DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		E SURVEY IPLETED
		345218	B. WING			0	C 2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	02	
MARY GR	AN NURSING CENTER			12	20 SOUTHWOOD DRIVE		
				С	LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
F 000	survey was conducte 02/17/22. The facility compliance with the r	equirement CFR 483.73, ness EVENT ID #508O11.	FC	000			
F 561	survey was conducte 02/14/22 through 02/	17/22. One out of the 11 was substantiated with	F 5	561			3/14/22
SS=D	CFR(s): 483.10(f)(1)-	(3)(8)	FC				3/14/22
	promote and facilitate through support of re	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)					
	activities, schedules (waking times), health						
		ident has a right to make s of his or her life in the cant to the resident.					
	with members of the	ident has a right to interact community and participate in poth inside and outside the					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electroni	cally Signed						03/10/2022

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

PRINTED: 03/21/2022

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345218	B. WING		C 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
				120 SOUTHWOOD DRIVE	
MARY GR	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 561	Continued From page	91	F 56	1	
	religious, and commu interfere with the right facility. This REQUIREMENT by: Based on observatio resident interviews th provide showers as s (Resident #29 and Re Findings included: 1. Resident #29 was 09/11/21. Diagnoses calorie malnutrition, e dependence on dialys The Minimum Data S assessment dated 12 #29 was cognitively a behaviors such as ref extensive assistance assistance with bed n extensive assistance assistance with perso impairments and used and required one staf bathing. Resident #2 of bowel and bladder pressure ulcer. Resident #29 ' s care for activity of daily livi performance deficit re- interventions including	tivities, including social, nity activities that do not ts of other residents in the " is not met as evidenced ns, record review, staff and e facility failed to offer and cheduled for 2 of 2 residents esident #36) observed. a admitted to the facility on included diabetes, protein nd stage renal disease, sis, anxiety, and depression. et (MDS) quarterly /22/21 revealed Resident ware and demonstrated no fusal of care. He required with two staff physical nobility and transfers, with one staff physical onal hygiene. He had no d a walker and wheelchair f physical assistance with 9 was frequently incontinent and had 1 stage IV plan revealed a plan of care		The statements made on this plan of correction are not an admission to annot constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has t or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility a sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561 Corrective Action for failing to offer an provide showers as scheduled for 2 or residents (Resident #29 and Resident #36) observed. For resident #29 a shower was offere and resident refused on 2/11, 2/13, 2/2/20, 2/23, 2/26, 2/27, 2/28 so a bed I was completed each day by the CNA. resident # 36 a shower was offered al refused on 2/16, 2/17, 2/18, 2/20, 2/2 2/22, 2/23, 2/25, 2/27 and 2/28/22 so bed bath was completed by the CNA. will continue to offer a shower twice weekly per shower schedule. Corrective Action for Potentially Affect Residents All residents have the potential to be affected. Beginning on 3/9/2022, all	d do ral aken ion d f 2 t d 17, bath For nd 1, a We

