Resident continues to have dry mouth/lips and a foul, strong odor coming from her mouth. There was not any documentation of a physician being notified. A nursing note dated 03/22/23 at 12:04 PM by Nurse #1 revealed Resident #65 continues to have dried lips and a very foul odor coming from mouth. The resident was offered oral care and refused. The medication aide stated resident began grabbing her hand along with another staff members hands and refused oral care. A nursing note dated 03/22/23 at 4:35 PM for Resident #65 revealed Director of Nursing (DON) evaluated resident gums and mouth. The resident was pleasant and agreed to let her look inside her	F 580	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. F 580 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to notify the physician when a resident #65 was noted to have redness and bleeding along the gumline. Corrective action for resident(s) affected by the alleged deficient practice: Resident#65 was assessed by the Director of Nursing on 3/22/23 with notification to provider of gum redness and inflammation, with no active bleeding. Orders received 3/22/23 to have resident evaluated by Dental services. On 3/23/23 Director of Nursing contacted the provider to inform of next available appointment with resident□s outside Dental Provider would be 30 days. Provider ordered for resident to be seen in emergency department for evaluation. 3/23/23 resident returned to facility 3/23/2023 with order for Peridex solution and instruction to follow up with Dental provider. 3/23/23 Peridex Solution 0.12% give 10 ml by mouth two times a day for was initiated. 3/27/23 resident was seen by in house Dental provider with orders to schedule resident for sedated cleaning. The appointment is set for May 4, 2023. 1. Corrective action for residents with the potential to be affected by the alleged	

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 03/23/2023

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 580	Continued From page 3 mouth. Resident's gums were red and inflamed, with no active bleeding noted. An interview was conducted with Nurse #1 on 03/22/23 at 5:00 PM. Nurse #1 said she was the nurse who wrote the 02/23/23 nursing note about Resident #65 having a strong mouth odor, dry lips, and no pain. She said she thought she faxed a note to MD #2 office informing him of what she observed. Nurse #1 said she did not follow-up with the MD's office to see if they received her information and should have. Nurse #1 said they could not find any documentation supporting she sent the fax to MD #10's office. The facility physician (MD) was interviewed by phone on 03/23/23 at 10:25 AM. The MD reported the first time he had been notified of Resident #65's mouth pain was on 12/2022, which the resident was treated with Peridex mouth swabs, and was later discontinued due to resident's non-compliance. MD said since 12/2022 he had no contact from the facility regarding resident's recent gum issues until yesterday (03/22/23). The MD reported he expected the NP or MD to be notified if a resident experienced mouth pain. An interview was conducted on 03/23/23 at 3:20 PM with the Administrator and DON. They both stated that they would expect their nurses to notify a resident's physician if a resident was assessed for mouth or gum odor, swelling, redness or strong odor.	F 580	deficient practice. All residents who are experiencing dental issues such as oral pain, reddened, inflamed or bleeding gums are at potential risk of being affected by deficient practice. The Director of Nurses and nursing supervisors initiated an audit of 100% of all residents for dental issues to include not limited to oral pain, reddened, inflamed or bleeding gums. This was completed by 3/27/2023. Findings: No others identified. On 4/3/2023 all residents were evaluated by the in-house Care Secure Mobile Dental provider with exception of 7 residents who refused evaluation to identify dental concerns. The Director of Nursing, Support Nurse completed corrective actions for the above residents including notification to Medical provider and patient representative and initiation of all new orders. On 4/6/2023 all residents were in compliance with physician notification, resident representative notification and any identified oral or dental concerns addressed, validated by the Director of Nursing Services. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/18/2023 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses 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 03/23/2023

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 580	Continued From page 4	F 580		

on the following topics:
" Conducting an oral assessment when oral pain, gum redness, inflammation, or bleeding noted.
" Notification of the physician/RP with resident change in condition or concerns.
" Documentation process for notification of the physician/RP.

The DON will ensure that any of the above identified staff who does not complete the in-service training by 4/21/2023 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation.

3. 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 Nurses or LPN Support Nurse will monitor compliance utilizing the F580 Quality Assurance Tool by completing an audit for a minimum of weekly x 4 then monthly x 2 months or until resolved. The audit will include monitoring during Daily QOL (Monday-Friday) for compliance with the notification process by auditing progress notes for documentation of resident concerns and observation of residents oral care to ensure that medical provider and patient representative where notified timely of any concerns.

4. Results of the monitoring will be presented to the Quality Assurance

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 03/23/2023

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 580	Continued From page 5	F 580	Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance: 4/28/2023	
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 record review, observation and staff interview, the facility failed to shave a resident who was dependent on the staff for activities of daily living (ADL) care for 1 of 1 sampled resident reviewed for ADLs (Resident #65). Findings included: Resident #65 was admitted to the facility on 10/17/22 with multiple diagnoses including metabolic encephalopathy, dementia, anxiety, and affective mood disorder. A Psychiatric follow-up evaluation dated 12/20/22 for Resident #65 revealed resident's cognition	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. F 677 The plan of correcting the specific deficiency. The plan should address the	4/28/23

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 03/23/2023

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 6 noted to decline indicating severe cognitive impairment, with mood stable and no increase in paranoia or anxiety per staff. Resident with history of severe aggression toward staff, behaviors controlled on current medications. The quarterly Minimum Data Set (MDS) dated 01/10/23 indicated that Resident #65 had severe cognitive impairment and needed total assistance with personal hygiene. Resident #65 was coded for physical and verbal behavioral symptoms directed toward others and rejection of care on 0 to 0 days out of 7 days. Review of the Nurse's Aide (NA) behavior documentation revealed that Resident #65 exhibited behaviors with rejection of care for 6 out of the last 22 days, from 03/01/23 through 03/22/23. An observation on 03/20/23 at 11:05 AM was conducted with Resident #65. Resident was sitting up in bed with a patch of white facial chin hair approximately 3 to 4 inches long. An observation on 03/20/23 at 1:30 PM was conducted with Resident #65. The resident's facial hair on her chin remained unchanged. Review of Resident #65's care plan dated 03/21/23 was conducted. The care plan problems were "I have an Activities of Daily Living (ADL) self-care performance deficit related to dementia. I am resistive to care such as bathing, turning, repositioning, and grooming related to dementia". Interventions included, in part, if the resident had an episode of inappropriate behaviors of yelling out for no apparent reason, cursing, or striking at staff, the staff member	F 677	processes that lead to the deficiency cited: The facility failed to shave a resident who was dependent on the staff for activities of daily living (ADL) care for resident #65. Corrective action for resident(s) affected by the alleged deficient practice: On 3/23/23 resident #65 facial hair on her chin was shaved off that morning by Nurse #1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All dependent residents requiring Activity of Daily living assistance have the potential to be affected by the alleged deficient practice. The Director of Nurses and nursing supervisors initiated an audit of 100% of all dependent residents for adequate receipt of necessary services to maintain adequate grooming of facial hair. This will be completed by 4/12/2023. The results included: 20 residents both male and female were noted with facial hair. Nurses and aides were notified of the findings and facial grooming was completed. On the follow up on 4/13/2023 all residents were in compliance with no facial hair except one who refused facial grooming. Staff attempted on different times by different associates with the same response. The Director of Nursing, Support Nurse or designee completed corrective actions for the above residents including removal of undesired facial hair.	

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 03/23/2023

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 7	F 677		

should leave the resident for a time, and come back later to complete the task.

An observation on 03/21/23 at 8:45 AM was conducted with Resident #65. The resident's facial hair on her chin remained unchanged.

An interview on 03/22/23 at 11:40 AM was conducted with Nursing Aide (NA) #2. She said Resident #65 refused her bath and oral care today. NA #2 said Resident #65 had facial chin hair, which needed to be shaved off. NA #2 said the reason the facial hair was not removed was because the resident would often become combative and would refuse ADL care. NA #2 said staff were supposed to shave residents after their daily bath, and if the resident was resistive to care, they were taught to walk away and come back later and try again. NA #2 said she could not remember the last time Resident #65 was shaved, but it had been a while. She said when she tried to shave the resident in the past the resident became combative, so she left as she was taught to do. She said she was too busy with other residents' morning care that she never went back to try again.

An interview on 03/22/23 at 11:45 AM was conducted with Nursing Aide (NA) #4. She said Resident #65 had a lot of facial chin hair, which the resident had had for a while, and needed to be shaved. NA #4 said the reason the resident was not shaved was because she could become combative and nursing staff did not want to deal with the resident becoming combative when you tried to touch her face. NA #4 said she could not remember the last time Resident #65 was shaved. She said staff usually shaved their residents after their morning bath. NA #4 said

On 4/13/2023 all residents with the exception of one resident who refused were in compliance with physician notification and concerns.

1. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 4/18/2023 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics:
" Ensuring residents that are unable to carry out activities of daily living receives the necessary services to maintain adequate grooming, personal and oral hygiene and good nutrition.
The DON will ensure that any of the above identified staff who does not complete the in-service training by 4/21/2023 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation.

2. 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 Nurses or LPN Support Nurse will monitor compliance utilizing the F580 Quality Assurance Tool by completing an audit weekly x 2 then monthly x 3 months or until resolved. The audit will include monitoring 5 residents to ensure adequate grooming of facial hair. Reports will be presented to the Quality Assurance Committee 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 03/23/2023

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 8 she could not remember the last time she attempted to shave the resident. She said if a resident became combative or abusive in any way they were instructed to walk away and come back later to try again. An interview and observation on 03/22/23 at 2:40 PM were conducted with Resident #65. The resident was observed to be alert, calm, and her facial hair had been shaved. When asked about her chin facial hair being gone, she said the facial hair on her chin was shaved off that morning by a nurse (Nurse #1). She said she had asked before for her facial hair to be removed, but no one removed it. She said she was not upset or angry that it took so long, but was glad the hair on her chin was removed. An interview on 03/22/23 at 5:00 PM was conducted with Nurse #1. She said she shaved Resident #65's facial hair with shaving cream and a wet warm washcloth that morning around 9:00 AM after she completed her 8:00 AM medication pass. She said the resident was not combative, was not in any pain, and seemed pleased to have the facial hair removed. The nurse said the resident had refused ADL care in the past and the NAs documented resident's refusals in the NA electronic charting system. The nurse said she had no answer as to why it had taken so long for the resident to be shaven. The nurse said NAs should have been more persistent, or asked one of the nurses for assistance, but did not. An interview on 03/22/23 at 4:00 PM was conducted with the Administrator. She stated Resident #65's facial hair should have been removed timely. The Administrator stated the resident had a known history of being combative	F 677	Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance: 4/28/2023	

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 03/23/2023

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 9 with care; however, she still expected her nursing staff to be persistent, wait a couple of hours and try again, or ask for additional nursing assistance. The Director of Nursing (DON) was interviewed on 3/23/23 at 11:20 AM. The Director of Nursing expected the staff to provide complete ADL care and if the resident was combative to leave and to try later.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to provide an ongoing resident centered activities program based on residents' individual interests for 2 of 7 residents reviewed for activities (Resident #27 and Resident #50). Findings included: a). Resident #27 was admitted to the facility on 12/23/13 with diagnoses of osteoarthritis with stiffness of right and left hand and glaucoma.	F 679	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. F679 The facility failed to provide an	4/28/23

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 03/23/2023

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 679	Continued From page 10 Resident #27's 10/28/22 Annual Minimum Data Set (MDS) assessment revealed resident was cognitively intact. Resident #27's activity preferences included keeping up with the news, activities with groups of people, favorite activities, going outside and religious activities were very important. Books and music were not important to Resident #27. Resident #27's care plan revealed an activities focus was added on 5/24/21 and reviewed on 1/28/23. The activities care plan focus stated Resident #27 enjoyed attending and participating in most activities at the facility. Resident #27's goal indicated resident will attend and participate in activities daily. Interventions included: assist to and from activities as needed, place activity calendar in room, provide praise for participating in and attending activities, and remind me about upcoming activities. Interview on 3/20/23 at 11:22 AM with Resident #27 revealed there was nothing to do on the weekends. Resident #27 indicated the facility used to have more activities, but they hadn't for a while. Resident #27 further revealed she used a wheelchair for mobility and was not able to propel her wheelchair due to arthritis in her hands and knee. If staff did not assist her, which they sometimes didn't, she was not able to attend activities. b). Resident #50 was admitted to the facility on 4/30/19 with diagnosis which included in part stroke with hemiparesis, blindness in left eye and depression. Resident #50's 4/24/22 annual MDS assessment indicated resident was cognitively intact and had	F 679	ongoing resident centered activities program based on resident individual interests. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #27, On 4/11/2023, the Activities Director interviewed the resident to obtain desired weekend activities. For resident #50, on 4/11/2023, the Activities Director interviewed the resident to obtain desired weekend activities. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 4/12/2023, the Activities Director held a resident council meeting with cognitively intact residents to obtain preferences of desired weekend activities. On 4/12/2023, the Activities Director interviewed all other alert and oriented residents for preferences of choice of activities, both facilities sponsored groups and individual activities, independent activities for weekends. The Activities Director implemented corrective actions by updating the Activities calendar with weekend activities. The Minimum Data Set Nurse ensured preferences of each resident was care planned. This will be completed by 4/14/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/18/2023, Director of Nursing, Nurse Consultant and the Nurse Manager began education to all full time, part time, PRN	

