DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			СОМ	E SURVEY IPLETED
		345218	B. WING				C 04/2015
NAME OF F	PROVIDER OR SUPPLIER	I	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		ED		1:	20 SOUTHWOOD DRIVE BOX 379		
MARTG	RAN NURSING CENT	EK		С	LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	FC	000			
	this complaint invest	iciencies cited as a result of stigation survey of 9/4/15. . Complaint intake #					
	and complaint inve	rough 9/4/15 a recertification stigation survey was /15 an extended survey was					
	483.13 at a scope F-221	and severity (J)					
	Resident #160 and (Resident #78). The medical symptom for rails for two resider restraints by allowin a resident that was out of bed resulting the side rail. Also side rail padding to again for Examples was another reside over the side rail with over the side rail and same resident with high-low mattress a (Resident #78).	y (IJ) began on 8/21/15 for began on 8/31/15 for e facility failed to have a or the continued use of side its with side rails used as ing the use of the side rails for observed attempting to get in a fall with her arm stuck in by failing to implement the prevent it from happening #1 (Resident #160). There int observed attempting to get ith one leg through and one leg one leg wedged between the and side rail for Example #2					
	483.25 at a scope a F-323	and severity (J)					
	example #1(Reside	y (IJ) began on 8/21/15 for ent #160). Immediate jeopardy or example #2 (Resident #78).					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/25/2015

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

PRINTED: 09/30/2015

		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000 F 157 SS=D	The facility failed to hazardous side rails observed by a famil out of bed resulting the side rail. Also b rail padding to preve (Resident #160). F attempting to get ov through and one leg second observation leg wedged betwee side rail (Resident # The Administrator w Jeopardy on 9/2/15 Jeopardy was removed when the facility impallegation of compliance a of D (no actual harr minimal harm that is ensure monitoring s effective. 483.10(b)(11) NOTI (INJURY/DECLINE A facility must immed consult with the ress known, notify the re- or an interested fam accident involving the injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life to clinical complication	assess residents for s for a resident that was ly member attempting to get in a fall with her arm stuck in by failing to implement the side ent it from happening again For another resident observed ver the side rail with one leg g over the side rail. Also with a n of the same resident with one en the high-low mattress and #78). was notified of the Immediate oved on 9/4/15 at 3:30 PM plemented a credible iance. The facility remained at the lower scope and severity m with potential for more than is not immediate jeopardy) to systems put in place are IFY OF CHANGES		157			10/2/15

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		345218	B. WING			(09/0	C)4/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	20 SOUTHWOOD DRIVE BOX 379		
MARY GR	AN NURSING CENT	ER		С	LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	consequences, or to treatment); or a dec the resident from th §483.12(a). The facility must als and, if known, the re or interested family change in room or r specified in §483.1 resident rights unde regulations as spec this section. The facility must ree the address and ph legal representative This REQUIREMEN by: Based on record re staff interviews, the physician and the r newly assessed bru (Resident #160) wit Findings included: Resident #160 was 5/8/15 with diagnos non-Alzheimer ' s D disturbances and w A review of the moss Data Set (MDS) dat MDS dated 5/15/15 short and long term A review of skin che	Attent due to adverse o commence a new form of dision to transfer or discharge e facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. AT is not met as evidenced eview, family interview and facility failed to notify the esponsible party (RP) of a tise for one of one resident h a bruise. admitted to the facility on es of hypertension, mementia with behaviors	F 1	57	The statements made on this plan correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or take the actions set forth in this plan correction. The plan of correction constitutes the facility is allegation of compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indica F157 Corrective Action for Affected Resid For resident # 160 the physician wa faxed by the charge nurse regarding	and do e will n of of be ated. ents s	

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		PLETED
		345218	B WING			
	PROVIDER OR SUPPLIER	545210	5	STREET ADDRESS, CITY, S	•	04/2015
				120 SOUTHWOOD DRIVE		
MARY G	RAN NURSING CENT	ER		CLINTON, NC 28328	DORONO	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	AN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 157			F 1	57		
F 157	of skin checks date no new skin area co During an interview Resident #160 ' s re the facility had notif concerning the resi caught in the side r lifting up the sleeve upper arm and her #160 ' s left arm wa Resident #160 ' s ri with a dark purple b long and 1 inch wid stated the facility ha right arm and her a bruised her. The re Resident #160 how stated she got her a During an interview stated she was not and stated she was not and stated she wou #7 was observed a had gotten the bruis she got her arm ca On 9/3/15 2:23 PM present, NA #12 sta Resident #160 on 9 the bruise. NA #12 assigned to be Res and saw the bruise 7:30 AM. NA #12 f thought about it unt about the bruise an #12 stated she ask thought it happened she hurt it in the side	ed 8/29/15 revealed there were	F 1	bruise to the right a immediately after a The physician resp an order to monitor Corrective Action for Residents All residents have a affected by this alle On 9/3/15 the nurs residents for abnor This includes bruis ulcers, and rashes were identified the reviewed to ensure been notified. If no occurred the nurse physician and resp completed on 09/0 Systematic Change On 9/3 and 9/4/15 began in-servicing (NA, RN, LPN, bott regarding the notific conditions to the cl physician. This in- following topics: Nursing assistants skin condition such pressure ulcer or ra charge nurse of the The nurse must the physician according guidelines for repo	assessing the bruise. onded at 3:15 PM with r the bruise. or Potentially Affected the potential to be eged deficient practice. es assessed all current mal skin conditions. es, skin tears, pressure . If any of these areas patients chart was e that the physician had otifications had not e contacted the onsible party. This was 3/15. es the nurse managers all current nursing staff h full time and part time cation of skin harge nurse and service included the who identify any new h as a bruise, skin tear, ash must inform the e condition. en contact the g to Interact 4 rting contusions. panied by significant ust immediately be	

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE Com	E SURVEY PLETED
		345218	B. WING	;		C 09/04/2015	
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	20 SOUTHWOOD DRIVE BOX 379		
MARY GF	RAN NURSING CENT	ER		C	CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Director of Nursing been a part of the of Resident #160 ' s 8 she met with the Ac and the MDS Coord expectation for staff	ge 4 on 9/4/15 at 11:56 AM the (DON) stated that she had dinical meeting concerning /21/15 fall. The DON stated finator. The DON stated her f would be to notify the ely when they found the	F	157	physician using their preferred cont method (paging/faxing) to notify the the skin condition. Physician contact information is located at the nurse 2 station and all nurses have been ed as to where this information is locat On 09/24/15, a Nursing in-service w held and all Nurses present were no of the following requirement for responsible party notification. The nurse must also notify the resid responsible party of the bruise and document notification in the inciden report or progress notes. The Director of Nursing will ensure any nurse who has not received this training by 10/02/15 will not be allow work until the training is completed. information has been integrated into standard orientation training for all and CNA¿s and will be reviewed by Quality Assurance Process to verify the change has been sustained. Quality Assurance The Director of Nursing will monitor issue using the "Survey Quality Ass Tool for Monitoring Bruises¿. The monitoring will include reviewing 5 s assessments for newly identified br and incident reports. From this rev to 10 patients will be reviewed for physician and responsible party notification. This will be completed for 4 weeks then monthly times 2 m or until resolved by Quality of Life/ Assurance Committee. Reports wil given to the monthly Quality of Life/ committee and corrective action initi	em of ct ,s ducated ted. vas otified dent¿s ot that s wed to . This o the nurses / the / that that s skin cuises / it that s urance skin cuises / iew up weekly nonths Quality II be - QA	

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		AND HUMAN SERVICES			F	FORM	09/30/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED C	
		345218	B. WING			09/04/2015	
NAME OF F	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From pa	ıge 5	F 1		as appropriate. The Quality of Life Committee consists of the Administra Director of Nursing, Assistant DON, S Development Coordinator, Unit Supp Nurse, MDS Coordinator, Business C Manager, Health Information Manage Dietary Manager and Social Worker.	Staff oort Office er,	
F 221 SS=J	PHYSICAL RESTR The resident has th physical restraints i discipline or conver	O BE FREE FROM AINTS ne right to be free from any mposed for purposes of hience, and not required to medical symptoms.	F 2	221			10/2/15
	by: Based on observat and family interview medical symptom f rails for two resider restraints by allowir a resident that was out of bed resulting the side rail and by rail padding to prev Example #1 (Resid observed attemptin one leg through and a second observati one leg wedged be and side rail for Exa facility also failed to the continued use of placed in a Geri-ch rising as a restraint	NT is not met as evidenced tions, record review and staff vs, the facility failed to have a or the continued use of side the use of the side rails for observed attempting to get in a fall with her arm stuck in failing to implement the side ent it from happening again for ent #160) and a resident g to get over the side rail with d one leg over the side rail and on of the same resident with tween the high-low mattress ample #2 (Resident #78). The b have a medical symptom for of a Geri chair for a resident air that prevented her from after she was assessed by g supervision while in the			Credible Allegation for Tag 221 Corrective Action for Affected Reside Resident # 78: resident was sent to hospital on 11/04/2014 for evaluation left hip and femur swelling. Resident returned to facility with status post OF (Open Reduction Internal Fixation). A time resident was continued with fall precautions of hi low mattress, chair alarm, personal alarm, bed alarm, flo mat, and floor mat alarm. Resident continues to use a geri-chair when ge up and is positioned at the nurse is station for monitoring by staff. The patient will be re-evaluated by therapy see if alternative seating arrangement can be made. Therapy screened the patient on 9/3/15 and decided to pick patient up for possible broda chair utilization. Additionally on 9/3/15 the	o of t RIF At that por etting by to nts c the	

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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			FORM OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		245249				C
		345218				04/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 221	Continued From pa	age 6	F 22 ⁻	1		
F 221	Geri-chair for one of (Resident #78) that after falling from the Immediate jeopardy 11:10 AM for exam Immediate jeopardy for example #2 (Re jeopardy was remo when the facility pro compliance. Exam cited at a G (isolate actual harm that is facility will remain of and severity of leve constitutes no actual than minimal harm jeopardy). The facil implementation and action. Findings included: 1. Resident #160 v 5/8/15 with diagnos non-Alzheimer 's E disturbances and w A review of the mos Data Set (MDS) da MDS dated 5/15/15	of one resident for Example #3 received a femur fracture	F 22	plan team evaluated the use of mattress. The team decided to the use of the hi low mattress a reevaluate weekly for a maximu days since the side rail reductio occurred. The care plan team completed a device evaluation the side rail and discontinued it 9/3/15 as a result of the evaluat Resident # 160: was admitted facility on 05/08/15. Resident fe 05/08/15, a urine analysis was and personal alarm and floor al place. Resident experienced a 05/10/15 and bed alarm was ac therapy was initiated on 05/12/ ⁷ 06/14/15 the resident fell and w at the nurses station with staff f monitoring. On 07/25/15 the res and a therapy screen was initia 08/21/15 the resident fell and si pads were ordered and non-ski were put in place. On 9/3/15 th were removed from the bed as the side rail assessment compl 9/3/15 by the care plan team. S bruise was located on the right the staff, family, resident intervi that it came from the side rail. physician was notified on 9/3/15 PM. He responded at 3:15 to m	continue nd um of 30 on has also also related to s use on tion. to the ell on ordered arm was in fall on ded and 15. On as placed or close sident fell ted. On de rail d socks e bedrails a result of eted on 0/3/15 a arm where ews stated The 5 at 1:58	
	symptoms directed care. She required and bed mobility wi not steady moving position and moving transfer. She had i	s having verbal behavioral toward others and rejected l extensive care for transfer th one person assist. She was from a seated to standing g form surface-to-surface mpairment on both sides of es. Bed rails, trunk restraint,		bruise Corrective Action for Potentially Residents All residents have the potential affected by this alleged deficien On 9/2-3/15 the nurse manager completed device evaluation fo current residents. This was acc	to be t practice. 's rms on all	

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	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY	
	FCORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG			
		345218	B. WING _			C 09/04/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•		
MARY GI	RAN NURSING CENT	TER		120 SOUTHWOOD DRIVE BO CLINTON, NC 28328	X 379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 221	Continued From pa	age 7	F 22	21			
	limb restraint or ch coded as not being	air that prevented rising were g used.		by going into every res determining what type or other potentially res	of side rails, hi low		
	A review of Reside	nt #160 ' s Care Area		were being used. This			
	Assessment (CAA) dated 5/21/15 revealed she		hi-low mattresses, Ger	i chairs, and other		
		viors and falls. Resident #160 term memory problems and a		cushions that might be restraints. Once a de			
		fusing medications over the		determined to be attac			
	last week and yelli	ng at a nurse (The assessment		the resident¿s body it	was evaluated by		
		She was admitted to the		the nurse to identify if i			
		om home for rehabilitation, endurance. The facility		patients freedom of mo access to the patient			
		plan due to behavioral		that were considered a			
	symptoms and a h			reviewed for medical n			
	Pesident #160's la	st side rail assessment was		evaluating nurse. If the identified as a restraint			
		15. Resident #160 was unable		indicated a reduction p			
	to state preference	e about her side rails. She was		by the care planning te	am. This review		
		1/2 length side rail on both		was completed by 9/3/			
		sessed as having a history of le while in bed. She did have		all patients have been restraining devices with			
		turn from side to side but had		necessity have been d			
	not attempted to g	et out of bed. She was		active reduction plans	with specified time		
		g a decreased safety		frames to accomplish t			
		confusion or judgment ecision was for her to continue		result of this review, 28 changes in bedrail utili			
	current side rail us			that utilize either geri-c			
	A			mattresses or other de			
		e plan dated 5/11/15 revealed s at risk for falls related to her		screened by therapy as their restraint reduction			
		safety needs. She had poor		Systematic Changes			
	communication an	d comprehension with gait and		On 9/3/2015, the QA N			
		All interventions were started		in-serviced all nurses r			
		re were no updates concerning d as a restraint after getting		managers, MDS, SDC restraints. Topics inclu			
	her arm caught in	the side rail on 8/21/15 or the		¿ Many devices can	be a restraint for a		
	padding to the side	e rails.		patient. For somethin			
		gress Notes dated 8/21/15 at		depends on why and h typically think of a rest	ow we use it. We		