Facility ID: 923329

PRINTED: 03/21/2022

		ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 03/21/202 DRM APPROVE NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		STRUCTION		ATE SURVEY OMPLETED
		345218	B. WING _				C 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
MARY GR	AN NURSING CENTER		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 561	Continued From page	e 2	F 5	61			
	staff assistance with hygiene. A record review of the schedule revealed he receive a shower on Saturdays. A review month of January and documentation that re only under the colum for showers given on and February had no the resident received An observation of Re revealed an alert and upright in his wheeld Resident was approprint	grooming and personal e Resident #29 ' s shower e was to be offered or Tuesdays, Thursdays and of the shower log for the d February revealed esident received bed baths in "bed bath," The columns the shower log for January o documentation to support a shower. esident #29 on 02/14/22 d oriented resident sitting	F ð	res CN sc by ac do ref CN Th Sy Or tea tim CN sh inc	sidents were offered by their a NA to shower according to the hedule. This education was co Director of Nursing. If the resi- iccepted the shower it was given becomented by the CNA. If the r fused the shower, the hall nurs tified for intervention. If the sh fused then it was documented NA as refused and a bed bath his was completed by 3/14/202 vstemic Changes in 3/8/2022, the Nurse manage am began in-servicing all current he, part time and PRN Nurses NA and agency staff. This in cluded the following topics: foll ower schedule, what to do wh sident refuses a shower, and o sident preferences.	shower ompleted ident n and resident se was ower was by the offered. 22. ement ent full and n-service lowing the en a	
	revealed he received getting dressed, but I received a shower in shower. Resident #2 offered showers and #29 stated if they offe definitely take one. F asked for a shower in would be getting a be An interview with Nur she believed Resider but she was not certa Resident #29 went to Wednesdays, and Fr	a long time and would like a 29 was asked if he was he stated "No." Resident ered him a shower he would Resident #29 stated he has in the past and was told he ed bath. rse #1 on 02/15/22 revealed int #29 was offered a shower,		the rec all rev pro be rec no co Qu Th mo too sc co	his information has been integree standard orientation training quired in-service refresher cour- above mentioned staff and wi- viewed by the Quality Assuran ocess to verify that the change- een sustained. Staff that have ceived the education by 3/14/2 to be allowed to work until it ha- impleted. uality Assurance he Director of Nursing or design onitor tag F661 using the Show of for auditing to ensure showed hedules are followed. Audits wi- mpleted weekly x 2 weeks the 3 months. Reports will be pres	and in the urses for ill be has not 2022 will is been nee will wers QA er vill be en monthly	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3		IPLETED
						С
		345218	B. WING		0	2/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
MARY GR	AN NURSING CENTER			120 SOUTHWOOD DRIVE		
	1			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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 561	Continued From page	e 3	F 56	1		
		station. Nurse #1 stated the		by the Administrator to ensur	e corrective	
	resident would refuse	e care at times, but mostly		action initiated as appropriate) .	
		and even if he refused to		Compliance will be monitored		
		nould at least be offered a ay, Thursday and Saturday.		ongoing auditing program rev weekly Quality Assurance Me		
	•	esident refused a shower,		weekly QA Meeting is attende	-	
		were supposed to let her		Administrator, Director of Nur		
		ncourage the resident to take ent if the resident continued		Coordinator, Therapy, Health		
	to refuse.			Manager, and the Dietary Ma	llager	
	An interview with NA #1 on 02/15/22 revealed she had given Resident #29 a bed bath before he went to dialysis on 02/14/22 and she also gave a bed bath on 02/15/22. NA #1 stated she did not offer him a shower on 02/14/22 or 02/15/22.					
	06/09/21. Diagnoses	admitted to the facility on included, in part, cellulitis of sue injury to left heel, isorder.				
	revealed Resident #3 demonstrated no beh care. Resident #36 m assistance with two s bed mobility and trans	taff physical assistance with sfers, total dependent with sistance with personal				
	of ADL self-care performant limited mobility with in	plan revealed a plan of care ormance deficit related to nterventions including, in nce with grooming and				

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/21/2022 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345218	B. WING		_	(02/ ⁻	; 17/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	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 PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	receive a shower on I Fridays. A review of to of January and Febru that resident received column "bed bath," T given on the shower I had no documentation received a shower. An observation of Res revealed resident was wheelchair and was w the hair salon. She w but somewhat unkem fingernails. An interview with Res revealed she had her but she added, she w and no one ever aske shower. Resident #30 baths but would really #36 stated she has as aides will just say "we bath." An interview with Nurs she believed Residen but she was not certa Resident #36 was out get her hair cut but sh resident received a sh (Monday). Nurse #1 kept at the nurse 's s Resident #36 should every Monday, Wedn stated if a resident ref	Monday, Wednesdays and the shower log for the month ary revealed documentation bed baths only under the he columns for showers og for January and February in to support the resident sident #36 on 02/14/22 is out of bed sitting in her vaiting to get her hair cut in vas appropriately dressed, pt with dirty hair and ident #36 on 02/14/22 hair cut and she felt good, ould love to get a shower ed her if she would like a 6 stated she received bed v like a shower. Resident sked for a shower, but the e are going to give you a bed se #1 on 02/15/22 revealed t #36 was offered a shower, in. Nurse #1 stated to fher bed on 02/14/22 to ne was not sure if the	F 561				

