FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTORY (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B, WING 345218 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 MARY GRAN NURSING CENTER CLINTON, NC 28328 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID PREFIX (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
The statements made on this plan of correction are not an admission to and do not constitute F 250 an agreement with the alleged deficiencies. The F 250 483.15(9)(1) PROVISION OF MEDICALLY remain in compliance with all federal and state RELATED SOCIAL SERVICE SS≂D regulations the facility has taken or will take The facility must provide medically-related social the actions set forth in this plan of correction. services to attain or maintain the highest The plan of correction constitutes the facility's practicable physical, mental, and psychosocial allegation of compliance such that all alleged well-being of each resident. deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected Resident #61 was seen by a Podiatrist on 9/28/11 This REQUIREMENT is not met as evidenced and was fitted for new diabetic shoes on 10/6/11. Corrective Action for Resident Potentially Based on record review, observations and Affected interviews, the facility failed to ensure that All residents who are diabetic are at risk for this residents received proper services as ordered by alleged deficient practice. All residents were physician for 1 of 1 resident's requiring a reviewed on 10/14/2011 by the Director of Nursing Podiatry appointment. (Resident #61) and Unit Managers to ensure no resident has a missed podiatry appointment. Resident #61 was admitted to the facility on Systemic Changes All nurses (RNs and LPNs) who currently work in 2/15/11 with diagnoses including Diabetes Mellitus. the facility will be in-serviced on 10/12/11 by the SDC on following physician orders with emphasis on residents keeping podiatry The most recent quarterly Minimum Data Set appointments. Any nurse who does not receive (MDS) Assessment dated 8/10/11 assessed training on 10/12/11 will not be allowed to work Resident #61 as being moderately impaired cognitively, independent with bed mobility and until in-service training has been completed. This information has been integrated into the standard eating, needing limited assistance with transfers, orientation training and in the required in-service having limited range of motion on her dominant refresher courses for all employees and will be upper and lower body, using a walker or reviewed by the Quality Assurance Process to verify wheelchair for mobility, having no pain and having that the change has been sustained. a Stage I pressure area. The resident was Quality Assurance identified by the facility as able to make her needs The Director of Nursing will monitor this issue known. using the "Appointment Audit Tool". The monitoring will include conducting 10 chart reviews Review of the Request for Patient Evaluation of resident appointments. This will be done week! Form dated 6/24/11 diagnosed Resident #61 with for four weeks and then monthly times three months an abscess of the left great toe. The plan or until resolved by QOL/QA committee. Reports documented Diabetic shoes and continue current will be given to the weekly Quality of Life- QA

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet Page 1 of 17

committee and corrective action initiated as

TITLE

appropriate.

Facility ID: 923329

PRINTED: 09/30/2011

treatment

LABORATORY-DIRECTOR'S OR PROVIDERISUPPLIER REPRESENTATIVE'S SIGNATURE

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345218 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 MARY GRAN NURSING CENTER CLINTON, NC 28328 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 250 Continued From page 1 F 250 Review of Resident #61 's medical record documented on 6/24/11 that the Nurse Practitioner ordered Diabetic shoes and a Podiatry consult when toes are healed. Review of the August 2011 Treatment Administration Record (TAR)documented that Resident #61's toes were healed on 8/30/11. Review of the September 2011 TAR documented that Resident #61 was to have a Podiatry consult "when toes healed.". The treatment was documented as discontinued on the September 2011 TAR. During an Interview with Nurse #3 on 9/22/11 at 8:55AM she stated that when an order is written for a Podiatry appointments the Unit Manager (UM) would get the pink copy of physician's order so that they (UM) could follow up on the order. The UM also would get a copy of the "Request for CMC patient eval form," which the physician or Nurse Practitioner completes when they see the resident. Nurse #3 stated that she was not working on this unit in June so she did not know what happened to the pink copies or the physician's visit (request for CMC patient evaluation form). Nurse #3 stated that when the issue was brought to the facility 's attention on 9/21/11 she made Resident #61 a Podiatry appointment for the week 9/26/11. During an interview with the Administrator on 9/22/11 at 10:30AM he stated that it was his expectation that the resident appointments would be made when the physician writes an order for one. Our goal is to provide quality care for our

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FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2011
FORM APPROVED
OMB NO, 0938-0391
(x2) MULTIPLE CONSTRUCTION
A, BUILDING

