PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				DATE SURVEY COMPLETED		
		345218	B. WING _			C 10/11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER		•	STREET ADDRESS, CITY, STATE, ZIF 120 SOUTHWOOD DRIVE CLINTON, NC 28329	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F (000		
F 550 SS=D	survey was conducte 10/11/2018. Immedia at CFR 483.25 at tag severity of J. Immedi 09/26/2018 and was extended survey was Resident Rights/Exer	ate Jeopardy was identified F 689 at a scope and iate Jeopardy began on removed on 10/11/2018. An conducted. rcise of Rights	F S	550		10/31/18
	self-determination, ar	Rights. ght to a dignified existence, nd communication with and nd services inside and cluding those specified in				
	with respect and dign resident in a manner promotes maintenand	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility eaintain identical policies and ransfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her f the facility and as a citizen				
APODATORY	DIDECTOR'S OR DROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITI F		(X6) DATE

Electronically Signed 10/26/2018

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.

NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER (X4) ID PREFIX TAG TAG F 550 Continued From page 1 \$483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	(X3) DATE SURVEY COMPLETED	
MARY GRAN NURSING CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	C 10/11/2018	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	10/11/2010	
§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal		
resident can exercise his or her rights without interference, coercion, discrimination, or reprisal		
§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:		
Based on observations and staff interviews, the facility failed to provide dignity for residents by failing to knock or announce themselves before entering residents rooms for 2 of 5 meal pass observations conducted. The statements made on this plan of correction are not an admission to and on not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has tak		
The findings included: 1. On 10/8/2018 a continuous meal pass observation was conducted on the 800 hall from 11:41 AM to 11:46 AM, during lunch. At 11:41 AM, Nursing Assistant (NA) #3 took a lunch tray or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.		
from the hall cart and walked into room 802 without knocking or announcing herself to the resident in the room. F550 1. For effected residents, a corrective action was obtained on 10/08/2018.		
At 11:43 AM NA #3 took a lunch tray into room 807 without knocking or announcing herself to the resident in the room. The CNA who failed to knock prior to entering the resident's room was verball counseled by the Staff Development	ly	
At 11:44 NA #3 walked into room 810, empty handed, without knocking or announcing herself to the resident in the room, then walked out and into room 805, empty handed, and without knocking or announcing herself to the resident in Coordinator on knocking on residents doors and asking permission to enter pr to entering a resident's room. 2. Corrective action for residents with		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			C	
		345218	B. WING			1) 11/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	11/2010
				12	20 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER			CLINTON, NC 28329			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 550	Continued From page	e 2	F:	550			
	the room.				the potential to be affected by the alleg	ed	
					deficient practice.	ou .	
	At 11:45 AM, NA #3 v	valked empty handed into			'		
		nocking or announcing			All residents have the potential to be		
		t in the room, then left and			affected by the alleged deficient practic	æ.	
		0 without knocking or			On 10/26/2018, the Staff Development		
	announcing herself to	the resident in the room.			Coordinator completed an audit observ	ing	
	0 40/0/0040 4 44 4				privacy practices for staff knocking on		
		6AM, an interview was			residents doors and asking permission	to	
		3 who stated when she om. she knocked on the			enter prior to entering. This audit was		
		on, she knocked on the			completed on all skilled halls.		
		announce herself at this			3. Systemic changes		
		ad already made rounds			o. Gysternie enanges		
		rk at 7:00 AM and she			In-service education was provided to a	II	
		the residents at that time, so			full time, part time, and as needed staf		
	they knew who she w	as already.			Topics included:		
		4 PM, an interview was			All staff must knock on a resident's		
	conducted with the S				door prior to entering the room even if	the	
		The SDC stated she had			door is open.	_	
		all staff in July 2018 to			All staff must ask permission prior	to	
		g a resident room. The SDC			entering the resident's room.		
		s open they still needed to s to let the resident know			This information has been integrated ir	nto	
	who was coming in.	s to let the resident know			the standard orientation training and in		
	who was coming in.				required in-service refresher courses for		
	On 10/10/2018 at 4:3	6 PM, an interview was			all staff and will be reviewed by the Qu		
		irector of Nursing (DON).			Assurance process to verify that the	,	
		expected staff to knock on			change has been sustained.		
		nemselves and tell the					
		re there, whether the door			4. Monitoring Procedure to ensure th		
	was open or closed.				the plan of correction is effective and the		
					specific deficiency cited remains correct	ted	
		as conducted on the 800 hall			and/or in compliance with regulatory		
		4 AM. NA #4 walked into			requirements.		
		ocking or introducing herself			The Stoff Development Counting to a		
	and pushed the beds a meal tray on it.	ide table to the resident with			The Staff Development Coordinator or designee will monitor procedures for		
	i a ilical liav Oll II		1		L Gesignee will mornior brockomes for		1

Facility ID: 923329

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
		345218	B. WING			C 10/11/2018	
NAME OF PE	ROVIDER OR SUPPLIER		- 	STREET ADDRESS, CITY, STATE, ZIP CODE		10/11/2016	
				120 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER			CLINTON, NC 28329			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION .	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE	COMPLETION DATE	
F 550	Continued From page	: 3	F 5	50			
	conducted with NA #4 the resident in Room back in to feed him ea usually knocked on the but she hardly ever knif it was open. On 10/10/2018 at 5:2 conducted with the St Coordinator (SDC). I given an in-service to knock before entering stated if the door was announce themselves who was coming in. On 10/10/2018 at 4:36	26 PM, an interview was all, who stated she had told 801 that she would come arlier. The NA stated she had door if the door was shut, nocked on a resident's door 4 PM, an interview was aff Development The SDC stated she had all staff in July 2018 to a resident room. The SDC open they still needed to be to let the resident know 6 PM, an interview was rector of Nursing (DON).		resident's rights weekly x 2 week monthly x 3 months using the Rerights/privacy Quality Assurance Monitoring will include auditing sknocking and asking permission resident's room prior to entering will be presented to the weekly Chassurance committee by the Adito ensure corrective action initiat appropriate. Compliance will be and ongoing auditing program rethe weekly Quality Assurance M The weekly QA Meeting is attended Administrator, Director of Nursin Coordinator, Therapy, Health Inf Manager, and the Dietary Manager.	esidents monitor. staff for to enter a . Reports Quality ministrator ted as monitored eviewed at eeting. ded by the g, MDS formation		
	the door, introduce th resident why they were was open or closed.	re there, whether the door					
	Comprehensive Asse CFR(s): 483.20(b)(1)(F6	36		10/31/18	
	a comprehensive, acc	luct initially and periodically					
	A facility must make a assessment of a resid	ent Assessment Instrument.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING			C 10/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE CLINTON, NC 28329	107	11/2010
(X4) ID PREFIX TAG	SUMMARY ST, (EACH DEFICIENC' REGULATORY OR L	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	by CMS. The assess the following: (i) Identification and divide (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavior (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutrition (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trighthe Minimum Data Se (xviii) Documentation assessment. The assinclude direct observa with the resident, as volicensed and nonlicer members on all shifts §483.20(b)(2) When retimeframes prescriber chapter, a facility musassessment of a residunction (iii) of this sections.	instrument (RAI) specified ment must include at least demographic information section and structural problems. In and health conditions and status. Its and procedures ing. In section of summary information and assessment performed gered by the completion of set (MDS). In of participation in seessment process must set ion and communication well as communication with used direct care staff	F	636			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345218	B. WING _			C 10/11/2018
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	10/11/2010		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 636	(i) Within 14 calendal excluding readmission significant change in mental condition. (Four "readmission" means following a temporary or therapeutic leave. (iii) Not less than once This REQUIREMENT by: Based on record reversacility failed to comprehensive assereviewed (Resident # Findings included: Resident #1 had beed diagnoses included disease, chronic kidred diabetes and depress. His most recent Quanch Assessment (MDS) vanual comprehensive assessment (MDS) vanual comprehensive and depress. (MDS) vanual comprehensive August 2018. She statis had been missed On 10/10/18 at 10:24 Director of Nursing (IDON stated it was hen urse to complete M assessment assignment	r days after admission, ons in which there is no the resident's physical or or purposes of this section, is a return to the facility of absence for hospitalization of every 12 months. To is not met as evidenced or iew and staff interviews the elete an annual resident elete an annual electron elete elete elete elete an annual electron elete elet	F 6	The statements made on this pla correction are not an admission to not constitute an agreement with alleged deficiencies. To remain in compliance with all f and state regulations the facility hor will take the actions set forth in plan of correction. The plan of corconstitutes the facility's allegation compliance such that all alleged deficiencies cited have been or w corrected by the dates indicated. F636 Comprehensive Assessr Timing For resident #1, a corrective action obtained on 10/12/18. On date 10/12/18, an Annual Min Data Set assessment was openeresident #1 with an Assessment Reference Date of 10/12/18 by the Minimum Data Set Nurse. This assessment was completed by the interdisciplinary team on 10/22/18 was submitted and accepted by set database on 10/25/18 in batch #1 Corrective action for residents with potential to be affected by the allegement of the practice.	o and do the federal has taken his rection of fill be ment and on was imum d for he as and state 1134. th the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRU IG	ICTION	(X3) DATE SURVEY COMPLETED				
		345218	B. WING			C			
	ROVIDER OR SUPPLIER AN NURSING CENTER	040210		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	T OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO			3E	(X5) COMPLETION DATE		
F 636	Continued From page	e 6	F	All res affecte On 10. Set Co all current to valid Minimum comple System On 10. Set Co training Coordi comple Data Sapprop chapte should between from o Set as This in the sta Minimum The mum the pla specifi and/or require	idents have the potential to be ed by the alleged deficient practic /25/18 the Regional Minimum Data consultant completed 100 % audit rent residents in the facility in ord date that all had a comprehensive um Data Set assessment eted within the past 366 days. Sesults of the audit were: 109 of 1 ants reviewed had a comprehensive um Data Set assessment eted within the past 366 days. The changes /26/18, the Regional Minimum Data Set assessment eted within the past 366 days. The changes /26/18, the Regional Minimum Data Set assessments within the priate timeframes as stated in er 2 of the RAI manual. There is the no more than 366 days en the assessment reference days en the assessment reference days en the assessment to the next. The comprehensive Minimum Data Set assessment to the next. The comprehensive Minimum Data seessment to the next. The comprehensive Minimum Data sees ment to the next. The comprehensive Minimum Data sees ment to the next. The comprehensive Minimum Data sees ment to the next. The comprehensive Minimum Data sees ment to the next. The comprehensive Minimum Data sees ment to the next.	ata t of der der de log log ata e Set of ates ata nto e hat cted ry			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345218	B. WING		C	
	ROVIDER OR SUPPLIER AN NURSING CENTER	343210	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	10/11/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 636	S483.20(b)(2)(ii) With determines, or should there has been a sign resident's physical or purpose of this section means a major declining the section of the	esment After Signifcant Chg iii) nin 14 days after the facility I have determined, that	F 63	Minimum Data Set Nurse will begin auditing the Minimum Data Set Assessment schedule using the quality assurance survey tool entitled "Comprehensive MDS (Minimum Data Set) Completion Date Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cit remains corrected and in compliance withe regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, He Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursir	ted vith ad be of as	

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	345218	B. WING				
ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	1 10/1	1/2010	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE	
itself without further in implementing standa interventions, that ha one area of the residurequires interdisciplin care plan, or both.) This REQUIREMENT by: Based on staff interventiality failed to perform Status Assessment (Status Assessmen	ntervention by staff or by rd disease-related clinical is an impact on more than ent's health status, and ary review or revision of the is not met as evidenced liews and record review the rm a Significant Change in SCSA) for 1 of 1 residents care. (Resident #71) mitted to the facility on liagnoses included anemia, as mellitus, hyperlipidemia, hyperlipidemia, hyperlipidemia, hyperlipidemia, hyperlipidemia, hyperlipidemia, hyperlipidemia, hyperlipidemia, hyperlipidemia, hyperl	F6	The statements made on this plan correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all fer and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of correctionstitutes the facility sallegation compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. F637 Comprehensive Assessment Significant Change For resident #71, a corrective action obtained on 10/26/18. On 10/25/18, the Regional Minimus Set Consultant opened a Significant Change Minimum Data Set Assess with an Assessment Reference Da 10/26/18 for Resident #71. The dufor this assessment to be complete 11/9/18. Corrective action for residents with potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	and do ne deral s taken his ection of be after n was m Data nt ment te of e date ed on is the led be actice.		
Review of Resident #	71's Minimum Data Set					
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page itself without further in implementing standar interventions, that ha one area of the reside requires interdiscipline care plan, or both.) This REQUIREMENT by: Based on staff interventions and the status and t	AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to perform a Significant Change in Status Assessment (SCSA) for 1 of 1 residents reviewed for hospice care. (Resident #71) Findings included: Resident #71 was admitted to the facility on 8/10/18. Her active diagnoses included anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, asthma, muscle weakness, and other sequelae of cerebral infarction. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 coded as an admission assessment revealed she was assessed as severely cognitively impaired. Resident #71 had no moods or behaviors. The MDS indicated that at the time of the assessment, the resident was not receiving hospice services. Review of Resident #71's orders revealed on 9/5/18 she was ordered to have a hospice	A BUILDIN 345218 B. WING ROVIDER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to perform a Significant Change in Status Assessment (SCSA) for 1 of 1 residents reviewed for hospice care. (Resident #71) Findings included: Resident #71 was admitted to the facility on 8/10/18. Her active diagnoses included anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, asthma, muscle weakness, and other sequelae of cerebral infarction. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 coded as an admission assessment revealed she was assessed as severely cognitively impaired. Resident #71 had no moods or behaviors. The MDS indicated that at the time of the assessment, the resident was not receiving hospice services. Review of Resident #71's orders revealed on 9/5/18 she was ordered to have a hospice referral. Review of Resident #71's chart revealed on 9/5/18 she began hospice care.	A BUILDING 345218 345218 STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTHWOOD DRIVE CLINTON, NC 28329 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LS: DENTIFYING INFORMATION) Continued From page 8 Fe37 The statements made on this plan correction are not an admission particularly and correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all fe and state regulations the facility has or will take the actions set forth in plan of correction. The plan of correction, asthma, muscle weakness, and other sequelae of cerebral infarction. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 coded as an admission assessment revealed she was assessed as severely cognitively impaired. Review of Resident #71's most recent minimum data set assessment, the resident was not receiving hospice services. Review of Resident #71's orders revealed on 9/5/18 she was ordered to have a hospice referral. Review of Resident #71's chart revealed on 9/7/18 she began hospice care. Page Manual Provision of the care plan of control of the safected by the alleged deficient practice. All residents #71's chart revealed on 9/7/18 she began hospice care. Page Manual Provision of Cultron, NC 28259 The statements made on this plan correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all fe and state regulations the facility in the plan of correction. The plan of correction. The plan of corrected by the dates indicated. F637 Comprehensive Assessment Significant Change F7637 Comprehensive Assessment Significant Change	A BUILDING 345218 BUNDIER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEPICIENCIES (EQUILATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 8 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REGUIREMENT is not met as evidenced by: Based on staff interviews and record review the carely plan or both or status Assessment (SCSA) for 1 of 1 residents reviewed for hospice care. (Resident #71) Findings included: Findings included: Findings included: Findings review of Resident #71's most recent minimum data set assessment severely cognitively impaired. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 coded as an admission assessment trevealed she was assessed as severely cognitively impaired. Review of Resident #71's roders revealed on 9/5/18 she was ordered to have a hospice referral. Review of Resident #71's orders revealed on 9/5/18 she was ordered to have a hospice referral. Review of Resident #71's roders revealed on 9/7/18 she began hospice care.	