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED	
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			09/04/2015		
R					
TER					
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIO DATE	
age 8	F 22 ⁻	1			
mmate 's family member. vealed the resident was found beside her bed with her left side rail. The nurse the family member stated that risitor observed her moving and "squirmed" until she had le of the bed and when her feet her sock feet slid. The nurse ed the family member stated is holding onto the side rail and he floor her arm got caught in nurse assessed her for injuries vas helped back into bed with g assessed as red and with no cident report dated 8/21/15 t #160 was found sitting on the ed with her left arm through the disposing physiological factors ent was confused, she had gait paired memory with her side ere 2 witnesses both visitors. to have side rails padded and be applied to the resident. he incident report revealed the 8/24/15 ogress Notes dated 8/31/15 at d that half rail padding was t #160 's side rails in the ation on 8/31/15 at 2:33 PM is observed in her bed with		 can be anything that limits a patability to move. ¿ The official definition of a prestraint is according to the State Operation Manual was reviewed Emphasis was put on the fact the bedrails, hi-low mattresses and can be considered restraints. ¿ Device evaluation forms mut completed on all patients on addreadmission, every 6 months and significant changes. Additionally a resident has fall where a device utilized the device must be evaluation to the patient. A device of form should be completed to dot this review in the medical record devices that the patient uses that meet the definition of a restraint above. If the device is consider restraint then the medical necess device is reviewed. If the device medically necessary then the interdisciplinary care plan team review the device to try and redue eliminate the use of the restraint Reduction plans should be review week during the daily clinical meet that the restraint is being This must continue until the restraint is being This must continue until	ient ¿s hysical e l with staff. at geri-chairs st be mission, d with y any time was uated to pose a evaluation cument l. The at all at may listed ed a sity of the e is should uce or t. wed every eeting to y reduced. raint is began taff (RN,		
		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345218 B. WING	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345218 STREET ADDRESS, CITY, STATE, ZIP CODE 3 STREET ADDRESS, CITY, STATE, ZIP CODE TER STREET ADDRESS, CITY, STATE, ZIP CODE TATEMENT OF DEFICIENCIES OWINGT EE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APR DEFICIENCY) Dage 8 F 221 Page 8 F 221 Page 8 F 221 Page 8 F 221 Page 8 F 221 Prestraint or wrist restraints but re can be anything that limits a pat big drail. The nurse dat he family member stated har sock feet slid. The nurse dat he family member stated har sholding onto the side rail and he floor her arm got caught in nurse assessed her for injuries vas helped back into bed with g assessed as red and with no cident report dated 8/21/15 the the was found sitting on the ed with her left arm through the disposing physiological factors ere 2 witnesses both visitors. e to have side rails padded and be applied to the resident. the incident report revealed the 3/24/15 F 2:10 Or 9/3/15 at the applied to the resident. the incident report revealed the 3/24/15 F additional medical record device shat the patient. A device e form should be completed to do this review in the medical record device is reviewed. If the device is consider mestraint then the restraint Reduction plans should look	E & MEDICAID SERVICES OMB NO. (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE (X2) MULTIPLE CONSTRUCTION A BUILDING (Y3) MUTIPLE CONSTRUCTION (Y3) DATE (X2) MULTIPLE CONSTRUCTION A BUILDING (Y3) MUTIPLE CONSTRUCTION (Y3) DATE (X3) DATE A BUILDING (Y3) MUTIPLE CONSTRUCTION (Y3) DATE (X2) MULTIPLE CONSTRUCTION A BUILDING (Y3) DATE (X3) DATE (Y3) MUTIPLE CONSTRUCTION (Y3) DATE (X3) DATE (Y3) DATE (Y3) DATE (X3) DATE (X3) DATE (Y3) DATE (X3) DATE (X3) DATE (Y3) DATE (X3) DATE (X3) DATE (X3) DATE (X3) DATE (X3) DATE (X3) DATE (X3) DATE (X3) DATE (X3) DATE	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY PLETED
					(C
		345218	B. WING		09/04/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 221	Continued From pa	age 9	F 22	21		
	inches over the sid	-	1 22	rails. The Director of Nursing	will	
				ensure that any employee who		
		on 9/1/15 at 3:08 PM the		received this training by 9/3/15	will not be	
	resident ' s Nursing Assistant (NA#11) stated Resident #160 was moving around in bed and			allowed to work until the training		
				completed. As of 9/3/15 appro		
		of bed and fell getting her arm rail. She had half rails and they		50 % of employees have receiv training. This in-service include		
		n top of the rails so that she		following topics:		
		irm caught in the side rails.		¿ There are lots of reason wh	iy we	
	Ū	0		should not use a restraint. Stud		
		PM Nurse #6 stated that she		shown that restraints do not pre		
		# 160 on 8/21/15. Nurse #6		and can actually cause harm to		
		slipped out of the bed onto the Resident #160 had been		This harm can include fractures injuries, or even death by strang		
		e bed she moved over on the		The survey guidelines that regu		
		ne stated the roommate 's		nursing facilities also include re		
		her that Resident #160 was		that protect the resident's right		
		de rail and she slid down onto		being restrained.		
		ft arm slid into the side rail.		¿ Restraints can include a ph	ysical	
		staff were getting her off the		restraint or chemical restraint	a ha a	
		rm out of the side rail. Nurse ssed the resident and her left		(medications). For something t restraint it depends on why and		
		ttle red but she had no skin		use it. We typically think of a r		
	tears.			being a vest restraint or wrist re		
				but restraints can be anything the		
		PM the roommate 's family		patient; s ability to move. The		
		e was in Resident #160 ' s		definition of a physical restraint	was	
		ne saw Resident #160 have her e side rail (8/21/15). She		 reviewed during the in-service. ¿ If a patient uses one of those 	a devices	
		every day and Resident #160		we need to ensure that the devi		
		rm through the side rail. She		hazard for the patient. If you no		
	stated on the day of	of the incident (8/21/15) the		patient throwing their legs over	the rails or	
		bdy wrapped up in a sheet.		gerichair, notify the charge nurs		
		s squirming and slid out of bed		immediately. The charge nurse		
		on her knees. The family Resident #160 was observed		ensure that the nurse manager		
		ne got her left arm stuck in the		The nurse manager will need to a device or side rail evaluation		
		member stated the resident		that the device is still medically		
		ere hurting and she went and		or they will need to make efforts		

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STATEMENT	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		345218			C 09/04/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/04/2010	
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC	
F 221	got someone to hel	p her. She stated she	F 22	remove the device.		
	observed staff lifting her up and saying for them to be careful getting her arm out of the rail. She stated the facility just put the cushion over the side rail yesterday (8/31/15). On 9/2/15 at 8:41 AM the Rehab Manager stated Resident #160 was admitted to the facility for Physical Therapy. Her therapy began on 5/12/15 and ended on 6/2/15 due to she was at her			¿ The survey manual says: Res may not be used for staff convenie However, if the resident needs em care, restraints may be used for br	nce. ergency ief	
				periods to permit medical treatmer proceed unless the facility has a ne indicating that the resident has pre made a valid refusal of the treatme	otice viously ent in	
	maximum potential transfers and gait a	. Rehab staff addressed and she was able to ambulate he could transfer to and from		question. If a resident¿s unanticipa violent or aggressive behavior plac him/her or others in imminent dang resident does not have the right to the use of restraints.	es ger, the	
	assistance. She wa cognition impairme from day to day. S	as inconsistent and had nt and could not remember he was assessed as being		¿ As you can see there are very situations where restraints should used.	be	
	assistance, but cou always required so discharged on 6/2/	utes with contact guard Id not stand by herself. She me assistance. She was 15 due to she was at her		¿ In general when dealing with a who is agitated there are some bas steps you can follow to try and red agitation. They include active liste	sic uce the ning,	
	referral in July 2018 her up for therapy b and had cognitive in	. Rehab staff did receive a 5 and made attempts to pick out she was very aggressive mpairment. The Rehab We did not evaluate her		provide reassurance, provide activ modify the environment, find other for the patient and check yourself ensuring your approach is calm an reassuring.	outlets	
	regarding the side			¿ Each patient is unique and interventions to minimize the risk of may range from offering favorite for		
	MDS Coordinator s with the Unit Manag (DON), and the Adr 8/21/15. She state	tated she had been involved ger, the Director of Nursing ministrator after the fall on d they had decided to put a		playing music or a TV program that may like. The patient is care plan include interventions that should be to try to calm the patient. The physical	t they will e used sician	
	cushions available cushion that came had nothing else in	de rail but there were no and they had to order a in on 8/31/15. She stated they place to prevent her from		should also be notified so that med interventions can be explored if the plan interventions do not work or if agitation is more severe than usua	e care the I. If	
	had nothing else in getting her arm stu				l. If do not	

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		AND HUMAN SERVICES				RINTED: 09/30/2015 FORM APPROVED MB NO. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345218	B. WING			09/04/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 SLINTON, NC 28328	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 221	were a restraint bed out of bed even the During an interview Resident #160 ' s re the facility had calle told her that her roo reported that Resid up in the covers, sli arm caught in the s told her that she did talking to the respo- lifting the sleeve fro no bruising observe approximately 2 ind The responsible pathe side rail had bru party asked Reside bruise and she stat the side rail. During an interview stated she was not and asked Residen bruise and she stat the side rail. On 9/3/15 2:23 PM present, NA #12 state be Resident #160 ' bruise while she wa #12 stated she ask thought it happened she hurt it in the sid area looked like an	age 11 ails were hazardous or they cause the resident could get bugh she was not safe. Ton 9/03/15 at 2:04 PM esponsible party stated that ed her about 2 weeks ago and ommate 's family member had ent #160 had gotten tangled id off the bed and got her left ide rail. She stated staff had d not have any bruising. While nsible party she was observed om her left arm and there was ed. She was then observed her right arm. Resident #160 ' d with a dark purple bruise ches long and 1 inch wide. rty stated her arm looked like uised her. The responsible ent #160 how she got the ed she got her arm caught in ton 9/3/15 2:06 PM Nurse #7 aware of her having a bruise to she got her arm caught in with Nurse #7 and NA #12 ated that she was assigned to s NA on 9/3/15 and saw the as bathing her at 7:30 AM. NA ed the resident how she d and Resident #160 told her le rail. Nurse #7 stated the older bruise that happened She stated it did look like the	F	221	additional directions, then notify the or nurse manager on call. ¿ Anytime a patient is actively try get up unassisted or if they are tryin get out of a gerichair unassisted or throwing their legs over a side rail, one supervision must be implement Staffing should be reallocated to co- patients until additional assistance called in to cover the one on one supervision. Your charge nurse sho contact the administrator and DON immediately if a patient meets this and to get assistance in coordinatin staffing needs. The administrators DON phone numbers are listed at the nursing station. One on one super- should be continued until the patier reviewed by the Quality Assurance and alternative safety interventions identified and implemented. The Q should ensure that the complete a evaluation or a siderail evaluation is completed. Also make sure to doc the restlessness and any fall in the electronic health record. To assist prevention make sure to include and devices (gerichair, bedrail. Bolster mattress or restraint) that was in us ¿ Restraints do not provide safet our patients and should only be use extreme emergencies. Restraints of both physical and chemical. Physic restraints may be items not typically thought of as a restraint such as a or chairs. It depends on how the do used and why we are using it. If yo caring for an agitated patient who is to get up unassisted please refer to	ing to ng to one on ted. over all can be ould criteria ng the and he vision it is team are A team device s ument in fall y se. y for ed in can be cian y sheet evice is u are s trying

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PRINTED: 09/30/2015 FORM APPROVED

					MB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345218	B. WING		C 09/04/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 221	Continued From pa	ige 12	F 22 ⁻	1	
	bruise was from the arm. During an interview Director of Nursing been a part of the of Resident #160's 8 she met with the Ac and the MDS Coord the resident 's arm and they ordered pa DON stated that the told her that Reside using the side rail to touched the floor sh socks and slid getti side rail. The DON witness statements incident report was fall. The DON furth a restraint was if it hey wanted to perf She further stated sh has a " right to fall. if she was aware th arm caught through bed, she was at risit that side rails can b assessed Resident enabler to help her stated that because side rails as an ena physician 's order f she was still investi the bruise on her rig stated they did order	e side rail on her upper right on 9/4/15 at 11:56 AM the (DON) stated that she had clinical meeting concerning /21/15 fall. The DON stated diministrator, the Unit Manager dinator. They discussed that did get caught in the side rail adding to go over the rail. The e roommate 's family member ent #160 slid out of the bed o hold on to and when her feet ne did not have on non-skid ng her arm caught through the stated she did not have any from the investigation and the what they used to discuss the her stated that her definition of prohibited them from having heir body or perform an activity form then it was a restraint. she had been told the resident " When the DON was asked at when a resident got their n a side rail while exiting her k for injury, the DON stated be hazardous but she had #160 's side rails as an move in her bed. The DON e the facility had coded her abler they did not have a for side rails. The DON stated gating why Resident #160 had ght upper arm. The DON er the side rail cover to avoid stuck in the side rail again.		 care plan for interventions to minir agitation. If they do not work conta physician. One on one supervision also be necessary for patient safer ¿ If you have questions please of your DON or Nurse Supervisor for clarifications. This training was incorporated into general orientation program and we discussed during all general orient programs that is completed started 9/2/15. Quality Assurance The Director of Nursing or designed monitor this issue using the Surve Quality Assurance Monitor for dev restraints. The monitoring will revia admissions to ensure that a device evaluation was completed on adm and any time a device is involved if accident or fall. This will be comple all admissions and incident reports times 4 weeks Monday thru Friday QOL then on 10 admissions/incide residents with devices monthly tim months or until resolved by QOL/O committee. Reports will be given to weekly QOL/QA committee and co action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Managers, Social Workers and Di Manager. 	act the n may y. contact the fill be ation d ee will y ces for ew all eission n an eted on s weekly in Daily ent es 2 A o the Trective Nurse etary

Facility ID: 923329

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345218	B. WING				C 04/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GI	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
				0		<u></u>	1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 221	Continued From par did not come until 8 expected her staff to was not available for 2. Resident #78 with 10/16/12 and re-add diagnoses including fall, History of Intrace Anxiety, and aftercat fracture of hip. Review of the most Data Set (MDS) Assidentified Resident a impaired (Brief Inter of 9). Resident #78 required extensive to bed mobility and trat her room or hallway and walking was co occur. She had nor She did not use a cat wheelchair for mobil and anti-depressant week. Restraints (b) restraints or chair the coded as being use Review of most reco with a revised goal for use of side rails to be the resident to main with bed mobility as for complications. In goal of minimizing to related to the use of	ge 13 9/31/15 and would have o let her know if the padding or that long. as admitted to the facility on mitted on 11/10/14 with g Senile Dementia, History of cranial injury, Osteoarthritis, are for healing traumatic recent quarterly Minimum sessment dated 8/20/15 #78 as moderately cognitively rview for Mental Status (BIMS) 8 had no behaviors. She two person assistance with ansferring. She did not walk in vs. Balance during transitions oded as 8 - activity did not range of motion limitations. ane/crutch/walker or ility. She received anti-anxiety t medications seven days a ed rails, trunk restraints, limb nat prevents rising) were not	F 2			RIATE	DATE
	continued need for	use of side rail and report to ely if resident was noted					

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	between the rail and Review of the Side 5/10/15 read the re- preference about the were ½ (half) rails in bed. The resident he history of falls from of bed climbing over mobile in the bed, se had made no attern and had difficulty we decreased safety and decision was to cor- usage. During an observat Resident #78 was re (half) side rails in the the bed. The rails he an approximate 4 in and top rail. There we top of bed to the stat approximately 2 fool high-low mattress we portion of the mattree observed to be place hi-low mattress. The on the floor next to observed to have he and her right leg the side rail lying horized in the direction of the against the wall. She During an observat Resident #78 was a observed in bed. Tup position on both was on floor.	-	F2	221			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	3:48 PM she stated from side to side in on her own and has continued by stating #78 will hang her le alarms if she gets u During an interview Nursing Assistant # can move around in She has alarms on because of a previo stated Resident #77 limitations. She stat the alarms on beca out of bed unassist During an interview 9:25 AM she stated was fighting and att she notified the Phy get out of bed by so exit. During an interview 09/01/2015 4:08 PM does move around will not roll on comr bed. She has a pre because of her hist During an observat Resident #78 was co of the bed wedged and the side rail try Nurse #5 was made resident ' s room. During an interview Nurse #5 stated up room, " this is why she tries to get out	d that Resident #78 can turn bed, is not supposed to get up s an alarming fall mat. She g that once in a while Resident egs over the bed but there are up. o n 09/01/2015 3:51 PM with 44 she stated that the resident in the bed and turn side to side. the bed and turn side to side. the bed and the fall mat ous fall and fractured hip. She 8 has no range of motion ted she thought the facility left use Resident #78 use to get ed. with Nurse #3 on 9/2/15 at d that on 6/19/15 the resident tempting to get out of bed so ysician. She stated trying to cooting to bottom of the bed to with the MDS Nurse on M she stated Resident #78 bed and roll side to side. She mand but she will move in the ssure alarm and fall mat alarm	F 2	21			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED C
		345218	B. WING				04/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 221	s get your leg up he During an interview 9/2/15 at 9:00 AM s for side rails read to resident is between old beds use to hav and the bed and resistated now that not a precaution. She fil evaluated but Resid is better if she has a in bed and move fro chair she will throw this makes me think bed rail. The MDS of Resident #78 would she decided to get middle or bottom of During a follow up i on 9/2/15 at 9:13 Al consider the hi-low because the reside even though not sa never realized that up, even unsafely, fa a restraint During an interview 9/2/15 at 9:44 AM s the hi-low mattress but enablers and bo believed the alarms rails have just " sta Resident #78 was of PM. She had a low	ere and turn you back in bed. with the MDS Nurse on the stated that the care plan o notify the nurse if the the rail and bed because the ve " a gap " between the rails sidents could get stuck. She e remains on the care plan as urther stated the alarms are dent #78 still "moves a lot" so it alarms. She stated she will roll om side to side. While in Geri her legs over the arms and k she could throw legs over Coordinator stated that d not know where to get up if up, whether it be the top, bed. nterview with the MDS Nurse M she stated that she did not mattress or side rail a restraint nt could still get out of them, fely. She stated that she if a resident attempted to get that this would be considered with Director of Nursing on she stated that she did not feel and side rails were restraints oundaries. She stated she s, hi-low mattress and side nyed " in place because to attempt to get out of bed	F	221			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		50		1:	20 SOUTHWOOD DRIVE BOX 379		
WARTG	RAN NURSING CENT	ER		С	CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	Continued From pa	ae 17	Εź	221			
		with the Director of Nursing					
		11:56 AM she stated that					
		gs through or around side rails					
		vior and had she been aware					
		ed immediately on the					
	situation.	vas notified of the Immediate					
		at 3:06 PM. The Immediate					
		oved on 9/4/15 at 3:30 PM					
		ble Action Plan. Interventions		ļ			
	listed on the plan in						
		S WERE PUT INTO PLACE					
	FOR THE REDIEN						
		on 9/3/15 the bedrails were					
		bed as a results of the side rail $0/3/15$ by the care plan		ļ			
		eted on 9/3/15 by the care plan ise was located on the right					
		f, family, resident interviews					
		from the side rail. The					
		ied on 9/3/15 at 1:58 PM. He					
		to monitor the bruise.					
		n 9/3/15 the care plan team					
		of the hi-low mattress. The					
		ntinue the use of the hi-low					
		aluate weekly for a maximum e side rail reduction has also					
		plan team also completed a					
		elated to the side rail and					
		e on 9/3/15 as a result of the					
	evaluation. Reside	nt #78 continues to use a		ļ			
		tting up and is positioned at					
		for monitoring by staff. The					
		valuated by therapy to see if					
		arrangements can be made. S WERE PUT IN PLACE FOR					
		NG THE POTENTIAL TO BE					
	AFFECTED?						
		A Nurse Consultant,					
		es managers (unit managers,					