PRINTED: 09/30/2011
(x3) DATE SURVEY
COMPLETED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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		345218	B. WING_		09/22/2011	
	OVIDER OR SUPPLIER AN NURSING CENTER		\$1			
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	The facility must ensure proper treatment and special services: Injections; Parenteral and entera Colostomy, ureterost. Tracheostomy care; Tracheol suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT by: Based on record revinterviews, the facility related services to at residents requiring diffet). Resident #61 was ad 2/15/11 with diagnost Mellitus and History with Hemiplegia. The most recent qua (MDS) Assessment of Resident #61 as bein cognitively, independenting, needing limited range upper and lower body	ntr/care for special. In that residents receive care for the following al fluids; omy, or ileostomy care; is not met as evidenced iew, observations and failed to provide medically tain diabetic shoes for 1 of 1 abetic footwear. (Resident mitted to the facility on as including Diabetes of Cerebrovascular Accident therly Minimum Data Set tated 8/10/11 assessed in moderately impaired ent with bed mobility and assistance with transfers, of motion on her dominant y, using a walker or	F 25	Corrective Action for Resident Aft Resident #61 was seen by a Podiatri and was fitted for new diabetic shoes	at risk for this residents were ector of Nursing ysicians' orders arrently work in 10/12/11 by the reders with an needs. Included cation protocol e department so ordered durable see who does not be allowed to be allowed to be completed. The the required inployees and will ance Process to ained. The 10 chart reviews will be done of the three three to the three th	
	wheelchair for mobili	ly, having no pain and having	1	1		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		345218	B. WING	3		09/2	2/2011
	OVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328	DE		
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F 328	known. Review of Resident #A documented that the I Diabetic shoes on 6/2 Review of the Request Form dated 6/24/11 dian abscess of the left documented Diabetic treatment. Review of the Request Form dated 8/9/11 doi: #61 had a Stage II presided the form a local store. The belose on the reside knee high hose which this time, Resident #6 to have special shoes. During an interview with the folial stage II presided the folial stage II presided the stage II presided the stage II presided the II presided that II presided the II presided II presided the II presided that II presided the II presided II presided that II presided	ea. The resident was y as able to make her needs 61 's medical record Nurse Practitioner ordered 4/11. It for Patient Evaluation lagnosed Resident #61 with great toe. The plan shoes and continue current It for Patient Evaluation cumented that Resident essure area on her left heel. It of Resident #61 's feet on the was observed to be to shoes with a brand name to shoes were observed to ant 's feet. She was wearing were not prescription. At 1 stated that she would like	F3				

PRINTED: 09/30/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING a, WING 345218 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 MARY GRAN NURSING CENTER CLINTON, NC 28328 PROVIDERS PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 328 Continued From page 4 F 328 During an interview with the Social Worker on 9//21/11 at 5:33pm she stated that she was unaware that resident had an order for diabetic shoes. She stated usually the nurse will tell me or give me the pink copy of the physician 's orders. During an interview with Nurse #3 on 9/21/11 at 5:45pm she stated that she did not know anything about diabetic shoes for Resident #61. During an interview with the Social Worker on 9/21/11 at 5:45PM, she stated that in the Nursing Notes there was an entry documenting that (name of company) was faxed an order for diabetic shoes and " will wait a response. " Nurse #1 had signed the entry. The Social Worker further stated that when she spoke with (name of company) today, on 9/21/11, they asked that another request be faxed to them. She stated that another request was faxed. During an interview with Nurse #3 on 9/22/11 at 8:55AM she stated that when an order is written for Diabetic shoes the Unit Manager (UM) would get the pink copy of physician's order so that they (UM) could follow up on the order. The UM also would get a copy of the "Request for CMC patient eval form," which the physician or Nurse Practitioner completes when they see the resident. Nurse #3 stated that she was not working on this unit in June so she did not know

evaluation form).

what happened to the pink copies or the physician's visit (request for CMC patient

During an interview with the Administrator on

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CENTER	S FUR WEDICARE &	MEDICAID SERVICES				CIVID IV	7. 0830-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER AN NURSING CENTER			1	REET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328		
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F 328 F 329 SS=D	expectation that the rethe diabetic shoes in were ordered. Our go for our residents. 483.25(I) DRUG REG UNNECESSARY DRI Each resident's drug unnecessary drugs. A drug when used in extended the expectation of the resident adverse consequence should be reduced or combinations of the resident, the facility of who have not used are given these drugs untitle record; and residents drugs receive gradual behavioral interventio	re stated that it was his esident would have received a timely fashion when they all is to provide quality care simely fashion when they all is to provide quality care. SIMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate or in the presence of as which indicate the dose discontinued; or any easons above. ensive assessment of a nust ensure that residents ntipsychotic drugs are not ess antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic dose reductions, and		328	Resident #199's order for Nystatin v 9/26/11. Corrective Action for Resident Po Affected All residents have the potential to this alleged deficient practice. I Managers will review all medicatio stop date to ensure all residen unnecessary medications. This will 10/14/11. Systemic Changes All nurses (RNs and LPNs) who could the facility will be in-serviced on SDC on following physician of emphasis on keeping residents free medications. Also included in the emedications that require a stop data alert physicians when a medical stopped. Any nurse who does not not 10/12/11 will not be allowed to service training has been conformation has been integrated in orientation training and in the recrefresher courses for all employer reviewed by the Quality Assurance that the change has been sustained. Quality Assurance The Director of Nursing will monite using the "MAR Audit Tool". The include conducting 10 chart reviews MAR to ensure they're free of unnem conductions. This will be done weeks and then monthly times three resolved by OOL/OA committee. It	be affected DON and Uns that requires are free be completed urrently work 10/12/11 by orders with a of unnecessed ducation will be so nurses of tree ive training owerk until completed. The other stand unired in-serves and will process to ver this issue monitoring will of resident's cessary cly for four amonths or ur teports will be tentiled to the stand unired in-serves and will process to ver this issue monitoring will be fresident's cessary cly for four amonths or ur teports will be	nit / O/14/1 c a of of oy in the an be an be ing in- his ord ce be fy
	by: Based on record revi	is not met as evidenced ew, pharmacist interview, e facility failed to ensure	The state of the s		given to the weekly Quality of Life and corrective action initiated as ap	QA committ propriate.	B