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 03/23/2023

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 679	Continued From page 11 impaired vision. Resident #50 indicated books, newspapers, pets and keeping up with the news were not very important, music was somewhat important and doing things with groups of people, doing favorite activities, religious activities and going outside were very important. Resident #50's care plan indicated an activities focus was added on 10/19/22 and reviewed on 1/9/23. The goal indicated Resident #50 would attend and participate in activities daily. Interventions included assist to and from activities, provide monthly activity calendar and remind about upcoming activities for the day. Interview on 3/20/23 at 1:22 PM with Resident #50 revealed she usually stayed in bed on the weekends because there was nothing to do. Resident #50 stated there were no activities available on weekends, so staff did not get her up out of bed. Interview on 3/21/23 at 1:10 PM with the Activity Director revealed she had been in the position since December 2022. Activity Director indicated she worked Monday through Friday and provided activities when she was in the facility. On the weekends, the Activity Director indicated she sometimes had volunteers that came in but right now it was usually only one Saturday during the month that volunteers came in the afternoon for an activity and some Sunday mornings she had a church that did a service. Activity Director did not know what to do for activities for residents on the weekends. A resident council meeting on 3/21/23 at 2:49 PM with a group of cognitively intact residents revealed there were no activities on the	F 679	and agency Nurses and CNA□s on the following: " Activities must meet Interest/Needs of each resident. " Staff responsibility to assist residents to activities / or assist in providing activities. " Supporting residents in their choice of activities, both facility sponsored groups, individual activities and independent activities designed to meet the interests of and support the physical, mental and psychosocial well being of each resident, encouraging both independence and interaction in the community " Staff responsibility of reviewing the Resident Activities Calendar for scheduled activities daily including weekends and ensuring aiding resident to activity. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 4/18/2023. 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	

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 03/23/2023

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 679	Continued From page 12 weekends. The residents indicated sometimes there was a church service but not every weekend. The residents stated they used to have a lot more activities but now there is nothing to do here on the weekends. The residents stated we have not had many activities here for a while and it can be boring on the weekends with nothing to do. Interview on 3/23/23 at 12:50 PM with Nursing Assistant (NA) #1 revealed there were no activities available on weekends. NA #1 stated sometimes they had church services on Sunday. NA #1 stated residents asked about activities on the weekends and complained they had nothing to do. NA#1 stated she did not have time on the weekends to provide activities for her residents. Interview on 3/23/23 at 2:50 PM with the Administrator revealed she thought the facility tried to have some activities on the weekend, but she couldn't recall what they did. The Administrator stated the facility sometimes had activities with outside groups of volunteers on the weekends but did not know how often or of any other activities on the weekends. The Administrator indicated the activity director was here during the week so that was when activities were provided. The activity calendar was reviewed with the administrator who stated she guessed there should be more activities provided for the residents on the weekends.	F 679	requirements. The Director of Nurses/Activities Director will monitor compliance utilizing the F679 Quality Assurance Tool monitor resident participation in activities including weekends weekly for 2 weeks then monthly x 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/28/2023	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		4/28/23

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 03/23/2023

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 684	Continued From page 13 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews the facility failed to obtain physician ordered laboratory tests for 1 of 3 residents reviewed for antibiotic use (Resident # 44). Findings included. Resident #44 was admitted to the facility on 02/24/23 with diagnoses including osteomyelitis (infection of the bone), urinary tract infection, and stage IV sacral ulcer. A physician's order dated 02/24/23 for Resident #44 revealed ertapenem sodium solution (antibiotic). Use 1 gram intravenously every 24 hours for infection to wounds for 28 Days via PICC line (peripherally inserted central catheter). A physician's order dated 02/24/23 for Resident #44 revealed weekly CBC (complete blood cell count), BMP (basic metabolic panel), ESR (erythrocyte sedimentation rate), CRP (c-reactive protein) (these labs are used to make treatment decisions) for 28 days while continuing intravenous antibiotics. The Minimum Data Set (MDS) admission assessment dated 03/03/23 revealed Resident #44 received antibiotics and had no rejection of care.	F 684	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. F684 Quality of care CFR(s): 483.25 The facility failed to obtain physician ordered laboratory test for Resident #44 Corrective action for resident(s) affected by the alleged deficient practice: On 3/23/23 support nurse #1 notified physician with orders to obtain lab. On 3/23/23 resident #44 lab for CBC, BMP, ESR, CRP was obtained per order. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring laboratory test have the potential to be affected by this alleged deficient practice. On 4/10/2023 the Director of Nurses and nursing team began auditing the past 14 days of ordered laboratory test to ensure	

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 03/23/2023

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 684	Continued From page 14 Review of Resident #44's electronic medical record on 03/23/23 revealed the laboratory (lab) tests for CBC, BMP, ESR, and CRP were drawn on 02/27/23 and on 03/07/23. There were no further laboratory tests drawn after 03/07/23. Resident #44 began antibiotics on 02/24/23 and remained on antibiotics as of 03/23/23. An interview on 03/23/23 at 04:36 PM with Nurse #1, revealed she was routinely the assigned nurse for Resident #44 and stated lab orders were entered into the resident's electronic medical record and would show on the residents Medication Administration Record (MAR). She stated labs were drawn nightly by an outside vendor when they were due. She stated the nurse records the labs to be drawn in the vendors notebook located at the nurse's station on the day the labs were due. The vendor looks in the notebook to determine who needs labs, then draws the labs and leaves a requisition form in the notebook to notify the facility of the date, time, and what labs were drawn. The labs were typically faxed back to the facility the next day and the physician is notified accordingly. She stated they had only used this vendor for a few months and were still getting used to recording the ordered labs in the vendor notebook. She stated the miscommunication for Resident #44's lab work not getting done was due to the nurse's failure to record the lab work that was ordered in the vendor notebook. She stated it was an oversight. An interview on 03/23/23 at 05:01 PM with the Director of Nursing (DON) revealed Resident #44 was to receive weekly monitoring of labs while receiving the course of IV (intravenous)	F 684	that laboratory test completed and medical provider notified of results. This will be completed by 4/12/2023 The results included: Urine sample was left in the fridge and not picked up timely by Vista Labs. MD was notified with order to redo UA on 4/11/2023. On 4/11/2023 the Director of Nursing and nursing team completed corrective action for those residents including notification to medical provider for any missed laboratory testing and clarification of orders and initiation of those orders. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 4/18/2023 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics: " Facility must ensure that resident receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident□s choices. " Facility must ensure that all Laboratory testing is completed per the physician order " Laboratory results must be reviewed and reported to physician timely for monitoring and management of medications. Urine Culture and Sensitivity report reviews to ensure that they have been addressed by the physician 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 03/23/2023

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 684	Continued From page 15 antibiotics for osteomyelitis. She stated lab orders were entered in the resident's electronic medical record, and the nurse had a process to follow, then the support nurse was to follow up to ensure the labs were done and the physician was notified as needed. She stated the process had not been followed which led to Resident #44 not getting the labs drawn. An interview on 03/23/23 at 5:27 PM with Support Nurse #1 revealed she was responsible for following up to ensure labs were drawn. She stated it was an oversight that she had not followed up on Resident 44's labs. She stated she notified the physician earlier when it was brought to her attention and the physician ordered her to draw Resident #44's labs tonight for review tomorrow. She indicated Resident #44's vital signs were stable, and she was asymptomatic. An interview on 03/23/23 at 05:59 PM with Nurse Practitioner #2 revealed the importance of the labs was to monitor Resident #44's white blood cell count, kidney function, sedimentation rate, and CRP and if the labs were abnormal, they would have referred back to the infectious disease physician. She indicated staff had not reported any change in Resident #44's condition and stated she was not in the facility and could not view the residents medical record but stated staff should be following the orders and drawing the labs.	F 684	appropriate orders received and implemented timely. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 4/21/2023 will not be allowed to work until training has been completed. 3. 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 Nurses or designee will monitor compliance utilizing the F684 Quality Assurance Tool for compliance by monitoring Orders for laboratory testing during daily clinical Monday through Friday and auditing 5 residents to ensure ordered laboratory test on the lab book, timely completion, receipt of results and notification to medical provider weekly x 2 weeks then monthly x 3 month or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the 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 Manager, Health Information 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 03/23/2023

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 684	Continued From page 16	F 684	and the Dietary Manager. Date of Compliance: 4/28/2023	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to obtain physician ordered weights for 2 of 2 residents (Resident # 39, Resident #44) reviewed for nutrition. Findings included. 1. Resident #39 was admitted to the facility on 10/28/22 with diagnoses including congestive	F 692	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	4/28/23

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 03/23/2023

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 692	Continued From page 17	F 692		

heart failure (CHF), and renal insufficiency.

Resident #39's care plan dated 12/05/22 revealed the potential for nutritional problems. Interventions included in part; to observe for, record, and report to the physician as needed for signs or symptoms of malnutrition, or significant weight loss.

The Minimum Data Set (MDS) quarterly assessment dated 03/07/23 revealed Resident #39 had moderately impaired cognition and required supervision with activities of daily living (ADLs). There was no weight loss or gain at the time of the assessment and no rejection of care.

A physician's order dated 03/13/23 for Resident #39 revealed to obtain daily weights. If resident gains greater than 5 pounds (lbs.), notify the physician and possibly restart Aldactone (a medication used to treat fluid retention).

Review of Resident #39's electronic medical record on 03/23/23 revealed the following weights were recorded:

3/23/2023	193.4 lbs.
3/18/2023	190.4 lbs.
3/17/2023	193.2 lbs.
3/14/2023	190.8 lbs.
3/13/2023	192.4 lbs.

An interview on 03/23/23 at 12:59 PM with Nurse Aide #7 revealed she routinely worked the 400 hall and was Resident #39's assigned nurse aide. She stated he was alert and oriented and did not refuse care. She stated when a resident required daily weights the nurse would notify the nurse

compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F692
Facility failed to obtain physician ordered weights for resident #39 and #44
Corrective action for resident (s) affected by alleged deficient practice.
For Resident #39 the facility failed to obtain daily weights per provider order. On 3/23/2023 the DON assessed resident for abdominal distention. Notified PCP of no abnormal findings. No new orders obtained. PCP to eval on next visit.

For Resident #44 the facility failed to obtain weekly weights for week of 3/13/23 and 3/20/23. On 3/23/2023 weight was obtained with no finding of concern. Monthly weight was gotten on 4/6/2023. On 4/10/2023 the DON notified the PCP of missed weights on 3/20/23 and 3/30/2023 with a weight review with no voiced concerns or new orders obtained.

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents have the potential to be affected by the alleged deficient practice.

On 4/10/2023 the Director of Nursing completed an all facility weight and supplement order review completed. Findings included: All monthly weights were obtained timely. No concerns noted with supplements. 4 residents with weight loss. MD was notified of concern and RD

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 03/23/2023

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 692	Continued From page 18	F 692		

aides and it would be written on the nurse aides assignment sheet by the nurse. She stated she was never made aware by any of the nurses that Resident #39 needed daily weights. She stated she worked last on 3/21/23 and the nurse did not notify her that the resident's weight was needed.

An interview on 03/23/23 at 01:04 PM with Nurse #1 revealed she routinely worked the 400 hall and was the assigned nurse for Resident #39. She stated Resident #39 did have orders in place for daily weights beginning 03/13/23 and she was not sure how some were missed. She indicated when the physician orders were entered into the resident's electronic medical record the order then flowed to the Medication Administration Record (MAR) and the nurse will see the order and notify the nurse aide and write it on the nurse aides assignment sheet. She stated she worked yesterday 03/22/23 and was the assigned nurse for Resident #39 but missed getting his weight. She stated the nurse aides typically obtained the weights, but the nurses would get the weights too as needed and indicated she must have forgotten to notify the nurse aides to get the weights which was an oversight. She stated she obtained Resident #39's weight this morning and he had weight gain but not greater than 5 lbs., and he was in no distress, with no shortness of breath and his vital signs were stable.

Resident #39 was observed on 03/23/23 at 01:15 PM lying in bed with no signs or symptoms of distress.

2. Resident #44 was admitted to the facility on 02/24/23 with diagnoses including osteomyelitis (infection of the bone), urinary tract infection, and stage IV sacral ulcer.

was notified to assess for dietary changes.

On 4/10/2023, Director of Nursing audited April admissions to ensure admission weights obtained and orders for weekly weights x 4 in place.
Findings included: All residents admitted in April were in compliance with orders for weekly weights x 4 and admission weights obtained on day of admission except one resident was weighed the next day.

On 4/10/2023 the Director of Nursing completed review of all residents with daily weight orders to ensure completion.
Findings included: Daily weights were audited and it was noted that 3 out of 3 residents had missed daily weights. PCP was notified of missing daily weights with new orders obtained to discontinue the order or change order to 3 times a week.

On 4/10/2023 the Director of Nursing completed review of all residents with weekly weights to ensure completion.
Findings included: One resident refused; 2 weekly weights were missed. Primary care provider notified and weight obtained. Also informed PCP□s to evaluate all weight orders for continued need. Changes were made according to PCP orders.