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	MDS, SDC and DO included: MDS, SDC and DO included: Many patient. For some depends on why an think of a restraint b restraints but restra a patient 's ability t maturestraint is accordin Manual is was revie was put on the fact mattresses and Ge restraints. Device completed on all pa readmission, every changes. Additionat where a device was evaluated to ensure pose a hazard to the form should be com review in the medic evaluations should patient uses that m restraint listed above a restraint then the device is reviewed. necessary then the team should review or eliminate the use plans should be review daily clinical meetin being reduced. This restraint is discontin On 9/3/15 the nurse all current nursing stime and part time to	oN) on restraints. Topics devices can be a restraint for a thing to be a restraint it ad how we use it. We typically being a vest restraint or wrist aints can be anything that limits o move. fficial definition of a physical ag to the State Operation ewed with staff. Emphasis that bedrails, hi-low ri chairs can be considered e evaluation forms must be atients on admission, 6 months and with significant ally any time a resident has fall s utilized the device must be e that the device does not ne patient. A device evaluation npleted to document this cal record. The device look at all devices that the ay meet the definition of a ve. If the device is considered medical necessity of the If the device to try and reduce e of the restraint. Reduction viewed every week during the ng to ensure that the restraint is is must continue until the	F	221			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT COM	E SURVEY IPLETED
		345218	B. WING				C 04/2015
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GF	RAN NURSING CENT	ER			120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	this training by 9/3/ until the training is of approximately 50 % this training. This in following topics: There should not use a re- that restraints do no actually cause harm include fractures, sl strangulation. The skilled nursing facilit that protect the resi restrained. Restra restraint or chemical something to be a r how we use it. We being a vest restrain restraints can be a r how we use it. We being a vest restrain restraints can be a r how we use it. We being a vest restrain restraints can be a r ability to move. The physical restraint we in-service. If a par devices we need to a hazard for the pat throwing their legs of notify the charge nu- nurse should ensur- notified. The nurse complete a device of ensure that the dev or they will need to device. The su- may not be used for	ployee who has not received 15 will not be allowed to work completed. As of 9/3/15 of employees have received n-service included the are lots of reason why we straint. Studies have shown of prevent falls and can n to a patient. This harm can kin injuries, or even death by survey guidelines that regulate ties also include regulations dent 's right against being ints can include a physical al restraint (medications). For estraint it depends on why and typically think of a restraint nt or wrist restraints but nything that limits a patient 's e official definition of a as reviewed during the tient uses one of those ensure that the device is not ient. If you notice the patient over the rails or Geri chair, arse immediately. The charge e that the nurse manager is manager will need to or side rail evaluation to ice is still medically necessary make efforts to remove the arvey manual says: Restraints r staff convenience. However,	F2	221			
	may not be used fo if the resident need						

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RAN NURSING CENT	ED		12	20 SOUTHWOOD DRIVE BOX 379		
MARTO	AN NURSING CENT	ER		С	LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	Continued From pa treatment to procee notice indicating tha made a valid refusa If a resident ' s unar aggressive behavio imminent danger, th right to refuse the u · As you situations where res · In gene patient who is agitar steps you can follow agitation. They incl reassurance, provic environment, find of check yourself ensu and reassuring. · Each p interventions to min range from offering music or a TV prog patient ' s care plan should be used to th physician should als interventions can be interventions do not more severe than u the care plan do no cannot provide addi the DON or nurse n · Anytim get up unassisted o a Geri chair unassis a side rail, one on o implemented. Staff	sc IDENTIFYING INFORMATION) age 20 ed unless the facility has a at the resident has previously al of the treatment in question. Inticipated violent or or places him/her or others in he resident does not have the use of restraints. It can see there are very few straints should be used. eral when dealing with a ted there are some basic w to try and reduce the lude active listening, provide de activities, modify the ther outlets for the patient and uring your approach is calm batient is unique and himize the risk of falling may favorite foods to playing ram that they may like. The n will include interventions that ry to calm the patient. The so be notified so that medical e explored if the care plan t work or if the agitation is isual. If interventions listed in it work and the physician itional directions, then notify nanager on call. ne a patient is actively trying to or if they are trying to get out of sted or throwing their legs over one supervision must be fing should be reallocated to	F 2		CROSS-REFERENCED TO THE APPROP		
	be called in to cove Your charge nurse	ntil additional assistance can r the one on one supervision. should contact the DON immediately if a patient					

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY IPLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	meets this criteria a coordinating the sta administrators and listed at the nursing supervision should is reviewed by the 0 alternative safety in implemented. The the complete a dev evaluation is compl document the restle electronic health re prevention make su (Geri chair, bedrail. that was in use. Restra our patients and sh emergencies. Rest and chemical. Phy not typically though sheet or chairs. It our used and why we a for an agitated patie unassisted please r interventions to mir not work contact the supervision may als safety. This training was in orientation program all general orientatii started 9/2/15. The Credible Action 1. Record review of and sign in sheets.	and to get assistance in	F	221			

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 ER	. ,	S 5 1	C LE CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	FORM MB NO. (X3) DATE COM (09/(09/30/2015 APPROVED 0938-0391 E SURVEY PLETED C 04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	 9/4/15 at 3:30 PM v and Nursing Assista and second shift co 3. For Resident #1 were removed from side rail assessmer care plan team. Re without her side rail 4. For Resident #7 evaluated the use of team decided to com mattress and reeva of 30 days since the occurred. The care device evaluation re discontinued its use evaluation. Reside Geri-chair when get the nurse 's station patient will be re-eva alternative seating a 5. A review of the life evaluations and that implemented. Obse all halls to assure the implemented. 3. Resident #78 wa 10/16/12 and re-add diagnoses including fall, History of Intrace Anxiety, and aftercat fracture of hip. Review of the most Data Set (MDS) As identified Resident impaired (Brief Inter of 9). Resident #78 	with Nurses, Unit Managers ants on all halls for both first onfirming recent in-service. 60 on 9/3/15 the side rails the bed as a results of the ht completed on 9/3/15 by the esident #160 was observed	F2	221			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	bed mobility and tra her room or hallway and walking was co occur. She had not She did not use a co wheelchair for mob and anti-depressan week. Restraints (b restraints or chair th coded as being use Review of the Care dated 10/1/14 for fa problems during tra since admission an antidepressants an seven days per wee developing a care p remained at an incr frequent attempts to along with increase were to monitor the get up unassisted co have contributed to needed to prevent f Review of the revise for falls identified th being at risk for falls Psychoactive drug frequent attempts to Interventions in me the risk of falls inclu- staff on fall precaut to be in view of staff educating staff to key when in Geri chair a room, personal alar place, floor mat ala place while in bed.	Area Assessment Summary ansider a sec ever institution of the second of the second and the second of the second of the second antianxiety medications and the second of the second of the second and the second of the second of the second antianxiety medications and the second of the second of the second and the second of the second of the second of the second and the second of	F2	221			

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIP		FORM MB NO.	: 09/30/2015 APPROVED : 0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	B		
		345218	B. WING	;			C 04/2015
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	in Geri chair docum the resident attemp supervision and the potential to improve position because of The recommendation agitated and trying for chair possibly due to No skilled OT recor Review of the Occur dated 10/6/14 for w chair) documented cognitive deficits an recommendation re cognitive impairment the Geri chair and r During an interview Manager on 9/3/15 Resident #78 was so resident appeared a up out of her Geri chair needed) therapist a stated that this infor communicated to n stating the resident for Geri chair position and on this date it w had cognitive impai out of the Geri chair required. During an interview (MDS) Nurse on 9/2 that while Resident would throw her leg During a follow-up i on 9/2/15 at 9:13 All	creening for positioning safety nented secondary to cognition, its to stand and required e resident did not have the e functional independence or f sitting long in the Geri chair. on read, patient appeared to get out/stand up from Geri to cognitive/Dementia deficits. mmended at this time. upational Therapy screen theelchair positioning (Geri that Resident #78 had nd confusion. The ead that the resident had ints and attempted to get out of required supervision from staff. with the Rehabilitation at 10:00 AM she stated that screen on 9/25/14 because the agitated and was trying to get thair. She stated that the Resident #78 was a PRN (as and not working. She further rmation would have been ursing. She continued by was seen again on 10/6/14 oning after a fall from the chair was again noted the resident irment and attempted to get r and supervision was	F	221			

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CENTER STATEMENT AND PLAN C NAME OF I MARY G	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER RAN NURSING CENT SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	A. BUILD B. WING ID PREFI	S 5 1 2 2 2	O LE CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	FORM . MB NO. (X3) DATE COM (09/(09/(09/30/2015 APPROVED 0938-0391 E SURVEY PLETED C 04/2015
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 221	though not safely. If follow commands a resident attempted would be considere was the reason the was not checked as assessment. Review of the Fall r documented Reside nurse, after hearing upright on her butto approximately six in #78 only stated " I She was assessed to bed. The intervent the staff to keep resident to bed. The intervent the staff to keep resident found sitting on the personal alarm was state what happene up " over and over and the resident was buring an interview (DON) on 9/2/15 at fall report of 10/28/10 on placing the resident that she was not the on 10/6/14 and did was done to protect another fall from the During an interview 9/3/15 at 3:05 PM, yo on 10/28/15 during	get up out of the chair, even She stated the resident cannot and she never realized that if a to get up unsafely that this ed a restraint. She stated this " chair that prevents rising " is a restraint on the MDS report dated 10/28/14 ent #78 was found by the g the personal alarm, sitting ocks on the floor in her room noches from the chair. Resident can ' t get up, I can ' t get up. " for injuries and assisted back ntion listed was to re-educate sident in view when in her Geri ing Progress Note dated ted that Resident #78 was floor of her room. The s sounding. She was unable to ed, only saying, " I can ' t get again. No injuries were noted as assisted to bed. with the Director of Nursing 9:10 AM she stated that the 14 read to re-educate the staff lent in view. She further stated e DON when Resident #78 fell not have an answer as to what t Resident #78 from having	F 2	221			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	sometime after dinr resident was restles Resident #78 down another resident. S back down the hall and went into the re #78 was sitting up of was going to get up was time to go to sl clear to her Residen down so she put he stated she set the a back with her feet u always put the chain elevated the feet. During an interview 3:30 PM, it was stat 10/28/14 she was p heard Resident #78 sounding. She enter resident sitting on the resident had been in the resident was not assessed the resider She had another nut resident to her bed. picked up and place Review of the Nursi 10/29/1/4 it was dot sitting in the Geri ch During an observation resident was out of room feeding herse During an interview 11:56 AM she state decided on the use #78. She stated wh to the facility she show	her. She remembered that the ss. She stated she laid and left the room to check on She stated when she came she heard the alarm going off esident 's room and Resident on the side of the bed like she on the floor. She stated she r in a reclining position and r with Nurse #1 on 9/3/15 at ted that on the evening of bassing medications when she be talking and her alarm ared the room to find the he floor. She stated the n her Geri-chair. She stated ot complaining of pain and she ent and everything looked fine. urse (Nurse #2) help return the . She stated the resident was ed in bed. ing Progress Noted dated cumented Resident #78 was hair in her room. ion on 9/2/15 at 8:35 AM the bed in her Geri chair in her	F 2	221			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	chair on 10/6/14 sh and was unaware th her legs over the G had seen or known over her side rail or said to be a restrair not aware that this even though educa were unaware to no She stated she cou 's Geri chair was n 10/6/15. She stated in a Geri chair was n 10/6/15. She stated in a Geri chair and considered a restra resident performing perform. She stated fall and with that kn knows that Geri cha stated behaviors su chairs are hazardou she would have act Review of the Nurs documented the nur room for morning m and the resident sta and hip pain and ye thigh was swollen a right leg. The phys received to send th room for evaluation Review of the Nurs 11/4/14 documente the hospital with a I Review of the Hosp documented a fract Review of the Hosp 11/4/14 documente	as far as a fall out of the Geri le was not the DON at the time hat the resident was throwing beri chair. She stated if she she was throwing her legs r Geri chair it would have been nt. She stated the staff were would have been a restraint, tion had been done and they brify the DON for this behavior. Ild not answer why the resident tot determined a restraint on d, at this time, if a resident is falls out, the chair would be aint because it prohibited the g an activity they wanted to d that a resident has a right to nowledge the facility now airs can be restraints. She uch as throwing legs over Geri us and if she had been aware ted on this. ing Note dated 11/4/14 urse entered the resident ' s nedication pass at 7:40 AM arted to complain of left leg ell out in severe pain. The left and the left leg shorter than the ician was notified and an order e resident to the emergency	F 2	21			