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 345218 09/22/2011 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER 120 SOUTHWOOD DR BOX 379 MARY GRAN NURSING CENTER CLINTON, NC 28328 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) F 329 Continued From page 6 F 329 residents were free from medication used for excessive duration for 1 of 10 sampled residents (resident #199) reviewed for unnecessary medications. Findings include: Resident #199 was admitted to the facility 2/25/11 and readmitted on 3/11/11. Cumulative diagnoses included Dysphagia and Gastrostomy on 3/9/11. Review of the Physician Progress Note, dated 3/18/11, under the Problem list did not note thrush. Review of the resident 's ears/nose/mouth/throat did not document any oral sores or thrush. Review of Physician's Orders dated 3/24/11 documented that Resident #199 was started on Nystatin 10cc (cubic centimeters) four times a day for 10 days. Nystatin belongs to the group of medicines called antifungals. The liquid forms of this medication are used to treat fungus infections in the mouth. Review of the Physician Progress Note, dated 4/1/11, noted the resident had thrush. Review of Physician's Orders dated 4/2/11 noted that the resident was to continue Nystatin

times 14 days.

until thrush resolved.

Review of the Physician Progress Note, dated 4/16/11, noted resident continued with thrush. Documented below Assessment and Plan was to resume Nystatin Suspension four time daily with a swab to be applied to the tongue and oral cavity