On 4/11/2023 the Director of Nursing implemented corrective action for those residents which included: Notification of the Primary Care Provider of daily/weekly missed weights. Notification to 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 03/23/2023

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 692	Continued From page 19 A physician's order dated 02/27/23 for Resident #44 revealed weekly weights for 4 weeks, then monthly and as needed. Resident #44's care plan dated 02/27/23 revealed the potential for nutritional problems related to needing assistance with meals and due to admission to the facility with signs of recent malnutrition. Interventions included in part; to observe for, record, and report to the physician as needed if signs or symptoms of malnutrition, or significant weight loss. The Minimum Data Set (MDS) admission assessment dated 03/03/23 revealed Resident #44 was severely cognitively impaired and required extensive to total dependent care with activities of daily living (ADLs). She had no rejection of care. Review of Resident #44's electronic medical record on 03/23/23 revealed the following weights were recorded: 3/6/2023 127.3 lbs. 3/2/2023 127.2 lbs. 2/27/2023 127.0 lbs. An interview on 03/23/23 at 01:04 PM with Nurse #1 revealed she routinely worked the 200 hall and was the assigned nurse for Resident #44. She stated Resident #44 was alert and cooperative with care and did have orders in place for weekly weights beginning 02/27/23. She stated review of the residents electronic medical record showed weekly weights had not been recorded which was	F 692	Registered Dietician to review the chart for any recommendations to ensure optimal health. Director of Nursing and the LPN Support Nurses implemented any new orders for initiating supplements, change in current supplements and orders for obtaining weights for monitoring. 2. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Weight Policy " Admission Checklist Procedures " Weight Meeting Procedures This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Quality Assurance monitoring procedure. The DON or designee will monitor weights weekly x 4 weeks and then monthly x 3 months or until resolved using the Weight Review QA Audit tool. Weight change reviews will include insuring weights are obtained per policy and significant weight changes are addressed properly and timely to maintain nutrition and hydration status. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective	

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 03/23/2023

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 692	Continued From page 20 an oversight but indicated all nurses assigned to the resident should be ensuring that weights were done. She stated it was an oversight. An interview on 03/24/23 at 05:14 PM with Support Nurse #1 revealed she was the assigned support nurse for the 200 and 400 hall and stated she was responsible for following up with weights, and to ensure the weight was obtained, recorded, and the physician notified as needed. She stated she did not follow up with Resident #39 or Resident #44's weight which was an oversight. Resident #44 was observed on several occasions during the survey being fed by staff, she was cooperative with care and in no distress. An interview on 03/23/23 at 03:10 PM with the Director of Nursing revealed the nurse, or the nurse aide could obtain the weights and stated Resident #39's daily weights had not been done and Resident #44's weekly weights had not been done according to the physician orders. She stated the nurses and nurse aides were responsible to make sure orders were carried out and should have documented daily and weekly weights. She stated the support nurse for the hall was also responsible for follow up and to make sure weights were recorded. An interview on 03/24/23 at 5:30 PM with the Administrator revealed there was a process in place to obtain physician ordered weights and the process was not followed. She indicated she was not sure why the process was not working.	F 692	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 Date of compliance: 4/28/2023	
F 732 SS=C	Posted Nurse Staffing Information	F 732		4/28/23

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 03/23/2023

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 732	Continued From page 21 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

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 03/23/2023

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 732	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to document accurate information on the daily nurse staffing sheets for 4 of 4 days (03/20/23, 03/21/23, 03/22/23, and 03/23/23) of the survey. Findings included: A review of the Staff Schedule/Assignment Sheets and daily Posted Nurse Staffing Information sheets for 03/20/23, 03/21/23, 03/22/23, and 03/23/23 revealed discrepancies in the areas of number of Registered Nurses (RNs) on staff, number of Licensed Practical Nurses (LPNs) on staff, and number of unlicensed staff (including Medication Aides (MAs) actual hours worked and actual nursing staff who worked including the licensed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). The number of licensed staff and actual hours worked of licensed staff on 1st shift (7:00 AM - 7:00 PM) were incorrect for the following days: 03/20/23, 03/21/23, 03/22/23, and 03/23/23. The number of licensed staff and actual hours worked of licensed staff on 2nd shift (7:00 PM - 7:00 AM) were incorrect for the following days: 03/20/23, 03/21/23, 03/22/23, and 03/23/23. The number of licensed and unlicensed staff and actual hours worked of licensed and unlicensed staff on 1st shift (7:00 AM - 3:00 PM), 2nd shift (3:00 PM - 11:00 PM), and 3rd shift (11:00 PM - 7:00 AM) were incorrect for the following days: 03/20/23, 03/21/23, 03/22/23, and 03/23/23.	F 732	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. F 732 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to document accurate information on the daily nurse staffing sheets for 4 o4 days (3/20/23, 3/21/23, 3/22/23, and 3/23/23) of the survey. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 4/10/2023 the Director of Nursing and Support Nurses and Nursing Secretary were educated by Administrator on the guidelines for daily staffing posting to include the following: The facility must post the following information on a daily basis: 1. Facility name 2. The current date 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per	

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 03/23/2023

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 732	Continued From page 23 An interview was conducted on 03/22/23 at 04:00 PM with the Administrator. She stated she was unaware the daily Posted Nurse Staffing Information sheets were inaccurate and did not reflect the correct actual working hours or the correct number of staff for 03/20/21, 03/21/23, and 03/22/23 days reviewed. Administrator said the facility's scheduler was new to the position and that as the current Administrator and previous Director of Nursing (DON) she would take it upon herself to train the new scheduler in how to fill out the schedule forms correctly and would review the forms daily to ensure the Staff Schedule/Assignment Sheets reports and the daily Posted Nurse Staffing Information sheets are filled out correctly. An interview on 03/23/23 at 5:04 PM was conducted with the facility scheduler. She verified that the number of licensed staff & unlicensed staff hours worked and total hours for nursing staff were incorrect for 4 out of 4 days. She stated she was not counting the support nurses and the support/wound nurse accurately on the staffing sheets. The scheduler stated the Administrator was working with her to ensure all the assignment sheets and daily nurse staffing posting reflects who was working the floor and when. A follow-up interview was conducted on 03/23/23 at 07:00 PM with the Administrator. She stated she was unaware the daily Posted Nurse Staffing Information sheets were inaccurate and did not reflect the correct actual working hours or the correct number of staff for 03/23/23. The administrator said the facility's scheduler was new to the position and that yesterday she had educated the scheduler on how to fill out the schedule forms correctly. Administrator said the	F 732	shift. To include: RN, LPN, Certified NA. 4. Resident Census Posting requirement: Must be posted clearly and readable format and in a prominent place readily accessible to residents and visitors. The facility must document accurate information on the daily nurse staffing sheets. This includes daily verifying the schedule/assignment sheet reports and the daily Post Nursing Staffing information sheets are correct and match. On 4/11/2023 the Director of Nursing implemented the required changes to the daily staffing posting with the nursing team. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 4/11/2023 the Director of Nursing reviewed staffing assignment sheet and verified the Daily staff Posting sheet was updated in accordance with the guidelines for the staffing posting. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses or LPN Support Nurse will review the daily staffing posting for accuracy. This will be done daily by DON or designee. The Administrator of designee will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then	

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 03/23/2023

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 732	Continued From page 24 03/23/23 staffing forms still had a couple of errors, and that the facility's scheduler will require additional education and follow-up audits, to verify the Staff Schedule/Assignment Sheets reports and the daily Posted Nurse Staffing Information sheets are correct.	F 732	monthly X3 utilizing the F732 Quality Assurance Tool. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nursing to ensure that corrective action for any concerns are initiated and monitored as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly x 4 then monthly x3 Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance:4/28/2023	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		4/28/23

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 03/23/2023

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 756	Continued From page 25 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Consultant Pharmacist interviews, the facility failed to address drug irregularities noted by the Consultant Pharmacist on two consecutive monthly Medication Regimen Reviews for 2 of 5 residents (Resident #43 and Resident #5) reviewed for unnecessary medications. Findings included: 1). Resident #43 was admitted to the facility on 7/24/20 with readmissions on 12/19/22 and 12/26/22. Resident #43's medical diagnoses included epilepsy, and anxiety. The 12/19/22 discharge summary medication list for Resident #43 included an order for lorazepam	F 756	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. F756 Drug Regimen Review, Report Irregular The facility failed to address drug irregularities noted by the Consultant Pharmacist on two consecutive monthly	

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 03/23/2023

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 756	Continued From page 26 0.5 milligrams (mg.) give 0.5 tablet three times per day as needed anxiety, agitation, seizure. The 12/26/22 discharge summary medication list for Resident #43 included an order for lorazepam 0.5 mg. give 0.5 tablet three times per day as needed anxiety, agitation, seizure. A physician order dated 12/19/22 was entered by Support Nurse #1 for lorazepam 0.5 mg. give 0.5 tablet by mouth three times per day. Review of Resident #43's December 2022 Medication Administration Report (MAR) revealed resident received lorazepam 0.5 mg. 0.5 tablet three times per day scheduled starting on 12/19/22 at 2:00 PM. Resident #43's 12/26/22 quarterly Minimum Data Set (MDS) revealed resident was severely cognitively impaired and received an antianxiety medication 6 of the 7 days in the review period. Consultant Pharmacist's Medication Regimen Review (MRR) on 1/20/23 stated: "Please note the following transcription error: Lorazepam was ordered prn (as needed) on 12/19/22 and 12/26/22 readmission orders. Nurse entered as 0.25 mg three times per day scheduled. There is not a current order for this. Please obtain this order if it was clarified on readmission. Must always upload clarification orders. " Review of the January 2023 MAR for Resident #43 revealed resident received lorazepam 0.5 mg. give 0.5 tablet three times per day daily for anxiety. Consultant Pharmacist's Medication Regimen	F 756	Medication Regimen Reviews for Resident #43 and Resident # 5. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/22/23 the Director of Nursing received clarification order by provider to keep Lorazepam 0.5 mg Give 0.5 tablet by mouth three times a day for anxiety for resident #43. On 3/23/23 the Director of Nursing educated Nurse #1 and Nurse #2 on responsibility of printing the pharmacy recommendations upon receipt and addressing recommendations in timely fashion. On 3/23/2023 the Director of nursing notified the physician of medication error for resident #5 related to administration of insulin for ordered Novolog 100u/milliliter. Hold for blood sugar less than 120. Resident assessed by M. Locklear, LPN on 3/23/2023 with no adverse events. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents receiving medications are at risk to be affected by this deficient practice. On 3/29/2023 the Director of Nursing began review of the April Consultant Pharmacy Medication Regimen to address recommendations. This completed on 4/11/2023. On 4/11/2023 the Director of Nursing/Support Nurses began auditing all residents with insulin parameters to	

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 03/23/2023

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 756	Continued From page 27 Review 2/22/23 revealed a second notice which stated: "Please note the following transcription error: Lorazepam ordered prn (as needed) on 12/19/22 and 12/26/22 readmit orders. Nurse entered as 0.25mg tid (three times per day) scheduled. There is not a current order for this. Please obtain this order if it was clarified on readmission. Must always upload clarification orders. " Review of the February 2023 MAR for Resident #43 revealed resident received lorazepam 0.5 mg. give 0.5 tablet three times per day daily for anxiety. Review of the March 2023 MAR for Resident #43 revealed resident received lorazepam 0.5 mg. give 0.5 tablet three times per day daily for anxiety. Interview with Support Nurse #1 on 3/23/23 at 1:00 PM revealed the pharmacy recommendations were divided by hall between herself and Support Nurse #2. Support Nurse #1 stated she was responsible for Resident #43's pharmacy recommendations as he was on one of her halls. Support Nurse #1 did not recall what happened with the pharmacy recommendations for January and February for Resident #43 which indicated a transcription error was made and the order for lorazepam required clarification. Support Nurse #1 revealed she received the pharmacy recommendations, printed them, and gave them to the provider in the facility or faxed them. It may be a while, she stated, before the recommendations were returned from the doctor. Support Nurse #1 stated she tried to have the pharmacy recommendations addressed by the time the pharmacist returned for the next visit but	F 756	ensure administration within the ordered parameters. This completed on 4/12/2023. On 4/11/2023 the Director of Nurses/Support Nurses auditing the past 7 days of admissions to ensure medications entered per discharge summary with medication reconciliation completed with clarification and documentation in progress note. This will be completed by 4/11/2023. The Director of Nurses and nursing team completed corrective action for those residents including notification to medical provider for clarification of orders and initiation of those orders. On 4/12/2023 all residents were in compliance with appropriate medication management. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 3/23/2023 the Nurse Consultant educated the Director of Nurses and nursing team on the following topics: " Timely review and follow up on Consultant Pharmacy Medication Regimen. " Admission process with completion third check during daily clinical with review of the discharge summary to ensure all medications/treatments entered correctly and medication reconciliation completed with documentation per provider clarification.	