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		& MEDICAID SERVICES	0.00		<u>10. 0938-039</u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY		
		345218	B. WING _		C 09/04/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 221 F 253 SS=D	extremity secondar some bruising on th Review of the Hosp 11/10/14 listed the hip fracture, status internal fixation). 483.15(h)(2) HOUS MAINTENANCE SE	f motion of the left lower y to the fracture. She had he legs. bital discharge summary dated discharge diagnoses as left post ORIF (open reduction	F 22 F 25		10/2/15		
	sanitary, orderly, ar This REQUIREMEN by: Based on observat facility failed to prov failing to clean the t formula for 2 of 2 st 54 and # 140). The findings include 1. Resident # 54 v 3/04/10 with diagno Accident, aphasia a receiving Glucerna On 8/31/15 at 4:45 the feeding pump a dime size light tan of feeding pole base a of the tube feed pol dime and nickel siz matter. On 9/1/15 at 3:39 F	xes necessary to maintain a nd comfortable interior. NT is not met as evidenced tions and staff interviews the vide a sanitary environment by tube feeding poles of feeding ampled residents. (Resident # ed: vas admitted to the facility on oses including Cerebrovascular and seizure disorder and was 1.5 via a gastrostomy tube. PM in Room # 503 the top of and face was observed with 6 drops of dried matter. The and the floor around the base le was observed with 12 to 17 ed light tan drops of dried PM in Room # 503 the top of and face was observed with 6		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all 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 is allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F 253 Corrective Action for Resident Affected For resident #54 and #140 the tube feeding pump, pole, and floor beneath			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	E CONSTRUCTION		0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:				· · ·	PLETED
						C	5
		345218	B. WING)4/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	20 SOUTHWOOD DRIVE BOX 379		
MARTG	RAN NURSING CENT	ER		С	LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 253	Continued From pa	age 29	F 2	253			
		le was observed with 12 to 17					
		red light tan drops of dried					
	matter.						
		PM in Room # 503 the top of			Corrective Action for Resident Pote	ntially	
		and face was observed with 6			Affected		
		drops of dried matter. The and the floor around the base			All resident with feeding poles have	the	
		le was observed with 12 to 17			potential to be affected. All current		
		red light tan drops of dried			residents that utilize a feeding pole	and	
	matter.				pump were audited on September		
	On 9/3/15 at 9:44 A	AM in Room # 503 the top of			for dried matter or debris on their fe		
	the feeding pump a	and face was observed with 6			pole, pump and floor beneath. This	was	
		drops of dried matter. The			completed by the Administrator. No		
		and the floor around the base			concerns were identified with this a	udit.	
		le was observed with 12 to 17			Sustamia Changaa		
	matter.	ed light tan drops of dried			Systemic Changes		
	During an interview	with the 200 hall			Effective September 25, 2015 the c	lailv	
		/3/15 at 9:44 AM she stated			cleaning of the tube feeding poles v		
		n and dusted the furniture,			assigned to the housekeeping		
		om, emptied trash, mopped			department. On September 23 and	24,	
	and wiped down th	e tube feeding poles.			the Housekeeping Department emp		
		with the Administrator on			FT, PT and PRN were in-serviced of	on	
		I she stated that she would			policy number HSK-110 by the		
		eding pumps and poles to be			Administrator. The topics included:		
	clean and staff wou	was readmitted to the facility			cleaning horizontal Surfaces. Clea dust using germicidal cleaner: Tub		
		gnosis including Protein			feeding poles, Tube feeding pump,		
		, Chronic Kidney Disease and			floors beneath the tube feeding pole		
		erna 1.5 at 40 cc/hour via a			window sills, bed rails, headboards		
	gastrostomy tube.				tables, chairs dressers, and beside	tables.	
		AM in Room # 207 the front of					
		vas observed with 4 dime size			Any in-house staff member who did		
		ried matter and where the			receive in-service training by Octob		
	with light tan drops	ne feed wheel was observed			2015 will not be allowed to work un training has been completed. This	ui	
		AM in Room # 207 the front of			information has been integrated inte	o the	
		vas observed with 4 dime size			standard orientation training for all		
	Lane resource pump v	ried matter and where the	1		etaniaana enontation training for all		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI I	E CONSTRUCTION (X3) [DATE SURVE	FY
	F CORRECTION	IDENTIFICATION NUMBER:				OMPLETED	
				-		С	
		345218	B. WING			9/04/201	15
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X: COMPL DA	
F 253	Continued From pa	age 30	F 2	53			
	with light tan drops During an interview Housekeeper on 9 that she wiped dow	v with the 200 hall /3/15 at 9:44 AM she stated vn and dusted the furniture,			reviewed by the Quality Assurance Process to verify that the change has been sustained.		
	cleaned the bathro and wiped down th During an interview 9/4/15 at 10:19 AM	om, emptied trash, mopped e tube feeding poles. with the Administrator on I she stated that she would eding pumps and poles to be			Quality Assurance The Staff Development Coordinator will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Tube Feeding Poles. The monitoring w include assessing tube feeding pumps, poles and the floors beneath for any sig of dried matter or other debris. This will be completed on a sample of 5 resident a week x 2 weeks then monthly for 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate The Quality of Life Committee consists the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary	ns s;	
F 280 SS=D	483.20(d)(3), 483. PARTICIPATE PLA	10(k)(2) RIGHT TO ANNING CARE-REVISE CP	F 2	80	Manager and Social Worker.	10/2/1	15
	incompetent or oth incapacitated under	er the laws of the State, to ing care and treatment or					

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CENTER STATEMENT AND PLAN O		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 ER	. ,	S S S	E CONSTRUCTION (X3) D/ CC	D: 09/30/2015 M APPROVED D. 0938-0391 ATE SURVEY DMPLETED C 0/04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the res legal representative and revised by a tea each assessment.	ge 31 he completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F	280		
	interviews and obse update the care pla (Resident #160) for for accidents. Findings included: Resident #160 was 5/8/15 with diagnos non-Alzheimer ' s D disturbances and w Resident #160 ' s la completed on 5/8/1 to state preference assessed to have ½ sides. She was ass falls and was mobil enough mobility to the not attempted to get assessed as having	record review, staff and family ervations the facility failed to n for a resident with falls one of two residents reviewed admitted to the facility on es of hypertension, bementia with behaviors ith a history of falls. ast side rail assessment was 5. Resident #160 was unable about her side rails. She was ½ length side rail on both sessed as having a history of e while in bed. She did have turn from side to side but had it out of bed. She was g a decreased safety confusion or judgment			F 280 Corrective Action for Resident Affected: For Resident #160, the residents care plan was reviewed and was noted to reflect her current fall interventions including personal alarm updated 05/11/15, bed alarm updated 05/11/15, and the side rail was discontinued on 09/03/15 and padded side rails had previously been updated to the care plan 08/23/15 and resolved on 09/03/15. This was completed by the MDS Coordinator. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this alleged deficient practice Beginning 09/28/15 the nurse managers began reviewing all current residents who	

Facility ID: 923329

		& MEDICAID SERVICES				. 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	`COM	e survey Ipleted
			5 14/11/0			С
		345218	B. WING			04/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE CLINTON, NC 28328	BOX 379	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
F 280	Continued From pa	qe 32	F 2	80		
	problems. Staff de current side rail usa A review of the Pro- revealed Resident a and was observed a for interventions ha a personal and floo A review of the Pro- revealed Resident a observed lying on h her roommate 's be attached to the bed as having a bruise by 2 cm on her left give a reason why s The facility for an ir added and therapy A review of her care revealed Resident a related to her being She had poor comr comprehension with The facility had inte the interventions co bed alarms, side ra included in the care A review of the mos Data Set (MDS) da MDS dated 5/15/15 short and long term Resident #160 was behavioral symptom rejected care. She transfer and bed m She was not steady standing position an	cision was for her to continue age. gress Notes dated 5/8/15 #160 had a fall from her bed sitting on the floor. The facility d a urine analysis ordered and r alarm were in place. gress Notes dated 5/10/15 #160 had a fall and was her back on the floor beside ed. The personal alarm was Resident #160 was assessed measuring 2 centimeters (cm) hip. The resident could not she had gotten up unassisted. htervention had a bed alarm was initiated. e plan last up-dated 5/11/15 #160 was at risk for falls unaware of safety needs. munication and h gait and balance problems. reventions in place but none of oncerning the personal, floor, ils or padded side rails were e plan. at recent quarterly Minimum ted 8/15/15 and her admission revealed Resident #160 had memory problems. coded as having verbal ns directed toward others and required extensive care for oblility with one person assist. moving from a seated to	ΓŹ	 have had a fall in the accomplish this, the printed a list of patinic incident report in the incident report was nurse managers to interventions for the reviewed by the nut that the intervention and care planned a orders. This process 10/02/15. Systemic Changes On 09/21/15, the C Consultant in-service Care plan updates. Updated on an ¿on to reflect the most of the resident. This care plan promptly Each discipline is renecessary so that i condition and need consisted of the MI Social Workers, Ac Manager. 	ents that had a fall he last 3 months. The then reviewed by the i dentify the vere put in place. e falls were then rse manager to ensure ns were appropriate and matched the MD so will be completed by corporate MDS ced the Care Plan and updating care ce content included: . Care plans should be going; basis in order current condition/needs s includes updating the after every falls review. esponsible for making to care plans as t will reflect resident ls. The Care Plan Team DS Coordinator, two ctivities, and Dietary member who did not raining by 10/02/15 will vork until training has	

Facility ID: 923329

	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MEILT	ripi			0938-039
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
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		345218	B. WING			09/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page 33 prevented rising were coded as not being used. A review of Resident #160 ' s Care Area			80	Members and will be reviewed by the Quality Assurance Process to verify t		
	Assessment (CAA) triggered for behav had short and long few episodes of ref) dated 5/21/15 revealed she iors and falls. Resident #160 term memory problems and a fusing medications over the			the change has been sustained.		
	date was 5/15/15.)	ng at a nurse (The assessment She was admitted to the om home for rehabilitation,			Quality Assurance The Director of Nursing or designee	will	
	strengthening and o proceeded to care symptoms and a hi	endurance. The facility plan due to behavioral			monitor this issue using the Survey Quality Assurance Monitor Care Plan Audit for monitoring updating care pl with new fall interventions as identifie	ı Ians	
	11:10 AM Nurse #6 s room by her room Documentation rev sitting on the floor b arm caught in the s	was called to Resident #160 ' nmate 's family member. ealed the resident was found peside her bed with her left side rail. The nurse			QA and physician orders. This will be completed on all residents with falls weekly times 4 weeks then on 10 residents with falls monthly times 2 months or until resolved by QOL/QA	A A	
	she and another vis about in her bed ar her feet off the side touched the floor, h	he family member stated that sitor observed her moving hd " squirmed " until she had e of the bed and when her feet her sock feet slid. The nurse d the family member stated			committee. See Attachment A. Repor will be given to the weekly QOL/QA committee and corrective action initia as appropriate. The QA/QOL Commi consist of the Administrator, Director Nursing, Nurse Managers, Social Wo	ated ittee of	
	Resident #160 was when she slid to the the side rail. The n and the resident was	holding onto the side rail and e floor her arm got caught in nurse assessed her for injuries as helped back into bed with			and Dietary Manager.		
	A review of the incir revealed the facility non-skid socks wer	red and no break in the skin. dent report dated 8/21/15 v ordered side rail pads and re already in place. gress Notes dated 8/31/15 at					
	11:49 AM revealed added to Resident morning (8/31/15).	that half rail padding was #160 ' s side rails in the PM the roommate ' s family					
	member stated she	was in Resident #160 ' s ne saw Resident #160 have her					

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	COM	E SURVEY PLETED C
		345218	B. WING	i			04/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	arm stuck in the sid she visited every da stuck her arm throu on the day of the in had her body wrapp #160 was squirming fell down on her kno stated as Resident of bed she got her I The family member knees were hurting someone to help he staff lifting her up a careful getting her a the facility just put t yesterday (8/31/15) During an interview MDS Coordinator s with the Unit Manag (DON), and the Adr 8/21/15. She stated cushion over the sid cushion that came i During an interview Director of Nursing been a part of the o Resident #160 ' s 8 she met with the Adv and the MDS Coord the resident ' s arm and they ordered pa stated that the MDS care plan during the have updated the c intervention. The D	de rail (8/21/15). She stated ay and Resident #160 usually ugh the side rail. She stated cident (8/21/15) the resident bed up in a sheet. Resident g and slid out of bed and she ees. The family member #160 was observed falling out left arm stuck in the side rail. r stated the resident stated her and she went and got er. She stated she observed nd saying for them to be arm out of the rail. She stated the cushion over the side rail of on 9/2/15 at 9:41 AM with the tated she had been involved ger, the Director of Nursing ministrator after the fall on d they had decided to put a de rail but there were no and they had to order a	F 2	280			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIE	PLE CONSTRUCTION	OMB NO	E SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G		IPLETED	
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		345218			09/	04/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 323	Continued From pa	ige 35	F 323	3			
F 323 SS=J	483.25(h) FREE OI HAZARDS/SUPER		F 323	3		10/2/15	
	environment remain as is possible; and	nsure that the resident ns as free of accident hazards each resident receives on and assistance devices to					
	by: Based on record re family interviews th residents for hazard that was observed to get out of bed re stuck in the side rail again (Resident #1) observed attemptin one leg through and a second observati one leg wedged be and side rail (Resid (Resident #160 and hazardous side rail provide supervision Geri chair resulting 1 of 1 resident (Res with a fracture. Immediate jeopardy 11:10 AM for exam	NT is not met as evidenced eview, observations, staff and e facility failed to assess dous side rails for a resident by a family member attempting sulting in a fall with her arm il and by failing to implement g to prevent it from happening 60) and for a resident g to get over the side rail with d one leg over the side rail and on of the same resident with tween the high-low mattress lent #78) for 2 of 2 residents d Resident #78) with s. The facility also failed to a while she was left alone in a in a fall and femur fracture for sident #78) reviewed for falls y (IJ) began on 8/21/15 at ple #1(Resident #160). y began on 8/31/15 at 2:30 PM esident #78). Immediate		Credible Allegation for Tag 323 Corrective Action for Affected Re Resident # 78 resident was sent hospital on 11/04/2014 for evalu left hip and femur swelling. Res returned to facility with status po (Open Reduction Internal Fixatio time resident was continued with precautions of hi low mattress, of alarm, personal alarm, bed alarr mat, and floor mat alarm. Reside continues to use a geri-chair wh up and is positioned at the nurse for monitoring by staff. The pat re-evaluated by therapy to see if alternative seating arrangement made. This will occur on 9/3/15 Additionally on 9/3/15 the care p evaluated the use of the hi low r The team decided to continue th the hi low mattress and reevaluat for a maximum of 30 days since siderail reduction has also occur	to ation of ident st ORIF on). At that fall chair n, floor ent en getting es station ient will be s can be lan team nattress. he use of ate weekly the		