Review of Physician 's Orders dated 4/16/11

PRINTED: 09/30/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

STATEMENT	OF DEFICIENCIES CORRECTION	(XI) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		345218	B, WI	IG		09/2	2/2011
	OVIDER OR SUPPLIER AN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328				
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F 329	did not specify duration Review of the Physici 4/28/11, 5/3/11, 5/11/1 and 9/6/11 noted under mouth and throat were present. Review of the Medical beginning 4/16/11 through that Resident #199 resure units/ML (milliliter) sure tongue four times per Review of the Pharma May, June, July, Augurevealed no documen for continued antifung evaluation by the attention by the attention of the Nystatin continued resident began to eat several weeks and on if he eats less than 75 During an interview won 9/21/11 at 11:10 and does not have a stand Nystatin. During an interview won 9/21/11 at 11:25 and thave addressed the Nystatin because the	ab to tongue QID. The order on of therapy. an Progress Note, dated 11, 7/9/11, 7/19/11, 8/3/11 ar Physical Exam that the enormal with no ulcers tion Administration Records ough 9/21/11 documented ceived Nystatin 100,000 spension swabbed to his day. acy Consultants notes for just and September 2011 station addressing the need all use or request for noting physician. lith Nurse #2 on 9/21/11 at that a family member wants d. She further stated that the pureed meals for the last sily receives his tube feeding	12.	329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING	-	00/0	2/2044
NAME OF PE	ROVIDER OR SUPPLIER	040210	STR	EET ADDRESS, CITY, STATE, ZIP CODE	USIZ	2/2011
MARY GR	AN NURSING CENTER		Į	20 SOUTHWOOD DR BOX 379		
	OUNTARY OF	THE CONTROL OF STREET		LINTON, NC 28328 PROVIDER'S PLAN OF CORRECT	ioni	~~
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F 329	both of which can lead the medication can be the medication can be 9/21/11 at 12:05PM shave thought that after would have been residents receiving tule problems with thrush, problems with thrush, problems with a lack of in June an order was the inside of his moutistated the he may not has been no harm in a physician in April 201 did document to take His primary physician the note was in the chephysician read the Ap 14days, the new physician read the Ap 14days, the new physician read the Nystatin was follow up on this. The that she would stop thresident does. Review of the Physici read to discontinue November 10:30am hexpect that on the momedications that pharmake recommendations should or should not the thought the facility stated that he would set in the should are the sould are the soul	d to thrush. She stated that a used prophylactically. ith the Nurse Practitioner on the stated that she would ar 8 weeks of use that it waluated. However, be feedings oftentimes have of moisture in his mouth and written for Oral Moisture to the three times a day. She need the Nystatin but there using it. When his primary 1 wrote his progress note he the medication for 14days. changed in May 2011 and If the medication for 14days. If and when the oncoming aril 2011 note stating use for alcian may have assumed completed and did not a Nurse Practitioner stated the Nystatin and see how the stated that he would nithly review of the macy consultant would ns of medications that the continued. He stated that missed this one .He further also expect that nurses medication is still being	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING		09/2:	2/2011
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F 371	483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, dis under sanitary conditions. This REQUIREMENT by: Based on observation facility failed to adequin 3 of 3 kitchen refrig Review of the policy ere Food Items "read, "I discarded after 72 hor indicated". During the initial tour at 10:35 am, reach-in container of cream so Observation of reach-container of cheese sopen plastic bag of chaluminum foil dated "yellow Jell-O dated" was observed to have dated 9/13/2011 in a second container of cheese sopen plastic bag of chaluminum foil dated "yellow Jell-O dated"	CURE, ERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food ons is not met as evidenced as and staff interviews, the ately monitor food storage erators. entitled, " Handling of Left Left over food items are unless otherwise on 9/19/2011 beginning at soler #1 contained a plastic up dated "9/11/11". in cooler #2 revealed one auce dated " 9/13/11", an atepped onions wrapped in 19/13/11, and ½ pan of diet 19/15/11 The walk in cooler a left over vegetable soup shallow metal pan.	F 371		ected from entially leged defici designee voutdated food of 10/14/11 stion has be on training a courses for by the Quahe change issue using monitoring voto ensure of timely. Tecks and to til resolved be given to committee a	vill I is on een all ity nas he vill all his en by
	9/19/11 at 10:35 am it	ith the Kitchen Menager on i was stated foods were to discarded. He indicated				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	8, WI	IG		09/2	2/2011
İ	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROMDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 371 F 372 SS=E	and discard any found discarded all the outd refrigerator. A cook was interviewed the stated the soup weekend. She reveal have a bowl of vegets staff saved the soup at the state the soup at the saved the soup at the kitchen Manager pm the kitchen makes each week and keeps likes soup at night. Helf over soup when the 483.35(i)(3) DISPOST PROPERLY The facility must dispersive the facility and failed to have a facility of the facility must dispersive the facility and failed to have a facility of the facility must dispersive the facility must dispersive the facility and failed to have a facility of the facility must dispersive the facility must dispersive the facility of the facility of the facility of the facility must dispersive the facility of the facility of the facility must dispersive the facility of the faci	eck daily for outdated foods d. The Kitchen Manager ated items found in the ed on 9/19/ AM at 11:45 am. was left over from the led one resident liked to lible soup at night so kitchen all week for the resident. Is stated on 9/21/11 at 2:35 is vegetable soup one day it for one resident who le stated staff discard any livey make the next pot. EGARBAGE & REFUSE Dise of garbage and refuse is not met as evidenced lins, staff interviews, and		371	Corrective Action for Resident Aff All trash was placed in the dumpster dumpsters were sprayed for yellow ja Corrective Action for Resident Pot Affected All residents are at risk for this a practice. Housekeeping Supervisor dumpsters daily for proper t Supervisor will also search for yell inform Maintenance Department if's Systemic Changes All housekeeping staff will be in-se on proper trash disposal. This infor integrated into the standard orientat in the required in-service refresher employees and will be reviewed Assurance Process to verify that been sustained. Quality Assurance The Administrator will monitor this "Trash Disposal Audit Tool". The include conducting daily rounds to is disposed of properly and if spra yellow jackets. This will be done weeks and then monthly times three	and the ackets. entially the ged deficie will review trash disposow jackets a pray is needed reviced 10/14/mation has be ion training a courses for by the Qual the change the change the change the grant all tray is needed weekly for formonths or unothers.	he fo/14// hd 1. 1. 11 en hd hill ty has he for our