Facility ID: 923329

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING _			C 10/11/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	11/2010
				12	20 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER			C	LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 637	Continued From page	9	F 6	37			
F 637	(MDS) assessments is completed. During an interview of Coordinator #1 stated position as the MDS of MDS Coordinator #2's She further stated she Nurse #2 to have periodule to hospice election. During an interview of Director of Nursing stated a significant charmonic complete.	n 10/10/18 at 8:51 AM MDS I she had just started her Coordinator on 10/8/18 and Is last day was on 10/4/18. It would have expected MDS I started her I start	F6	637	residents who have been admitted to o discharged from hospice care during the past 90 days to ensure that Significant Change Minimum Data Set assessment have been completed. The audit results are: • 4 residents found to have been admitted to hospice care during the past 90 days. • 1 of the 4 residents was admitted to the facility as a hospice resident; therefore, an Admission Minimum Data Set assessment was completed. • 1 of the 4 residents had already be identified by surveyor as not having a Significant Change Minimum Data Set assessment after being admitted to hospice. This was Resident #71. Significant Change in Status Minimum Data Set Assessment was opened with Assessment Reference Date of 10/26/2014. • 2 of the remaining 4 residents reviewed were found to not have had a Significant Change in Status Minimum Data Set completed after being admitted to hospice care. Significant Change assessments were opened by the Regional Minimum Data Set Consultant for both of these residents on 10/25/18 with Assessment Reference Dates of 10/26/18. Systemic Changes On 10/26/2018, the Minimum Data Set Nurse Consultant in consider the	st to a nan 18.	
					Nurse Consultant in serviced the Minimum Data Set Coordinator on the requirement for and importance of		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING			l '	C 11/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	11/2016	
					20 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER			С	LINTON, NC 28329			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JLD BE COMPLE		
F 637	Continued From page	÷ 10	F	637	completing a Significant Change Minim Data Set assessment for all residents ware either admitted to or discharged fro hospice services. This information has been integrated into the standard orientation training for new Minimum Date Coordinators. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements; The Director of Nursing or Minimum Dates Coordinator will review 5 residents who have been either admitted to or discharged from hospice services during the past 60 days to ensure that a Significant Change in Status Minimum Data Set assessment has been completed as required. This will be donusing the quality assurance tool entitled "Significant Change in Status MDS Completion Audit Tool." This audit will done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director on Nursing to ensure corrective action for trends or ongoing concerns is initiated appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction;	who m ata at last sted y ata last be be fass		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	COMPLETED		
		345218	B. WING			C 10/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	,	13/11/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECT O			SHOULD BE	(X5) COMPLETION DATE	
F 637	Continued From pag		F 63	Administrator and /or Director	of Nursing.		
	CFR(s): 483.21(b)(1)		F 65	56		10/31/18	
	implement a compreicare plan for each re resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identifiassessment. The cordescribe the following (i) The services that or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, include treatment under §483. (iii) Any specialized sere abilitative services provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation with resident's represental (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Facwhether the resident's	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's dimental and psychosocial fied in the comprehensive mprehensive care plan must grane to be furnished to attain ent's highest practicable dipsychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized as the nursing facility will FPASARR a facility disagrees with the RR, it must indicate its ent's medical record.					

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 10/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	'	10/11/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	F 656 Continued From page 12 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to update the care plan to reflect a resident's need for supervision outside and hospice status for 1 of 22 resident care plans reviewed. (Resident #71) Findings included: Resident #71 was admitted to the facility on		F 6	The statements made on this correction are not an admission not constitute an agreement wi alleged deficiencies. To remain in compliance with a and state regulations the facilit or will take the actions set forth plan of correction. The plan of constitutes the facility sallegar compliance such that all allege	n to and do ith the all federal y has taken n in this correction ation of		
8/10/18. Her active diagnoses included anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, asthma, muscle weakness, and other effects following a cerebral infarction. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 revealed she was assessed as severely cognitively impaired. Resident #71 had no moods or behaviors. She required extensive assistance with bed mobility, locomotion on and off unit, dressing, eating, toilet use, and personal hygiene. She was totally dependent on staff for transfers. Resident #71 was always incontinent of bowel and bladder. No restraints or alarms of any kind were used. Review of Resident #71's orders revealed on 9/5/18 she was ordered to have a hospice referral.			deficiencies cited have been or corrected by the dates indicate F656 Develop/Implement Com Care Plan For resident #71, a corrective a obtained on 10/9/18. The care plan for Resident #71 updated to include that she is r hospice care. This update was by the Minimum Data Set Nurs 10/9/18. Corrective action for residents potential to be affected by the adeficient practice. All residents who receive hosp have the potential to be affected alleged deficient practice. On the Minimum Data Set Nurse Conducted a 100% audit on all residents who are currently received.	r will be ed. prehensive action was I was receiving s completed se on with the alleged ice services ed by the 10/25/18, Consultant current			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MARY GR	AN NURSING CENTER				20 SOUTHWOOD DRIVE		
				C	CLINTON, NC 28329		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	656 Continued From page 13		F6	656			
	9/7/18 she began hos	spice care.			hospice care in order to ensure that the	eir	
					care plans accurately reflect that they	are	
	Review of Resident #	71's nurse ' s notes			receiving hospice services.		
	revealed there were r	no nursing notes on 9/26/18.					
					The results of this audit were:		
		nurse's note dated 9/27/18					
		Resident #71 was alert and			108 residents reviewed for current		
		s noted and no complaints of			hospice orders.		
	-	oted on her lower right arm			7 of 100 regidents are surrently under		
	and it was reported to Hospice Nurse #1 that Resident #71 was outside on 9/26/18 and became overheated.				7 of 108 residents are currently under hospice care.		
					Hospice care.		
	became overneated.				5 of 7 residents who are currently		
	Review of a hospice t	fall report dated 10/2/18			receiving hospice services do have a		
		Resident #71 sustained a			current hospice care plan.		
	witnessed fall from he	er wheelchair in the facility			·		
	parking lot. The contr	ibuting factors were noted to			2 of 7 residents who are currently		
	be confusion and disc	orientation. Resident #71			receiving hospice services did not have	e a	
		ies and facility staff were			hospice care plan.		
		nt #71 was not allowed			Those 2 residents□ care plans were		
		one. The responsible party			immediately updated by the Minimum		
	was called and inform	ned of the fall.			Data Set Nurse Consultant on 10/25/18	3 to	
	Dovious of a boonies	nursels note dated 10/2/19			reflect hospice care.		
		nurse's note dated 10/2/18 I Resident #71 sustained a			Systemic Changes		
		nair in the parking lot which			Systemic Changes		
	was witnessed by a n	· · · · · · · · · · · · · · · · · · ·			On 10/26/2018, the Minimum Data Set		
	-	pain and no obvious injuries			Nurse Consultant in-serviced the facilit		
		: #71 was brought back to			Minimum Data Set Nurse on the	,	
		nad a complaint of being			importance of maintaining up to date c	are	
	thirsty and ice water v	was given to her. Resident			plans that are reflective of each		
	#71's responsible par	ty was called but there was			resident□s current condition and		
		#71 complained of arm			treatment plans. Emphasis was placed		
	_	ream, a moisturizer, was			on the importance of ensuring that any		
	applied to areas on a	rms and hands.			resident who is receiving hospice care		
					has a hospice care plan in order to		
		nurse's note dated 10/2/18			coordinate services and care between		
		Resident #71's responsible			facility and hospice staff to best meet		
party returned the phone call and was informed				resident□s needs.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345218	B. WING _		10	0/11/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E		
				120 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER	t .		CLINTON, NC 28329			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION DATE	
F 656	Continued From page	ge 14	F 6	56			
	that Resident #71 h	ad fallen and there were no					
	injuries noted or cor			This information has been into	egrated into		
	,	•		the standard orientation traini	-		
	Review of a health	status note dated 10/2/18 at		Minimum Data Set Coordinate	-		
	1:14 PM revealed a	n interdisciplinary team					
	meeting was held to	discuss Resident #71		The monitoring procedure to	ensure that		
	beginning to exhibit	exit seeking behaviors. A		the plan of correction is effect	ive and that		
	group decision was	made to apply a wander		specific deficiency cited rema			
	~	nt. Resident #71's responsible		and/or in compliance with the	regulatory		
		ility and was made aware and		requirements;			
		n. It was documented she was		The Director of Nursing or Min			
		Il the morning of 10/2/18. The		Set Nurse will review 5 reside			
		as well as Resident #71's		currently receiving hospice se			
		fied of the fall and wander		ensure that their care plan ref			
	guard placement.			hospice care. They will use the assurance tool entitled Care I			
	Peview of a nurse's	note dated 10/2/18 at 5:00		Tool. This will be done on a v			
		rse documented she was		for 4 weeks then monthly for 2	-		
		ce nurse that Resident #71		Reports will be presented to t			
		side. The hospice nurse and a		Quality Assurance committee			
		nt got the resident off the		Director of Nursing to ensure	•		
	ground and brought	•		action for trends or ongoing c			
	3			initiated as appropriate. The			
	Review of a fall revi	ew and follow up dated		Quality Assurance Meeting is			
		revealed Resident #71 fell		the Director of Nursing, Minim	-		
	outside of the buildi	ng attempting to reach over		Set Coordinator, Unit Manage	er, Support		
	the side of her whee	elchair to get something.		Nurse, Therapy, Health Inform	nation		
				Manager, Dietary Manager ar	nd the		
		#71's care plan on 10/8/18 at		Administrator.			
		she was not care planned for		The title of the person respon			
		lent #71 was care planned to		implementing the acceptable	plan of		
	be an elopement ris	sk and wanderer on 10/4/18.		correction; Administrator and /or Director	of Nursing		
	During an interview	on 10/8/18 at 12:23 PM		, tarring and for Director	or italoning.		
		tated she admitted Resident					
		e further stated Hospice Nurse					
		hospice nurse. Hospice					
	1	spice Nurse #1 had told her					
		esident #71 outside the facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218			` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 10/11/2018	
		B. WING _					
	NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO. 120 SOUTHWOOD DRIVE CLINTON, NC 28329		0/11/2016	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	further stated the res was not that great wi #71 to hospice and hospice and hospice and hospice she had be and would not have to Resident #71 being of the property of the pro	fallen into some ants. She ident's level of functioning nen she admitted Resident dospice Nurse #2 was been outside unsupervised been comfortable with outside unattended. In 10/9/18 at 9:58 AM ated Resident #71 was not de unattended. Hospice responsible party had not not go outside without of an incident the week she stayed outside too long and had blisters on her arm. The staff in the facility knew in the staff in	F6				
	needed one on one s She further stated sh supervision since he 2018. Nurse #2 state be repositioned in he because she would s risk for falls so staff k	supervision when outside. e was to be on one on one r admission in August of d Resident #71 needed to r chair often through the day slump in her chair and was at new she needed supervision e. She stated there was a					