Facility ID: 923329

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TATEMENT		K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
	UURREUTIUN	IDENTIFICATION NUMBER.	A. BUILD	ING	;		C	
		345218	B. WING			09/04/2015		
NAME OF F	PROVIDER OR SUPPLIER	I	1	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
MARY G	RAN NURSING CENT	ER			120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 323	Continued From pa	age 36	F 3	323				
	cited at a G (isolate actual harm that is facility will remain of and severity of leve constitutes no actua than minimal harm jeopardy). The facil implementation and action. The findings includ Example #1 Reside facility on 5/8/15 wi non-Alzheimer 's E disturbances and w Resident #160 's of completed on 5/8/1 to state preference assessed to have 1 sides. She was as falls and was mobil enough mobility to not attempted to ge assessed as having awareness due to of problems. Staff de current side rail usa	ent #160 was admitted to the th diagnoses of hypertension, Dementia with behaviors vith a history of falls. only side rail assessment was 5. Resident #160 was unable about her side rails. She was ½ length side rail on both sessed as having a history of e while in bed. She did have turn from side to side but had et out of bed. She was g a decreased safety confusion or judgment cision was for her to continue			 discontinued its use on 9/3/15 as a of the evaluation. Resident has not fall since 10/28/14. Resident # 160 was admitted to the on 05/08/15. Resident fell on 05/08 urine analysis was ordered and peralarm and floor alarm was in place. Resident experienced a fall on 05/12/15. On 06/14 resident fell and was placed at the station with staff for close monitorin 07/25/15 the resident fell and side rail pads were ordered and non-skid socks were pplace. On 9/3/15 the bedrails were removed from the bed as a result of side rail assessment completed on by the care plan team. 9/3/15 a br was located on the right arm where staff, family, resident interviews staff, family, resident interviews staff, family, resident at 3:15 to mon bruise. Corrective Action for Potentially Aff Residents All residents have the potential to the sock of the sock of	t had a e facility 8/15, a rsonal 10/15 rapy 4/15 the nurses ng. On rrapy the e out in e 9/3/15 uise e the ated 1:58 itor the		
	and was observed documented she w room by her persor was found on the fl				affected by this alleged deficient pr On 9/2-3/15 the nurse reviewed all patients who have had a fall in the months. To accomplish this the nu managers printed a list of patients	current last 12 Irse that		
	She already had in	led an order for urinalysis. place a personal alarm and a mat that alarms when it is			had a fall incident report. The incid report was then reviewed by the nu manager to identify the reason and contributing factors for the fall. Thi	ırse I/or		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED	
		345218	B. WING		C 09/04/2015		
NAME OF	PROVIDER OR SUPPLIER	0.0210		STREET ADDRESS, CITY, STATE, ZIP CODE	09/0	03/04/2013	
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 323	Continued From pa	ae 37	F 32	3			
	A review of the Pro revealed Resident is and was observed beside her roomma alarm was attached was assessed as h centimeters (cm) b resident could not of gotten up unassiste intervention include therapy was initiate A review of her card revealed Resident is related to her being She had poor com comprehension wit The facility had inter included she neede bed in low position report to the physic of bruising 72 hours were started on 5/1 updates concerning alarms or padding A review of the Phy 5/12/15 revealed R beginning 5/12/15 a she was at her max #160 was documer assistance and cou to the wheelchair w was inconsistent ar and could not reme always required so A review of Reside Data Set (MDS) da recent quarterly ME	gress Notes dated 5/10/15 #160 had a fall from her bed lying on her back on the floor ate 's bed. The personal d to the bed. Resident #160 aving a bruise measuring 2 y 2 cm on her left hip. The give a reason why she had ed. The facility 's new ed the use of a bed alarm and d. e plan last revised on 5/11/15 #160 was at risk for falls g unaware of safety needs. munication and h gait and balance problems. erventions in place that ed a safe environment with her and to monitor, document and ian any signs and symptoms s after a fall. All interventions 1/15 and there were no g the personal, floor, bed to the side rails. rsical Therapy notes dated esident #160 received therapy and ended on 6/2/15 because kimum potential. Resident the as able to ambulate with and cognition impairment ember from day to day. She	Γ 32	included reviewing falls for any in that the bed rail contributed to the accident. Interventions for the fat then reviewed by the nurse mana ensure that the interventions wer appropriate. Interventions may in alarms but also included medicat evaluations, pharmacy evaluation therapy evaluations for alternativ positioning/strengthening exerciss increased supervision, one on or supervision, and other specificall to the individual resident. Any in- involving a bed rail was also revie ensure that the bed rail had beer discontinued if no longer required patient. Any resident who was id that did not have a falls prevention intervention or whose fall preven intervention was not related to th fall was reviewed by the care pla team (nursing, social, activities a therapy) on 9/3/15 and interventii identified and implemented as appropriate. Interventions may in alarms but also included medicat evaluations, pharmacy evaluation therapy evaluations for alternativ positioning/strengthening exerciss increased supervision, one on or supervision, and other specificall to the individual resident. Systematic Changes On 9/3/15 the QA Nurse Consult serviced all nurses managers (un managers, MDS, SDC and DON restraints. Topics included: ¿ Daily during clinical meeting	e Ils were ager to e acclude tion ns, e ess, ne y related cident ewed to n d by the entified on tion e specific nning nd ons were nclude tion ns, e ess, ne y related on tion e specific nning nd ons were nclude		

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IAIEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED	
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		345218	B. WING _			09/04/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX CLINTON, NC 28328	(379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 323	Continued From pa	qe 38	F 32	23			
F 323	verbal behavioral si others and she reje person extensive as mobility. She was n seated to standing surface-to-surface. sides of her lower of restraint, limb restra- rising were coded a A review of Resider Assessment (CAA) triggered for behavi- had short and long few episodes of ref last week and yellin date was 5/15/15.) hospital to the facili rehabilitation, stren facility proceeded to symptoms and a hi A review of the Pro- revealed Resident as s station in a Broda floor in a sitting pos resident what happ For the intervention at the Nurse 's stat A review of the Pro- 11:38 AM revealed sounding and she w on the floor in a sitti assessed for injurie	ymptoms directed toward octed care. She required one ssistance for transfer and bed out steady moving from a position and moving from She had impairment on both extremities. Bed rails, trunk aint or chair that prevented as not being used. Int #160 ' s Care Area dated 5/21/15 revealed she iors and falls. Resident #160 term memory problems and a using medications over the ag at a nurse (The assessment She was admitted from the ty after a fall from home for gthening and endurance. The o care plan due to behavioral story of falls. gress Notes dated 6/14/15 # 160 was sitting at the Nurse ' o chair and was found on the sition. When staff asked the ened she stated she tripped. A, staff placed Resident # 160 tion for close monitoring. gress Notes dated 7/25/15 at Resident #160 ' s alarm was was observed at her bedside ing position. She was es and assisted back to a vention after her fall a therapy	F 32	nurse managers. This identifying any devices been involved in the fal they are appropriate for These devices include to bedrails, hi low mattr gerichairs. Devices shu determine if the device could have contributed device/siderail evaluation completed to ensure the is a restraint that a rest is developed and imple investigation should be electronic health record include details regardin staff, family interviews a completed. Once the r fall is identified the clinit identify the appropriate interventions for the patimplement such intervent obtained and document Assurance Review. ¿ Upon completion of interventions should be linterventions should be evaluations, therapy eval alternative positioning/s exercises, increased su one supervision, and of related to the individual should never be substitied interventions should be	that could have I to ensure that r the patients care. but are not limited resses or ould be reviewed to was a hazard that to the fall. A on should be at the if the device traint reduction plan mented. This document in the d and should g any resident, that have been oot cause of the ical team will prevention tient and will entions. s should also be ted in the Quality f this review, e identified. de alarms, , pharmacy raluations for strengthening upervision, one on ther specifically I resident. Alarms		

Facility ID: 923329

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI			0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
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		345218	B. WING			09/04/2015		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328	379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		BE	(X5) COMPLETIO DATE		
F 323	Continued From pa	ge 39	F 3	23				
	she was at her max #160 was able to an could transfer to an wheelchair with mir inconsistent and ha could not remembe assessed as being contact guard assis herself. She always The Rehab Departr July 2015 and made therapy but she was cognitive impairmen did not evaluate her A review of the Prog 11:10 AM Nurse #6 room by her roomm Documentation reve sitting on the floor b arm caught in the s documented that th she and another vis moving about in her she had her feet off her feet touched the did not have on her further documented Resident #160 was when she slid to the the side rail. The n and the resident wa her arm only being	kimum potential. Resident mbulate with assistance. She d from the bed to the nimal assistance. She was d cognition impairment and er from day to day. She was able to stand 2 minutes with stance, but could not stand by s required some assistance. ment did receive a referral in e attempts to pick her up for s very aggressive and had nt. The Rehab Department r regarding the side rails. gress Notes dated 8/21/15 at was called to Resident #160's nate's family member. ealed the resident was found beside her bed with her left	F3	923	that are being utilized for these patient This is especially true if a patient is it to get up unassisted out of a gerichal over a bedrail or hi low mattress. ¿ If 1:1 supervision is initiated by a nurse/nursing assistant review the p during daily clinical meeting to deter if 1:1 should continue and what other interventions may be initiated to min the risk. This review should also ind the completion of a device/siderail evaluation form to ensure that restra- are identified. ¿ If a restraint is identified then the committee should create a restraint reduction plan. The restraint reduct plan should include reduction strates and a time frame for the re-evaluation completion of the process. On 9/3/15 the nurse managers bega in-servicing all current nursing staff LPN, NA both full time and part time regarding the use of devices and sid rails. The Director of Nursing will ensure that any employee who has received this training by 9/3/15 will r allowed to work until the training is completed. As of 9/3/15 approxima 50% of employees have received th training. This in-service included the following topics: ¿ Patients who are restless or tryi	trying air or a batient mine er himize clude aints e tion gies on and (RN, e de not hot be ately his e		
	on the day she saw stuck in the side rai visited every day ar her arm through the	was in Resident #160's room Resident #160 have her arm (8/21/15). She stated she and Resident #160 usually stuck e side rail. She stated on the (8/21/15) the resident had her			get out of bed should not be left unattended as this could result in a ¿ In general when dealing with a p who is agitated there are some basi steps you can follow to try and reduc agitation. They include: listening,	patient ic		

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
			A. BUILDIN	IG		C	
		345218	B. WING			09/04/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 323	Continued From pa	ge 40	F 32	23			
	squirming and slid on her knees. The Resident #160 was she got her left arm family member stat knees were hurting someone to help he staff lifting her up a careful getting her up a careful getting her at the facility just put the facility just put the stated she was call the roommate's fam Resident #160 sittin with her left arm can stated the roommate floor. Nurse #6 furt family member told holding onto the be the floor and her left arm affloor they got her an #6 stated she asset upper arm was a litt tears. A review of the incide the stated as floor they got her an #6 stated she asset upper arm was a litt tears.	M Nurse #6 stated that she #160 on 8/21/15. Nurse #6 ed into the resident's room by hily member and found ng on the floor beside her bed ught in the side rail. Nurse #6 te's family member told her had been moving around in pped out of the bed onto the ther stated the roommate's her that Resident #160 was d rail and she slid down onto ft arm slid into the side rail. staff were getting her off the rm out of the side rail. Nurse ssed the resident and her left tle red but she had no skin dent report dated 8/21/15 ordered side rail pads.		 providing reassurance, inva activities, modify the enviro outlets for the person¿s en yourself to ensure your con calming and reassuring. ¿ Each patient is unique interventions to minimize th may range from offering fai playing music or a TV prog may like. The patient¿s cai include interventions that s to try to calm the patient. T should also be notified so t interventions can be explor plan interventions do not w agitation is more severe that interventions listed in the cai work and the physician can additional directions, then n or nurse manager on call. ¿ Anytime a patient is ac get up unassisted or if they get out of a gerichair unass throwing their legs over a s one supervision must be in Staffing should be reallocan patients until additional ass called in to cover the one of supervision. Your charge n contact the administrator a immediately if a patient me and to get assistance in co staffing needs. The admin 	onment, find lergy, check inmunication is and he risk of falling vorite foods to ram that they ure plan will hould be used The physician hat medical red if the care ork or if the an usual. If are plan do not not provide hotify the DON tively trying to a re trying to sisted or side rail, one on nplemented. ted to cover all sistance can be on one nurse should nd DON sets this criteria ordinating the		
	11:49 AM revealed added to Resident = morning (8/31/15). During an interview	gress Notes dated 8/31/15 at that half rail padding was #160's side rails in the on 9/2/15 at 9:41 AM, the tated she had been involved		DON phone numbers are li nursing station. One on or should be continued until th reviewed by the Quality Ass and alternative safety inter- identified and implemented	ne supervision ne patient is surance team ventions are		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO. ((X3) DATE COMP		
		345218			C 09/04/2015		
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	00/04/2010		
	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 323	(DON), and the Adr 8/21/15. She state cushion over the sic cushions available cushion that came had nothing else in getting her arm stu The MDS Coordina not think the side ra During an observat Resident #160 was padded side rails. T with the ends of the inches over the sid During an interview Resident #160's res that the facility had and told her that he had reported that F tangled up in the co her left arm caught staff had told her th bruising. While tall lifting the sleeve fro and there was no b was then observed arm. Resident #160 dark purple bruises and 1 inch wide. T like it was bruised to Resident #160 how stated she got her a During an interview #7 stated she was having a bruise and	ger, the Director of Nursing ministrator after the fall on d they had decided to put a de rail but there were no and they had to order a in on 8/31/15. She stated they place to prevent her from ck through the side rails again. tor further stated that she did ails were hazardous. ion on 8/31/15 at 2:33 PM observed in her bed with The padding was observed e padding extending 2 to 3 e rails. on 9/03/15 at 2:04 PM sponsible party (RP) stated called her about 2 weeks ago er roommate's family member Resident #160 had gotten overs, slid off the bed and got in the side rail. She stated wat she did not have any king the RP was observed om Resident #160's left arm ruising observed. The RP lifting the sleeve of her right 0's arm was observed with a approximately 2 inches long he RP stated her arm looked ov the side rail. The RP asked of she got the bruise and she arm caught in the side rail. on 9/3/15 at 2:06 PM Nurse not aware of the resident d asked Resident #160 how bruise and she stated she got	F 32	3 should ensure that the complete a evaluation or a siderail evaluation completed. Also make sure to do the restlessness and any fall in th electronic health record. To assis prevention make sure to include a devices (gerichair, bedrail. Hi low mattress or restraint) that was in a This training was incorporated integeneral orientation program and w discussed during all general orient programs that is completed starte 9/2/15. Quality Assurance The Director of Nursing or design monitor this issue using the Surve Quality Assurance Monitor for mo fall interventions. This audit will reincident reports that have occurre the last review. The patient will be reviewed to ensure that if a device involved that it has been evaluate determine if it is a restraint and if a continued need for the device. newly identified falls interventions be reviewed to ensure that they a promptly implemented. This will be completed on all falls weekly time weeks then on 10 falls monthly tim months or until resolved by QOL/4 committee. Reports will be given if weekly QOL/QA committee and c action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing Managers, Social Workers and D Manager.	is cument e t in fall any use. o the vill be tation d ee will ey nitoring eview all d since e e was d to there is Any will also re e s 4 nes 2 QA to the orrective e e , Nurse		

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT OF DEF AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF PROVIDE	ER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GRAN N		ED	120 SOUTHWOOD DRIVE BOX 379				
	OKSING CENT	ER		С	LINTON, NC 28328		
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
prese be Re bruiss #12 s thoug she h area sever bruiss arm. Durin Direc been Resid she n and t the re and t DON told h using touch socks side i witne incide fall. V that v a side for in hazai s side bed. why F	esident #160's e while she was stated she ask out it happened out it in the sid looked like an ral days ago. S e was from the ag an interview tor of Nursing a part of the of dent #160 's 8 net with the Ac hey ordered pa stated that the net side rail to be the side rail to be the floor sh s and slid getti rail. The DON ss statements ent report was When the DON vhen a resider e rails as an er The DON stat Resident #160 r arm. The DON rail cover to av e side rail again	age 42 ated that she was assigned to NA on 9/3/15 and saw the as bathing her at 7:30 AM. NA ed the resident how she d and Resident #160 told her le rail. Nurse #7 stated the older bruise that happened She stated it did look like the e side rail on her upper right on 9/4/15 at 11:56 AM the (DON) stated that she had clinical meeting concerning /21/15 fall. The DON stated dministrator, the Unit Manager dinator. They discussed that did get caught in the side rail adding to go over the rail. The e roommate's family member ent #160 slid out of the bed o hold on to and when her feet he did not have on non-skid ng her arm caught through the stated she did not have any from the investigation and the what they used to discuss the N was asked if she was aware ht got their arm caught through ting her bed, she was at risk stated that side rails can be had assessed Resident #160 ' habler to help her move in her ted she was still investigating had the bruise on her right ON stated they did order the void her getting her arm stuck h. She stated she was not ding did not come until 8/31/15	F 3	323	Immediate Jeopardy Removal Date 9/3/2015		

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PRINTED: 09/30/2015 FORM APPROVED

			0038 0301			
(X2) MU	LTIPLE CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY			
A. BUILI	DING		PLETED			
B. WING	i		04/2015			
•	STREET ADDRESS, CITY, STATE, ZIP CODE					
	120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328					
	IX (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE			
n of , ely MS) in nd cur. d ek. ot ek. ot at s on						
	A BUILE B. WING B. WING PREF TAG F : PREF TAG F : in of 5, ely MS) c in ind ccur. id cur. id cur. id cur. id cur. id cur. id cur. id cur. id cur.	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328 PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY) F 323 F 323 No of in of in ind ccur. id ek. ot in s on 14, /2	A. BUILDING 09/ B. WING 09/ STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328 PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323 A f 323 F 323 A f 1 // 2 // 2 // 2 // 2 // 2 // 2 // 2			