	Findings include: The dumpster area behind the kitchen was observed on 9/19/2011 at 1:40 pm. Scattered pieces of paper and boxes were observed around the four trash dumpsters. Yellow Jackets were noted to be swarming around the outside walls,				resolved by QOL/QA committee, given to the weekly Quality of Life and corrective action initiated as app	be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BULDINS 345218 NAME NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER SUMMARY STAYMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED IN FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 372 Continued From page 11 massing on the doors, and flying inside all four trash dumpsters. A econd observation was made on 9/20/2011 at 2:30 pm while first shift workers were taking trash out to the dumpsters. The dumpsters were in the same condition. A third observation on 9/21/2011at 2:45PM revealed three of four trash dumpster and around the outside of the door. In an interview with the Kitchen Manager on 9/21/2011 at 2:50 pm he stated maintenance sprayed for insects at the facility. On 9/22/2011@ 10:25 am Maintenance sprayed for insects at the facility. On 9/22/2011@ 10:25 am Maintenance Employee #1 stated they spray all the time. He indicated the spray used was like fly spray. He revealed the spray told some good for a while but then the yellow jackets someone complains. Maintenance employee #1 reported the facility.	CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391					
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER (A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (PACH DEFICIENCY) F 372 Continued From page 11 F372 Tag Summary statement of Deficiencies (PACH DEFICIENCY) F 372 Continued From page 11 F372 A second observation was made on 9/20/2011 at 2:30 pm while first shift workers were taking trash out to the dumpsters. The dumpsters were in the same condition. A third observation on 9/21/2011at 2:45PM revealed three of four trash dumpster doors were closed and had no yellow jackets. The first dumpster had an open door and yellow jackets were observed to be in the dumpster and around the outside of the door. In an interview with the Kitchen Manager on 9/21/2011 at 2:50 pm he stated maintenance sprayed for insects at the facility. On 9/22/2011 @ 10:25 am Maintenance Employee #1 stated they spray all the time. He indicated the spray used was like fly spray. He revealed the spray disches were back. Maintenance Employee #1 stated staff go back and spray again whenever someone complains. Maintenance employee #1 propried the facility				1 '						
MARY GRAN NURSING CENTER 120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328	,		345218				09/22	/2011		
F 372 Continued From page 11 massing on the doors, and flying inside all four trash dumpsters. A second observation was made on 9/20/2011 at 2:30 pm while first shift workers were taking trash out to the dumpsters. The dumpsters were in the same condition. A third observation on 9/21/2011at 2:45PM revealed three of four trash dumpster doors were closed and had no yellow jackets. The first dumpster had an open door and yellow jackets were observed to be in the dumpster and around the outside of the door. In an interview with the Kitchen Manager on 9/21/2011 at 2:50 pm he stated maintenance sprayed for insects at the facility. On 9/22/2011@ 10:25 am Maintenance Employee #1 stated staff go back and spray again whenever someone complains. Maintenance employee #1 stated staff go back and spray again whenever someone complains. Maintenance employee #1 reported the facility			·		12	20 SOUTHWOOD DR BOX 379	···			
massing on the doors, and flying inside all four trash dumpsters. A second observation was made on 9/20/2011 at 2:30 pm while first shift workers were taking trash out to the dumpsters. The dumpsters were in the same condition. A third observation on 9/21/2011at 2:45PM revealed three of four trash dumpster doors were closed and had no yellow jackets. The first dumpster had an open door and yellow jackets were observed to be in the dumpster and around the outside of the door. In an interview with the Kitchen Manager on 9/21/2011 at 2:50 pm he stated maintenance sprayed for insects at the facility. On 9/22/2011@ 10:25 am Maintenance Employee #1 stated they spray all the time. He indicated the spray used was like fly spray. He revealed the spray did some good for a while but then the yellow jackets were back. Maintenance Employee #1 stated staff go back and spray again whenever someone complains. Maintenance employee #1 reported the facility	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	COMPLETION		
had a contract with (name of pest control company), Inc who visited the facility two times a month or as needed. He said they have called (name of pest control company) about the yellow jackets. During a phone interview with the Branch Manager of (name of pest control company) on 9/22/2011 at 11:30 Am he stated they typically do not spray dumpsters unless there is an issue reported. He revealed he did not ever recall	F 372	massing on the doors trash dumpsters. A second observation 2:30 pm while first shi out to the dumpsters, same condition. A third observation or revealed three of four closed and had no ye dumpster had an ope were observed to be in the outside of the door the outside of the door the interview with the 9/21/2011 at 2:50 pm sprayed for insects at On 9/22/2011@ 10:29 Employee #1 stated to indicated the spray us revealed the spray us revealed the spray did then the yellow jacket Employee #1 stated sagain whenever some Maintenance employed had a contract with (in company), Inc who vimonth or as needed. (name of pest control jackets. During a phone interview Manager of (name of 9/22/2011 at 11:30 An not spray dumpsters of the second of the spray dumpsters of the second of the sec	was made on 9/20/2011 at a lift workers were taking trash. The dumpsters were in the a 9/21/2011at 2:45PM trash dumpster doors were allow jackets. The first in door and yellow jackets in the dumpster and around in the dumpster and around in the kitchen Manager on the stated maintenance the facility. 5 am Maintenance the facility spray all the time. He sed was like fly spray. He disome good for a while but is were back. Maintenance staff go back and spray some complains. The facility ame of pest control sited the facility two times a He said they have called company) about the yellow the stated they typically do unless there is an issue	E	372					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