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 03/23/2023

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 756	Continued From page 28 if not, the Pharmacy Consultant wrote a second notice. Interview on 3/21/23 at 4:45 PM with the Director of Nursing (DON) revealed Support Nurses #1 and #2 were responsible for printing the pharmacy recommendations upon receiving via email from the Consultant Pharmacist. DON further stated Support Nurses #1 and #2 were expected to review, provide copies to the medical providers, and follow up on all recommendations. DON indicated she had recommendations from January and February on her desk that she meant to follow up on. DON further indicated there was not a system for tracking the recommendations but would be implementing one. Interview with Consultant Pharmacist on 3/22/23 at 3:36 PM revealed she sent the recommendations via email to the Support Nurses, Director of Nursing and Administrator and expected the recommendations were addressed by the next monthly visit at the least, but hopefully sooner than that. The Consultant Pharmacist revealed clarification of the order was not received following the medication regimen reviews on 1/20/23 or 2/22/23. Consultant Pharmacist stated this type of order was one that would be a priority to have clarified but there was a breakdown in communication. Consultant Pharmacist revealed there had been change over in the position of Support Nurse and this may have resulted in some things falling through the cracks. Interview on 3/22/23 at 5:15 PM with Resident #43's physician revealed he signed and responded to pharmacy recommendations timely,	F 756	Beginning on 4/182023 the Director of Nursing educated all full time, part time, prn RN, LPN, Med aide, Med tech staff on the following topics: " Preventing medication errors " What is a medication error? " Holding medication administration per parameters " Examples of safe practice to incorporate into your daily med pass routine This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 4/21/2023 will not be allowed to work until training has been completed. 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 Nurses or designee will monitor compliance utilizing the F756 Quality Assurance Tool for compliance with the Drug Regimen Review Process related to Medication Reconciliation and Preventing Medication errors Reports weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor 5 Urine Culture and Sensitivity Reports to ensure an appropriate antibiotic is ordered with follow through of	

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 03/23/2023

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 756	Continued From page 29 usually within 24 hours of receiving them. If he had received the pharmacist note regarding clarification of the lorazepam order, the Physician stated he would have responded promptly. The Physician could not recall if he received the pharmacy recommendations for January and February for Resident #43. 2). Resident #5 was admitted to the facility on 6/5/19 with diagnoses which included in diabetes and long term use of insulin. Resident #5's 2/15/23 quarterly Minimum Data Set (MDS) assessment revealed resident with moderate cognitive impairment and received injections and insulin 7 days during the lookback period. Assessment indicated Resident #5 had orders for insulin changed once in the look back period. Review of December Medication Administration Record revealed: Novolog 100 units/milliliter Inject 16 units before lunch and dinner. Hold for blood sugar less than 120. 12/1/22 at 5 PM blood sugar 119. Insulin administered. 12/10/22 at 11 AM blood sugar 106. Insulin administered. 12/16/22 at 5 PM blood sugar 111. Insulin administered. 12/26/22 at 5 PM blood sugar 114. Insulin administered. Review of January Medication Administration Record revealed: Novolog 100 units/milliliter Inject 16 units subcutaneous before dinner and lunch. Hold for blood sugar less than 120. 1/1/23 at 5 PM blood sugar 114. Insulin	F 756	physician review and that all orders received are initiated. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the 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 Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/28/2023	

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 03/23/2023

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 756	Continued From page 30	F 756		

administered.
1/2/23 at 5PM blood sugar 116. Insulin administered.
1/4/23 at 5 PM blood sugar 100. Insulin administered.

Novolog Solution 100 units/milliliter Inject 8 units subcutaneously one time a day every morning. Hold if blood sugar less than 100.
1/2/23 blood sugar 93. Insulin administered.

Consultant Pharmacist Medication Regimen Review on 1/20/23 indicated:
Please note the following errors and write up-Novolog should have been held on the following days due to hold parameters but was given January 1, 2,4 at 5:00 PM.

Review of February Medication Administration Record revealed:
Novolog 100 units/milliliter Inject 16 units twice per day before lunch and dinner. Hold if blood sugar less than 120.
2/5/23 at 11 AM blood sugar 110. Insulin administered.
2/7/23 at 5 PM blood sugar 97. Insulin administered.
2/8/23 at 11 AM blood sugar 107. Insulin administered.

Novolog 100 units/milliliter Inject 8 units twice per day before lunch and dinner. Hold if blood sugar less than 120.
2/13/23 at 5 PM blood sugar 110. Insulin administered.
2/24/23 at 5 PM blood sugar 12. Insulin administered.

Novolog 100 units/milliliter. Inject 4 units every

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 03/23/2023

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 756	Continued From page 31	F 756		

morning. Hold for blood sugar less than 120.
2/15/23 at 8AM blood sugar 101. Insulin administered.

Consultant Pharmacist Medication Regimen Review on 2/22/23 indicated:
Staff continues to administer Novolog when doses should be held-New parameters are to hold for Blood Sugar less than 120. This must be discussed with staff.

Review of March Medication Administration Record revealed:
Novolog Insulin 4 units subcutaneous every morning. Hold for blood sugar less than 120.
3/4/23 blood sugar 111. Insulin administered.
3/14/23 blood sugar 104. Insulin administered.

Interview on 3/21/23 at 4:45 PM with the Director of Nursing (DON) revealed Support Nurses #1 and #2 were responsible for printing the pharmacy recommendations upon receiving via email from the Consultant Pharmacist. DON further stated Support Nurses #1 and #2 were expected to review, provide copies to the medical providers, and follow up on all recommendations. DON indicated she had recommendations from January and February on her desk that she meant to follow up on. DON further indicated there was not a system for tracking the recommendations but would be implementing one.

Interview on 3/22/23 at 12:38 PM with the Nurse Practitioner (NP) revealed that insulin administered below the parameter could result in hypoglycemia. NP stated she had not been notified of Resident #5 receiving insulin outside of the parameters, had not been made aware of 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 03/23/2023

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 756	Continued From page 32 Consultant Pharmacist Medication Regimen Reviews for January and February and had not been involved in any follow up regarding this. Interview on 3/22/23 at 3:50 PM with the Consultant Pharmacist revealed she had reviewed Resident #5's medications and noted the issue with the insulin, blood sugars and not following parameters. Consultant Pharmacist stated the risk would be that resident would experience hypoglycemia (low blood sugar) if insulin was administered outside the parameter. Resident #5's blood sugars were labile and required adjustments, so it was especially important that the nurses followed the orders as written. Consultant Pharmacist stated there had been changes in the Support Nurse position and that may be why the pharmacy recommendations were not addressed. Interview on 3/23/23 at 1:00 PM with Support Nurse #1 revealed she did not recall addressing the pharmacy recommendation regarding the insulin being given outside of the parameters and did not complete any education or follow up regarding insulin and following parameters. Interview with the Director of Nursing (DON) on 3/23/23 at 4:41 PM revealed she did not know why the Consultant Pharmacist's Medication Regimen Reviews for Resident #5 for January and February were not addressed but she would begin tracking the recommendations more closely.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		4/28/23

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 03/23/2023

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 758	Continued From page 33	F 758		

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record 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 03/23/2023

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 758	Continued From page 34 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner and Consultant Pharmacist interviews, the facility failed to 1). accurately transcribe and administer a medication used to treat anxiety resulting in resident was administered antianxiety medication on a scheduled basis instead of as needed per the physician order, and 2) accurately transcribe and administer a medication used to treat depression and insomnia resulting in resident received 22 doses of the medication at a higher dose than ordered for 2 of 5 residents (Resident #43 and Resident #5) reviewed for psychotropic medication (a medication used to treat behavior, mood, thoughts, or perception). Findings included: 1). Resident #43 was admitted to the facility on 7/24/20 with readmissions on 12/19/22 and 12/26/22. Resident #43's medical diagnoses included in part intellectual disability, epilepsy, and anxiety. Resident #43's care plan revealed a focus initiated on 7/24/20 and reviewed on 1/15/23 of received anti-anxiety medication with risk for adverse side effects. The goal indicated Resident #43 would be free from discomfort or adverse reactions related to antianxiety therapy. Interventions included Consultant Pharmacist to	F 758	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. F758 The facility failed to 1). Accurately transcribe and administer a medication used to treat anxiety resulting in resident was administered antianxiety medication on a scheduled basis instead of as needed. 2). Accurately transcribe and administer a medication used to treat depression and insomnia resulting in resident received 22 doses of medication at a higher dose than ordered for Resident #43 and Resident #5. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #43 Director of Nursing received order on 3/22/23 to keep resident on scheduled dose of Lorazepam 0.5mg give 0.5 tablet three times a day daily.	

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 03/23/2023

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 758	Continued From page 35 review psychotropic medications quarterly and as needed for possible changes or reductions and give anti-anxiety medication as ordered by the physician. The 12/19/22 discharge summary medication list for Resident #43 included an order for lorazepam 0.5 milligrams (mg.) give 0.5 tablet three times per day as needed. The 12/26/22 discharge summary medication list for Resident #43 included an order for lorazepam 0.5 mg. give 0.5 tablet three times per day as needed. A physician order dated 12/19/22 was entered by Support Nurse #1 for lorazepam 0.5 mg. give 0.5 tablet by mouth three times per day. Review of Resident #43's December 2022 Medication Administration Report (MAR) revealed resident received lorazepam 0.5 mg. 0.5 tablet three times per day scheduled starting on 12/19/22 at 2:00 PM. Resident #43's 12/26/22 quarterly Minimum Data Set (MDS) revealed resident was severely cognitively impaired and received an antianxiety medication 6 of the 7 days in the review period. Consultant Pharmacist's Medication Regimen Review (MRR) on 1/20/23 stated: "Please note the following transcription error: Lorazepam was ordered prn (as needed) on 12/19/22 and 12/26/22 readmission orders. Nurse entered as 0.25 mg three times per day scheduled. There is not a current order for this. Please obtain this order if it was clarified on readmission. Must always upload clarification orders. "	F 758	For resident #5 Trazodone 100mg q HS was discontinued by the pharmacist on 1/23/2023. Resident continued on smaller dose of Trazodone 75mg q HS as ordered by the provider. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 4/11/23 the Director of nursing / support nurses reviewed the past 30-day pharmacy consultant recommendations to ensure timely follow up of recommendations. This completed by 4/11/2023 . On 4/11/2023 the Director of nursing/support nurses reviewed the past 7 days of all admissions to ensure no transcription orders compared to discharge summary and medication reconciliation documented in medical record for all clarifications. This completed by 4/11/2023. On 4/11/2023 the Director of Nursing / Support nurses implemented corrective action for all the above residents by notification to provider, clarification orders implemented, medication reconciliation documented in medical record and medication error report for any found errors. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 4/10/23 the 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 03/23/2023

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 758	Continued From page 36 Review of the January 2023 MAR for Resident #43 revealed resident received lorazepam 0.5 mg. give 0.5 tablet three times per day daily. Consultant Pharmacist's Medication Regimen Review 2/22/23 revealed: "Please note the following transcription error: Lorazepam ordered prn (as needed) on 12/19/22 and 12/26/22 readmit orders. Nurse entered as 0.25mg tid (three times per day) scheduled. There is not a current order for this. Please obtain this order if it was clarified on readmission. Must always upload clarification orders. " Review of the February 2023 MAR for Resident #43 revealed resident received lorazepam 0.5 mg. give 0.5 tablet three times per day daily. Interview on 3/21/23 at 4:45 PM with the Director of Nursing revealed when a resident was admitted or readmitted from the hospital the Support Nurse, if available entered the orders in the computer from the discharge summary. The floor nurse was to complete the second check comparing the discharge paperwork with the physician orders entered in the computer. DON stated there was supposed to be a QA system in place for a 3rd check of the physician orders. The Support Nurse was to notify the provider when the resident was admitted or readmitted, verified the orders and made any changes. DON stated she was not aware of the discrepancy with the lorazepam order that was entered until this week and did not know how it occurred. DON stated she did not know how the order was entered incorrectly if the checks were completed as they were supposed to be.	F 758	Consultant educated the Director of Nurses and nursing team on the following topics: " Drug regimen reviews should include an audit of the monthly pharmacy consultant recommendations to assure that they have been addressed by the physician and orders received as a result of recommendations have been implemented timely. " Drug regimen reviews are uploaded to the individual resident documents once all steps in the process have been completed. Beginning on 4/18/2023 the Director of Nursing will begin educating all full time, part time, prn RN, LPN nurses on the Admission process and Drug regimen review to include preventing medication error process. o Preventing transcription errors during the admission/readmission process o Admitting nurse□s responsibility to get a second nurse to compare the Order Summary Sheet to the Admitting Orders, discharge summary, and any other hospital documentation to ensure all orders are accounted for and entered correctly. o Nurse Responsibilities for Verbal orders and Written orders o Medication or Treatment Errors: o Purpose of adequate review to ensure no unnecessary treatment with medications such as Psychotropic meds This information has been integrated into the standard orientation training and in 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 03/23/2023

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 758	Continued From page 37 Follow up interview with the DON on 3/22/23 at 10:00 revealed clarification was received via phone on 3/22/23 from the provider regarding the scheduled order for lorazepam for Resident #43. Interview with Consultant Pharmacist on 3/22/23 at 3:36 PM revealed she sent the recommendations via e mail to the Unit Managers, Director of Nursing and Administrator and expected the recommendations were addressed by the next monthly visit at the least, but hopefully sooner than that. The Consultant Pharmacist stated the order for Resident #43 for lorazepam dose as needed was entered and administered scheduled which was a medication error. The Consultant Pharmacist revealed clarification of the order was not received following the medication regimen reviews on 1/20/23 or 2/22/23. Consultant Pharmacist stated this type of order was one that would be a priority to have clarified but there was a breakdown in communication. Interview on 3/22/23 at 5:15 PM with Resident #43's physician revealed he signed and responded to pharmacy recommendations timely, usually within 24 hours of receiving them. If he had received the pharmacist note regarding clarification of the lorazepam order, the Physician stated he would have responded promptly. The Physician could not recall if he was notified of clarification needed of lorazepam dose. The Physician stated the dose of lorazepam given would not have caused harm, but it was a medication error in that the facility did not follow the orders as written from the hospital. Interview with Support Nurse #1 on 3/23/23 at 1:00 PM revealed she entered the orders for	F 758	required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 4/21/2023. 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 Nurses or designee will monitor compliance utilizing the F758 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor for Drug regimen review and Admission process. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance unnecessary medications and psychotropic medications. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/28/2023	

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 03/23/2023

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 758	Continued From page 38	F 758		

Resident #43 when he returned from the hospital on 12/19/22. Support Nurse # 1 stated she did not recall having made a transcription error when she entered the order for Resident #43 for lorazepam 0.25 mg. three times per day scheduled instead of as needed. Support Nurse #1 indicated she had not verified the orders or received clarification changing the dose from as needed to scheduled when Resident #43 was readmitted to the facility. Support Nurse #1 stated she did not rec what happened with the pharmacy recommendation that indicated a transcription error was made and the dose of lorazepam 0.25 milligrams for Resident #43 required clarification. Support Nurse #1 revealed she received the Consultant Pharmacy recommendation printed them and gave them to the provider in the facility or faxed them. It may be a while, she stated before the recommendations were returned from the doctor. Support Nurse #1 stated she tried to have the pharmacy recommendations addressed by the time the pharmacist returned for the next visit but if not, the Consultant Pharmacist wrote a second notice.