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH CO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
wandering poster boad well as near the nurse placed her on that list She further stated she #71 was not on the list had not reported to an aides that Resident # because she thought. During an interview of Hospice Nurse Aide # Resident #71 since Significant was placed on hospice Resident #71 was abled her feet. She stated significant she was clean and powent to her next hospice Resident #71 for the Inverse Aide further stated been placed on his supposed to have	ard next to the time clock as e's station, but they had not a prior to the fall on 10/2/18. The did not know why Resident st prior to 10/2/18 and she myone besides her nurse 71 needed supervision it was general knowledge. In 10/9/18 at 11:47 AM the stated she had cared for eptember 2018 when she are care. She further stated le to self-propel herself with the helped a nursing student to for the day on 10/2/18. She further stated once exitioned in her chair she wice resident and did not see rest of the day. The Hospice are dever since Resident #71 hospice care she was convision when exiting the stility. She further stated this not #71 tended to slump in risk to falling from her chair, repositioned in her chair the Hospice Nurse #1 would dents required supervision when with an eneded supervision when when 10/9/18 Nurse Aide #2 moved fast and if you don't would disappear. She ere to keep up with where	F	656			
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page wandering poster boa well as near the nurse placed her on that list She further stated she #71 was not on the list had not reported to a aides that Resident # because she thought During an interview o Hospice Nurse Aide # Resident #71 since S was placed on hospice Resident #71 was ab her feet. She stated s get her bathed and up when she had her fall she was clean and powent to her next hosp Resident #71 for the Nurse Aide further stated been placed on hospice was because Resider #71 for the Nurse Aide further stated been placed on hospice her chair and was at so she needed to be often. She further statinform her which reside when outside the facility and was been one who outside. During an interview of stated Resident #71 resi	AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 wandering poster board next to the time clock as well as near the nurse's station, but they had not placed her on that list prior to the fall on 10/2/18. She further stated she did not know why Resident #71 was not on the list prior to 10/2/18 and she had not reported to anyone besides her nurse aides that Resident #71 needed supervision because she thought it was general knowledge. During an interview on 10/9/18 at 11:47 AM Hospice Nurse Aide #1 stated she had cared for Resident #71 was able to self-propel herself with her feet. She stated she helped a nursing student get her bathed and up for the day on 10/2/18 when she had her fall. She further stated once she was clean and positioned in her chair she went to her next hospice resident and did not see Resident #71 for the rest of the day. The Hospice Nurse Aide further stated ever since Resident #71 had been placed on hospice care she was supposed to have supervision when exiting the locked area of the facility. She further stated this was because Resident #71 tended to slump in her chair and was at risk to falling from her chair, so she needed to be repositioned in her chair often. She further stated Hospice Nurse #1 would inform her which residents required supervision when outside the facility and Resident #71 had always been one who needed supervision when	A BUILDII 345218 B. WING ROVIDER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 Wandering poster board next to the time clock as well as near the nurse's station, but they had not placed her on that list prior to the fall on 10/2/18. She further stated she did not know why Resident #71 was not on the list prior to 10/2/18 and she had not reported to anyone besides her nurse aides that Resident #71 needed supervision because she thought it was general knowledge. During an interview on 10/9/18 at 11:47 AM Hospice Nurse Aide #1 stated she had cared for Resident #71 since September 2018 when she was placed on hospice care. She further stated Resident #71 was able to self-propel herself with her feet. She stated she helped a nursing student get her bathed and up for the day on 10/2/18 when she had her fall. 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She further stated staff were to keep up with where Resident #71 was because she sometimes sat at	ROVIDER OR SUPPLIER 345218 ROVIDER OR SUPPLIER AN NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 16 wandering poster board next to the time clock as well as near the nurse's station, but they had not placed her on that list prior to 10/2/18 and she had not reported to anyone besides her nurse aides that Resident #71 needed supervision because she thought it was general knowledge. During an interview on 10/9/18 at 11:47 AM Hospice Nurse Aide #1 stated she had cared for Resident #71 since September 2018 when she was placed on hospice care. She further stated Resident #71 was able to self-propel herself with her feet. She stated she helped a nursing student get her bathed and up for the day on 10/2/18 When she had her fall. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED C 10/11/2018	
		B. WING _					
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DRIVE CLINTON, NC 28329		10/11/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 656	outside by herself wh living side of the facilit to the skilled unit in S #71 was not to go our unsupervised by staff a staff member would her. She further state this by word of mouth outside the facility un report the concern to already knew. She further stated she was not suppose since sometime in Se visitors would let her to bring her back in a During an interview o #3 stated she was far care. She further stated this decline when she mo side in August on 201 did not know if other unsupervised on their did not report her conoutside unsupervised staff to not let her be During an interview o Nurse #2 stated she and nurses that Resident was not supposed to the state of the	en she was on the assisted ty but ever since she came eptember 2018 Resident tside the facility. If she wanted to go outside I need to go outside with d she was made aware of that she was not to go supervised and she did not anyone because everyone rther stated she did not her being outside for an me or getting overheated. It do be outside on her own eptember and sometimes outside and staff would have and educate the visitors. In 10/9/18 at 3:50 PM Nurse miliar with Resident #71's ed Resident #71 was not to dervised during her shifts. It was due to her cognitive eved to the skilled nursing las. She further stated she murse's let her go outside or shifts, and she stated she her cept to ask visitors or unsupervised outside. In 10/10/18 at 8:08 AM had told other nurse aides dent #71 was not to go but had never brought this	F 6	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C 1 0/11/2018	
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIR 120 SOUTHWOOD DRIVE CLINTON, NC 28329	•	10711/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Resident #71's Nurse Resident #71 was in living section of the Practitioner stated R gradual decline in sther kidney function. the hospital and can debilitated due to he Nurse Practitioner s decision was made hospice resident. Sh Resident #71 was in to make safety decis returned from the hohad a very noticeable further stated one do in the sun and fell as sunburn with some it possibly related to k further stated following the facility staff superclosely when she was Practitioner concludin safety awareness she agreed with the guard for safety and cognizant of where so During an interview Nurse #1 stated she as the MDS Coordin Nurse #2's last day she had worked on facility prior to just b MDS Nurse #1 stated were created and upfurther stated if there	in 10/10/18 at 8:18 AM is e Practitioner stated in the facility in the assisted facility. The Nurse desident #71 had sustained a atus including deterioration of Resident #71 then went to the back in August 2018 very the kidney function decline. The poke with the family and the to make the resident a the further stated when the assisted living she was able sions, however, once she to spital in August 2018 she the cognitive decline. She the ay Resident #71 went outside the sleep and had gotten a to blistering to both forearms, tidney failure as well. She ting this incident she believed the sions and the service of Resident #71 more the soutside. The Nurse the Resident #71 had declined the since her hospitalization and placement of the wander for staff to be more	F	656			

OLIVIEIV	OT OIL WILDIO, WE G	WEDIO/ ND CEITVICEC				CIVID IVE	7. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 50125	_		، ا	С
		345218	B. WING			l	/11/2018
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	11/2010
					20 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER				CLINTON, NC 28329		
()(1) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMIENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	n 10		050			
1 030	Continued From page			656			
	-	d then discussed in the					
		meeting and updated on					
	•	rther stated if a resident					
		nitive or functional decline it that the frontline staff would					
		nary team to address the					
		ition and the care plan. She					
	further stated Resident #71 had sustained a severe decline when she came back to the facility						
	from the hospital in A						
	stated Resident #71's						
		declined following her					
	_	ne was then placed on					
		r 2018. She further stated if					
	she went outside it w	as to be with family who					
	would supervise her	outside and she was not to					
	-	. If it was noticed she was					
		self the staff would stop her					
	_	n the unit. She further stated					
	_	by the locked door and if a					
		ld ask them to hold the door					
		empt to go out to the front of					
	·	er stated at that time she did					
		'1 on her unit and did not					
		reported the concern of her					
		She stated it was a general g the frontline nurses and					
		t #71 was not to be outside					
		e did not know why it was					
	not known by the Dire	<u> </u>					
	Administrator, or other	<u> </u>					
	·	. She stated she did not					
		nce she moved to the 300					
		Nurse #2 if Resident #71					
		de before opening the door					
	, ,	tell her no, she had to be					
		ne facility. She further stated					
	I -	be supervised outside the					
		rn from the hospital in August					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345218	B. WING		C 10/11/2018	
NAME OF PROVIDER OR SUPPL MARY GRAN NURSING CE	I IER	s 1	STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		
PREFIX (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
that Nurse #2 a of Resident #7 the door, and of charge nurse, I flagged the character stated she would to have updated seeking behave further stated Fabeen care pland done until 10/9. During an internity Director of Nurstaff saw Reside outside, had conside, had consider in cognities in cog	ner stated it was the expectation and other staff to bring the concern 1's change in condition, waiting by decreased safety awareness to the MDS Nurse for care planning, and art for the physician. She further all have expected MDS Nurse #2 at the care plan regarding her exit ior and need for supervision. She Resident #71 should have also uned for hospice and it was not 1/18. Eview on 10/10/18 at 9:57 AM the sing stated it was her expectation if the the state of the state of the sing stated it was her expectation if the the state of	F 656	The statements made on this plan of correction are not an admission to and	10/11/18	

PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

		` IDENTIFICATION NUMBED: `		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245249	B. WING			С	
NAME OF B		345218	B. WING _		10	0/11/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MARY GR	AN NURSING CENTER			120 SOUTHWOOD DRIVE			
				CLINTON, NC 28329			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 21		F 68	39			
	the facility failed to pra a severely cognitively #71) who displayed with known by some staff outside from being or unsupervised for 1 of accidents. Immediate Jeopardy Resident #71 was left unsupervised by staff her right forearm. The inside by a concerned Resident #71 was let supervision in her who parking lot where she injury. The resident with no physical injuring removed on 10/11/18 and implemented an Immediate Jeopardy remains out of compliseverity of "D" (no hamore than minimal hamore than mini	rovide supervision to prevent impaired resident (Resident vandering behaviors and was to require supervision while utside the facility 4 residents reviewed for began on 9/26/18 when to outside the facility 4 and developed blisters to be resident was brought back divisitor. On 10/2/18 outside the facility without the facility without reelchair in the facility without resulting assessed and retrieved and returned to the facility ites. Immediate jeopardy was so when the facility provided acceptable allegation of		not constitute an agreement wir alleged deficiencies. To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility sallegal compliance such that all alleged deficiencies cited have been or corrected by the dates indicate. Credible Allegation for Supervision prevent accidents. Address how corrective action accomplished for those resident have been affected by the deficiencies. On 09/26/2018 the resident has sitting outside on the front porcivisitor assisted her in the front alerted the Unit Manager. This around 1PM. The resident was back to her unit by the Unit Manan assessment performed revesigns, SPO2, and blood sugar normal limits for this resident. The Manager stated that the resident was warm and dry. No blisters were observed to the residents extremities at this time. A repor immediately given to the FNP wassessed the resident. The FN that the Unit Manager reported the resident had been brought outside due to appearing sleep sitting out doors. The Unit Manager sitting out doors.	Ill federal y has taken in this correction ition of d will be d. sion to will be nts found to cient d been th when a door and occurred assisted nager and ealing vital were within The Unit nt's skin or redness upper t was who then P stated to her that in from y and was ger took		
F 689	the facility failed to pra a severely cognitively #71) who displayed with known by some staff outside from being our unsupervised for 1 of accidents. Immediate Jeopardy Resident #71 was left unsupervised by staff her right forearm. The inside by a concerned Resident #71 was let supervision in her who parking lot where she injury. The resident work by Hospice Nurse #1 with no physical injuring removed on 10/11/18 and implemented an Immediate Jeopardy remains out of compliseverity of "D" (no hamore than minimal hamore are effective. Findings included: Resident #71 was ad 8/10/18. Her active dinypertension, diabeted dementia, depression weakness. Review of Resident # data set assessment	rovide supervision to prevent impaired resident (Resident vandering behaviors and was to require supervision while utside the facility if 4 residents reviewed for began on 9/26/18 when it outside the facility if and developed blisters to be resident was brought backed visitor. On 10/2/18 outside the facility without deelchair in the facility if as sustained a fall without was assessed and retrieved and returned to the facility ites. Immediate jeopardy was so when the facility provided acceptable allegation of removal. The facility inance at a lower scope and arm with the potential for arm that is not immediate monitoring systems put in mitted to the facility on itagnoses included anemia, as mellitus, hyperlipidemia, in, asthma, and muscle	F 68	not constitute an agreement wir alleged deficiencies. To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility sallegal compliance such that all alleged deficiencies cited have been or corrected by the dates indicated. Credible Allegation for Supervision prevent accidents. Address how corrective action accomplished for those resident have been affected by the deficiencies. On 09/26/2018 the resident has sitting outside on the front porcivisitor assisted her in the front alerted the Unit Manager. This around 1PM. The resident was back to her unit by the Unit Manan assessment performed revessigns, SPO2, and blood sugar normal limits for this resident. The Manager stated that the resident was warm and dry. No blisters were observed to the residents extremities at this time. A repor immediately given to the FNP vassessed the resident. The FN that the Unit Manager reported the resident had been brought outside due to appearing sleep	Il federal y has taken in this correction ition of d will be d. sion to will be nts found to cient d been th when a door and occurred assisted nager and ealing vital were within The Unit nt's skin or redness upper rt was who then P stated to her that in from y and was ger took ported Il within her		