00111011	or of the block the or	ALL PROPERTY OF THE PARTY.	ara	IN TIME	CONCTRICTION	(X3) DATE SU	DVEA	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	iultiple Loing	CONSTRUCTION		COMPLETED	
		345218	B, WA	IG		09/2	2/2011	
	OVIDER OR SUPPLIER AN NURSING CENTER			120	T ADDRESS, CITY, STATE, ZIP CODE SOUTHWOOD DR BOX 379 NTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 372	stated any time the far had an area of concerbook provided by (nar company). The service requested. The Branch Manager company had some pextremely toxic to yell treatment would take complete. He indicate and residents not to be The Branch Manager allergic to yellow jack big health issue for enthey were stung. During an interview w #2 on 9/22/2011 at 1: been at the facility for revealed the yellow jamonths every year will He indicated the inserventher gets colder. An interview was contemployee #3 on 9/22 stated she had been and took trash out even indicated the insects since she started wor revealed she had heat the yellow jackets. Tithrew the bags of trast	umpsters at the facility. He cility needed a service or rn they noted it in the log me of pest control ce man then completed the stated the pest control restrictes that would be low jackets. He stated the	F	372				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
F4101 E 41 01	VOIII LO II VII	TOURING TOUR	A. BUILDING	3			
		345218	B. WING		09/2	2/2011	
	ROVIDER OR SUPPLIER AN NURSING CENTER	1	1	REET ADDRESS, CITY, STATE, 2IP CODE 120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328	Ε	10.00	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE)	(X5) COMPLETION DATE	
F 372 F 428 SS=D	from 6/4/2011 - 9/9/ indicating the yellow dumpsters nor any them. 483.60(c) DRUG RI IRREGULAR, ACT	ity pest control log book dated 2011 showed no entries I jackets were present at the equest for services to remove		Corrective Action for Resident #199's order for Nys 9/26/11. Corrective Action for Resident Affected All residents are at risk for practice. DON and Unit Manuedications that require a sesidents are free of unnecess & Unit Managers will review reports monthly to ensure me	statin was stopped ent Potentially this alleged defi- magers will review stop date to ensur- sary medications. It w Pharmacy Consu- edications are not g	cient y all e all DON Itant tven	
	reviewed at least or pharmacist. The pharmacist must the attending physic	ice a month by a licensed st report any irregularities to lan, and the director of eports must be acted upon.		for an excessive duration. The 10/14/11. Systemic Changes All nurses (RNs and LPNs) the facility will be in-service SDC on following physicemphasis on keeping resider medication. Also included in inedications that require a salert physicians when a stopped. Any nurse who do on 10/12/11 will not be allowed.	who currently wo sed on 10/12/11 becan orders with the free of unneces to the education we top date so nurse medication should the second traceive traceive traceive	rk in y the an ssary il be s can d be ining	
	by: Based on record re and staff interview, consultant pharmac for excessive durati- residents (resident in Resident #199 was and readmitted on 3 included Dysphagia Review of the Physi 3/18/11, under the F thrush. Review of the	view, pharmacist interview, the facility failed to ensure the list identified medication given on for 1 of 10 sampled (199). Findings include: admitted to the facility 2/25/11 (1/1/11. Cumulative diagnoses and Gastrostomy on 3/9/11. cian Progress Note, dated Problem list did not note e resident 's roat did not document any oral		service training has been cor Manager will in-service Phensuring medications are not duration. This will be comp information has been integrorientation training and in refresher courses for all erreviewed by the Quality Assuthat the change has been sust Quality Assurance The Director of Nursing will using the "MAR Audit Tool" include conducting 10 chart of MAR to ensure they're free comedications. This will be do weeks and then monthly time resolved by QUL/QA committee.	mpleted. The Phar narmacy Consultant given for an excepted by 10/14/11 rated into the stant the required in-semployees and wind urance Process to value. In monitor this issue of the monitoring reviews of resident of unnecessary of the weekly for four estimates of the months or ittee. Reports will	chacy I on Ssive I his Indard Service I be Verify Vill I's	