Follow up interview with the DON on 3/23/23 at 4:35 PM revealed she did not know why this order for lorazepam was transcribed incorrectly and was not addressed. DON stated she was not sure how the order was transcribed incorrectly as there was a system that required another nurse to confirm the orders to make sure the medication was transcribed to include right patient, right medication, right dose, right frequency, right route, and the right time to ensure all orders were transcribed correctly. DON stated she was not aware until this week that there had been a medication error made with Resident #43's

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 03/23/2023

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 758	Continued From page 39	F 758		

medication.

2). Resident #5 was admitted to the facility on 6/5/19 with diagnoses which included in part depression, schizophrenia, and dementia.

Consultant Pharmacist Medication Regimen Review on 12/21/22 indicated: "Continues on Trazodone 100 mg. qhs (at bedtime) Please consider a small reduction of the Trazodone to 75 mg. to help establish the lowest, effect dose to reduce risks of developing side effects.

Consultant Pharmacist Medication Regimen Review with recommendation to reduce Resident #5's trazodone to 75 mg. at bedtime was signed on 12/23/22.

A physician order dated 12/26/22 was entered by Support Nurse #1 for trazodone 75 mg. at bedtime.

Review of Resident #5's December 2022 MAR revealed resident received:
trazodone 75 mg. at bedtime nightly from 12/27/22 through 12/31/22.
trazodone 100 mg. at bedtime nightly from 12/1/22 through 12/31/22.

Resident #5's care plan indicated a focus reviewed on 1/4/23 of received antidepressant medication with increased risk for adverse side effects. Interventions included Consulting Pharmacist to review my psychotropic medications quarterly and as needed for possible changes or reductions and give antidepressant medications ordered by physician.

Review of Resident #5's January 2023 MAR

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 03/23/2023

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 758	Continued From page 40	F 758		

revealed resident received:
trazodone 75 mg. at bedtime nightly from 1/1/23 through 1/31/23.
trazodone 100 mg. at bedtime nightly from 1/1/23 through 1/17/23 with discontinuation date listed as 1/18/23.

Consultant Pharmacist Medication Regimen Review on 1/20/23 indicated: "Please note the following error needs to be written up. Trazodone reduced to 75 mg. q hs (at bedtime) on 12/26/22 and order entered however staff did not d/c (discontinue) the old order for 100 mg. Cannot tell what resident had been receiving Pharmacist indicated she will d/c the 100 mg. today."

Resident #5's 2/15/23 quarterly Minimum Data Set (MDS) revealed resident with moderate cognitive impairment and received an antidepressant 7 days during the lookback period.

Interview on 3/22/23 at 12:38 PM with the Nurse Practitioner (NP) revealed she was not made aware of the medication error in which Resident #5 received an increased dose of trazodone or the Consultant Pharmacist Medication Regimen Review regarding the error. NP stated that an increased dose of trazodone would result in increased sleepiness. NP stated that the order written for 75 mg. trazodone should have been entered and administered as ordered with the previous order for 100 mg. trazadone discontinued.

Interview on 3/22/23 at 2:02 PM with the Director of Nursing (DON) revealed the nurses were responsible for transcribing and entering orders correctly into the computer.

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 03/23/2023

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 758	Continued From page 41 Interview on 3/22/23 at 3:50 PM with the Consultant Pharmacist revealed over sedation and increased risk of falls would be the risk associated with an increased dose of trazodone. Consultant Pharmacist indicated this was an error that should have been addressed and the facility should have investigated the process of how the error occurred. Interview with Support Nurse #1 on 3/23/23 at 1:00 PM revealed she entered the order for trazodone 75 milligrams at bedtime but did not recall an error with not discontinuing the previous dose. When the physician or provider wrote an order to decrease or change a dose, Support Nurse #1 stated, the previous dose was to be discontinued. Support Nurse #1 stated Resident #5's previous dose of trazodone should have been discontinued when the new dose was started. Interview with the Director of Nursing (DON) on 3/23/23 at 4:45 PM revealed that when the physician wrote an order for a dose reduction the prior dose should be discontinued. DON indicated she was not aware there had been a medication error with Resident#5's trazadone orders.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner and Consultant Pharmacist interviews, the facility	F 760	The statements made on this plan of correction are not an admission to and do	4/28/23

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 03/23/2023

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 760	Continued From page 42 failed to follow parameters for administration of a medication used to treat hyperglycemia resulting in 16 doses administered in error for 1 of 1 resident (Resident #5) reviewed for medication error. Findings included: Resident #5 was admitted to the facility on 6/5/19 with diagnosis which included in part diabetes and long term use of insulin. Resident #5's 2/15/23 quarterly Minimum Data Set (MDS) assessment revealed resident with moderate cognitive impairment and received injections and insulin 7 days during the lookback period. Assessment indicated Resident #5 had orders for insulin changed once in the look back period. Resident #5's care plan indicated a 6/6/19 focus of Diabetes Mellitus with risk for complications. The focus was reviewed on 1/4/23. The goal indicated diabetes would be adequately managed in order to minimize risk for complications. Interventions included Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Follow facility protocol for episodes of hypoglycemia (low blood sugar), follow physician orders for episodes of hyperglycemia (high blood sugar). Review of December Medication Administration Record revealed: Novolog 100 units/milliliter Inject 16 units before lunch and dinner. Hold for blood sugar less than 120. 12/1/22 at 5 PM blood sugar 119. Insulin administered.	F 760	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. F760 the facility failed to follow parameters for administration of a medication used to treat hyperglycemia resulting in medication error for resident #5. 1. A corrective action for the resident involved On 3/23/2023 the Director of Nursing notified provider of the medication error related to administration of Insulin with hold parameter for blood sugar less than 120. On 3/23/2023 Support Nurse # 1 assessed the resident with no finding of adverse effects. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who are receiving medications withhold parameters are at potential risk of being affected by deficient practice. Beginning on 4/11/2023, the Director of Nursing / support nurses audited all current physician orders to identify orders with parameters to hold medication and audited to ensure held per order. This process was completed by 4/12/2023. Findings: All residents MARS were	

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 03/23/2023

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 760	Continued From page 43 12/10/22 at 11 AM blood sugar 106. Insulin administered. 12/16/22 at 5 PM blood sugar 111. Insulin administered. 12/26/22 at 5 PM blood sugar 114. Insulin administered. Review of January Medication Administration Record revealed: Novolog 100 units/milliliter Inject 16 units subcutaneous before dinner and lunch. Hold for blood sugar less than 120. 1/1/23 at 5 PM blood sugar 114. Insulin administered. 1/2/23 at 5PM blood sugar 116. Insulin administered. 1/4/23 at 5 PM blood sugar 100. Insulin administered. Novolog Solution 100 units/milliliter Inject 8 units subcutaneously one time a day. Hold if blood sugar less than 100. 1/2/23 blood sugar 93. Insulin administered. Consultant Pharmacist Medication Regimen Review on 1/20/23 indicated: Please note the following errors and write up-Novolog should have been held on the following days due to hold parameters but was given January 1, 2,4 at 5:00 PM. Review of February Medication Administration Record revealed: Novolog 100 units/milliliter Inject 16 units twice per day before lunch and dinner. Hold if blood sugar less than 120. 2/5/23 at 11 AM blood sugar 110. Insulin administered. 2/7/23 at 5 PM blood sugar 97. Insulin	F 760	audited for the month of April: 1 Resident receiving retacrit every 2 weeks depending on Hgb were given retacrit with no documentation of the hgb. 1 Resident was given diltiazem 60 mg with parameters to hold if SBP less than 110 or HR less than 60. SPB was 103 and the diltiazem was given. Beginning on 4/10/2023, the Director of Nursing or support nurse completed a medication pass observation for 3 nurses / med aides on each shift to observe for medications administered per the medication order and ensure that any medication with parameters held per order. This audit was completed on or before 4/13/2023. 3. Systemic Changes Beginning on 4/18/2023 the Director of Nursing will begin educating all full time, part time, prn RN, LPN nurses on the following topic: Medication Errors. " What is a Medication Error? Emphasizing attention to physician□s orders that include parameters. " How to avoid making a medication error? " How to minimize errors for specific medications. " How to Avoid Medication Errors during administration. The 6 rights. " What to do once a Medication Error is Discovered? The DON will ensure that any of the above identified staff who does not complete the in-service training by	

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 03/23/2023

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 760	Continued From page 44 administered. 2/8/23 at 11 AM blood sugar 107. Insulin administered. Novolog 100 units/milliliter Inject 8 units twice per day before lunch and dinner. Hold if blood sugar less than 120. 2/13/23 at 5 PM blood sugar 110. Insulin administered. 2/24/23 at 5 PM blood sugar 12. Insulin administered. Novolog 100 units/milliliter. Inject 4 units every morning. Hold for blood sugar less than 120. 2/15/23 at 8AM blood sugar 101. Insulin administered. Consultant Pharmacist Medication Regimen Review on 2/22/23 indicated: Staff continues to administer Novolog when doses should be held-New parameters are to hold for Blood Sugar less than 120. This must be discussed with staff. Review of March Medication Administration Record revealed: Novolog Insulin 4 units subcutaneous every morning. Hold for blood sugar less than 120. 3/4/23 blood sugar 111. Insulin administered. 3/14/23 blood sugar 104. Insulin administered. Interview on 3/22/23 at 12:38 PM with the Nurse Practitioner (NP) revealed that Resident #5 received long and short acting insulin. Insulin administered below the parameter could result in hypoglycemia. NP stated she had not been notified of resident receiving insulin outside of the parameters and had not been made aware of the pharmacy notation regarding the doses of insulin	F 760	4/21/2023 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 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 and/or clinical leadership team member in her absence will monitor completion of ongoing audits for F 760 a minimum of weekly X 4 weeks and then monthly X 2 months or until resolved. This audit will be completed by randomly auditing five nurse med passes (to include all shift and weekends) to assess that medications administered per order and hold parameters were followed. Any negative findings will immediately be addressed and reviewed with the facility QA nurse consultant for interventions or additional training. 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: 4/28/2023	

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 03/23/2023

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 760	Continued From page 45	F 760		

given outside of the parameters.

Interview on 3/22/23 at 3:50 PM with Consultant Pharmacist revealed she had reviewed Resident #5's medications and noted the issue with the insulin, the blood sugar and not following parameters. Consultant Pharmacist stated the risk would be that resident would experience hypoglycemia (low blood sugar) if insulin was administered outside the parameter. Resident #5's blood sugars are labile and have required adjustments, so it was especially important that the nurses followed the orders as written.

Interview on 3/22/23 at 4:24 PM with Nursing Supervisor revealed she had been in this role since November 2022. Nursing Supervisor revealed that she was assigned to check the blood sugar and administer insulin some days when a Medication Aide was assigned to Resident #5. Nursing Supervisor indicated a check mark with the initials on the MAR indicated the dose was administered. MARs were reviewed with the Nursing Supervisor who stated she administered the insulin in error when it should have been held when below the specified parameter according to the physician order. Nursing Supervisor stated if Resident #5 had not eaten and the blood sugar was below the parameter, she still administered the insulin according to her nursing judgement.