Facility ID: 923329

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218			` ′	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		B. WING		,	C 10/11/2018		
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		STREET ADDRESS, CITY, STATE, ZIP CODE		0/11/2016	
	10 115211 011 001 1 2.2.1			120 SOUTHWOOD DRIVE	-		
MARY GR	AN NURSING CENTER			CLINTON, NC 28329			
	OUR MAA DV OT	ATEMENT OF REFIGIENCIES					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	689 Continued From page 22		F 6	39			
F 689	Resident #71 had no required extensive as locomotion on and of use, and personal hydependent on staff for was always incontine restraints or alarms or Review of Resident # revealed she was car falls. The intervention meet her needs as migrip strips on floor in #71, family, and care reminders and what the encourage her to weak was not wearing show effects from medication and gait and report to changes in gait or bar past falls and attempt falls, record possible remove any potential. Review of Resident # there were no nursing	moods or behaviors. She sistance with bed mobility, funit, dressing, eating, toilet giene. She was totally ratransfers. Resident #71 nt of bowel and bladder. No fany kind were used. 71's care plan dated 8/14/18 e planned to be at risk for s included to anticipate and uch as possible, criss cross her room, educate Resident givers about safety to do if a fall occurs, ar non-skid socks when she es, observe for possible side ons that may affect balance on urse if Resident #71 had ance, review information on to determine the cause of root causes, and alter or causes if possible.	F 6	appear to be in any distress". states that she was aware of t sitting outside alone as she had resident sitting on the front por frequently and no concerns we with this activity. No medical in were required due to this even 09/27/2018 the Hospice nurse facility to assess the resident a blisters on the resident's right resident was complaining of its area. The hospice nurse direct hospice aide to apply cream to and apply sleeves to prevent the from scratching the area and the nails. The hospice nurse state completed on 09/27/2018. On 10/02/2018, the Director of and the Administrator met and the incident regarding the fall of determined the root cause of the was that the resident now requisive supervision while outside. • Corrective action for the area signed a wander guard brace prevent her from going outside unsupervised due to her safet.	the resident as seen the arch ere seen the recherce seen the recherce seen the reventions at. On a was in the and noted arm. The ching in this ted the control the arca the resident to trim her as this was af Nursing I discussed outside and the incident wired affected esident was celet to established.		
	at 1:28 PM revealed active with no distressipain. Blisters were no	Resident #71 was alert and s noted and no complaints of steed on her lower right arm be Hospice Nurse #1 that		On 10/02/2018 the Director of interviewed and assessed the the need of wander guard placement and monitoring. On 10/02/2018 at approximate the resident was assisted thro	nursing resident for cement and ard		
	revealed at 10:00 AM witnessed fall from he	all report dated 10/2/18 Resident #71 sustained a er wheelchair in the facility ibuting factors were noted to		double doors onto the front ha activities assistant. The reside proceeded to go out the front on on the front porch as per her n	all way by the ent doors to sit		

Facility ID: 923329

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345218	B. WING		C 10/11/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/11/2010
				120 SOUTHWOOD DRIVE	
MARY GR	AN NURSING CENTER			CLINTON, NC 28329	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
F 689	Continued From page	e 23	F 689	9	
	be confusion and disc	orientation. Resident #71		routine. Per the staff interviews cond	ucted
		ries and the facility staff were		including the FNP this was her norma	al
		nt #71 was not allowed		routine up until 10/02/2018. The activ	-
		one. The responsible party		assistant observed the resident still s	sitting
	was called and inforn	ned of the fall.		on the front porch at approximately	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		9:45AM. At approximately 10:15AM t	
	•	nurse's note dated 10/2/18		resident was observed leaning over i	
		Resident #71 sustained a		wheel chair as to pick something up	
		hair in the parking lot which nursing student. Resident		the ground and fell out of her wheel of the resident did not sustain an injury	
		no obvious injuries were		result of this fall. The fall occurred	as a
		was brought back to her		between the canopy and the first	
		a complaint of being thirsty		handicapped parking spot. The hosp	ice
		ven to her. Resident #71		nurse was immediately summoned to	
	_	s called but there was no		assess the resident. After assessmen	
	answer. Resident #7	1 complained of arm itching		was completed the resident was	
	and cream was applic	ed to areas on arms and		transported inside and the responsib	le
	hands.			party and MD were notified by the ho	spice
				nurse and the Director of Nursing.	
		atus note dated 10/2/18 at		On 10/02/2018 the Director of Nursin	-
		interdisciplinary team		and the Administrator met and discus	ssed
	meeting was held to			the incident and determined the root	
		exit seeking behaviors. A		cause of the incident was that the res	
		nade to apply a wander . Resident #71 responsible		 now required supervision while outside Corrective action for affected res 	
	_	ty and was made aware and		On 10/02/2018 the resident was assi	
		It was documented she was		a wander guard bracelet to prevent h	~ I
	,	the morning of 10/2/18. The		from going outside unsupervised due	
		well as Resident #71's		her safety risk.	
		ed of the fall and wander		Address how the facility will identify of	other
	guard placement.			residents having the potential to be	
	· · · ·			affected by the same deficient practic	ce.
		note dated 10/2/18 at 5:00		An REQ (Review to Ensure Quality)	was
		2 documented she was		initiated on 10/05/2018. On 10/05/20	
		e nurse that Resident #71		the Director of Nursing initiated an au	
		de. The hospice nurse and a		all current residents and ran a report	
	_	ne resident off the ground		Point Click Care of residents' elopem	
	and brought her back	cinside.		risk scores for the last 3 months to a	
				for a risk score of moderate or high ri	isk