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) W	ULTIP	LE CONSTRUCTION	(X3) DATE SURV			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BU	LDING	<u> </u>	00.00	•		
		345218	8. WIN	IG		09/22	/2011		
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		.]		
MARY GR	AN NURSING CENTER			120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 428	documented that Res Nystatin 10cc (cubic of day for 10 days. Nyst medicines called antil this medication are us in the mouth. Review of the Physicial Additional Physician noted that the resider until thrush resolved. Review of the Physician o	s Orders dated 3/24/11 ident #199 was started on centimeters) four times a atin belongs to the group of fungals. The liquid forms of sed to treat fungus infections an Progress Note, dated dent had thrush. s Orders dated 4/2/11 at was to continue Nystatin an Progress Note, dated ant continued with thrush. assessment and Plan was to bension four time daily with a athe tongue and oral cavity s Orders dated 4/16/11 ab to tongue QID. The order on of therapy. Ian Progress Note, dated (11, 7/9/11, 7/19/11, 8/3/11 ar Physical Exam that the re normal with no ulcers ation Administration Records ough 9/21/11 documented deceived Nystatin 100,000 aspension swabbed to his	F	428					

CENTERS FOR MEDICARE & MEDICALD SERVICES							
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY (ED
		345218	B. Wil	ю		09/2	2/2011
	OVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	May, June, July, Augirevealed no document for continued antifung evaluation by the atteraction of the automatic problems with thrush, problems with a tack in June an order was the inside of his moult stated the heart of the may no has been no have and marming the may no has been no harm in	acy Consultants notes for ust and September 2011 station addressing the need all use or request for anding physician. With Nurse #2 on 9/21/11 at that the femily wants the fire further stated that the pureed meals for the last ally receives his tube feeding 5% of his meals. With the Director of Nursing an she stated that the facility ding order for the use of the resident has a dry mouth a gastrostomy tube, do to thrush. She stated that e used prophylactically.	F	428			

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0									
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			i						
345218			8. Wil	(G		09/22/2011			
NAME OF PR	NOVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE				
MARY GR	AN NURSING CENTER		120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328						
	AUMMANY	אירי וגרונ עם טבפוטופוןטופט	10	1	PROVIDER'S PLAN OF CORRECT	ION	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	COMPLETION DATE		
F 428	Continued From page	÷ 16	F	428		-			
:		the medication for 14days.							
:		changed in May 2011 and if							
	the note was in the cl physician read the Ac	nart when the oncoming oril 2011 note stating use for	1						
	14days, the new phys	sician may have assumed							
		completed and did not Nurse Practitioner stated				-			
		ne Nystatin and see how the							
	resident does.	•							
	Review of the Physici read to discontinue N	ian's orders dated 9//21/11 ystatin.							
	9/22/11 at 10:30am hexpect that on the momentum medications that the make recommendation should or should not he thought the facility stated that he would a	pharmacy consultant would ons of medications that be continued. He stated that missed this one .He further also expect that nurses medication is still being							
		•							
					,				

		I AND HUMAN SERVICES & MEDICAID SERVICES	MUA	(4 4 701)	FORM APPROV OMB NO. 0938-03	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER BUPPLIENCLIA IDENTIFICATION NUMBER:	(XX) MUL	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01 ,	(X8) DATE SURVEY COMPLETED	
		345218	B. WING	·	10/14/2011	
ĺ	ROVIDER OR SUPPLIER	'ER		YREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DR BOX 376 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Yemeny of deficiencies y must be preceded by full sc identifying information)	ID PREFIX TAG	Provider's Plan of Corre (Each Corrective action sh Cross-Referenced to the API Deficiency)	CONFIGURE CONFIGUR	ж
K 017 SS⊭E	Corridors are separ constructed with at rating. In sprinklers required to resist th non-sprinklered but above the ceiling. (at the underside of permitted by Code. waiting areas, dinin may be open to the conditions specified be separated from	rated from use areas by walls least ¼ hour fire resistance and buildings, partitions are only e passage of smoke. In Idings, walls properly extend (Corridor walls may terminate ceilings where specifically Charting and clerical stations, g rooms, and activity spaces corridor under certain I in the Code. Gift shops may corridors by non-fire rated is fully sprinklered.)	K 01'	Unsealed opening in our 30 repaired. All corridor walls reviewed This will be added to Main Department's Preventative logs for monitoring. Any deficient practice will QA Comm.	for openings. tenance Maintenance	7
K 029 8S≠F	Surveyor: 27871 Based on observation approximately 8:30 were noncompliant, corridor wall located room had a unsealed inches. Rating of we construction type of 42 CFR 483.70(a) NFPA 101 LIFE SA One hour fire rated fire-rated doors) or	s not met as evidenced by: ons and staff interview at am onward, the following item specific findings include: d on 300 hall near soiled utility ed opening greater than 2 all be maintain to meet facility. FETY CODE STANDARD construction (with % hour an approved automatic fire m in accordance with 8.4.1	K 02	K29 Self Closing mechanism ad Records storage door. This is the potential to affer This will be added to Main Department's Preventative logs for monitoring. Any deficient practice will QA Comm.	ct all residents. tenance Maintenance	3/1
	7	er/Supplier representative's bign		A Jones A.	te 11/2	
ther salegue	y statement ending with a	en esteriek (*) denotes a deficiency white tection to the patients, (See instructions	ch the Institution.) Except (ution may be excused from correcting pro- for nursing homes, the findings stated abo	NAM RID ((ISO)O287)O SO OHÀ	•

Any deficiency statement ending with an exterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CM9-2567(02-09) Praylous Versions Obsoleto

Evant ID: GGE421

Facility (D: 923329

If continuation sheet Page 1 of 4

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERISUPPLIENCLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B, WING_ 345218 10/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD OR BOX 379 MARY GRAN NURSING CENTER CLINTON, NG 28328 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 029 Continued From page 1 K 029 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor, 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include; door to Med. Records is not self closing.

K 038

K38

1 lock removed from PT & Med Room

This will be added to Maintenance Department's monthly PM logs for

This has the potential to affect all residents.

Any deficient practice will be reviewed by

FORM CMS-2507(02-09) Previous Versions Obsolete

42 CFR 483.70(a)

19.2.1

Surveyor: 27871

K 038

SS≈E

7.1.