Interview with Nurse #1 on 3/22/23 at 4:50 PM revealed that a check mark with the initials on the MAR indicated that the dose was administered. Review of the MARs with Nurse #1 indicated she had checked Resident #5's blood sugar and administered the insulin in error. Nurse #1 indicated that when she obtained the blood sugar

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 03/23/2023

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 760	Continued From page 46 outside of the parameter, she should have held the insulin dose according to the parameter designated in the physician order. Nurse #1 did not recall having had an in service regarding insulin administration and parameters recently. Nurse #1 stated she must have missed looking at the parameter as part of the order for insulin administration for Resident #5. Interview with Resident #5 on 3/23/23 at 9:06 AM revealed she is diabetic, and her sugar is up and down. Resident #5 stated she gets dizzy sometimes and doesn't feel well when her sugar is low. Resident #5 stated she had history of falls and that she had fallen due to being dizzy. Interview on 3/23/23 at 1:00 PM with Support Nurse #1 revealed she was not aware Resident #5 received insulin outside of the parameters. Support Nurse #1 stated she did not recall addressing the pharmacy recommendation regarding the insulin being given outside of the parameters and did not complete any education or follow up regarding insulin and following parameters. Interview with the Director of Nursing (DON) on 3/23/23 at 4:41 PM revealed she was not aware of the issue with Resident #5's insulin being given outside of parameter. DON stated she had not in serviced the staff regarding administration of insulin and following parameters. DON stated nurses should be following the parameters and should contact the provider and document if they had a question about a parameter for a medication.	F 760		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5)	F 790		4/28/23

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 03/23/2023

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 790	Continued From page 47 §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that	F 790		

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 03/23/2023

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 790	Continued From page 48 led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and Physician interviews the facility failed to obtain dental care for a resident with painful inflamed upper gums, and strong mouth odor for 1 of 1 resident reviewed for dental (Resident #65). The findings included: Resident #65 was admitted to the facility on 10/17/22 with multiple diagnoses including metabolic encephalopathy, dementia, anxiety, and affective mood disorder. A review of the quarterly Minimum Data Set (MDS) dated 01/10/23 indicated that Resident #65 had severe cognitive impairment and needed total assistance with personal hygiene. Resident #65 was coded for no issues with her teeth, no pain, coded for enteral feeding, and was coded for physical and verbal behavioral symptoms directed toward others and rejection of care. Review of Resident #65's recent visits from her Primary Physician dated 12/07/22 and 01/27/23 indicated the following: "Mouth & Throat - Normal." A nursing note dated 02/16/23 at 2:31 PM by Nurse #7 revealed Resident #65 has strong foul odor coming from mouth, redness and bleeding noted on gum line and teeth. Resident has verbalized that there is pain in her mouth on several occasions. Nurse #7 no longer worked at	F 790	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. F 790 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to obtain dental care for resident #65 with painful inflamed upper gums and strong mouth odor. Corrective action for resident(s) affected by the alleged deficient practice: Resident#65 was assessed by the Director of Nursing on 3/22/23 with notification to provider of gum redness and inflammation, with no active bleeding. Orders received to have resident evaluated by Dental services. On 3/23/23 Director of Nursing contacted the provider to inform of next available appointment with resident□s outside Dental Provider would be 30 days. Provider ordered for resident to be seen in emergency department for evaluation. 3/23/23 resident returned to facility with order for Peridex solution and instruction to follow	

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 03/23/2023

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 790	Continued From page 49 the facility and was unable to be reached for an interview. A nursing note dated 02/23/23 at 7:08 PM by Nurse #1 revealed Resident #65 remains in bed today, denies any pain. Resident continues to have dry mouth/lips and a foul, strong odor coming from her mouth. Review of Resident #65's care plan dated 03/21/23 was conducted. The care plan problems were "I have an Activities of Daily Living (ADL) self-care performance deficit related to dementia. I am resistive to care such as bathing, turning, repositioning, and grooming related to dementia." Interventions included, in part, if the resident had an episode of inappropriate behaviors of yelling out for no apparent reason, cursing, or striking at staff, the staff member should leave the resident for a time, and come back later to complete the task. A nursing note dated 03/22/23 at 12:04 PM by Nurse #1 revealed Resident #65 continues to have dried lips and a very foul odor coming from mouth. The resident was offered oral care and refused. The medication aide stated resident began grabbing her hand along with another staff members hands and refused oral care. An interview was conducted with Nurse #1 on 03/22/23 at 5:00 PM. Nurse #1 said she was the nurse who wrote the 02/23/23 nursing note about Resident #65 having a strong mouth odor, dry lips, and no pain. She said she thought she faxed a note to Primary Physician's office informing him of what she observed. Nurse #1 said she did not follow-up with the Primary Physician's office to see if they received her information and should	F 790	up with Dental provider. 3/23/23 Peridex Solution 0.12% give 10 ml by mouth two times a day for mouth pain was initiated. 3/27/23 resident was seen by in house Dental provider with orders to schedule resident for sedated cleaning. The appointment is set for May 4, 2023. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who are experiencing dental issues such as oral pain, reddened, inflamed or bleeding gums are at potential risk of being affected by deficient practice. The Director of Nurses and nursing supervisors initiated an audit of 100% of all residents for dental issues to include not limited to oral pain, reddened, inflamed or bleeding gums. This will be completed by 3/27/2023. On 4/6/2023 all residents were evaluated by the in-house Care Secure Mobile Dental provider with exception of 7 residents who refused evaluation to identify dental concerns. The Director of Nursing, Support Nurse completed corrective actions for the above residents including notification to Medical provider and patient representative and initiation of all new orders. On 4/6/2023 all residents were in compliance with physician notification, resident representative notification and any identified oral or dental concerns addressed.	

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 03/23/2023

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 790	Continued From page 50 have. Nurse #1 said they could not find any documentation supporting she sent the fax to Primary Physician's office. Nurse #1 said they could not find any documentation to support the resident had any Dental visits at all. Nurse #1 said Resident #65 was never placed on the list to be seen by the visiting dentist, or any documentation of the resident ever leaving the facility to see a dentist. An observation initiated by the Director of Nursing (DON) of Resident #65's mouth was conducted on 03/22/23 at 4:35 PM in resident's room. The resident was pleasant, and the DON asked if she could look into her mouth, and the resident agreed. Resident's upper gums appeared red and inflamed with no active bleeding noted. The DON then asked the resident if her mouth was painful and hurt. Resident responded yes. The resident asked the DON if she would call her MD for her. The DON informed the resident that she would call him as soon as she left her room. A nursing note dated 03/22/23 at 4:38 PM for Resident #65 revealed the DON phoned the Primary Physician's office to discuss resident's gums. The DON spoke with the nurse at the resident's Physician's office and described Resident #65's gums were red and swollen, resembling gingivitis, and would feel better if we got her on something as well as a dental consult. A nursing note dated 03/22/23 at 5:04 PM for Resident #65 revealed the DON received a call from Primary Physician's office regarding resident's gums and ordered a dental consult. The facility Primary Physician was interviewed by phone on 03/23/23 at 10:25 AM. The Primary	F 790	2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/18/2023 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics: " Conducting an oral assessment when oral pain, gum redness, inflammation, or bleeding noted. " Notification of the physician/RP with resident change in condition or concerns. " Documentation process for notification of the physician/RP. " Facility assisted residents in obtaining routine and 24-hour emergency dental care. " Must if necessary or if requested assist the resident in making appointments and arranging for transportation to and from the dental services location. " Must promptly within 3 days refer residents with lost or damaged dentures for dental services. " Facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. The DON will ensure that any of the above identified staff who does not complete the in-service training by 4/21/2023 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation.	

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 03/23/2023

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 790	Continued From page 51 Physician said since December/2022 he had no contact from the facility regarding resident's recent gum issues until yesterday (03/22/23). He said residents on enteral feeding will have dental issues. An interview was conducted on 03/23/23 at 3:20 PM with the Administrator and DON. They both stated that they would expect their nurses to notify a resident's physician if a resident was assessed for mouth or gum odor, swelling, redness or strong odor. The Administrator stated her expectations were for every resident to be seen for dental concerns.	F 790	3. 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 Nurses or LPN Support Nurse will monitor compliance utilizing the F790 Quality Assurance Tool by completing an audit weekly x 2 then monthly x 3 months or until resolved. The audit will include monitoring during Daily QOL (Monday-Friday) for compliance with the notification process by auditing progress notes for documentation of resident concerns and observation of resident□s oral care to ensure that medical provider and patient representative where notified timely with timely follow up appointment. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance: 4/28/2023	
F 810 SS=E	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices	F 810		4/28/23

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 03/23/2023

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 810	Continued From page 52 The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and resident interviews the facility failed to provide an adaptive handled cup for 1 of 1 resident (Resident #27) reviewed for accommodation of needs. Findings included: Resident #27 was admitted to the facility on 12/23/13 with diagnoses of osteoarthritis with stiffness of right and left hand. Resident #27's 1/28/23 quarterly Minimum Data Set (MDS) assessment revealed resident was cognitively intact and required set up assist and supervision with eating. Resident #27 had functional limitation of range of motion of upper extremity on both sides. Resident #27's care plan indicated a focus entered on 6/17/20 and revised on 1/28/23 of required set up assistance with eating meals and handled cups for all meals. Interventions included a handled cup with all meals, set up meal tray and report if increased assistance was needed with eating and drinking. Observation on 3/20/23 at 12:56 PM revealed Resident #27sitting in wheelchair with meal tray on the tray table in front of her. Resident #27's drinks were not served in handled cups.	F 810	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. F810 1. For dietary services, a corrective action was obtained on 3/23/2023. Based on observation, record review, and interviews the facility failed to provide adaptive equipment as care planned for 1 of 1 resident reviewed. Resident #27 reassessed by therapy 3/20/2023 to assess adaptive equipment needs. Orders, meal ticket, and care plan was updated 3/20/2023 to reflect therapy recommendations. On 4/13/2023 Primary Care Provider was notified of Resident #27 with the last 3-month weights which show a 1 to 1.2 lb increase each month and that therapy was evaluating her for nutrition adaptive needs. Primary Care Provider ordered CMP, CBC, 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 03/23/2023

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 810	Continued From page 53 Observation on 3/21/23 at 8:56 AM of breakfast meal revealed Resident #27 did not have handled cups on her meal tray for her drinks. Observation of the meal ticket on her tray revealed a diet order of regular diet and did not list handled cup for meals. Observation and interview with Resident #27 on 3/22/23 at 8:56 AM revealed resident sitting in wheelchair with breakfast tray on the table in front of her and resident feeding herself. Resident #27's meal tray was observed with coffee in a plastic handled cup and juice in a plastic cup with no handles and a straw in it. Resident #27was observed putting her thumb inside the cup of juice and lifting with her thumb and the side of her hand unsteadily to her mouth to drink, Resident #27 stated it was difficult and sometimes she spilled but she tried to do the best she could and did not want to bother anyone. Resident #27 stated if the drink was served in a cup with a lid and a straw, as it sometimes was, she could not lift the cup and instead had to move her head down to the cup to drink. Resident #27 stated a cup with handles would be easier to drink from, but she had not had one for a long time. Interview on 3/22/23 at 9:45 AM with the Occupational Therapist indicated Resident #27 received occupational therapy in June 2020 and recommendation was made for handled cups for all meals. Occupational Therapist stated that handled cups for all meals should still be in place. Interview on 3/23/23 at 1:15 PM with the Dietary Manager revealed she had been in the position since June 2022. The Dietary Manager revealed that the dietary department did not provide a handled cup for Resident #27 for meals. Dietary	F 810	pre-albumin to be obtained on 4/14/2023 to review nutrition and hydration status. On 4/10/2023 IDT reviewed Resident #27 for nutritional status. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. Rehab Director reviewed 100% of residents to assess for possible adaptive equipment needs. completed on 4/13/2023. Those residents identified with potential need for further evaluation were referred to Occupational therapy for evaluation. Once evaluation is completed the order, meal tickets and care plans will be updated prior to compliance date 4/28/23. Findings Included: 12 Residents identified with potential need of adaptive equipment. All 12 Residents will be referred to Occupational Therapy for evaluation. On 4/14/2023 the rehab director/Material data set nurse audited all current residents with orders for adaptive equipment to ensure that the adaptive equipment is in place for resident, order, care plan and meal tickets are all correct. Findings Included: 4 Residents with adaptive equipment. All orders for adaptive equipment is in place, order, care plan and meal tickets are all correct.	