		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C 1 0/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	10/2/18 at 5:14 PM results of the building the side of her wheel Resident #71 had no neurological check we negative. Review of Resident # revealed she was caselopement risk and we included to assess Results monitor for fatigue ar structured activities we and outside, and results and outside, and results are signs, pictures and replanned to have a weak Review of a fall review 10/4/18 at 3:05 AM rechanges in condition neuro checks were not remperature was 85 was sunny. During an interview of Hospice Nurse #2 state #71 to hospice care. Nurse #1 was her pri	w and follow up dated evealed Resident #71 fell g attempting to reach over chair to get something. complaints of pain and a ras performed which was for planned to be an avanderer. The interventions esident #71 for fall risk, and weight loss. Provide with toileting, walking inside rientation strategies including nemory boxes. She was care ander guard in place. W and follow up dated evealed Resident #71 had no following her fall and her egative. Dom for Mount Olive revealed was 88 degrees Fahrenheit 9/26/18. On 10/2/18 the high degrees Fahrenheit and it Don 10/8/18 at 12:23 PM ated she admitted Resident She further stated Hospice mary hospice nurse.	F 68	for elopement. Resident's with score of moderate or high risk elopement were then reviewed following: mobility status when chair or ambulating and if they BIMS of 11 or less to determine for wander guard placement or supervision when going outside. Residents that had a BIMS of and who were independently in reviewed by the Director of Nu Nurse Consultant for the need wander guard placement or su due to potential over exposure going outside. This was finalize 10/08/2018. There were no net that were identified as needing guard bracelet or supervision woutside. Address what measures will be place or systemic changes maensure that the deficient practic recur. On 10/05/2018 the Staff Devel Coordinator, began in-servicing time, part time, and as needed resident safety and monitoring included: All Staff: Do not forget that frequent and supervision are needed in ensure resident safety. This myou should be aware of the resident safety.	for I for the up in their had a e the need e. e. 11 or less nobile were rsing and of a pervision when ed on w residents a wander while e put into de to ce will not opment g all full staff on . Topics t monitoring order to neans that sident's		
	#71 to hospice care. Nurse #1 was her pri Hospice Nurse #2 sta told her someone had outside the facility an some ants. She furth	She further stated Hospice		ensure resident safety. This m	neans that sident's ander guard sident ts not		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							2	
		345218	B. WING _			10/	11/2018	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MARYCE	AN NURSING CENTER			1	20 SOUTHWOOD DRIVE			
WART GR	AN NURSING CENTER			C	CLINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	e 25	F 6	689				
	she had been outside	e unsupervised and would			that sit on the front porch or out in the			
		ortable with Resident #71			courtyards should be monitored for			
	being outside unatter				location, hydration, and safety needs.	Risk		
	9				include falls, dehydration, sun burn. Of			
	During observation o	n 10/9/18 at 8:39 AM			fluids, toileting, and rest periods by			
		served in bed. Her right			coming in from outside throughout you	r		
	forearm was wrapped	d in bandages as ordered			shift. Notify the nurse if the resident			
	and no broken skin w	vas visible.			refuses to come in. Encourage patients	S		
					who like to sit outdoors for long periods	s of		
	During an interview of	on 10/9/18 at 9:58 AM			time to use sunscreen and drink fluids	to		
	Hospice Nurse #1 wh	no was the nurse that			prevent adverse events. Make routine			
	responded to Reside	nt #71 fall stated she had			visits to check on the resident.			
	gone to Resident #71	I's room to find Resident #71						
	and she went to all th	ne halls and could not find			10/10/2018: Residents are monitored to	-		
	her. She further state	ed she asked Resident #71's			nurses and CNA's during routine round			
		where Resident #71 was,			at all times including while sitting outside			
	-	w. She then stated the			Residents noted sitting for extended tir			
		ard her asking for Resident			should be 1. Offered fluids (fluids may	be		
		Nurse #1 Resident #71 was			obtained from the lobby from the			
		dd because she was not			beverage dispenser that is replenished	i		
		de unattended. Hospice			twice a day by the kitchen staff), 2.			
	Nurse #1 stated the r				Sunscreen should be applied as neede	∌d		
		nt not go outside without			to exposed extremities and face of	•		
		of an incident the week			residents sitting for extended periods of)Τ		
		she stayed outside too long			time in the sun (sunscreen can be			
	_	Hospice Nurse #1 stated she			obtained from each nurses cart), 3.			
		ident #71's forearms and she lide #1 place cream on			Residents should be monitored for	rina		
	•	and wrap them. She stated			clothing appropriate to the season (dur warm months residents are not dresse	•		
		said it might have been			heavy coats placing them at risk for	u III		
		outside in the sun too long			overheating and during cold months			
	_	e further stated other staff in			residents are not wearing clothing			
		o let Resident #71 outside			generally worn during warm months su	ıch		
	•	taff member who took			as shorts that could cause cold exposu			
		e did not know because she			concerns such as hypothermia), 4.			
		outside. Hospice Nurse #1			Signage has been placed in the lobby			
		going outside and heard			next to the beverage dispenser alerting	ן		
		eed a nurse outside." When			visitors and families of the location of	•		
		of the building she saw			sunscreen, how to attain additional flui	ds,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245240	D WING			С	
		345218	B. WING _			0/11/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE		
MARY GR	AN NURSING CENTER			120 SOUTHWOOD DRIVE			
MAKI OK	AN NOROMO OLIVILI			CLINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From pag	ge 26	F 6	89			
		against the curb in the		and who to contact if concer	ne arica		
		g spot across the parking lot		regarding residents sitting o			
		Nursing Student was with		porch.	ir the hont		
		as brushing ants off her. She		poron.			
		Student was in his car in the		Residents at risk for eld	pement are		
		erved Resident #71 sustain a		identified by this facility by p	•		
		. She further stated the		picture of the resident in an	-		
		her she was trying to pick		Risk notebook that is located	•		
		e parking lot and had tumbled		nurse's station, receptionist			
	out of the chair and	he responded to her		poster at the time clock. It is	each		
	immediately. She st	ated Resident #71 did not hit		employee's responsibility to	review this		
	her head. Hospice N	Nurse #1 stated she assessed		notebook at the beginning o	f each shift so		
		nere were no signs of injuries,		that you are familiar with res	sidents who		
		ng on her which she and the		are at risk.			
	_	shed off Resident #71. She		The Director of Nursing is re	•		
		ason Resident #71 was not to		ensuring the elopement risk	notebooks		
		ended was because she		and poster are up to date.			
		ome back in and had poor		If a resident begins to e			
	_	She further stated Nurse #2		seeking behaviors such as s			
		71 on 10/2/18 knew Resident utside alone. Hospice Nurse		periods of time at the doors,			
	#1 concluded Resid	•		exit doors, exhibits anxiousr leaving or expecting a family			
		her wheelchair and must		arrive, and other activities the			
		elf to the other side of the		trying to leave the facility or			
		curb where she sustained her		that they want to leave or ar	-		
	fall.			leave. Notify the Nurse imm			
				Redirect the resident by end			
	During an interview	on 10/9/18 at 11:06 AM Nurse		them to participate in activiti	• •		
	_	amiliar with Resident #71's		enjoy or meeting physical ne	•		
	care. She further sta	ated Resident #71 would think		toileting or hunger/thirst. As	sess for		
	she could do what s	he used to be able to do.		evidence of pain and addres			
		to come and go in the facility		indicated. The care plan/kar			
	-	n she was in assisted living,		resource for additional interv			
	but now needed mo			Once the resident starts	•		
		e further stated Resident #71		seeking behavior, if the inter			
		supervision when outside.		not effective in redirecting th			
		sident #71 was to be on one		then one-on-one should be			
		since August of 2018. She		you should call the Administ			
	turther stated on 10	/2/18 one of the nursing		when this occurs. The MD, I	≺P, DON, &		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			7 501251	_		(С	
		345218	B. WING				11/2018	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MARY GR	AN NURSING CENTER				20 SOUTHWOOD DRIVE			
MAKI OK	AN NOROING GENTER			С	LINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Resident #71 had eat	ent #71 in the parking lot. ten her breakfast, got up in	F	689	Administrator should be notified of the seeking behavior for further interventio	ns.		
	further stated she did outside and instead, locked door where the	It in the hall. Nurse #2 Inot take Resident #71 Resident #71 scooted to the e Activities Director opened she was heading to stand			 If new exit seeking behavior is not check the resident's vital signs and assess for a change in condition. Notify MD of the findings. Changes in condition that could af 	/		
	up meeting. Nurse #2 must have proceeded She further stated the	2 stated Resident #71 then d to go out the front door. e Activities director did not owed to go outside on her			a resident's safety include: new or worsening: confusion, behavioral changes, level of cognition, or mood changes. If you notice any of these			
	own and needed ano Nurse #2 stated Resi repositioned in her ch	ther person to sit with her. dent #71 needed to be nair often through the day			changes in your resident notify the nur- for assessment and MD notification if indicated.	se		
	risk for falls. She furth	lump in her chair and was at ner stated she spoken with and educated her. She ministrator had also			 If the resident does not have a wander guard band on, then initiate on Additional wander guard bands are located in the top drawer of desk in EN 			
	educated staff to not unattended since her	allow Resident #71 outside return in August 2018. She ras a wandering poster			back up computer office at end of 400 beside nurses station. The CNA's check placement of the	hall		
	board next to the time nurse's station. She placed her on that list	e clock as well as near the further stated they had not t prior to the fall on 10/2/18 she had not been placed on			wander bracelet q shift and this is documented on the electronic charting POC. If the bracelet is not found on the resident, immediately notify the nurse fa replacement.	in :		
		n 10/9/18 at 11:29 AM the			 Function of wander guards is completed by the 11-7 shift nurse. This 			
	the standup meeting	ted she was on her way to which started at 9:15 AM s right behind her as she			 check is documented on the eMAR. If an elopements occurs, complete incident report with notification of MD a 			
	went through the doo Resident #71 to go or	r and she held the door for ut of the locked area of the Director stated she then			RP. You must also immediately notify t Administrator or Director of Nursing. Any time an exit door alarm sound	he		
	went to the conference went in as Resident # door. The Activities D	the room door on that hall and #71 was heading to the front princetor further stated at that have Resident #71 was not to			a squeal box alarms, then a staff mem must immediately physically go to that door and check to see if a resident has exited or attempted to exit before reset	oer		
		tended by staff. She stated			the alarm.	-		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345218	B. WING) 11/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	11/2010	
					20 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER				CLINTON, NC 28329			
	OLIMAN DV OT	ATEMENT OF REFIGIENCIES			T			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	e 28	F	689				
		id her fall in the parking lot,	•	000	At no time can a staff member disa	ahla		
		nformed her Resident #71			an exit door/wander guard system alar			
		ocked area unattended by			without the knowledge and approval of			
		ed sometimes the staff send			Administrator or DON.	uio		
		forming them of who could			, tarrimination of Bort.			
		ked area unattended and			All Staff:			
	other times the staff v	erbally inform her of who			Wander guard system			
		ed area unattended. She			We have a wander guard system that w	vill		
	further stated the only	reason she held the door			alarm if a resident is trying to leave the			
	open for Resident #7	1 on 10/2/18 was because			facility. This system will alarm when a			
	she was unaware Re	sident #71 was to be under			resident comes through the double doo	ors		
	•	side the locked area of the			on the front hall way and after they mo			
	-	her no one told her, she			past the first conference room door bef	ore		
	missed the email, or i	no email was sent.			nearing the second conference room door.			
	During an interview o	n 10/9/18 at 11:47 AM						
	Hospice Nurse Aide #	#1 stated she had cared for			IF AN ALARM SOUNDS			
	Resident #71 since S	eptember 2018 when she			Staff should quickly respond to the	;		
	was placed on hospic	ce care. She further stated			location and determine the cause of the)		
	Resident #71 was ab	le to self-propel herself with			alarm.			
		stated she helped a nursing			If it is possible that a resident has	left		
	_	#71 bathed and up for the			the facility then implement the missing			
		she had her fall. She further			person procedure.			
		clean and positioned in her			Complete an incident report for QA	4		
		next hospice resident and			follow up.			
		#71 for the rest of the day.			- EMEDOENCY CANITOLI			
		ther stated she was told			EMERGENCY SWITCH There is an emergency quiteb that	· io		
		fall the next day on 10/3/18. ide further stated ever since			o There is an emergency switch that covered at each door. This is only to be			
	•	en placed on hospice care			used in the case of emergency.	C		
		have supervision when			o There is an alarmed cover over th	is		
		a of the facility. She further			switch.			
	_	n was needed because						
		to slump in her chair and			WHEN THE SYSTEM MAY NOT WOR	K		
	was at risk to falling from her chair, so she • The system shuts down anytime the							
	_	oned in her chair often. She			fire alarm is sounded. During this time			
		spice Nurse #1 would inform			at risk residents should be monitored a			
	her which residents re	equired supervision when			exit doors checked to ensure residents	do		
		d Resident #71 had alwavs			not exit during the fire alarm. All doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			С	
		345218	B. WING _			1 10)/11/2018	
NAME OF PI	ROVIDER OR SUPPLIER	.	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, ., ., ., ., ., ., ., ., ., ., ., ., .,</u>		
				1:	20 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER	₹			CLINTON, NC 28329			
(VA) ID	STIMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(Y5)	
(X4) ID PREFIX TAG	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 689	Continued From pa	ige 29	F	689				
	· ·	ded supervision when outside.			should be checked to make sure that t	hev		
	Soon one who have	add daportioidir mileir dateide.			lock back after the fire alarm is finishe	-		
	During an interview	on 10/9/18 at 1:56 PM the			The charge nurses responsible for tha			
	_	stated she had not been			area should check. Main doors and			
	_	1 had been outside the			employee entrance should be checked	d by		
	previous week on 9	0/26/18 and overheated until			the 100 hall nurse for all 3 shifts.			
	after Resident #71	s fall on 10/2/18. She further			If a resident stands (the alarm will	be		
		nbers brought the concern to			sounding) at the door for more than 20			
		esident #71 had been outside			seconds and applies pressure the doc			
	_	ated or had a decline safety			will release. If a resident is seen stand	ding		
		ther stated sitting outside was			at the door they should be redirected.			
		al for Resident #71 and she			Any time the system is not function The property the administrator and	ning		
		ed any one on one care and no brought to her by staff prior to			properly the administrator and maintenance director should be			
		nt #71's Responsible Party and			immediately notified.			
		nt Resident #71 outside			For Nurses			
		they had a meeting after the			When completing the risk assessment			
		eting following Resident #71's			UDA:			
	_	then did inform the Director of			Risk assessments are completed	on		
	Nursing about the o	concern of the family and			all new admissions and readmissions			
	Nurse #2 informed	the Director of Nursing that			quarterly reviews. Once the UDA is			
	Resident #71's resp	oonsible party had wanted			completed review the score by clicking	ງ on		
	Resident #71 to no	t be outside unattended. She			the score beside the completed			
		mily member shared a			assessment. If the Skilled resident sco			
		f member it was her			moderate (5-10) or high (11 or higher)			
		e staff member brings that			elopement risk then apply a wander gu	Jard		
		inistrative staff to follow up on.			bracelet and enter batch orders for			
		Nurse #2 did not bring the			bracelet function and placement check			
		inistrative staff and should of Nursing concluded to her			The bracelet must remain in place unt reviewed by the DON and QOL team.	d		
		nt #71 had been in the facility			 During the daily Clinical meeting 			
		ssisted living and had recently			review, the DON will ensure that with	each		
	_	skilled nursing unit following			newly identified resident at risk for	, 3011		
		but she had always been let			elopement that the resident's picture is	3		
	outside unsupervis				placed in each Elopement Risk notebo			
	,				within 72 hours of identification.			
	During an interview	on 10/9/18 at 2:16 PM the			Physician's orders will be initiated by t	he		
	_	d Resident #71 had been			hall nurse who completes the Risk UD	Α		
	having some chang	ges recently and he felt it would			that identifies the resident at risk for			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI			١ ,	С
		345218	B. WING			l) 11/2018
NAME OF PI	ROVIDER OR SUPPLIER	ı		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 .0,	12010
				12	20 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER			С	LINTON, NC 28329		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	e 30	F	689			
	be best for the wande		•		elopement when the score is generate	4	
		0/2/18. He further stated the			clopement when the score is generate	u.	
	_	Resident #71 had been			Conclusion		
		ed period and a guest was			Remember to monitor all residents	for	
		oo warm. He further stated			location and safety needs on routine		
	he was not aware of	the blisters to the resident's			visits.		
	right arm until after th	ne fall on 10/2/18 but			 When exit seeking behavior is not 	ed,	
		ry lethargic when she came			try to redirect the resident. If the reside	nt	
		neone was concerned she			is not redirectable, then initiate one on		
		er stated from that point he			one and notify the Administrator and		
		sure they were aware of her			initiate a wander guard band. Assess f		
		ecautions. He further stated			change in condition and notify the R/P	and	
		en outside every day since			MD.		
		acility for years and because creasing he wanted staff to			If you have questions or need clarificat	ion	
	_	ne was. He further stated no			please contact your nurse	1011	
		is attention that Resident			manager/Director of Nursing.		
		rty had requested Resident			internagen 2 ii eeter er i tereinig.		
	#71 not be left outside				Resources		
		ated he was not aware that			Please provide supporting resources		
	front line nurses and	nurse aides had not been			including:		
	allowing Resident #7	1 to go outside unsupervised			Resident safety and health progra	m	
	and thought it had alv	ways been her routine to go			and Liberty Elopement Policy and		
		ated if a family member			Procedure		
		ch as supervision while			On 10/05/2018 the Nurse Consultant		
		ion, it was his expectation			educated the Director of Nursing on		
		bring this concern to the			reviewing residents with a moderate ar	nd	
		ition to be addressed in the			high score for risk of elopement daily		
		meetings. He further stated			Monday through Friday in the Clinical		
	-	cation verbally to staff to			quality of life meeting for the need of	2	
		are of where Resident #71 utside following the incident			wander guard placement or supervisio When a risk assessment is completed		
		concerned about her			a resident on admission, quarterly, and		
	overheating. He furth				with significant changes the elopement		
		#71's nurse and nurse aide			risk score will populate to the point clic		
	•	esident #71's location on			care dashboard for review. If the reside		
		spice nurse was asking			is independently mobile and has a BIM		
	where her location wa	· -			score of 11 or less then the resident is		
		0/2/18 he met with the			be reviewed for the need of a wander		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
						(С	
		345218	B. WING _			10/	11/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				12	20 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER			С	LINTON, NC 28329			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 689	Continued From page	2 31	F 6	889				
	responsible party and	I she shared with him she			guard placement and or supervision wl	nen		
	had spoken to an unn	named staff member that			going outside.			
		#71 to have supervision			The Staff Development Coordinator wil			
	while outside. He furtl	her stated this was the first			ensure that any employee who has not			
	time he had heard this				received this training by 10/09/2018 wi			
		ce a wander guard on			not be allowed to work until the training	j is		
	Resident #71 followin	g the fall on 10/2/18.			completed. As of 10/09/2018			
	, .	40/0/40 11 11/4			approximately 50% of employees have			
	_	n 10/9/18 Nurse Aide #1			received this training. This in-service			
		moved fast since she came			included the following topics:			
		she did not keep up with			Indicate how the facility plans to monito)ľ		
		uld disappear. She further eep up with where Resident			its performance to make sure that solutions are sustained.			
		aide stated Resident #71			The Director of Nursing or Staff			
		herself when she was on			Development Coordinator will complete	2		
		e of the facility. She further			the Quality Assurance (QA) for residen			
		e to the skilled unit at some			safety daily Monday thru Friday times 2			
		018 Resident #71 was not to			weeks then monthly x three months:			
	·	unsupervised by staff. If			monitoring will include observing reside	ents		
	Resident #71 wanted				sitting outside for safety concerns such			
	member would need t	to go outside with her. She			overheating, incontinence care, safety			
	further stated she was	s made aware of this by			issues. In addition to this a quality			
		esident #71 was not to go			assurance monitor will be completed to)		
		supervised. She further			review residents with a newly complete			
		ow anything about her being			risk assessment to audit the elopemen			
		ed period of time or getting			risk score for appropriate interventions			
	overheated. She cond				This monitor will be completed by the			
		71 was not supposed to be			Nurse consultant on 5 residents weekly			
		nce sometime in September			for 2 weeks then monthly for 3 months.			
		rs would let her outside and			Reports will be presented to the weekly	/		
		ing her back in and educate			QA committee by the Administrator or	,		
	the visitors.				Director of Nursing to ensure corrective action is initiated as appropriate.	-		
	During an interview o	n 10/9/18 at 3:50 PM Nurse			Compliance will be monitored and			
		miliar with Resident #71's			ongoing auditing program reviewed at	the		
		ed Resident #71 was not to			weekly QA Meeting. The weekly QA			
		ervised during her shifts.			Meeting is attended by the Administrate	or.		
	•	s was due to her cognitive			DON, MDS Coordinator, Therapy, HIM			
		ved to the skilled nursing			and the Dietary Manager.	,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING _				C 11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE LINTON, NC 28329	1 10/	11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 689	side in August on 201 did not know what off she stated she did no Resident #71 being of to ask visitors or staff unsupervised outside. During an interview of Administrator stated hedocumentation regard when the resident was lethargic and the warm. During observation or distance Resident #7 to the area she sustain measured with the Plabe 68 feet. During an interview of Nurse #2 stated some #71's fall on 10/2/18, brought Resident #71 because she had overy warm. Unit Manaby the nurse station at Resident #71 had got Resident #71's Nurse did an assessment of stated Resident #71's and then had placed #71 was lethargic and been in the morning. had told other nurse at Resident #71 was not	8. She further stated she her did on their shifts, and t report her concern for utside unsupervised except to not let her be 10/9/18 at 4:24 PM the he did not have any ling the incident on 9/26/18 s brought in by a visitor and her was a concern she was 10/9/18 at 5:35 PM the her traveled from the entrance hed a witnessed fall was hant Operations Supervisor to 10/10/18 at 8:08 AM her time prior to Resident her told Nurse #2 that her over heated. She stated her practitioner and Nurse #2 Resident #71. She further her in her chair for a while her in her room. Resident her in her room. Resident horse #2 further stated she	F	689	The administrator is responsible for assuring the implementation of the credible allegation. Completion date 10/10/2018			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							C
		345218	B. WING			10/	11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHWOOD DRIVE LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Resident #71's Nurse Resident #71 was in living section of the fa Nurse Practitioner star much more than the familiar with Resident stated Resident #71 decline in status with deterioration of her kithen went to the hosp August 2018 very defunction decline. The with the family and the make the resident at stated when Resident she was able to make once she returned from 2018 she had a very She further stated on outside in the sun and a sunburn with some possibly related to kit stated she did not do anywhere because hon Resident #71. She incident she believed Resident #71 more coutside. She further she seident #71 on 10/10 opened and were itch had ordered cetirizing Practitioner conclude in safety awareness she agreed with the guard for safety and cognizant of where she	en 10/10/18 at 8:18 AM e Practitioner stated the facility in the assisted acility for a long time. The ated she saw Resident #71 physician and was very t #71. The Nurse Practitioner had sustained a gradual a huge bump in dney function. Resident #71 pital and came back in politiated due to her kidney Nurse Practitioner spoke the decision was made to the prospice resident. She further t #71 was in assisted living the safety decisions, however, the hospital in August the hospital in August the facility staff supervised the facility staff super	F	689			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345218	B. WING				11/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 .0,	20.0
				1	20 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER				CLINTON, NC 28329		
(V4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
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F 689	Continued From page	24	_	000			
1 003				689			
	Nurse #1 stated if the						
		nt it would be brought to					
		ntion by the floor nurse and					
		interdisciplinary team on the care plan. She					
		ident began to have a					
	cognitive or functiona						
		rontline staff would notify the					
		to address the decline in					
		ne care plan. She further					
		had sustained a severe					
		me back to the facility from					
		t 2018. She further stated					
		and cognitive awareness					
	-	ollowing her hospitalization					
	and she was then pla	iced on hospice in					
	September 2018. She	e further stated if Resident					
	#71 went outside it w	as supposed to be with					
		pervise her outside and					
		t to be outside by herself. If it					
		going outside by herself the					
	· •	and bring her back on the					
		ed Resident #71 would					
	, ,	ed door and if a visitor came					
		to hold the door for her and					
		out to the front of the facility. e cared for Resident #71					
		back from the hospital on the it #71 hardly got out of bed					
		further stated once she					
	_	Resident #71 began getting					
		ne stated it was around the					
	I -	ber 2018 when Resident #71					
		and at that time MDS Nurse					
		dent #71 on her unit and did					
		had reported the concern of					
		or. MDS Nurse #1 stated it					
		standing among the frontline					
	_	es Resident #71 was not to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345218	B. WING			C 10/11/2018		
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DRIVE CLINTON, NC 28329	DDE	10/11/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 689	why it was not known Administrator, or othe interdisciplinary team have Resident #71 or hall so she would as was okay to go outsi and Nurse #2 would to be supervised outstated Resident #71 the facility since her August 2018. MDS Nothe expectation that of Resident #71's charge nurse, MDS Nothe door, and decreat charge nurse, MDS Nothe the door, and decreat charge nurse, MDS Nothe the door, and decreat charge nurse, MDS Nother the door, and decreated with Unit Manager #1 stated as she was returning to break with Unit Manager #71's unit manager. Coming into the front and a visitor was bring from outside and said seem like herself and Resident #71 inside.	sed and she did not know in by the Director of Nursing, ser members of the in. She stated she did not ince she moved to the 300 k Nurse #2 if Resident #71 de before opening the door itell her no, Resident #71 had side the facility. She further was to be supervised outside return from the hospital in lurse #1 further stated it was Nurse #2 bring the concern range in condition, waiting by sed safety awareness to the Nurse for care planning, and the physician. In 10/10/18 at 12:40 PM Unit pproximately two weeks ago the facility from her lunch ranger #2 who was Resident She further stated they were of the building around 1 PM ranging Resident #71 inside that Resident #71 didn't it dasked them to help her get Unit Manager #1 stated they	F	689				
	#71's Nurse Practition stated she took Resistated she took Resistated she took Resistated she did not recall any vital significant for her blood sugfurther stated she did not resident #71 at the	ere Nurse #2 and Resident ner were. Unit Manager #1 dent #71's vital signs, oxygen od sugars because Resident it Manager #1 stated she did gns being abnormal at that gar being abnormal. She if not do a skin assessment nat time. She stated if I her Resident #71 was not de or needed to be						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING			C 10/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	she thought Reside unsupervised. She was not outside with was brought in by a other residents and Resident #71. She if would sit at the lock to open the door an further stated after if was aware Residen however prior to 10 members, or hospic did not want Resided. During an interview Hospice Nurse Aide Nurse #1 told her al #71's arms Hospice cream to Resident # She further stated the weeks ago but did in stated when she first forearms it looked liskin was peeling, ar scratching at it. She on Resident #71's for She further stated in to heal and they we right forearm. During an interview Manager #2 stated in the interview Manager #3 stated in the interview Manager #4 stated in the interview Manager #5 stated in the interview Manager #6 stated in the interview M6 stated in the interview M7 stated in the interview M6	ge 36 have been alarming because int #71 could go outside further stated a staff member in Resident #71 on the day she concerned visitor, however visitors were outside with further stated Resident #71 led door and wait for someone id let her go outside. She her fall outside on 10/2/18 she it #71 needed supervision, 12/18 no staff, family le staff had informed her they int #71 outside unsupervised. On 10/2/18 at 2:02 PM led #1 stated when Hospice lout the blisters to Resident Nurse #1 asked her to place led #71's blisters and wrap them. In his happened about two loot remember the date. She lot observed Resident #71's like a sun burn because her lind Resident #71 was stated she placed the cream orearms and wrapped them. Ow the left arm had appeared are currently only wrapping the on 10/10/18 at 2:14 PM Unit she was coming back from with Unit Manager #1 le stopped Unit Manager #1 le thing to her about Resident led #71 back	F 6	89			