NFPA 101 LIFE SAFETY CODE STANDARD

Exit access is arranged so that exits are readily

This STANDARD is not met as evidenced by:

Based on observations and staff interview at -

approximately 8:30 am'onward, the following Item were noncompliant, specific findings include: doors to PT and Med. Records require two motions of hand to open door to corridor.

accessible at all times in accordance with section

Event ID: GGE421

Facility ID: 923329

monitoring.

QA Comm.

If continuation sheat Page 2 of 4

PRINTED, IVIZ4/ZUTT

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 8, WING 345218 10/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAYE, ZIP CODE 120 SOUTHWOOD DR BOX 378 MARY GRAN NURSING CENTER CLINTON, NG 28328 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION) (XZI) COMPLETION (X4) ID PREFIX YAG PREFIX TAG DEFICIENCY) K 038 | Continued From page 2 K 038 42 CFR 483.70(a) K 051 NFPA 101 LIFE SAFETY CODE STANDARD K 051 SS≒E A fire alarm system with approved components. devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. K51 Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or Strobe light in Unit I Dining Room extinguishing system operation. Pull stations in replaced. patient sleeping areas may be omitted provided This has the potential to affect all residents. that manual pull stations are within 200 feet of This will be added to Maintenance nurse's stations. Pull stations are located in the path of egress. Electronic or written records of Department's monthly PM logs for tests are available. A reliable second source of monitoring, power is provided. Fire alarm systems are Any deficient practice will be reviewed by maintained in accordance with NFPA 72 and records of maintenance are kept readily available. QA Comm. There is remote annunclation of the fire alarm system to an approved central station. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include; on activation of fire alarm, strobe in Unit 1 dining

FORM CMS-2507(02-90) Previous Versions Obsolete

room dld not work.

Eyent ID: GGE421

Fechity ID: 923328

If continuation sheet Page 3 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B. WING			FORM APPROVED OMB NO. 0938-0381 (X3) DATE SURVEY COMPLETED 10/14/2011		
345218							
	ROVIDER OR SUPPLIER RAN NURSING CENT	ER		12	eey address, city, state, zip code 20 southwood dr box 379 Linton, nc 28328		,
(X4) ID PREFIX YAG	(BACH DEFICIENCY	Tement of deficiencies 'Must be preceded by full so identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X4) COMPLETION DATE
K 051	Continued From pa	ge 3	K	051			
K 056 SS∞F	1			056	K56 Storage is Med Records rinches of sprinkler head. All storage rooms have be all material is 18 inches bhead. This will be added to Ma Department's monthly PM monitoring. Any deficient practice will QA Comm.	cen review elow sprin intenance i logs for	ed so kler
	Surveyor: 27871 Based on observation approximately 8:30 in were noncompliant, room located in Cen	ons and staff interview at one and staff interview at onward, the following item specific findings include: riser tral supply room is not uge with in 18 inches of d. Record room.					

		HAND HUMAN SERVICES B MEDICAID SERVICES			•	•	FORM	APPROVED 0.0938-0391	
SYATEMEN	IT OF DEFICIENCIES OF CORRECYION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	SULTIPI ILDING	LE CONSTRUCTION 02 - BUILDING 02	**************************************	(X3) DATE (COMPL	GURVEY	
' 348218		B, WING				10/14/2011			
<u> </u>	PROVIDER OR SUPPLIER FRAN NURSING CENT	ER		120	et address, offy, state, southwood dr box : inton, nc 28328		I	19841	
(X4) ID PREFIX TAG	X (EACH OBFICIENCY MUSY DE PRECEDED BY FULL			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
K 038 SS≓E	Exit access is arran	FETY CODE STANDARD ged so that exits are readily es in accordance with section	Ко	036					
K 147 SS=F	Surveyor: 27871 Based on observation approximately 8:30 on the work of the control of the contro	FETY CODE STANDARD equipment is in accordance anal Electrical Code. 9,1,2 not met as evidenced by: as and staff interview at m onward, the following item specific findings include; along used in rooms 202,204	K14	47 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	K147 Plug taps were rem 204 & 806, All plug taps were resident rooms. This will be added Department's week! nonitoring. Any deficient practi (A Comm.	removed to Maint y PM log	from oth onance gs for	er 11/18/	
HOOKATORY	DIRECTOR'S OR PROVIDE	RIBUPPLIER REPRESENTATIVE'S SIGN	ATURE		Administr	o Fer		X0) DATE/	
her nalagyert	is provide enticlant prote	usterisk (*) donotes a doficiency whice gillon to the patients. (See instructions of a piece of correction is provided. Fo	.) Except (for nur	ones the firm of the same of t	atad above a	ng ji je delom iro disclasab	mined that	

Any deficiency sistement anding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other asterguerits provide outfollows provide outfollows to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the data of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.