Facility ID: 923329

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PRINTED: 09/30/2015

		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345218	B. WING	;			C 04/2015
NAME OF	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	the resident to mair with bed mobility as for complications. In goal of minimizing to related to the use of periodically (at leas continued need for the nurse immediat between the rail and During an interview 09/01/15 4:08 PM so move around in bed not roll on comman She had a pressure because of her hist During an interview 9/2/15 at 9:00 AM so for side rails read to resident was betwee the old beds use to rails and the bed ar She stated now tha plan as a precautio alarms are evaluate "moves a lot" so it i stated Resident #77 from side to side. So Geri chair she woul and this made her to legs over the bed ra stated that Resident get up if she decide top, middle or botto Review of the Side 5/10/15 read the re preference about th were ½ (half) in len	The function of the stated that the care plan on the stated that the care plan on the stated that the care plan on ontify the nurse if the sen the rail and bed because on the stated that the care plan on the stated the stated the on the stated that the care plan on the stated the stated the on the stated the stated the stated the stated the stated the state stated the stated the stated the state stated the stated the stated the state stated the stated the stated the state state stated the stated the stated the state state stated the stated the stated the state state stated the state stated the states stated the states st		323			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RAN NURSING CENT	ED		1	20 SOUTHWOOD DRIVE BOX 379		
MARTO	NAN NURSING CENT	ER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 45	FS	323			
		bed or attempts to get out of					
		or around rails. She was					
		nd did not turn side to side.					
		ith balance/trunk control and afety awareness. The side rail					
		ntinue with the current side					
	rails.						
		ician Communication note					
		a concern that Resident #78					
		ff Zoloft (anti-depressant					
		0/15. Resident #78 was now ought she could walk again					
		ells of yelling at staff and					
		ason and had increased					
	nervousness.						
		with Nurse #3 on 9/2/15 at					
		I that on 6/19/15 the resident					
		tempting to get out of bed so ysician. She stated Resident					
		et out of bed by scooting to					
	bottom of the bed to						
	During an observati	ion on 8/31/15 at 2:30 PM					
		noted to be in her bed with $\frac{1}{2}$					
		ne up position on both sides of					
		ad a top and bottom rail with					
		nch gap between the bottom was approximately 16 " from					
		art of side rail which was then					
		ot long. The mattress was a					
		vith the upper and lower					
		ess high and a portion in the					
		ess lower. The side rail was					
		ced next to the low area of the ere was an alarming fall mat					
		the bed. The resident was					
		er left leg over the side rail					
		rough the top portion of the					
	side rail lying horizo	ontal in her bed with her head					
	in the direction of th	ne wall. The bed was pushed					

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CENTER STATEMENT AND PLAN C	INTMENT OF HEALTH AND HUMAN SERVICES FORM A INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE IN OF CORRECTION ID ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION IN OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION IN OF SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION				04/2015 (X5) COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		RIATE	DATE
F 323	During an observati Resident #78 was a observed in bed. T up position on both was on floor. During an interview 3:48 PM she stated from side to side in up on her own and continued by stating #78 would hang her were alarms if she g During an interview Nursing Assistant # can move around in She had alarms on because of a previo stated Resident #78 limitations. She stat the alarms on beca out of bed unassist During an observati Resident #78 was c of the bed wedged and the side rail wit the fall mat. Nurse a entered the residen During an interview Nurse #5, upon ent she stated " This is because she tries to then took the reside resident, " let 's ge you back in bed. " Resident #78 was c PM. She had a low	e was alert but not oriented. ion on 8/31/15 at 5:12 PM asleep in her bed with legs he half side rails were in the sides and an alarming fall mat with Nurse #5 on 9/1/15 at that Resident #78 could turn bed, was not supposed to get had an alarming fall mat. She g that once in a while Resident r legs over the bed but there got up. on 09/01/2015 3:51 PM with 4 she stated that the resident n the bed and turn side to side. the bed and a fall mat ous fall and fractured hip. She 8 had no range of motion ted she thought the facility left use Resident #78 used to get ed. ion on 9/1/15 at 4:52 PM observed with her right leg out between the hi-low mattress h her foot dangling towards #5 was made aware and t ' s room. on 9/1/15 at 4:55 PM with ering Resident #78s room, a why we keep the alarms o get out of bed. " Nurse #5 ent ' s leg and stated to the et your leg up here and turn observed on 9/3/15 at 2:00 bed, high-low mattress and arms in place. The side rails	F	323		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDII			FORM MB NO. (X3) DATE COM	09/30/2015 APPROVED 0938-0391 E SURVEY PLETED
		345218	B. WING			09/	04/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	During an interview 11:56 AM she state putting legs or arm hazardous; but she residents having the have acted on the is The Administrator v Jeopardy on 9/2/15 Jeopardy was remo- based on the Credil listed on the plan in The Administrator v Jeopardy on 9/2/15 Jeopardy was remo- listed on the plan in The Administrator v Jeopardy on 9/2/15 Jeopardy was remo- listed on the plan in The Administrator v Jeopardy on 9/2/15 Jeopardy was remo- listed on the state was removed from side rail assessmer care plan team. For Resident #160 placed on the side r were removed from side rail assessmer care plan team. For Resident #78 o evaluated the use of team decided to com mattress and reeva of 30 days since the occurred. The care device evaluation re discontinued its use evaluation. WHAT MEASURES RESIDENTS HAVIN AFFECTED? All residents have the this alleged deficier nurse reviewed all o a fall in the last 12 r	with the DON on 9/4/15 at d that behaviors such as through side rails are was unaware of these ese behaviors or she would ssue immediately. vas notified of the Immediate at 3:06 PM. The Immediate oved on 9/4/15 at 3:30 PM ble Action Plan. Interventions	F 3	23			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345218	B. WING	;			C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	had a fall incident in then reviewed by the the reason and/or of This included review that the bed rail cor Interventions for the the nurse manager interventions were a may include alarms evaluations, pharm evaluations for alter positioning/strength supervision, one or specifically related incident involving a ensure that the bed no longer required who was identified prevention interven intervention was no was reviewed by th social, activities and interventions were in appropriate. Interven but also included m pharmacy evaluation alternative positioni increased supervisi and other specifical resident. WHAT SYSTEMS N PREVENT THE DE REOCCURRING? On 9/3/15 the QA N all nurse 's manage SDC and DON) on Daily of incident reports will	report. The incident report was ne nurse manager to identify contributing factors for the fall. wing falls for any indication intributed to the accident. e falls was then reviewed by to ensure that the appropriate. Interventions is but also included medication hacy evaluations, therapy renative nening exercises, increased none supervision, and other to the individual resident. Any bed rail was also reviewed to d rail had been discontinued if by the patient. Any resident that did not have a falls ation or whose fall prevention of related to the specific fall he care planning team (nursing, d therapy) on 9/3/15 and identified and implemented as rentions may include alarms nedication evaluations, ons, therapy evaluations for ing/strengthening exercises, ion, one on one supervision, illy related to the individual WERE PUT IN PLACE TO EFICIENT PRACTICE FROM Nurse Consultant, in serviced iers (unit managers, MDS,		323			

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	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIP		FORM MB NO. (X3) DATI	09/30/2015 APPROVED 0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	Ĵ		PLETED
		345218	B. WING	;			C 04/2015
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MARY G	RAN NURSING CENT	ER			120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	devices that could r to ensure that they patients care. Thes limited to bedrails, r chairs. Devices sho if the device was a contributed to the fa evaluation should b the device is a restr plan is developed a investigation should electronic health re- details regarding ar interviews that have root cause of the fa will identify the appri- interventions for the such interventions. . Witnes obtained and docur Assurance Review. . Upon o interventions should may include alarms pharmacy evaluation alternative positioni increased supervisi and other specifical resident. Alarms sh staff supervision or . Always for resident who are unassisted. Also co being utilized for the especially true if a p unassisted out of a high-low mattress.	have been involved in the fall are appropriate for the se devices include but are not hi low mattresses or Geri ould be reviewed to determine hazard that could have all. A device/side rail be completed to ensure that if raint that a restraint reduction and implemented. This d be document in the cord and should include hy resident, staff, family e been completed. Once the ill is identified the clinical team ropriate prevention e patient and will implement ss statements should also be mented in the Quality completion of this review, d be identified. Interventions a, medication evaluations, ons, therapy evaluations for ing/strengthening exercises, ion, one on one supervision, lly related to the individual would never be substituted for	F	323			

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			FORM MB NO. (X3) DAT COM	09/30/2015 APPROVED 0938-0391 E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GI	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETION DATE
F 323	Continued From pa	ge 50	F:	323			
F 323	daily clinical meetin continue and what of initiated to minimize also include the cor- evaluation form to e- identified. If a res- committee should of plan. The restraint reduction strategies re-evaluation and c- On 9/3/15 the nurse all current nursing s- time and part time r and side rails. The ensure that any em this training by 9/3/1 until the training is of approximately 50% this training. This in following topics: Patients who are re- bed should not be be result in a fall. In general when de agitated there are s follow to try and red include: listening, p- resident in activities outlets for the perso	ge 50 g to determine if 1:1 should other interventions may be a the risk. This review should mpletion of a device/side rail ensure that restraints are straint is identified then the create a restraint reduction reduction plan should include a and a time frame for the ompletion of the process. The managers began in-servicing staff (RN, LPN, NA both full regarding the use of devices the Director of Nursing will ployee who has not received 15 will not be allowed to work completed. As of 9/3/15 of employees have received the stless or trying to get out of eft unattended as this could aling with a patient who is nome basic steps you can luce the agitation. They providing reassurance, involve a, modify the environment, find on 's energy, and check your communication is calming	F3	323			
	minimize the risk of offering favorite foo program that they n plan will include inte to try to calm the pa	ue and interventions to falling may range from ds to playing music or a TV nay like. The patient 's care erventions that should be used atient. The physician should that medical interventions can					

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	be explored if the c work or if the agitat If interventions liste and the physician c directions, then not on call. Anytime a patient is unassisted or if they chair unassisted or rail, one on one sup implemented. Staff cover all patients un be called in to cove Your charge nurses administrator and D meets this criteria a coordinating the sta administrators and listed at the nursing supervision should is reviewed by the C alternative safety in implemented. The the complete a dev evaluation is compl document the restle electronic health re- prevention make su (Geri chair, bedrail. that was in use. The Credible Allega 1. Record re content and sign in 2. Interviews 9/4/15 at 3:30 PM v and Nursing Assista and second shift co 3. For Resid	are plan interventions do not ion is more severe than usual. d in the care plan do not work annot provide additional ify the DON or nurse manager actively trying to get up y are trying to get out of a Geri throwing their legs over a side pervision must be fing should be reallocated to ntil additional assistance can r the one on one supervision. should contact the DON immediately if a patient and to get assistance in affing needs. The DON phone numbers are y station. One on one be continued until the patient Quality Assurance team and terventions are identified and QA team should ensure that ice evaluation or a side rail eted. Also make sure to essness and any fall in the cord. To assist in fall ure to include any devices hi-low mattress or restraint) ation was verified by: view of In-Service Education	F3	323			

Facility ID: 923329

If continuation sheet Page 52 of 68

		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345218	B. WING				C 04/2015
NAME OF F	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GI	RAN NURSING CENT	ER			120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	 team. Resident #10 side rails 4. For Reside plan team evaluated mattress. The team of the hi-low mattree maximum of 30 day has also occurred. Completed a device rail and discontinue of the evaluation. 5. A review of rail evaluation and to implemented. 3. Resident #78 wat 10/16/12 and re-add diagnoses including fall, History of Intraoc Anxiety, and aftercas fracture of hip. Review of the most Set (MDS) Assessin Resident #78 as be of 4). Resident #78 required the assistat mobility and transfer room or corridor. Remotion limitations. S (cane/crutch/walker steady, only able to while moving from states and states and states and states and states and the assistates and states and the assistates and states and the assistates and the assistates	ge 52 eted on 9/3/15 by the care plan 60 was observed without her ent #78 on 9/3/15 the care d the use of the hi-low n decided to continue the use ss and reevaluate weekly for a ys since the side rail reduction The care plan team also e evaluation related to the side d its use on 9/3/15 as a result of the list of residents with side that the evaluation was as admitted to the facility on mitted on 11/10/14 with g Senile Dementia, History of cranial injury, Osteoarthritis, are for healing traumatic recent annual Minimum Data nent dated 10/1/14 identified sing cognitively impaired (BIMS 8 had no behaviors. She ance of two persons with bed erring. She did not walk in her esident #78 had no range of She used no mobility devices r or wheelchair). She was not stabilize with staff assistance seated to standing position ace transferring (between bed	F	323			
	and chair or wheeld walking, turning aro the toilet -this activi had had one fall wit	chair) and balance during bund and moving on and off ty did not occur. Resident #78 th no injury. She weighed 106 red an anti-anxiety and					