02.11.2.1	O I OIT INLEDIO ITE G	. OLIVIOLO				U D 110	. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345218	B. WING				11/2018
NAME OF PR	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	20 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER			c	CLINTON, NC 28329		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
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F 689	Continued From page	e 37	F	689			
	in to the facility. Unit I	Manager #2 stated Unit					
	•	Resident #71 to Nurse #2					
		e #2 she had been stopped					
		concern about Resident					
	#71's health. She furt	her stated Unit Manager #1					
	and Nurse #2 did an	assessment on Resident					
	#71 and everything se	eemed okay. Unit Manager					
	#2 further stated at th	at time to her knowledge no					
		done. She further stated					
		en the blisters to Resident					
		ed but they were brought to					
		18. Unit Manager #2 stated					
	it was brought to her						
		's nurse had documented a					
		r documentation. She					
		s not aware of any blisters to					
		m that Hospice Nurse #1					
	•	ide #1 wrapped on 9/27/18. en Resident #71 was on the					
		ne was able to self-propel.					
	_	turned from the hospital to					
) hall but was not as active.					
		ner since Resident #71 went					
		/18 she began to self-propel					
		gain. She further stated					
	_	yays had a routine of going					
		der the car port when she					
	was in assisted living	. She further stated prior to					
	10/2/18 she would ha	ve opened the door and let					
	the resident go outsid	le unsupervised. Unit					
		o staff, family members, or					
		ught to her attention their					
	concerns with Reside	5 5					
		. She further stated it was					
	her expectation that it	•					
		report to her and she could					
		implementing a plan and					
	updating the care pla	n.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	_	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER AN NURSING CENTER	343210	STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		/E	10/11/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 689	Director of Nursing sinew formal risk assessment since he when she was on the Nurse Aide #1 stated 300 hall in September since that time Residuated by staff. The Administrator an immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopardy of 10/10/18 at 4:30 AM following credible alle immediate jeopar	n 10/10/18 at 5:25 PM the ated Resident #71 had no sement or elopement risk r admission on 8/10/18 100 hall. n 10/11/18 at 10:30 AM Resident #71 came to the r of 2018. She further stated ent #71 was not to go ea of the facility represes. d DON were notified of the on 10/9/18 at 4:35 PM. On the facility provided the egation of compliance for emoval: or Supervision to prevent ve action will be see residents found to have deficient practice. I sident had been sitting orch when a visitor assisted and alerted the Unit red around 1PM. The disack to her unit by the Unit	F	589			
		lanager reported to her that n brought in from outside					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDING		TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 10/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 120 SOUTHWOOD DRIVE CLINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pag	e 39	F	689			
	doors. The Unit Many signs and reported the signs and reported the "well within her norm not appear to be in at that she was aware of alone as she has see front porch frequently with this activity. No required due to this element and noted be arm. The resident was this area. The hospic aide to apply cream to prevent the reside and to trim her nails. this was completed and to trim her nails. this was completed and to trim her nails. this was completed and to trim her nails. The resident required supervision. Corrective a resident: On 10/02/20 assigned a wander g from going outside un safety risk. On 10/02/2018 the Dand assessed the resident was assisted onto the front hall was the resident proceed to sit on the front por	Director of Nursing and the d discussed the incident side and determined the root was that the resident now while outside. Incition for the affected D18 the resident was uard bracelet to prevent her insupervised due to her dischard for the need of wander dischard for the need of wander dischard for the duble doors of the proximately 9:15AM the dischard for the duble doors of the proximately 9:15AM the dischard for the foot doors of the proximately 9:15AM the dischard for the foot doors of the proximately 9:15AM the dischard for the foot doors of the proximately 9:15AM the dischard for the foot doors of the proximal routine.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 10/11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	 	10/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	resident still sitting or approximately 9:45A 10:15AM the resident in her wheel chair as ground and fell out or resident did not sustathis fall. The fall occur and the first handical hospice nurse was in assess the resident. completed the reside and the responsible play the hospice nurse On 10/02/2018 the DAdministrator met and determined the root of that the resident now outside. Corrective and On 10/02/2018 the rewarder guard bracel outside unsupervised Address how the facing residents having the the same deficient promotes and ran a report from residents 'elopemer months to audit for a high risk for elopemer score of moderate or were then reviewed for status when up in the they had a BIMS of 1 need for wander guards.	vity assistant observed the in the front porch at M. At approximately it was observed leaning over to pick something up off the if her wheel chair. The ain an injury as a result of arred between the canopy oped parking spot. The inmediately summoned to After assessment was and the Director of Nursing. Firector of Nursing and the discussed the incident and cause of the incident was a required supervision while action for affected resident: esident was assigned a let to prevent her from going in due to her safety risk. Illity will identify other potential to be affected by actice. Ensure Quality) was initiated 0/05/2018, the Director of audit of all current residents	F	589		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345218	B. WING			C 10/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 120 SOUTHWOOD DRIVE CLINTON, NC 28329	DE	10/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	were reviewed by the Nurse Consultant for placement or superviewed by the Nurse Consultant for placement or supervision 10/08/2018. There were identified as not bracelet or supervision Address what meast systemic changes in deficient practice will On 10/05/2018 the SC Coordinator, began if time, and as needed monitoring. Topics in All Staff: Do not forgund supervision are resident safety. This aware of the resident the wander guard syresident supervision. In addition as elopement risk shifter location. Reside or out in the courtyal location, hydration, a include falls, dehydratiolieting, and rest periouside throughout your the resident refuses patients who like to so of time to use sunsciprevent adverse ever check on the resident	o were independently mobile e Director of Nursing and the need of a wander guard ision due to potential over g outside. This was finalized e were no new residents that reding a wander guard on while outside. Ures will be put into place or ade to ensure that the I not recur. Staff Development on-servicing all full time, part staff on resident safety and oncluded: Let that frequent monitoring oneeded in order to ensure of means that you should be of t's location. Do not accept stem as a substitution for to this, residents not identified could also be monitored for ents that sit on the front porch ods should be monitored for and safety needs. Risk action, sun burn. Offer fluids, riods by coming in from our shift. Notify the nurse if to come in. Encourage sit outdoors for long periods onts. Make routine visits to	F	689			
	and CNA's during re	outine rounds at all times g outside. Residents noted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C 0/11/2018	
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		10/11/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
sitting fluids the be a day be appliance of time in each reach rea	(fluids may be everage dispender by the kitchen oblied as needed fresidents sitting the sun (sunspection of control of the sun of sunscreed in the longer alerting vision of sunscreed and who to cooling residents as it is a feet of the sun of sunscreed at each nursuand a poster and	imes should be 1. Offered obtained from the lobby from ser that is replenished twice staff), 2. Sunscreen should do to exposed extremities and any for extended periods of screen can be obtained from Residents should be grappropriate to the season is residents are not dressed in them at risk for overheating this residents are not wearing orn during warm months such cause cold exposure pothermia), 4. Signage has abby next to the beverage sitors and families of the interest in the front porch. At risk for elopement are lity by placing a picture of the ment Risk notebook that is et a station, receptionist to the time clock. It is each sibility to review this notebook ach shift so that you are so who are at risk. In gis responsible for ent risk notebooks and	F6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG			ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page		F	689			
	encouraging them to they enjoy or meeting toileting or hunger/thipain and address as plan/kardex is a good interventions. Once the reseeking behavior, if the exit seeking behavior, and the exit seeking the exit seeking in the exit seeking in condition. If new exit seeking in condition. Changes in condition. Changes in condition. Changes in resident 's safety incomposition of the exit seeking in condition. The exit seeking in condition. The changes in your residual assessment and MD. If the reside guard bands of desk in EMAR back of 400 hall beside nuther the exit seeking in the exi	sident starts exhibiting exit he interventions are not g the behavior, then e initiated and you should or DON when this occurs. Administrator should be eking behavior for further eeking behavior is noted, vital signs and assess for a Notify MD of the findings. condition that could affect a lude: new or worsening: I changes, level of cognition, you notice any of these lent notify the nurse for notification if indicated. In the does not have a wander initiate one. Additional are located in the top drawer k up computer office at end rses station. Check placement of the ift and this is documented on g in POC. If the bracelet is dent, immediately notify the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER AN NURSING CENTER	0.02.0	STREET ADDRESS, CITY, STATE, ZIP C 120 SOUTHWOOD DRIVE CLINTON, NC 28329				
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F 689	squeal box alarms, the immediately physical to see if a resident has before resetting the analysis and the second of the process of the proce	diately notify the ctor of Nursing. exit door alarm sounds or a men a staff member must ly go to that door and check as exited or attempted to exit alarm. It an a staff member disable an ard system alarm without the eval of the Administrator or muard system that will alarm if leave the facility. This en a resident comes through the front hall way and after rest conference room door.	F6				
	EMERGENG There is an eme at each door. This is of emergency. There is an alar WHEN THE SYSTEM The system	CY SWITCH rgency switch that is covered only to be used in the case med cover over this switch. M MAY NOT WORK shuts down anytime the fire uring this time, all at risk					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		` ′	(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		107112010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	checked to ensure re the fire alarm. All doc make sure that they I is finished. The chark that area should chec employee entrance s hall nurse for all 3 sh If a resident sounding) at the door and applies pressure resident is seen stand be redirected. Any time the properly the administ director should be im For Nurses When completing the Risk assess new admissions and reviews. Once the UI score by clicking on t completed assessme scores moderate (5-1 elopement risk then a bracelet and enter ba function and placeme must remain in place and QOL team. During the co the DON will ensure to identified resident at resident's picture is Risk notebook within Physician's orders w nurse who completes	monitored and exit doors sidents do not exit during ors should be checked to ock back after the fire alarm ge nurses responsible for ck. Main doors and hould be checked by the 100 iffs. stands (the alarm will be for more than 20 seconds the door will release. If a ding at the door they should be system is not functioning rator and maintenance mediately notified. The risk assessment UDA: The ments are completed on all readmissions and quarterly DA is completed review the he score beside the sent. If the Skilled resident allo) or high (11 or higher) for apply a wander guard atch orders for bracelet until reviewed by the DON daily Clinical meeting review,	F	889			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION	
F 689	location and safety when exit to redirect the reside redirectable, then in the Administrator are band. Assess for a centre the R/P and MD. If you have question contact your nurse of the R/P and MD. If you have question contact your nurse of the R/P and MD. If you have question contact your nurse of the R/P and MD. Resources Please provide support of the Director of Nurs with a moderate and elopement daily Mo Clinical quality of life wander guard place risk assessment is admission, quarterly the elopement risk solick care dashboard independently mobilion ress then the resined of a wander guard place of a wander guard place of a wander guard place was the staff Development that any employee was training by 10/09/20 until the training is capproximately 50% this training. This in following topics:	r to monitor all residents for needs on routine visits. seeking behavior is noted, try ent. If the resident is not itiate one on one and notify id initiate a wander guard change in condition and notify as or need clarification please manager/Director of Nursing. Porting resources including: afety and health program and Policy and Procedure Nurse Consultant educated ing on reviewing residents at high score for risk of inday through Friday in the emeeting for the need of ment or supervision. When a completed on a resident on a resident on a review. If the resident is the and has a BIMS score of 11 dent is to be reviewed for the uard placement and or	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 10/11/2018	
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 120 SOUTHWOOD DRIVE CLINTON, NC 28329	•			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 689	sustained. The Director of Nursin Coordinator will comp (QA) for resident safet times 2 weeks then monitoring will include outside for safety conincontinence care, sathis a quality assurant to review residents w assessment to audit the appropriate interventic completed by the Nurweekly for 2 weeks the Reports will be prese committee by the Adr Nursing to ensure conappropriate. Compliate ongoing auditing proguent on the Administrator, Therapy, HIM, and the The administrator is removal was validate which removed the In 10/10/18, as evidence in-service record revises included inforces assessments and how identification of reside elopement, and what appears to be at risk in the safe times.	and or Staff Development oblete the Quality Assurance observing residents sitting ocerns such as overheating, fety issues. In addition to oce monitor will be completed of the anewly completed risk of the elopement risk score for ons. This monitor will be see consultant on 5 residents of the monthly for 3 months. Inted to the weekly QA of the elopement of of the elopement.	F 6			10/21/19	
F 690	Bowel/Bladder Incont	inence, Catheter, UTI	F 6	90		10/31/18	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		LETED
		345218	B. WING			C 11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	<u> </u>	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 690 SS=D	resident who is continuadmission receives a maintain continence of condition is or become not possible to maintain systems. See the comprehensive assessment that the condition of the condition	nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical nes such that continence is ain. esident with urinary on the resident's ssment, the facility must ters the facility without an not catheterized unless the adition demonstrates that necessary; ters the facility with an r subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's	F 69	90		
	ensure that a resident receives appropriate restore as much norm possible. This REQUIREMENT by:	ssment, the facility must at who is incontinent of bowel treatment and services to mal bowel function as I is not met as evidenced on, staff interviews, and		The statements made on this plar	n of	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G	· ,	E SURVEY MPLETED
		345218	B. WING		1	C 0/11/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	'	0/11/2010
				120 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER			CLINTON, NC 28329		
0(0)15	CHMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR	PECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 690	Continued From page	2 49	F 6	90		
F 690	record review the faci catheter bag from cor for 1 of 2 residents re (Resident #23) Findings included: Resident #23 was ad 9/28/12. His active did hypertension, benign neurogenetic bladder Review of Resident # data set assessment Resident #23 was as independence with demoods or behaviors. extensive assistance and toilet use. Resident dependent on staff for hygiene. The resident indwelling catheter.	lity failed to keep a urinary ming in contact with the floor viewed for catheter care. mitted to the facility on agnoses included prostatic hyperplasia, and 23's most recent minimum dated 7/23/18 revealed sessed as modified ecision making and had no The resident required with bed mobility, eating,	F 6	correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility allegatic compliance such that all alleged deficiencies cited have been or corrected by the dates indicated was obtained on 10/09/2018. On 10/09/2018 the Director of N ensured the bed for resident #23 an appropriate height as to not a catheter bag to touch the floor we resident was resting in bed. Starmembers responsible for the caresident #23 were educated by the Director of nursing regarding po	h the I federal h has taken in this correction ion of d will be d. ve action Jursing 3 was at allow the while ff re of the	
	revealed the resident infections related to the	was care planned for risk of ne presence of a catheter. uded to check catheter		of the bed to prevent catheter be touching the floor.	_	
	tubing for kinks through	ghout shift, position catheter the level of the bladder and oom door, and provide		Corrective action for resider the potential to be affected by the deficient practice.		
	During observation or Resident #23 was ob #23's catheter bag wa the bed frame and the	n 10/8/18 at 11:31 AM served in bed. Resident as observed hanging from be bottom half of the catheter ag on the floor with the bed		All residents with foley catheters potential to be affected by the all deficient practice. On 10/09/201 managers completed an audit of all current residents with foley catheter for correct placement of the fole the bed frame to ensure the fole not touching the floor.	lleged 8, the Unit bserving atheters ey bag on	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	· '	TE SURVEY MPLETED
		345218	B. WING			C 0/11/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/11/2010
MADV CD	AN NURSING CENTER			120 SOUTHWOOD DRIVE		
WARTGR	AN NURSING CENTER			CLINTON, NC 28329		
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 690	Continued From page	e 50	F 69	90		
F 690	During an interview of #1 stated catheter bathe level of the bladder in contact with the flow #23 she stated the rethe floor and it should with the floor due to rethe floor and it should with the floor due to rethe floor and it should with the floor due to rethe floor and it should with the floor due to rethe floor and it should with the floor due to rethe floor f	n 10/8/18 at 11:35 AM Nurse gs were to be placed below er and were to never come or. Upon observing Resident sident's catheter bag was on I not have been in contact isk for infection. n 10/9/18 at 8:43 AM served in bed. Resident as observed hanging from the bottom of the catheter bag in contact with the floor again	F 69	3. Systemic changes In-service education was provided full time, part time, and as needed CNA's, Med Tech's, and Med Aider Topics included: • Why it is import to ensure the bag does not touch the floor. • Where to attach the foley bag frame of the bed in order to prever bag from touching the floor. • Auditing the foley bag for correlacement when making care rour. • Adjusting the height of the been sure bag does not touch floor. This information has been integrat the standard orientation training are required in-service refresher course all nursing staff as stated above as be reviewed by the Quality Assura process to verify that the change he been sustained. 4. Monitoring Procedure to ensute the plan of correction is effective as specific deficiency cited remains contents.	nurses, s. foley on the at the ect ads. d to ed into ad in the es for ad will ance as re that and that	
				and/or in compliance with regulator requirements. The Staff Development Coordinated designee will monitor placement obags weekly x 2 weeks then month months using the Infection control Assurance monitor. Monitoring will auditing placement of the foley bagensuring it does not touch the floor	ry or or f foley nly x 3 Quality include	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
			7 5012511			С
		345218	B. WING _			10/11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690	Continued From page		F 6	Reports will be presented to the we Quality Assurance committee by the Administrator to ensure corrective initiated as appropriate. Compliant be monitored and ongoing auditing program reviewed at the weekly of Assurance Meeting. The weekly of Meeting is attended by the Admin Director of Nursing, MDS Coording Therapy, Health Information Managand the Dietary Manager	the action ace will guality QA istrator,	10/04/40
	Drugs and biologicals labeled in accordance professional principles appropriate accessor instructions, and the eapplicable. §483.45(h) Storage of \$483.45(h)(1) In accordance Federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance \$483.45(h)(2) The fact locked, permanently a storage of controlled of the Comprehensive Drugs Control Act of 1976 at abuse, except when the	of Drugs and Biologicals sused in the facility must be with currently accepted s, and include the y and cautionary expiration date when If Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized	F 7	61		10/31/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI				c
		345218	B. WING				/11/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADV CD	AN NURSING CENTER			12	20 SOUTHWOOD DRIVE		
WARTGR	AN NORSING CENTER			С	LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	by: Based on observation interviews, the facility medication refrigerate and unit 4 refrigerate and unit 4 refrigerate and unit 4 refrigerate and edications, date an refrigerate eye drops for 4 of 4 medication 100/200, 300, 400 and loose medications in reviewed (cart 100/20). Findings included: 1. On 10/10/18 at 4:1 medication room was The Unit 2 medication with a temperature refrahrenheit (F). No telling and could not be local An interview with Nur 10/10/18 at 4:18 PM. refrigerator temps show the dications within the 2- Tuberculin purified milliliter (ml) vials. The indicated to store at 36- Pneumococcal vacable.	ris not met as evidenced ns, record review and staff failed to monitor and report or temperatures for 3 of 3 ors reviewed (unit 1, unit 2 rs), failed to remove expired nulti dose insulin pen, and insulin not yet opened carts reviewed (cart d 800), and failed to discard 3 of 4 medication carts 00, 400 and 800). 8 PM the Unit 1 and 2 robserved with Nurse #1. or refrigerator was observed rading of 22 degrees mperature log was observed atted by Nurse #1. rese #1 was conducted on The nurse stated the bould have been checked. e refrigerator included: protein injection 5/0.1 e medication packaging		761	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 federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. A corrective action for the out of ratemperatures, expired medications was obtained 10/10/2018. Corrective action for loose pills in medication carts was obtained on 10/26/2018. The Director of Nursing removed all medications that were stored in the Un Unit 2, and Unit 4 medication room refrigerators and discarded. All new medications were ordered immediately replacement from McNeill's Pharmacy medication carts were cleaned and loo pills were removed and audited for expired medications by Unit Managers Staff Development Coordinator, and Director of Nursing on 10/26/18.	al ken on ange s n	
	36-46 degrees F. 24- Pneumococcal 13	B-valent conjugate vaccine lication packaging indicated			 Corrective action for residents with the potential to be affected by the alleg deficient practice. 		

PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILDI	NG _			c l
		345218	B. WING			1) /11/2018
NAME OF PRO	OVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADV CDA	N NURSING CENTER			12	20 SOUTHWOOD DRIVE		
WART GRA	N NURSING CENTER			С	LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	ml inhaler doses. The indicated to store at 3 in-Liraglutide injection. The medication packabefore first use- do not indicated to store at 3 in-Liraglutide injection. The medication packaging 1-Humulin R 100 u/m packaging indicated "5-exenatide extended mg/pen. The medicate "Store refrigerated 36 in 4-Humulin 70/30 u-1 medication packaging unopened." 24- Novolog injection medication packaging unopened." 22-Epoetin alfa 10,000 pharmacy label on the "refrigerate immediate 12- Promethazine suppharmacy label on the "refrigerate immediate 22- Promethazine suppharmacy label on the "refrigerate immediate 22- Promethazine suppharmacy label on the "refrigerate immediate 22- Promethazine suppharmacy label on the "refrigerate immediate 23. On 10/10/18 at 4:1 medication room was The Unit 1 medication with a temperature refrigerator. The tempit was for Unit 2, the refrigerator. The tempit was for Unit 2, the refrigerator.	ate 15 micrograms (mcg)/2 e medication packaging 66-46 degrees F. n pen 6 milligrams (mg)/ml. aging indicated "refrigerate of freeze" -100 10 ml vial. The g indicated "do not freeze." If 3 ml vial. The medication refrigerate, do not freeze." If release injection pens 2 ion packaging indicated 6-46 degrees. Do not freeze." Of injection pens. The g indicated "refrigerate pens 100 u/ml. The g indicated "refrigerate until Of units 1 ml vials. A e packaging indicated ely upon receipt." popositories 12.5 mg. A e packaging indicated ely upon receipt." popositories 25 mg. A e packaging indicated ely upon receipt." Popositories 25 mg. A e packaging indicated ely upon receipt." 8 PM the unit 1 and 2 e observed with Nurse #1. In refrigerator was observed fading of 28 degrees eperature log was observed	F	761	All residents have the potential to be affected by the alleged deficient practic On 10/15/2018, the Staff Development Coordinator completed an audit observall current medication room refrigerator for the following: refrigerator temperatulogs in place and filled out daily with the temperature, observed temperatures logged and current temperature to ensithe correct range is noted, and audited each medication in the refrigerator for date opened and expiration dates. All medication carts were audited for expir medications and loose pills. 3. Systemic changes In-service education was provided to a full time, part time, and as needed nursimedication aides, and Medication Tech Topics included: Nightly on 11-7 shift each hall nursinesponsible for logging the medication refrigerator temperatures on Units 1, 2, and 4 prior to midnight. Acceptable medication refrigerator temperature range is 36-46 degrees fahrenheit. What you should do in the event the current temperature falls outside the acceptable temperature range. Who to notify when the temperature falls outside the acceptable temperature range. Proper storage of medications. Medication cart cleaning schedule. Cleaning spills and pills from the	ring rs ire e ure ure ed II ses, r's. se is	