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 03/23/2023

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 810	Continued From page 54 Manager revealed that the dietary department used to provide assistive devices for eating for residents, but it had been a long time since they had done that. Dietary Manager stated she thought nursing provided assistive devices for eating for the residents. Interview with the Director of Nursing on 3/23/23 at 4:20 PM revealed the dietary department should provide assistive devices including handled cups for residents. DON stated she was not aware that Resident #27 was to have a handled cup and was not getting one for meals. DON stated that she expected residents would be provided with assistive devices for eating and drinking.	F 810	3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: • Purposes of Adaptive Equipment • Process for assessing and ordering adaptive equipment in PCC and PCC Traycard. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director and Nursing staff will monitor procedures for providing adaptive equipment weekly x 4 weeks then monthly x 2 months using the QA Audit which will include reviewing meal trays at each meal to ensure adaptive equipment provided as ordered. 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	

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 03/23/2023

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 810	Continued From page 55	F 810	Manager, and the Dietary Manager	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain potentially hazardous food items within safe temperature range for cold food items, at or below 41 degrees Fahrenheit (F) during the lunch meal service. The findings include: An observation of the lunch meal tray line on 03/20/232 at 11: 30 AM. Temperature monitoring, with the Dietary Manager on 11/07/22 at 12:20 PM revealed the following temperatures: garden salads 48 degrees F. The four garden salads	F 812	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. F812	4/28/23

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 03/23/2023

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 812	Continued From page 56 were observed not on ice, kept on a food tray on top of an empty food cart next to the food tray line, ready to be placed on residents' food trays. The garden salads contained lettuce, shredded carrots, tomatoes, and cheese. During an interview with the Dietary Manager on 03/20/23 at 12:45 PM, she stated that she expected dietary staff to serve cold foods 41 degrees F or below and if cold foods were higher than 41 degrees F the food items should be discarded prior to serving. She also stated the salads should have been kept cool below 41 degrees F just prior to serving and was not. During an interview with the Director of Dietary Services on 03/22/23 at 8:45 AM, she revealed cold food temperatures were required to be below 41 degrees F when served from the tray line. During an interview with the Administrator on 03/23/23 at 7:00 PM it was revealed it was her expectation the facility's kitchen would follow all regulatory guidelines for food and kitchen sanitation safety.	F 812	1. For dietary services, a corrective action was obtained on 03/20/2023. Based on observation dietary services failed to follow tray line production policies and properly maintain temperatures for 4 of 4 salads for meal service. On 3/20/2023 Dietary Service Director removed salads from service with need to be brought down to appropriate temperature and placed on ice to maintain temperature during service. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/20/2023, the Dietary Service Director completed a temperature review of all items for meal service. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Temperature danger zone. " Production and Trayline Procedure Policies. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify 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 03/23/2023

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 812	Continued From page 57	F 812	change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will monitor procedures for proper monitoring of temperature weekly x 4 weeks then monthly x 2 months using the Dietary QA Audit which will include additional temperature reviews for at least one meal every day. 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 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an	F 847		4/28/23

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 03/23/2023

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 847	Continued From page 58	F 847		

agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n)(2) The facility must ensure that:
(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance

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 03/23/2023

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 847	Continued From page 59	F 847		

with §483.10(k).
This REQUIREMENT is not met as evidenced by:
Based on record review, administrative staff, and resident interview the facility failed to explain the arbitration agreement, including the right to rescind the agreement within 30 days, prior to having the resident or responsible party sign the agreement for 2 of 3 residents (Resident #83 and Resident #88).

Findings included:

The facility's "Resident and Facility Arbitration Agreement" stated the resident agrees that 1). he/she has read and understands the arbitration agreement, 2) the arbitration agreement had been explained to the resident to his or her satisfaction, 3) he/she does not have any unanswered questions, 4). he/she had executed the agreement of his or her own free will and not under duress, and 5). he/she received a copy of the agreement. The agreement further stated the resident understood that "he/she had the right to revoke the arbitration agreement by written notice delivered and received by the facility within fourteen days of signing the agreement."

a. Resident # 83 was admitted on 3/13/23. Record review revealed a "Resident and Facility Arbitration Agreement" signed by Resident #83 on 3/13/23.

Interview with Resident #83 on 3/22/23 at 11:46 AM indicated he was alert and oriented to person, place, time, and situation. He revealed he signed his admission paperwork including the arbitration agreement. Resident #83 revealed the "Resident and Facility Arbitration Agreement" had not been

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.
F847
1. Immediate action(s) taken for the resident(s) found to have been affected include:

Resident # 83 and resident #88 reside within the facility and both are their own responsible party. Administrator educated the Admission□s Director March 23, 2023, that all residents cognitively intact and able to comprehend and sign arbitration agreements must be given the opportunity to and for those with cognitive deficits, the responsible party in a manner he or she understands with either resident when applicable and/or the responsible party when applicable will acknowledge understanding. The Admission□s Director was educated by the Administrator on March 23, 2023, regarding the arbitration agreement, once signed, the resident or his or her representative is granted the right to rescind the agreement within 30 calendar

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 03/23/2023

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 847	Continued From page 60 explained to him and that he was simply asked to sign it. b. Resident #88 was admitted to the facility on 1/20/23. Resident #88's 1/27/23 Admission Minimum Data Set (MDS) revealed resident was cognitively intact. Record review revealed a "Resident and Facility Arbitration Agreement" signed by Resident #88 on 1/23/23. Interview on 3/22/23 at 11:51 AM with Resident #88 revealed he recalled he signed his admission paperwork when he came to the facility. Resident #88 stated the Admissions Coordinator told him to do the best he could and to go ahead and sign the paperwork including the arbitration agreement, without an explanation. Interview with the Admissions Coordinator on 3/22/23 at 12:41 PM revealed the arbitration agreement was part of the admission packet she had signed by the resident or representative on admission. The Admission Coordinator indicated she reviewed the "Resident and Facility Arbitration Agreement" with the resident or family member briefly. If the resident or family asked about the arbitration agreement, she explained that it was an agreement that said that if something happened to the resident in the facility, they wanted to handle it within the facility first, rather than going outside the facility to resolve it. The Admissions Coordinator stated she did not go into explaining it any further. The Admission Coordinator stated usually the resident or family did not have any questions, so she did not explain it anymore. The Admissions Coordinator revealed about half of the residents or	F 847	days of signing it. On March 23, 2023, the Director of Clinical Services was notified by the Clinical Services Consultant that the arbitration agreement would need modified to include the updates regulatory verbiage. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. The facility has determined that all new admissions have the potential to be affected by this practice. All residents who have admitted within past 30 days will be presented with an updated Arbitration Agreement, this will be presented to the resident and/or the responsible party, depending on which is applicable, by the Admission□s Coordinator on or before 4/28/2023. 3. Systemic changes The organizational legal department was notified by the Vice President of Operations on April 7th, 2023, of needed changes to the Arbitration Agreement and the Arbitration Agreement was revised on April 11, 2023. The Revised Arbitration Agreement was provided to the Admission□s Coordinator on April 11, 2023, to use going forward; the agreement was provided by the legal department. On April 12, 2023, The Admission□s Coordinator audited all current residents who are residing within the facility. All residents admitted to the skilled nursing	

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 03/23/2023

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 847	Continued From page 61 representatives signed it. Interview with the Administrator on 3/23/23 at 2:15 PM revealed she had tried to understand arbitration, but still was not sure about the requirements for this or what it meant. The Administrator stated arbitration was offered at admission as part of the admissions packet. The Administrator stated she thought arbitration was if a resident or family had a disagreement, they would resolve it within the facility rather than using the court. The Administrator stated arbitration was offered to all residents/responsible parties, but she did not know how it was explained to the residents or representatives. The Administrator stated the arbitration agreement, including the right to rescind within 30 days of signing, should be explained fully to the resident or representative prior to having them sign the agreement.	F 847	facility within past 30days will have an updated Arbitration Agreement signed and filed in the document center of Point Click Care, this will be completed no later than 4/28/2023 by the Admission□s Coordinator. The Admission□s Director will ensure the resident and/or the responsible party understand the Arbitration Agreement and acknowledges understanding. The resident and/or responsible party (whichever applicable) will understand the right to rescind the agreement within 30 calendar days of signing. 4. Quality Assurance monitoring procedure. The Administrator and/or DON in her absence will monitor this process by auditing 5 arbitration agreements weekly X 4 weeks, then monthly X 3 month ensure that all arbitration agreements are signed/dated and if the resident is able, that he resident is offered to sign and if not, then the designated responsible party. The results of the audit will be taken to the quality assurance meeting monthly for a minimum of 3 months. Corrective action completion date: 4/28/2023	
F 848 SS=D	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that:	F 848		4/28/23

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 03/23/2023

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 848	Continued From page 62 (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on a record review, administrative staff, and resident interview the facility failed to provide an arbitration agreement that provided for 1). a selection of a neutral arbitrator agreed upon by both parties and 2). selection of a venue that was convenient to both parties for 3 of 3 residents reviewed for arbitration (Resident #294, Resident #83, and Resident #88). The findings included: A review of the facility's arbitration agreement titled "Resident and Facility Arbitration Agreement" was conducted. The arbitration agreement that included the following: "...it was understood and agreed by the facility and the resident that any controversy or claim arising out of the Resident Admission Agreement, or any service or health care provided by the facility to the resident shall be resolved by binding arbitration, which shall be conducted in North Carolina by a panel of 3 arbitrators in accordance with the American Health Lawyers Association and not by a lawsuit or resort to court process."	F 848	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. F848 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 83 and resident #88 reside within the facility and both are their own responsible party. Resident #294 discharged from the facility on March 24, 2023. The Director of Clinical Services was notified by the Clinical Services	

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 03/23/2023

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 848	Continued From page 63 The remainder of the agreement did not include verbiage that stated a neutral arbitrator would be agreed upon by both parties (the facility and the resident or their representative) and did not state a venue would be selected that was convenient to both parties. The agreement was provided in the facility admission packet and was offered during the admission process for residents admitted to the facility. The facility had no residents or resident representatives that entered into binding arbitration. a.Resident #294 was admitted to the facility on 3/14/23. Record review revealed a "Resident and Facility Arbitration Agreement" signed by Resident #294's Responsible Party on 3/14/23. Interview on 3/22/23 at 11:39 AM with Resident #294's Responsible Party revealed she signed the facility arbitration agreement as part of the forms that were presented to her in the admission packet. Resident #294's Responsible Party was not aware the agreement she signed did not provide for neutral arbitrators or a venue convenient to both parties. b.Resident # 83 was admitted on 3/13/23. Record review revealed a "Resident and Facility Arbitration Agreement" signed by Resident #83 on 3/13/23. Interview with Resident #83 on 3/22/23 at 11:46 AM indicated he was alert and oriented to person, place, time, and situation. He revealed he signed his admission paperwork including the arbitration agreement. Resident #83 revealed the "Resident	F 848	Consultant on March 23, 2023 that the arbitration agreement needed to be modified to include selection of a neutral arbitrator agreed upon by both parties, and selection of a venue that is convenient to both parties. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. The facility has determined that all new admissions have the potential to be affected by this practice. All residents who have admitted within past 30 days will be presented with an updated Arbitration Agreement, this will be presented to the resident and/or the responsible party, depending on which is applicable, by the Admission□s Coordinator on or before 4/28/2023. The updated Arbitration Agreement will include selection of a neutral arbitrator agreed upon by both parties, and selection of a venue that is convenient to both parties. 3. Systemic changes The organizational legal department was notified by the Vice President of Operations on April 7th, 2023, of needed changes to the Arbitration Agreement and the Arbitration Agreement was revised on April 11, 2023. The Revised Arbitration Agreement was provided to the Admission□s Coordinator on April 11, 2023, to use going forward; the agreement was provided by the legal	

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 03/23/2023

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 848	Continued From page 64 and Facility Arbitration Agreement" had not been explained to him and that he was simply asked to sign it. Resident #83 answered no, he was not aware that the agreement was supposed to provide for the selection of a neutral arbitrator and the selection of a venue convenient to both parties. c.Resident #88 was admitted to the facility on 1/20/23. Resident #88's 1/27/23 Admission Minimum Data Set (MDS) revealed resident was cognitively intact. Record review revealed a "Resident and Facility Arbitration Agreement" signed by Resident #88 on 1/23/23. Interview on 3/22/23 at 11:51 AM with Resident #88 revealed he recalled he signed his admission paperwork when he came to the facility. Resident #88 stated the Admissions Coordinator told him to do the best he could and to go ahead and sign the paperwork including the arbitration agreement, without an explanation. Resident #88 was not aware that the agreement he signed was supposed to provide for the selection of a neutral arbitrator and the selection of a venue convenient to both parties. An interview with the Administrator on 3/23/23 at 2:00 PM revealed that the "Resident and Facility Arbitration Agreement" was prepared by the corporate office, and she did not fully understand it. The Administrator reviewed the "Resident and Facility Arbitration Agreement" and agreed it did	F 848	department. On April 12, 2023, The Admission□s Coordinator audited all current residents who are residing within the facility. All residents admitted to the skilled nursing facility within past 30 days will have an updated Arbitration Agreement signed and filed in the document center of Point Click Care, this will be completed no later than 4/28/2023 by the Admission□s Coordinator. 4. Quality Assurance monitoring procedure. The Administrator and/or DON in her absence will monitor this process by auditing 5 arbitration agreements weekly X 4 weeks, then monthly X 3 month ensure that all arbitration agreements are signed/dated and if the resident is able, that he resident is offered to sign and if not, then the designated responsible party. The results of the audit will be taken to the quality assurance meeting monthly for a minimum of 3 months. Corrective action completion date: 4/28/2023	

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 03/23/2023

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 848	Continued From page 65 not include the verbiage that 1). an arbitrator would be selected that was agreed upon by both parties and 2). a venue convenient to both parties would be selected. When the Administrator was asked if she was aware of the regulatory requirements pertaining to the arbitration agreement, she stated she was not.	F 848		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		4/28/23

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 03/23/2023

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 867	Continued From page 66	F 867		

development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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 03/23/2023

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 867	Continued From page 67	F 867		

of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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 03/23/2023

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 867	Continued From page 68 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance & Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following a recertification and complaint survey on 02/17/22. This was for 2 repeat deficiencies that were originally cited in the areas of notification and nutrition and were subsequently recited on the current recertification and complaint survey on 03/23/23. The continued failure during 2 surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F580: Based on observation, record review, staff, and Physician interviews, the facility failed to notify the physician when a resident was noted to have redness and bleeding along the gumline for 1 of 1 resident reviewed for dental care (Resident #65). During the recertification and complaint survey on 02/17/22, the facility failed to notify the Physician and Responsible Party of a resident's significant weight loss and failed to notify Physician and RP of a resident's significant weight gain. F692: Based on observations, record review, and staff interviews the facility failed to obtain	F 867	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. F867 the facility failed to maintain implement procedures and monitor interventions that the committee put into place following a recertification and complaint survey on 2/17/2022. This was 2 repeat deficiencies that were originally cited in the areas of notification and nutrition and were subsequently recited on the current recertification and complaint survey on 3/23/23. This tag is cross referenced to: F580: Facility failed to notify the physician when a resident was noted to have redness and bleeding along the gumline for resident #65. F692: Facility failed to obtain ordered weights for 2 of 2 residents (Resident #39 and Resident #44).	