If continuation sheet Page 53 of 68

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/GUPPLIER/CLA LIDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SUPPLIER B WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE EQX 379 CLINTON, NC 23238 (X4) ID PROVIDER SUPPLIER B WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE EQX 379 CLINTON, NC 23238 (X4) ID PROVIDER SUPPLIER B WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE EQX 379 CLINTON, NC 23238 (X4) ID PROVIDER SUPPLIER B WING CITY STATE, STATE, WING SUPPLIER B WING CITY STATE, WING STREE PRECEDED BY FULL TAG PROVIDER SUPPLIER CROSS REFERENCED TO THE APPROPRIATE D PROVIDERS AND OF CORRECTION D PROVIDERS AND OF CORRECTION B WING CITY STATE, WING STREE PRECEDED BY FULL TAG PROVIDER SUPPLIER B WING CITY STATE, WING STREE PRECEDED BY FULL TAG PROVIDER SUPPLIER B WING CITY STATE, WING STREE PRECEDED BY FULL TAG PROVIDER SUPPLIER B WING CITY STATE, WING STREE PRECEDED BY FULL TAG PROVIDER SUPPLIER B WING CITY STATE, WING STREE PRECEDED BY FULL TAG PROVIDER SUPPLIER B WING CITY STATE, WING STREE PRECEDED BY FULL TAG PROVIDER SUPPLIER B WING CITY STATE, WING STREE PRECEDED STREET COORS REFERENCED TO THE APPROPRIATE CROSS REFERENCED TO THE APPROPRIATE D PROVIDER SUPPLIER SUPPLIER TAG F 323 F 323 F 323 F 323 F 323 F 323 </th <th></th> <th></th> <th>AND HUMAN SERVICES</th> <th></th> <th></th> <th></th> <th>FORM</th> <th>: 09/30/2015 APPROVED . 0938-0391</th>			AND HUMAN SERVICES				FORM	: 09/30/2015 APPROVED . 0938-0391
345218 B. WING 09/04/201 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MARY GRAN NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (A) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST EN PROFOND FORMATION) ID PREFIX CONTINUE ION 379 CLINTON, NC 28328 (A) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST EN PROFOND FORMATION) ID PREFIX OF CONTINUE ION 379 CLINTON, NC 28328 (A) ID PREFIX Continued From page 53 anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were coded as not being used. F 323 F 323 Continued From page 53 anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were coded as not being used. F 323 F 400 Review of the Care Area Assessment (CAAs) Summary dated 10/1/14 triggered in the areas of Cognitive Loss/Dementia, Delirium, Falls and Psychotropic Drug Use. F action of Definition for the areas of Cognitive Loss/Dementia, Delirium, Falls and Psychotropic on days per week. Care plan considerations included: (Resident #78) remains at an increased risk for falls due to frequent attempts to get out of bed unassisted, along with increased confusion at times. The staff were to monitor resident for any attempts to get up unassisted or falls ridue tors that may have contributed to a fall	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		LE CONSTRUCTION	(X3) DAT COM	E SURVEY
MARY GRAN NURSING CENTER 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328 (X4)10 TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH OEND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Comment OF COMMENT DEFICIENCY F 323 Continued From page 53 anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were coded as not being used. Review of the Care Area Assessment (CAAs) Summary dated 10/1/14 triggered in the areas of Cognitive Loss/Dementia, Delirium, Falls and Psychotropic Drug Use. Review of the CAA revealed falls was triggered related to balance problems during transitioning, having at least one fall since admission and she received antidepressants and antianxiety medications seven days per week. Care plan considerations included: (Resident #78) remains at an increased risk for falls due to frequent attempts to get up other factors that may have contributed to a fall and intervene as needed to prevent falls from occurring. Review of the revised care plan dated 10/6/14 for falls identified the Focus area as Resident #78 being at risk for falls related to Confusion, Psychoactive drug use, history of falls and frequent attempts to get up unassisted. Interven			345218	B. WING	i			
MARY GRAN NURSING CENTER CLINTON, NC 28328 Majib PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH OFFICENCY WIST DE NOT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Op PREFIX TAG F 323 Continued From page 53 anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were coded as not being used. Review of the Care Area Assessment (CAAs) Summary dated 10/1/14 triggered in the areas of Cognitive Loss/Dementia, Delirium, Falls and Psychotropic Drug Use. Review of the Care Area Assessment (CAAs) Sumary dated 10/1/14 triggered related to balance problems during transitioning, having at least one fall since admission and she received antidepressants and antianxiety medications seven days per week. Care plan considerations included: (Resident #78) remains at an increased risk for falls due to frequent attempts to get out of bed unassisted, along with increased confusion at times. The staff were to monitor resident for any attempts to get up unassisted or any other factors that may have contributed to a fall and intervene as needed to prevent falls from occurring. Review of the revised care plan dated 10/6/14 for falls identified the Focus area as Resident #78 being at risk for falls related to Confusion, Psychoactive drug use, history of falls and frequent attempts to get up unassisted. Interventions in meeting the goal of minimizing	NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONHEL DEFICIENCY) F 323 Continued From page 53 anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were coded as not being used. Review of the Care Area Assessment (CAAs) Summary dated 10/1/14 triggered in the areas of Cognitive Loss/Dementia, Delirium, Falls and Psychotropic Drug Use. Review of the CAA revealed falls was triggered related to balance problems during transitioning, having at least one fall since admission and she received antidepressants and antianxiety medications seven days per week. Care plan considerations included: (Resident #78) remains at an increased risk for falls due to frequent attempts to get out of bed unassisted, along with increased confusion at times. The staff were to monitor resident for any attempts to get up unassisted or any other factors that may have contributed to a fall and intervene as needed to prevent falls from occurring. Review of the revised care plan dated 10/6/14 for falls identified the Focus area as Resident #78 being at risk for falls related to Confusion, Psychoactive drug use, history of falls and frequent attempts to get up unassisted. Interventions in meeting the goal of minimizing	MARY G	RAN NURSING CENT	ER					
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the risk of falls included, in part: repeated interventions of keeping the resident at the nursing station for supervision, re-educating staff on fall precautions and the need for the resident to be in view of staff while up in Geri chair, educating staff to keep resident at nurses station when in Geri chair and to putting Resident #78 in bed if in her room, keeping the bed in the lowest position, having the personal alarm in place, the chair alarm in place, the floor mat alarm in place and the bed alarm in place while in bed. During an interview with the Rehabilitation	F 323	anti-depressant me Restraints (bed rail restraints or chair the coded as not being Review of the Care Summary dated 10 Cognitive Loss/Der Psychotropic Drug Review of the CAA related to balance p having at least one received antidepress medications seven considerations inclu at an increased risk attempts to get out increased confusion monitor resident for unassisted or any of contributed to a fall prevent falls from of Review of the reviss falls identified the F being at risk for fall Psychoactive drug frequent attempts to Interventions in me the risk of falls inclu- interventions of kee nursing station for s on fall precautions to be in view of staff educating staff to k when in Geri chair a bed if in her room, position, having the chair alarm in place and the bed alarm	dications seven days a week. s, trunk restraints, limb hat prevents rising) were used. Area Assessment (CAAs) /1/14 triggered in the areas of nentia, Delirium, Falls and Use. revealed falls was triggered problems during transitioning, fall since admission and she asants and antianxiety days per week. Care plan uded: (Resident #78) remains of falls due to frequent of bed unassisted, along with n at times. The staff were to r any attempts to get up other factors that may have and intervene as needed to occurring. ed care plan dated 10/6/14 for focus area as Resident #78 s related to Confusion, use, history of falls and o get up unassisted. eting the goal of minimizing uded, in part: repeated eping the resident at the supervision, re-educating staff and the need for the resident ff while up in Geri chair, eep resident at nurses station and to putting Resident #78 in keeping the bed in the lowest e personal alarm in place, the e, the floor mat alarm in place in place while in bed.	F	323			

Facility ID: 923329

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	. ,	ING		FORM MB NO. (X3) DATE COM	09/30/2015 APPROVED 0938-0391 E SURVEY PLETED C 04/2015
MARY GRAN NURSING CENTER				1	120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Resident #78 was s the resident appear get up out of her Ge recommendation w supervised while in stated that Residen Geri chair positionin She stated that on Resident #78 had c attemptedto get out supervision was rec Review of the Fall n the nurse heard Re and found her sitting the floor in her room from the chair. Res get up, I can ' t get Nurse #1 for injuries The intervention list to keep the residen Geri chair. Review of the Nursi 10/28/14 document found sitting on the personal alarm was state what happene up " over and over and the resident was During an interview (DON) on 9/2/15 at fall report of 10/28/7 on placing the reside #78 gets up unassis reminded to place h During an interview 9/3/15 at 3:05 PM, y on 10/28/14 during	at 10:00 AM she stated that creened on 9/25/14 because ed agitated and was trying to eri chair. She stated the as that Resident #78 would be her Geri chair. She further t #78 was seen on 10/6/14 for ng after a fall from the chair. 10/6/14 it was noted that ognitive impairment and of the Geri chair and quired. eport dated 10/28/14 revealed sident #78 's personal alarm g upright on her buttocks on n approximately six inches ident #78 only stated " I can ' t up. " She was assessed by s and assisted back to bed. red was to re-educate the staff t in view when she was in her ing Progress Note dated ed that Resident #78 was floor of her room. The sounding. She was unable to ed, only saying, " I can ' t get again. No injuries were noted is assisted to bed. with the Director of Nursing 9:10 AM she stated that the 14 read to re-educate the staff tent in view because Resident sted and the staff need to be	F3	323			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	IARY GRAN NURSING CENTER				20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	sometime after dinr resident was restles Resident #78 down another resident. S back down the hall and went into the re #78 was sitting up of was going to get up was time to go to sl clear to her Resider down so she put he stated she set the a back with her feet u always put the chai elevated the feet. During an interview 3:30 PM, she stated 10/28/14 she was p heard Resident #78 sounding. She enter resident sitting on the resident was not assessed the resider She had another nut resident to her bed. picked up and place Review of the Nurs 10/29/14 revealed F Geri chair in her root pain in the left leg. S physician was conta x-ray at approximat During an interview 11:56 AM she stated decided on the use #78. She stated wh to the facility she sh	her. She remembered that the ss. She stated she laid and left the room to check on She stated when she came she heard the alarm going off esident 's room and Resident on the side of the bed like she b. NA #1 told the resident it leep. NA #1 stated that it was nt #78 was not going to lay er back into the Geri chair. She alarms and leaned the chair up. She further stated she r in a reclining position and with Nurse #1 on 9/3/15 at d that on the evening of bassing medications when she 8 talking and her alarm ered the room to find the he floor. She stated the in her Geri-chair. She stated ot complaining of pain and she ent and everything looked fine. urse (Nurse #2) help return the . She stated the resident was ed in bed. ing Progress Note dated Resident #78 was sitting in the om and was complaining of She was given Tylenol and the acted to obtain an order for an	F3	323			

Facility ID: 923329

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		AND HUMAN SERVICES			FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING	 		C 04/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER		20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 F 441 SS=D	resident was throwi chair. Review of the Nursi documented the nu room for the mornin and the resident sta and hip pain and ye thigh was swollen a than the right leg. T an order received to emergency room fo Review of the Nursi 11/4/14 documented the hospital with a le Review of the Hosp documented a fract Review of the Hosp 11/4/14 documented pain. The left leg was decreased range of extremity secondary some bruising on th Review of the Hosp 11/10/14 listed the of hip fracture, status internal fixation). 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of	she was unaware that the ing her legs over the Geri ing Note dated 11/4/14 irse entered the resident 's ing medication pass at 7:40 AM arted to complain of left leg ell out in severe pain. The left and the left leg was shorter The physician was notified and o send the resident to the or evaluation. ing Progress Note dated d the resident was admitted to eft Proximal Femur fracture. bital x-ray report dated 11/4/14 ture proximal left femur. bital physical exam dated d the chief complaint as hip as short and rotated. She had f motion of the left lower y to the fracture. She had he legs. bital discharge summary dated discharge diagnoses as left post ORIF (open reduction N CONTROL, PREVENT	F 3			10/2/15
	(a) Infection Contro The facility must es	l Program tablish an Infection Control	l			

Facility ID: 923329

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DEPART	MENT OF HEALTH	I AND HUMAN	SERVICES				FI		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID	SERVICES	•			OI	<u>MB NO.</u>	0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA TON NUMBER:	` '		LE CONSTRUCTION		COM	E SURVEY PLETED
		34	5218	B. WING			-		C 04/2015
NAME OF F	PROVIDER OR SUPPLIER				9	STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
MARY G	RAN NURSING CENT	ER				120 SOUTHWOOD DRIVE B CLINTON, NC 28328	OX 379		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		DED BY FULL	ID PREFIZ TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 441	Continued From par Program under whi (1) Investigates, co in the facility; (2) Decides what p should be applied t (3) Maintains a rect actions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d hand washing is in professional practic (c) Linens Personnel must ha transport linens so infection.	ich it - introls, and pre- rocedures, suc- o an individual ord of incidents infections. ead of Infection tion Control Pre- esident needs of infection, the st prohibit emple ease or infected with residents ransmit the dis- trequire staff f irect resident c dicated by acce ce.	ch as isolation, resident; and s and corrective ogram isolation to be facility must oyees with a d skin lesions or their food, if ease. to wash their contact for which epted	F 4	141				
	This REQUIREMEN by: Based on record re interviews, the facil of infection by place bedside table after wearing visibly soild wipes from a dress and placing a lunch table for 1 of 1 sam	eview, observa lity failed to ens ing soiled linen providing inco ed gloves while er and turning n tray on an un	ations and staff sure the spread is directly on a ntinence care, e removing off a call light wiped bedside			The statements mac correction are not an not constitute an agre alleged deficiencies. compliance with all fe regulations the facility take the actions set for correction. The plan	admission to eement with th To remain in ederal and stat y has taken or orth in this pla	and do e æ will	
FORM CMS-25	67(02-99) Previous Versions	s Obsolete	Event ID: LTXF11		Fa	acility ID: 923329	If continuati	on sheet I	Page 58 of 68

PRINTED: 09/30/2015

							0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		SURVEY
			-			С	
		345218	B. WING _			09/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE
F 441	Continued From pa	age 58	F 44	11			
	whose personal ca	-			constitutes the facility¿s allegation of	f	
	Findings included:				compliance such that all alleged deficiencies cited have been or will be	e	
	During an observat	tion of incontinent care for			corrected by the date or dates indicat	tea.	
		/31/15 at 11:25 AM, NA #11			F 441		
		ndo the brief. Stool was			Corrective Action for Affected Reside	ents	
		thighs, vagina, and when			Resident # 45, the involved CNA was		
		ocks. The NA had gloves on			reeducated on 09/16/15 by the Staff		
	-	et washcloth to clean the so much stool she stated she			Development Coordinator on infectio		
		#11 then walked over to the			prevention strategies when providing perineal care to a resident.	1	
		isibly soiled gloves opened the			Corrective Action for Potentially Affect	cted	
		resser and removed the box of			Residents		
		bserved on her gloves. She			All residents have the potential to be		
		the bed. She then began			affected. On 09/21/15, the QA Nurse		
		ent with the wipes and using the			Consultant completed an audit of the	•	
		gloves trying to remove stool nurse knocked on the door			facility on 09/21/15, 09/22/15, and 09/23/15. The audit reviewed staff		
		use the call light was on. NA			practices for proper hand washing		
		ith her visibly soiled gloves on			techniques; glove use; soiled gloves		
		Il light off. Stool was observed			removed and disposed properly befo		
	on the gloved hand	 NA #11 began using 			touching other equipment or patient		
		ove the stool from the resident			surroundings; observed for proper		
	•	bly soiled washcloths directly			precautions used for the disposal of s	soiled	
		le. NA #11 was observed to ent care wiping from front to			linens; and if linens and laundry are handled in a manner that prevents th		
		d her gloves after cleaning the			spread of infection. No negative finding		
		sident and re-gloved. She then			were noted as a result of this audit.	ingo	
		to her left side and cleaned the			Systematic Changes		
		nt. Again, stool soiled					
		laced directly on top of the			On 09/24/15 the Staff Development		
		#11 kept wiping her gloves off			Coordinator in-servicing all current		
		ve stool. Upon completion of ne resident was turned back to			nursing staff (CNA, RN, LPN, both fu time and part time. In-service topics	111	
		ew brief fastened. The resident			included: Glove use, change gloves		
		by NA #11 while she wore the			during use if torn and when heavily se		
		e provided incontinent care.			(even during use on the same patient		
		resident the NA removed the			After use on each patient discard in		

Facility ID: 923329

	-	AND HUMAN SERVICES			PRINTED: FORM <u>OMB NO.</u>	APPROVE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	`́сом	E SURVEY PLETED
		345218	B. WING _			C 04/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER		120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 441	them into a plastic l plastic bag to the set the bin and washed returned to hall and Resident #45 from tray on bedside tab clean or wipe the be the tray on top. During an interview 8/31/15 at 12:11 PM have changed her g incontinent care wh them instead of tryi was supposed to pl not on the bedside have wiped the bed lunch tray on top. During an interview Coordinator on 9/3/ the policy to change visibly soiled. The soiled gloves to ope off the call light. The placed in a bag and before going down room. One hand is Hands are washed stated the bedside	Ige 59 rom bedside table by placing bag. NA #11 then carried the oiled utility room and placed in a her hands. She then I grabbed the lunch tray for the cart and placed the lunch le. She was not observed to edside table prior to placing with Nursing Assistant #11 on A she stated that she should gloves after providing then the gloves had stool on ing to clean off gloves and she lace soiled linens in a bag and table. She stated she should lside table before placing the with the Staff Development (15 at 10:15 AM she stated it is e your gloves once they are NA should not have used en the dresser drawer or turn the soiled linens are to be d then one glove removed the hall to the soiled linen o glove free to open doors. in the soiled linen room. She table should have been ting the lunch tray on top.	F 44	41 appropriate receptacle. Never w WIPE, or reuse disposable glow Contaminated linen should never placed on the resident is bed si over bed table or any other equi- the room. It must be bagged wh removed from the resident bed. also true for disposable briefs a If equipment contamination occ area should be wiped down usin disinfectant wipes. You should p hand hygiene immediately after gloves. If your hands become w contaminated wash your hands with soap and warm water or, if not visibly contaminated, use an alcohol-based hand rub. Any in-house staff member who receive in-service training by 10 not be allowed to work until train been completed. This informatio been integrated into the standard orientation training for all nurses CNA;s and will be reviewed by Quality Assurance Process to w the change has been sustained Quality Assurance The Staff Development Coordin monitor this issue using the "Su Quality Assurance Tool for Mon Infection Control Practices. The monitoring will include observing practices for glove use and disp removal and disposal, and hand by observing resident care on 8 weekly for 4 weeks then monthl months or until resolved by Qua- Life/Quality Assurance Committ Reports will be given to the mor	es. er be de table, pment in en This is nd wipes. urs, the og berform removing risibly thoroughly hands are d did not /02/15 will hing has on has d s and the erify that ator will rvey toring g staff osal, linen I hygiene residents y times 2 lity Of ee.	