Facility ID: 923329

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			10	C / 11/2018
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1	71172010
					SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER				NTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI	BE	(X5) COMPLETION DATE
					DEFICIENCY)		
F 761	Continued From pag	e 54	F 7	'61			
	temperature log shedindicated "temperature around 4-5 AM by the nurses. Any temperature as 36-46 must be reches in the above range of Nursing)." An interview with Nursing at 4:18 PM refrigerator temps should be reches in the above range of Nursing)." An interview with Nursing at 4:18 PM refrigerator temps should be refrired by the r	et notation at the bottom are must be checked daily e even numbered hall ature not ranging between ecked 1/2 hour later if still not eport to DON (Director of rse #1 was conducted on . The nurse stated the hould have been checked. The refrigerator included: The nebulizer doses. The g indicated to store at 36-77 Ion pen 40 mg/0.8 ml. The g indicated to store at 36-46 and 3 ml vial. The medication "refrigerate, do not freeze" 0 ml vial. The medication "refrigerate until opened." 48 PM the Unit 4 medication "refrigerate until opened." 48 PM the Unit 4 medication with the Director of Nursing medication refrigerator was perature reading of 29 (F). The temperature log e refrigerator indicated it was 18. There was only one entry 18 and noted a refrigerator egrees F. The temperature the bottom indicated		t t r r r r r r r r r r r r r r r r r r	This information has been integrated he standard orientation training and required in-service refresher courses all nurses, Medication Aides, and Medication Tech's and will be reviewed the Quality Assurance process to verified the change has been sustained. 4. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains correction in compliance with regulatory requirements. The Staff Development Coordinator of the staff Development Coordinator Compliance will be monified and ongoing auditing program review the weekly Quality Assurance Meeting in attended to Administrator, Director of Nursing, Michanger, and the Dietary Manager	in the for ed by fy that that ected or m and ons vacy will be trator stored ed at g. by the DS	
	(DON). The Unit 4 m observed with a tem degrees Fahrenheit sheet attached to the for the month of 10/1 on the log for 10/3/1 temperature of 36 de log sheet notation at "temperature must b	perature reading of 29 (F). The temperature log e refrigerator indicated it was 8. There was only one entry and noted a refrigerator egrees F. The temperature		7 A	The weekly QA Meeting is attended by Administrator, Director of Nursing, MI Coordinator, Therapy, Health Informa	y the OS	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	· /	MPLETED
		345218	B. WING _			C 10/11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	I	10/11/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 761	rechecked 1/2 hour I range report to DON On 10/10/18 at 5:48 DON was conducted refrigerator temperat and logged and if the DON should be notif not know why the ter documented on or the Medications within the 9- Acetaminophen 6: packaging indicated 1- Novolin N 10 ml v indicated "keep unop 36-46 degrees F. Do 1- Humulin R U-100 packaging indicated 4. On 10/10/18 at 4:1 medication cart was One 10 ml vial of Hu observed and noted An interview with Nu 10/10/18 at 4:12 PM expired and should hurse also stated the type of insulin. 5. On 10/10/18 at 5:2 observed with Nurse a. One Novolog insuloserved dated as o	ging between 36-46 must be ater if still not in the above." PM an interview with the . The DON stated the ures should be checked daily temps are not in range the ied. The DON stated she did implogs had not been e temps checked. The refrigerator included: The product packaging bened in the refrigerator included: The product packaging benedicted in the product pac	F 7	61		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ' '	ELE CONSTRUCTION	, ,	COMPLETED		
		345218	B. WING			C 10/11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		10/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	observed with the pindicating it had bee marked when the in c. One Xalatan eye the safety seal still indicated it had bee instructions on the bunopened bottle in ftemp for 6 weeks." An interview with Nt. 10/10/18 at 5:23 PM insulin pen was exp discarded and the ir have been marked vistated the eye drops pharmacy the day been discarded and the ir have been marked vistated the eye drops pharmacy the day been discarded and the ir have been marked vistated the eye drops pharmacy the day been discarded and the ir have been marked vistated the eye drops pharmacy the day been discarded and the ir have been discarded and the ir have been marked vistated the eye drops pharmacy the day been discarded and the ir have been discarded with storage until opened, after ir The prescription date. An interview with Nt. 10/11/18 at 8:38 AM pen should have been should have been stock bottle of the expiration date of 7/2 and 10/11/18 at 8:30 and 10/11/11/18 at 8:30 and 10/11/11/11/18 at 8:30 and 10/11/11/11/11/11/11/11/11/11/11/11/11/1	ne injection pen was roduct safety seal broken, in opened. The label was not sulin had been opened. drop bottle was observed with intact. A label on the bottle in opened on 10/9/18. The rottle indicate "Store ridge. Opened store room arse #4 was conducted on in She stated The Novolog ired and should have been insulin glargine pen should when opened. The nurse is had come from the refore and were to start today. 38 AM the 100/200 hall in reviewed with Nurse #1. In injection pen was observed still on, not marked as is instructions to "refrigerate initial use do not refrigerate." in was noted as 10/5/18. arse #1 was conducted on in The nurse stated the insulin in en stored in the refrigerator	F 76			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING				C 11/2018
	ROVIDER OR SUPPLIER AN NURSING CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHWOOD DRIVE CLINTON, NC 28329	1 10/	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE		
F 761	not currently have any medication. She also medications were disk would alert the DON a can review the cart are medications. 8. On 10/10/18 at 4:1 medication cart was read to a cart of 10 lose pills bottom of the second medication cart. 9. On 10/10/18 at 5:2 reviewed with Nurse at 13 loose pills were distincted the left side second distincted to a cart was read to a car	The nurse stated she did y residents receiving this stated when expired covered on the cart she and the next shift so they and check for further expired 2 PM the 800 hall eviewed with Nurse #5. were discovered in the and third drawers of the 3 PM the 400 hall cart was #4. A total of scovered in the bottom of rawer. 38 AM the 100/200 hall eviewed with Nurse #1. ontained many twist off tabs ose pill was discovered. A were discovered in the vers. AM an interview with the The DON stated it was her raing staff to check the ures and notify her if the lat of range, to clean the kly and as needed and to cations from the cart.		761			
F 880 SS=D	Infection Prevention 8 CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	(2)(4)(e)(f) htrol	F	880			10/31/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3	B) DATE SURVEY COMPLETED
		345218	B. WING			C
	ROVIDER OR SUPPLIER AN NURSING CENTER	J-0210		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		10/11/2018
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 880	infection prevention a designed to provide a comfortable environmedevelopment and transiseases and infection \$483.80(a) Infection program. The facility must esta and control program (a minimum, the follow \$483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visiting providing services unarrangement based unconducted according accepted national stating system of surveil possible communicable distaff. (i) A system of surveil possible communicable disease infections before they persons in the facility (ii) When and to whom communicable disease reported; (iii) Standard and transit to be followed to prevent (iv) When and how is cresident; including but (A) The type and durating to the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent (iv) When and how is cresident; including but (A) The type and durating the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent (iv) When and how is cresident; including but (A) The type and durating the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent the system of surveil possible communicable disease reported; (iii) Standard and transit to be followed to prevent the system of surveil possible communicable disease reported; (iii) Standard and transit the system of surveil possible communicable disease reported; (iii) Standard and transit the system of surveil possible communicable disease reported; (iii) Standard and tran	and control program a safe, sanitary and bent and to help prevent the asmission of communicable ans. brevention and control blish an infection prevention IPCP) that must include, at ving elements: Immorrance for preventing, identifying, and controlling infections aseases for all residents, bors, and other individuals and a contractual and pon the facility assessment at to §483.70(e) and following and ards; astandards, policies, and bogram, which must include, allance designed to identify alle diseases or an apread to other and possible incidents of and po	F 88	80		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 10/11/2018	
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DRIVE CLINTON, NC 28329		10/11/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected slacontact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease of infected in disease or infected slacontact will transmit to (vi)The hand hygiene by staff involved in disease of involved involved in disease of involved inv	at the isolation should be the ble for the resident under the set under which the facility bees with a communicable kin lesions from direct or their food, if direct he disease; and procedures to be followed rect resident contact. The for recording incidents acility's IPCP and the en by the facility. The store, process, and to prevent the spread of the incidents of the incidents of the incidents of the incidents. The store is not met as evidenced on the incidents of the incident of the i	F 8	The statements made on the correction are not an admission not constitute an agreement alleged deficiencies. To remain in compliance with and state regulations the factor will take the actions set for plan of correction. The plan of constitutes the facility's alleg compliance such that all alled deficiencies cited have been corrected by the dates indicated.	sion to and do with the h all federal cility has taken orth in this of correction gation of eged n or will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			10/	C 11/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	11/2010
				120	0 SOUTHWOOD DRIVE		
MARY GRAN NURSING CENTER				CLINTON, NC 28329			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 60		F 8	80			
	Review of the facility's contact precautions policy revised 5/2014 revealed when a resident was on				F880		
					1. For resident #96, a corrective action	on	
	contact precautions s entering the resident's			was obtained on 10/09/2018.			
					The CNA who failed to put on the corre	ct	
	During observation or			PPE was verbally counseled by the			
	Aide #1 was observed in Resident #96's room				Director of Nursing on 10/09/20018		
	with a mask on but no gown or gloves assisting Resident #96 with breakfast. Resident #96's room was a contact isolation room with the appropriate				regarding donning any applicable PPE		
					such as gown, gloves, mask, goggles,		
				face shields as indicated on the isolatic			
	signage and personal protective equipment placed at the entrance to the room. The signage stated to don a gown and gloves prior to entering				sign posted on the outside of the affect residents room.	eu	
					residents room.		
	_	Nurse Aide #1 discarded			2. Corrective action for residents with	,	
	her mask, exited Resident #96's room, and				the potential to be affected by the alleg		
	performed hand hygiene with hand sanitizer.				deficient practice.		
	During an interview on 10/9/18 at 8:35 AM Nurse				All residents on transmission based		
		d not gown and glove when			precautions have the potential to be		
	providing assistance with breakfast to R				affected by the alleged deficient practic On 10/09/2018, the Staff Development		
	#96 because whatever the resident had was in her urine.		Coordinator completed infection control				
	nei unite.				rounds to observe staff entering and	1	
	During an interview o	n 10/9/18 at 8:46 AM the			exiting resident rooms who are on		
	_	ated if residents were on			isolation precautions. The staff were		
	_	would place gown and			audited for donning correct PPE		
		ding care. She further stated			according to the isolation precaution sign	gn	
	it was her expectation	that when providing care in			posted outside the resident door prior to	0	
	a contact isolation roo	om that staff always gown			entering the room and doffing the PPE		
		ering and Nurse Aide #1			prior to exiting the room and the PPE w	/as	
	should have had a go assisting Resident #9	wn and gloves on when 6 with breakfast.			properly disposed.		
					3. Systemic changes		
					On 10/31/2018, the Staff Development		
					Coordinator provided an in-service		
					education to all full time, part time, and	as	
					needed nurses, CNA's, Med Tech's,		
					House Keeping Staff, Dietary Staff,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
			D. MINO			С		
		345218	B. WING _			10/11/2018		
	ROVIDER OR SUPPLIER AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	CROSS-REFERENCED TO T	TION SHOULD B THE APPROPRIA	DATE.		
F 880	Continued From page	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 61		Maintenance Staff, and Department Manager staff. Topics included: • Donning PPE prior to entering a resident room that is on isolation precautions according to the required PPE listed on the posted isolation sig. • Doffing the PPE prior to exiting the resident's room and how to properly dispose of the PPE. • Hand hygiene after exiting the isolation room. 4. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains corrand/or in compliance with regulatory requirements. The Staff Development Coordinator of designee will monitor procedures for resident's rights weekly x 2 weeks the monthly x 3 months using the Reside rights/privacy Quality Assurance mor Monitoring will include auditing staff for knocking and asking permission to ensertied to the weekly Quality Assurance committee by the Administor ensure corrective action initiated a appropriate. Compliance will be mon and ongoing auditing program review the weekly Quality Assurance Meetin The weekly QA Meeting is attended the Administrator, Director of Nursing, Manager, and the Dietary Manager.		at nat cted n ts or. er a orts ator ored d at . the S		