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 03/23/2023

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 867	Continued From page 69 Physician ordered weights for 2 of 2 residents (Resident # 39, Resident #44) reviewed for nutrition. During the recertification and complaint survey on 02/17/22, the facility failed to reweigh and assess a resident with significant weight loss and failed to reweigh and assess a resident with significant weight gain, and failed to obtain a reweigh for a resident who was documented as having a significant weight loss. An interview with the Administrator on 03/23/23 at 6:06 PM revealed she believed their QAPI place was ineffective for notification and weight processes and that the facility needed to review these processes to make corrections where needed with best practices, and then re-evaluate and distinguish where their process needs to be adjusted.	F 867	1.Corrective action for resident(s) affected by the alleged deficient practice: Resident#65 was assessed by the Director of Nursing on 3/22/23 with notification to provider of gum redness and inflammation, with no active bleeding. Orders received 3/22/23 to have resident evaluated by Dental services. On 3/23/23 Director of Nursing contacted the provider to inform of next available appointment with resident□s outside Dental Provider would be 30 days. Provider ordered for resident to be seen in emergency department for evaluation. 3/23/23 resident returned to facility 3/23 with order for Peridex solution and instruction to follow up with Dental provider. 3/23/23 Peridex Solution 0.12% give 10 ml by mouth two times a day for was initiated. 3/27/23 resident was seen by in house Dental provider with orders to schedule resident for sedated cleaning. The appointment is set for May 4, 2023. For Resident #39 the facility failed to obtain daily weights per provider order. On 3/23/2023 the Director of Nursing assessed resident for abdominal distention. Notified medical provider of no abnormal findings. No new orders obtained. Medical provider to evaluate on next visit. For Resident #44 the facility failed to obtain weekly weights for week of 3/13/23 and 3/20/23. On 3/23/2023 and 4/6/2023 weight was obtained with no finding of concerns. On 4/10/2023 the Director of Nursing notified the medical provider of missed weekly weights and weight review with no voiced concerns or new orders	

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 03/23/2023

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 867	Continued From page 70	F 867		

obtained.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:

F580
" All residents who are experiencing dental issues such as oral pain, reddened, inflamed or bleeding gums are at potential risk of being affected by deficient practice.
" The Director of Nurses and nursing supervisors initiated an audit of 100% of all residents for dental issues to include not limited to oral pain, reddened, inflamed or bleeding gums. This was completed by 3/27/2023.
" Findings include: No concerns of dental issues noted. One resident did have pain due to a tooth extraction.
" On 4/3/2023 all residents were evaluated by the in-house Care Secure Mobile Dental provider with exception of 7 residents who refused evaluation to identify dental concerns.
F692
All residents have the potential to be affected by the alleged deficient practice.

On 4/10/2023 the DON completed and all facility weight and supplement order review. Findings include: All monthly weights were obtained timely. No concerns noted with supplements. 4 residents with weight loss. MD was notified of concern and RD was notified to assess for dietary changes.
On 4/10/2023, DON audited April admissions to ensure admission weights

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 03/23/2023

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 867	Continued From page 71	F 867	obtained and orders for weekly weights x 4 in place. Findings include: All residents admitted in April were in compliant with orders for weekly weights x 4 and admission weights obtained on day of admission except one resident was weighed the next day. On 4/10/2023 the Director of Nursing completed review of all residents with daily weight orders to ensure completion. Findings include: Daily weights were audited and it was noted that 3 out of 3 residents had missed daily weights. PCP was notified of missing daily weights with new orders obtained to discontinue the order or change order to 3 times a week. On 4/11/2023 the Director of Nursing completed corrective action for those residents which include: notification to medical provider, notification to Registered dietician for recommendations and implemented any new orders for initiating supplements, change in current supplement, and orders for obtaining further weights for monitoring. The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 4/14/2023 to review the deficiencies from the March 20, 2023 to March 23,2023 annual recertification survey, CI survey, and reviewed the citations. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 4/13/2023, the Nurse Clinical Consultant in-serviced the facility administrator and the Quality Assurance	

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 03/23/2023

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 867	Continued From page 72	F 867	Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. On 4/14/2023 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 4/28/2023 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 compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee 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 03/23/2023

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 867	Continued From page 73	F 867	Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/28/2023	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		4/28/23

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 03/23/2023

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 880	Continued From page 74 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 03/23/2023

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 880	Continued From page 75 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement their infection control policy for Contact Precautions when 2 of 2 staff members (Nurse #2 and Nurse Aide #1) failed to don gloves and gown prior to entering 2 of 2 resident rooms (Resident #39, Resident #4) who were on Contact and Enteric Precautions. Findings included. The facility's policy titled "Contact Precautions" revised March 2020 read in part; use contact precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct or indirect contact. Wear gloves when entering the room and when touching residents' intact skin, surfaces, or articles in close proximity. Wear a gown when entering room when clothing will touch resident items or potentially contaminated environmental surfaces. Enteric precautions included to wear gloves and gown and use soap and water instead of alcohol-based hand sanitizer for hand hygiene when caring for residents with CDI (clostridium difficile infection/ C. diff). 1. A physicians order dated 03/15/23 for Resident #39 revealed to maintain contact precautions due to MRSA (methicillin resistant staphylococcus aureus) in urine. An observation of the 400 hall on 03/20/23 at 12:30 PM revealed Resident #39 was on contact	F 880	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. F 880 The facility failed to implement their infection control policy for Contact Precautions when 2 of 2 staff members (Nurse #2 and Aide #1) failed to don gloves and gown prior to entering (Resident #39 and #4) who were on Contact and Enteric Precautions. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/21/23 the Nurse Consultant educated Nurse #2 on Infection Prevention policy and contact precaution policy with Education on contact SPICE signage with expectations of the facility to adhere to stated policies to prevent spread of infection. Nurse # 2 was able to verbalize understanding of the education on 3/21/23. On 3/21/23 the Unit manager educated	

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 03/23/2023

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 880	Continued From page 76 precautions. The signage by the doorway instructed staff to clean hands before entering and when leaving the room, and wear gloves and gown when entering room and remove before leaving the room. Continuous observations from 12:30 PM to 12:32 PM revealed Nurse #2 touching the resident and potentially contaminated surfaces including the bedside table without wearing gloves or a gown. Upon seeing the surveyor outside of the room, she exited the room and sanitized her hands. During an interview on 03/20/23 at 12:35 PM with Nurse #2 she stated Resident #39 was on contact precautions for MRSA (methicillin resistant staphylococcus aureus) in the urine and had recently returned from the hospital; and came out of his room in his wheelchair, and she pushed him back into the room and didn't think to apply gloves and gown prior to assisting him. She acknowledged she was in the room assisting the resident and touching potentially contaminated surfaces and stated she knew she should have donned gloves and gown before assisting the resident to prevent the spread of infection and stated she just didn't take the time to do it. She stated she had received infection control training regarding caring for residents on contact precautions. An observation of the 400 hall on 03/21/23 at 12:13 PM revealed Resident #39 remained on contact precautions. The signage by the doorway instructed staff to clean hands before entering and when leaving the room, and wear gloves and gown when entering room and remove before leaving the room. Continuous observations from 12:13 PM to 12:14 PM revealed Nurse #2 touching the resident and potentially	F 880	Aide #2 on Infection Prevention policy and enteric Precaution policy with education on Enteric SPICE signage with expectations of the facility to adhere to stated policies to prevent spread of infection. Aide #2 was able to verbalize understanding of the education on 3/21/23. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents requiring Contact and Enteric Precautions are at risk to be affected by a failure to follow and maintain appropriate Isolation precautions, when performing procedures such as assisting resident who dependent diners or when resident request assistance. The Director of Nurses/ Infection Preventionist began audits on 4/11 / 2023 on random shifts and days times 3 days for compliance with staff adherence to PPE utilization for Transmission Based Precautions. This will be completed by 4/19/2023. Findings included: On 3 separate days 3 separate shifts all staff followed the PPE utilization for the Transmission Based Precaution. 1. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Root Cause Analysis was completed on 4/13/2023 with the following staff in attendance: Administrator, Director of Nurses /Infection Control Preventionist, Dietary Manager, House Keeping	

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 03/23/2023

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 880	Continued From page 77 contaminated surfaces including the bedside table without wearing gloves or a gown. Upon seeing the surveyor outside of the room, she exited the room and sanitized her hands. During a follow up interview on 03/21/23 at 12:14 PM with Nurse #2 she stated she put her gloves and gown on prior to entering the room and after she removed them the resident called her back over and she assisted him without reapplying gloves or a gown. She stated she should have taken the time to reapply her gloves and gown before assisting the resident. During an interview on 03/22/23 at 12:20 PM with the Director of Nursing (DON) she stated Nurse #2 had received education on PPE (personal protective equipment) use and providing care for residents on contact precautions. She stated Nurse #2 had been observed more than once by staff not wearing PPE and education had been provided at that time. She stated more education would be provided. 2. A physicians order dated 03/20/23 for Resident #4 revealed an order in place for enteric precautions due to clostridium difficile infection. An observation of the 400 hall on 03/20/23 at 12:47 PM revealed Resident #4 was on enteric precautions. The signage by the doorway instructed staff to clean hands before entering and when leaving the room, and wear gloves and gown when entering room and remove before leaving the room and wash hands with soap and water instead of alcohol-based hand sanitizer for hand hygiene. Continuous observations from 12:47 to 12:48 revealed Nurse Aide #1 sitting in a	F 880	Manager, Support Nurse and the Nurse Consultant. Root cause analysis was done related to staff members failing to apply appropriate PPE for residents requiring Contact and Enteric Precautions. Upon interview of the staff/agency it was determined that the root cause was infection control breach may result in exposure to any bodily fluids. Types of potential infectious substances that can be harbored on the containment instruments or devices should be determined. Basically, the infectious substance can be transferred to any item of the infected person and therefore gloves should be worn at all times that there would be any contact with person and personal items. Staff not following strict adherence to Transmission Based precautions. On 3/21/2023 the Director of Nurses/ICP initiated education for all registered nurses, licensed practical nurses, certified nursing assistants, medication aides and agency on IC practices related to Infection Prevention Policy, Contact and Enteric Precaution policy including review of the SPICE associated signage with expectation of facility to adhere to utilization of required PPE to prevent further spread of infections. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 3/27/2023 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in 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 03/23/2023

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 880	Continued From page 78 chair at the bedside feeding the resident without wearing gloves or a gown. She washed her hands with soap and water and exited the room. During an interview on 03/20/23 at 12:48 PM with Nurse Aide #1 she stated she was told she did not have to wear gloves and a gown while feeding the resident on enteric precautions. She stated she had touched potentially contaminated surfaces such as the bedside table. She stated she had received infection control training and did not read the sign by the doorway that instructed staff to don gloves and gown prior to entering the room. During an interview on 03/21/23 at 4:44 PM with the DON who was also the infection control nurse she stated Resident #4 was on enteric precautions for Clostridium difficile. She stated staff were required to read the precaution signs and follow the instructions on the sign including donning gloves and gown. She stated that included entering the room for any reason such as feeding a resident and assisting with care. She stated she did random observations to ensure staff were following infection control guidelines and she continued to provide education to staff. During an interview on 03/24/23 at 5:00 PM with the Administrator she stated staff had been educated many times on infection control and they should be following the necessary precautions. She stated continued education and audits would be conducted.	F 880	required in-service refresher courses for all staff as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The Director of Nurses/ Infection Control Preventionist/ implemented IC rounds to include monitoring for appropriate PPE utilization for those residents requiring Contact and Enteric precautions. The training will be validated by the Director of Nurses/Infection Control Preventionist with observation audits in resident care areas and resident rooms for compliance with facility policy on the utilization of the above identified IC areas. . 2. 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 Nurses/Infection Control Preventionist/designee will observe and monitor at least 3 staff/agency on various shifts to include weekends for staff adherence to infection control compliance with the appropriate PPE utilization for residents requiring Isolation Precautions. Immediate resolution or coaching will be done when required. Monitoring to be done weekly x 2 weeks and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance	

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 03/23/2023

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 880	Continued From page 79	F 880	Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing/Infection Control Preventionist, Minimum Data Set Coordinator, Therapy, Health Information Manager and Dietary Manager. A Directed Plan of Correction was completed on 4/19/2023 and alleged compliance will be in place by 4/28/2023.	