Facility ID: 923329

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
/			A. BUILD	ING _			C
		345218	B. WING			09/	04/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MARY GRAN NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				0 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE
F 441 F 460		ge 60 BEDROOMS ASSURE FULL	F 4		Quality of Life- QA committee and corrective action initiated as approp The Quality of Life Committee cons the Administrator, Director of Nursir Assistant DON, Staff Development Coordinator, Unit Support Nurse, M Coordinator, Business Office Mana Health Information Manager, Dietar Manager and Social Worker.	ists of ng, IDS ger,	10/2/15
SS=E	VISUAL PRIVACY Bedrooms must be	designed or equipped to ivacy for each resident.	Γ4	FOU			10/2/13
	In facilities initially c except in private roo ceiling suspended c the bed to provide t	ertified after March 31, 1992, oms, each bed must have curtains, which extend around otal visual privacy in ljacent walls and curtains.					
	by: Based on observat interviews the facilit privacy for residents not wide enough for The findings include 1. On 8/31/15 at 3:2 s closed privacy cur foot gap from the en The resident in Bed not provide her with On 9/4/15 at 11:35 a closed privacy curta	ed: 26 PM in Room # 311 Bed # 2 ' tain was observed with a 3 nd of the curtain to the wall. # 1 stated that the curtain did			F 460 Corrective Action for Resident Affect For the affected residents in the foll rooms: 311 bed 2, 511 bed 1 and 2, bed 1and 2, 508 bed 1 and 2, 507 be and 2, 505 bed 1 and 2, 503 bed 1 506 bed 1 and 2, 312 bed 2, 804 be 1and 2, 813 1 and 2, and 815 1 and residents privacy curtains were repl with appropriate length privacy curta providing full privacy when pulled. T was completed by the maintenance	lowing , 509 bed 1 and 2, ed 1 2 the laced ains This	

Facility ID: 923329

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PRINTED: 09/30/2015

	COF DEFICIENCIES	& MEDICAID SERVICES	(YO) MUU	TIPLE CONSTRUCTION	OMB NO.		
	F CORRECTION	IDENTIFICATION NUMBER:		NG	()	(X3) DATE SURVEY COMPLETED C	
					(
		345218	B. WING		09/0	04/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
MARY GRAN NURSING CENTER				120 SOUTHWOOD DRIVE BO> CLINTON, NC 28328	(379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 460	Continued From pa	ige 61	F 4	60			
		vation of Room # 511 on		director and housekeep September 4, 2015.	oing director on		
	9/01/15 at 3:15 PM, the privacy curtain did not provide full visual privacy for bed #1 and bed # 2. The closed privacy curtain for Bed # 1 was			Corrective Action for Re Affected:	esident Potentially		
	to the end of privac	oot gap at the foot of the bed y curtain. Bed # 2 was oot gap from the end of the		All residents have the paffected. All resident ro			
	closed privacy curta On 9/2/15 at 2:07 F	ain to the wall. PM in Room # 511 Bed # 1 ' s		by the Maintenance Dir if curtains in other room			
		curtain was observed to not rivacy for bed #1 and bed # 2.		privacy. Forty six rooms needing wider privacy of			
	Bed # 1 's closed p	brivacy curtain was observed the foot of the bed to the end		September 22, 2015 ar with Phoenix Textile Co	n order was placed		
	of privacy curtain.	Bed # 2 ' s closed privacy		replace any curtains the	at do not provide		
	end of the privacy of	ed with a 2 foot gap from the		full privacy. Until these arrive, privacy curtains			
	On 9/3/15 at 9:37 A curtain did not full v	M in Room # 511, the privacy visual privacy for Bed #1 and		obtained from other fac the gaps.			
	observed with a 1 f	s closed privacy curtain was oot gap at the foot of the bed y curtain. Bed # 2 ' s closed		Systemic Changes			
	from the end of the	observed with a 2 foot gap privacy curtain to the wall. 1 PM in Room # 509 Bed #1 ' s		On September 23, 201 in-serviced the Housek Maintenance Directors.	eeping and		
	was observed with	the privacy curtain closed and erved from the foot of the bed		content included: Priva of appropriate width to	cy curtains must be		
	curtain for Bed # 2	rtain. The closed privacy in room # 509 was observed isual privacy for 16 feet from		privacy for both resider There cannot be any ga resident.			
	the end of the priva	PM in Room # 509 Bed #1 ' s		On September 24, 201			
	gap from the foot o	ain was observed with a 1 foot f the bed to the end of the		was held with FT, PT a and Nurses. The Staff	Development		
	observed to not pro	closed privacy curtain was wide full visual privacy for 16 f the privacy curtain to the		Coordinator covered th Privacy curtains must b providing care to the re	e pulled when		
	wall.	M in Room # 509 Bed #1 ' s		curtain does not adequ privacy, then notify Mai	ately provide full		

Facility ID: 923329

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	E CONSTRUCTION		0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
				-		C	2	
		345218	B. WING _			09/04/2015		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MARY GRAN NURSING CENTER					20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 460	Continued From pa	age 62	F 4	60				
	closed privacy curta gap from the foot o curtain. Bed # 2 ' s provide full visual p of the privacy curta 4. On 9/1/15 at 3:30 closed privacy curta gap at the end of th Bed #2 ' s closed p not provide full visu end of the privacy o On 9/2/15 at 2:05 I closed privacy curta gap from the end o wall. Bed #2 ' s clo observed to not pro- feet from the end o wall. On 9/3/15 at 9:35 A closed privacy curta gap at the end of th privacy curtain did I for 2 feet from the end the wall. 5. On 9/1/15 at 3:33 closed privacy curta gap from the end o wall. On 9/2/15 at 2:03 F closed privacy curta gap from the end o wall. On 9/2/15 at 9:35 A s closed privacy curta gap from the end o wall. On 9/3/15 at 9:35 A s closed privacy curta gap from the end o wall.	ain was observed with a 1 foot f the bed to the end of the s closed privacy curtain did not rivacy for 16 feet from the end in to the wall. 0 PM Room # 508 Bed #1 ' s ain was observed with a 1 foot he curtain. Also in Room # 508 rivacy curtain was observed to al privacy for 2 feet from the			Any in-house staff member who did receive in-service training by Octob 2015 will not be allowed to work un training has been completed. This information has been integrated inti- standard orientation training for all housekeepers, maintenance emplo- nurses and CNA¿s and will be revie by the Quality Assurance Process to that the change has been sustained Quality Assurance The Administrator or designee will of this issue using the Survey Quality Assurance Monitor for monitoring p curtains. This tool will audit 10 room privacy curtain issues such as not providing full privacy when pulled. The completed weekly times four we then monthly times three months of resolved by QOL/QA committee. Se Attachment A. Reports will be giver weekly QOL/QA committee and con action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Managers, Social Workers and Die Manager.	er 2, til o the oyees, ewed o verify d. monitor privacy ns for This will ees r until ee n to the rrective		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 460	Observations of Be revealed the end of observed with a 3 fc curtain to the wall. On 9/2/15 at 2:01 P closed privacy curta gap from the foot of curtain. Observation privacy curtain reve of the curtain to the On 9/3/15 at 9:34 A closed privacy curta gap from the foot of curtain. Bed # 2 ' s observed with a 3 fc curtain to the wall. 7. On 9/1/15 at 3:38 was observed with a 4 foot gap from the the curtain. Observ curtain for Bed # 2 foot gap from the eff On 9/3/15 at 9:26 A closed privacy curta gap from the foot of curtain. Bed # 2 ' s observed with a 4 fc curtain to the wall. 8. On 9/1/15 at 3:42 s privacy curtain wa foot gap from the eff Observations of the observations of the	d # 2 ' s closed privacy curtain the privacy curtain was bot gap from the end of the "M in Room # 505 Bed # 1 ' s ain was observed with a 2 foot f the bed to the end of the ns of Bed # 2 ' s closed ealed a 3 foot gap from the end wall. M in Room # 505 Bed # 1 ' s ain was observed with a 2 foot f the bed to the end of the closed privacy curtain was bot gap from the end of the so gap from the end of the closed privacy curtain closed and he foot of the bed to the end of vations of the closed privacy in room # 503 Red # 1 the privacy curtain to the wall. M in Room # 503 Bed # 1 ' s ain was observed with a 4 foot f the bed to the end of the closed privacy curtain was bot gap from the end of the closed privacy curtain to the wall. M in Room # 503 Bed # 1 ' s ain was observed with a 4 foot f the bed to the end of the closed privacy curtain for Bed bot gap from the end of the closed privacy curtain for Bed curtain revealed a 5 foot gap	F 4	460			

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI COM	E SURVEY IPLETED
		345218	B. WING	i			C 04/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	MARY GRAN NURSING CENTER				120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 460	Continued From pa	ge 64	F	460			
	On 9/2/15 at 2:04 F closed privacy curta gap from the end o 2 ' s privacy curtain gap from the end o On 9/3/15 at 9:25 A closed privacy curta gap from the end o 2 ' s closed privacy foot gap from the e 9. On 9/3/15 at 9:4' s closed privacy cu foot gap from the e On 9/4/15 at 11:34	PM in Room # 506 Bed # 1 ' s ain was observed with a 2 foot f the curtain to the wall. Bed # was observed with a 5 foot f the curtain to the wall. M PM Room # 506 Bed # 1 ' s ain was observed with a 2 foot f the curtain to the wall. Bed # curtain was observed with a 5 nd of the curtain to the wall. 1 AM in Room # 312 Bed # 2 ' rtain was observed with a 4 nd of the curtain to the wall. AM in Room # 312 Bed # 2 ' s		+00			
	gap from the end of During an interview the Housekeeping s housekeeping was curtains. She ackno privacy curtains we Housekeeping Sup staff was responsible curtains that they h She stated the floor was responsible for clean and wide end privacy curtains we taken down and wa Supervisor revealed tell housekeeping s needed to be taken stated if she obserview	ain was observed with a 4 foot f the curtain to the wall. f on 09/03/2015 at 10:19 AM Supervisor revealed responsible for the privacy owledged that most of the re too short. The ervisor said housekeeping le for hanging the privacy ad enough privacy curtains. f technician in housekeeping ensuring the curtains were high. She added that if the re dirty the curtains were hished. The Housekeeping d the Nursing Assistants would taff if the privacy curtains down and washed. She also yed that the curtains needed to ould take them down and					

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF I	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENT	ER			20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 460	revealed her expectation was for staff if the privacy of inform the floor tech technician was gon change the privacy Supervisor stated s measure the privacy During an interview Administrator stated privacy curtains to p all residents. On 9/4/15 at 10:46 the Administrator th Rooms # 503, 505, curtains were again visual privacy when 10. During an obse PM in room 804, th was 12 inches too s privacy curtain to th bed A. The privacy bed B was short by privacy curtains for remained the same During an observat room 804 the priva B remained the same	Housekeeping Supervisor Nursing Assistants to tell her ourtains were not clean, to nnician, and if the floor e, to inform her and she would curtains. The Housekeeping he would have maintenance y curtains. To 9/4/15 at 10:16 AM the d that she would expect provide full visual privacy for AM during an observation with the closed privacy curtains in 506, 507, 508, 509 and 511 n observed to not provide full pulled around resident beds. rvation on 9/01/2015 at 3:48 he privacy curtain for bed A short from the end of the ne wall adjacent to the head of curtain between bed A and 4 feet from the end of the ne wall adjacent to the head of short from the end of the ne wall adjacent to the head of curtain between bed A and 4 feet from the end of the ne wall adjacent to the head of short from the end of the ne wall adjacent to the head of curtain between bed A and a feet from the end of the ne wall adjacent to the head of curtain between bed A and a feet from the end of the ne wall adjacent to the head of and a feet from the end of the ne wall adjacent to the head of a feet from the end of the feet from the end of the ne wall adjacent to the head of a feet from the end of the feet from the end of the feet from the end of the ne wall adjacent to the head of a feet from the end of the feet feet from the end of the feet from the end of the feet feet feet feet feet feet feet	F 4	60			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUR COMPLETE C 345218 B. WING 09/04/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	IER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X1) PROVIDER/SUPPLIER/CLIA		
345218 B. WING C 09/04/20		A DOILDI	IDENTIFICATION NUMBER:		
00/04/2		B. WING	345218		
	STREET ADDRESS, CITY, STATE,	<u> </u>		PROVIDER OR SUPPLIER	NAME OF F
120 SOUTHWOOD DRIVE BOX 379	120 SOUTHWOOD DRIVE BOX				
MARY GRAN NURSING CENTER CLINTON, NC 28328	CLINTON, NC 28328		MARY GRAN NURSING CENTER		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATEDEFICIENCY)	Y FULL PREFIX (EACH CORRECTIVE AC MATION) TAG CROSS-REFERENCED TO	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
F 460 Continued From page 66 F 460 PM in room 813, the privacy curtain between bed A and bed B was 4 feet short from the end of the privacy curtain to the wall adjacent to the head of bed B and was also missing two privacy curtain hooks. F 460 During an observation on 9/2/15 at 2:54 PM in room 813, the privacy curtain between bed A and bed B remained the same. During an observation on 9/3/15 at 10:00 AM for room 813, the privacy curtain between bed A and bed B remained the same. 12. During an observation on 09/01/2015 at 3:52 PM in room 815, the privacy curtain for bed A was missing 6 hooks and was 24 inches short from the end of the privacy curtain to the wall adjacent to the head of bed B. The privacy curtain between Bed A and Bed B was short by 2 feet, from the end of the privacy curtains for bed A and bed B remained the same. During an observation on 9/3/15 at 10:101 AM in room 815, the privacy curtains for Bed A and bed B remained the same. During an observation on 9/3/15 at 10:11 AM in room 815, the privacy curtains for Bed A and bed B remained the same. During an interview on 09/03/2015 at 10:19 AM the Housekeeping Supervisor revealed housekeeping Supervisor revealed housekeeping Supervisor revealed housekeeping Supervisor sid housekeeping staff was responsible for the privacy curtains. She achnowledged that most of the privacy curtains were too short. The Housekeeping Supervisor sid housekeeping staff was responsible for hanging the privacy curtains. She stated the foor technica in housekeeping staff was responsible for hanging the privacy curtains. She stated the foor technica in housekeeping	etween bed end of the he head of by curtain 4 PM in bed A and 00 AM for bed A and 15 at 3:52 bed A was ort from II adjacent in between rom the 6 PM in A and bed 01 AM in A and bed 0:19 AM i privacy of the eeping rivacy curtains.		The privacy curtain between bed feet short from the end of the ne wall adjacent to the head of or missing two privacy curtain ion on 9/2/15 at 2:54 PM in acy curtain between bed A and e same. ion on 9/3/15 at 10:00 AM for acy curtain between bed A and e same. rvation on 09/01/2015 at 3:52 e privacy curtain for bed A was id was 24 inches short from acy curtain to the wall adjacent B. The privacy curtain between as short by 2 feet, from the curtain to the wall. ion on 9/2/15 at 2:56 PM in acy curtains for bed A and bed ne. ion on 9/3/15 at 10:01 AM in acy curtains for Bed A and bed ne. on 09/03/2015 at 10:19 AM Supervisor revealed responsible for the privacy owledged that most of the re too short. The ervisor said housekeeping ble for hanging the privacy ad enough privacy curtains.	PM in room 813, th A and bed B was 4 privacy curtain to th bed B and was also hooks. During an observat room 813, the priva- bed B remained the During an observat room 813, the priva- bed B remained the 12. During an observat room 813, the priva- bed B remained the 12. During an observat room 815, the priva- to the head of bed I Bed A and Bed B w end of the privacy of During an observat room 815, the priva- B remained the sar During an observat room 815, the priva- B remained the sar During an interview the Housekeeping was curtains. She acknop privacy curtains we Housekeeping Sup staff was responsib curtains that they housekeeping Sup	F 460

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		AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345218	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GRAN NURSING CENTER					20 SOUTHWOOD DRIVE BOX 379 LINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 460	was responsible for clean and wide eno privacy curtains we taken down and wa Supervisor revealed tell housekeeping s needed to be taken stated if she observi- be changed, she we change them. The revealed her expectation was for staff if the privacy of inform the floor tech technician was gon change the privacy Supervisor stated s measure the privacy On 9/03/2015 at 10 Supervisor observe where the privacy of During an interview	r ensuring the curtains were bugh. She added that if the re dirty the curtains were ished. The Housekeeping d the Nursing Assistants would staff if the privacy curtains down and washed. She also yed that the curtains needed to ould take them down and Housekeeping Supervisor r Nursing Assistants to tell her surtains were not clean, to hinician, and if the floor e, to inform her and she would curtains. The Housekeeping she would have maintenance	F	460			

Facility ID: 923329

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