Facility ID: 923329

If continuation sheet Page 5 of 26

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/21/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345218	B. WING				C 17/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	, STATE, ZIP CODE		
				120 SOUTHWOOD DRIV	/E		
MARY GR	AN NURSING CENTER			CLINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 561 F 580 SS=E	An interview with NA a had given Resident #3 and 02/16/22. NA #1 a shower on 02/15/22 An interview was cond Nursing (DON) on 02/ DON reviewed the shithe nurse's station for Resident #36 and condition were given for the more february and the shot The DON stated here a staff was to ensure the offered a shower on the document if they refuse and let the charge nur the facility had 6 show bed all in working ordewhy the residents showers if they wante Notify of Changes (Inj CFR(s): 483.10(g)(14) Notific (i) A facility must immer consult with the resider consistent with his or representative(s) where (A) An accident involver results in injury and has physician intervention (B) A significant changes (Construction the construction of the constru	ent continued to refuse. #1 on 02/16/22 revealed she 36 a bed bath on 02/15/22 stated she did not offer her ducted with the Director of (17/22 at 2:48 PM. The ower log which was kept at or Resident #29 and firmed that only bed baths nths of January and wer columns were blank. expectation of the nursing e residents were being heir shower days and to sed or received a shower rese know. The DON stated ver chairs and one shower er and there was no reason build not be receiving d one. ury/Decline/Room, etc.))(i)-(iv)(15) ration of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident n there is- ring the resident which as the potential for requiring ; ge in the resident's physical,	F 54		DEFICIENCY)		3/14/22
		, mental, or psychosocial eatening conditions or					

Event ID: 508O11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345218	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MARY GR	AN NURSING CENTER				20 SOUTHWOOD DRIVE CLINTON, 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provin- physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9).); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations	F	580	The statements made on this plan of		
		ctioner (NP), and Registered			correction are not an admission to and	do	

Facility ID: 923329

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PRINTED: 03/21/2022

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	LE CONSTRUCTION		3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	• •		(^	COMPLETED
						С
		345218	B. WING			02/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, O	CITY, STATE, ZIP CODE	
				120 SOUTHWOOD I	DRIVE	
MARTGR	AN NURSING CENTER			CLINTON, NC 28	329	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH (VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
F 580	Continued From page	e 7	F 5	30		
		ews, the facility failed to			e an agreement with the	
		and Responsible Party (RP)		alleged defici	-	
		ant weight loss (Resident		To remain in	compliance with all federal	
	#134), failed to notify	-			gulations the facility has take	n
		n (Resident #27), and failed			ne actions set forth in this	
		or a resident who was			ction. The plan of correction	
		ng a significant weight loss of 4 residents observed for			ne facility⊡s allegation of such that all alleged	
	Nutrition.	of 4 residents observed for		· · ·	cited have been or will be	
					the dates indicated.	
	Findings included:			F580		
					action for failing to failed to	
		s admitted to the facility on			ysicians and Responsible	
		admitted from the hospital			f Residents' significant weigh	it
	-	noses to include, in part, r, diabetes, dysphagia and			nt #134), failed to notify d RP of significant weight	
	gastrostomy.	r, diabetes, dyspilagia and			nt #27), and failed to obtain a	a
	guotiootoniji				a resident who was	
	Resident #134's 5-da	y Minimum Data Set (MDS)		0	as having a significant	
	dated 01/27/22 revea	led resident had severe			Resident #37) for 3 of 4	
	cognitive impairments	5.			served for Nutrition.	
					#134, the physician and R/P	
	listed: required tube	plan goals dated 02/07/22			of the weight loss on MDS Nurse.	
	-	ng aspiration, infection,			#27, the physician and R/P	
	-	dequate nutrition. Potential			of the weight gain on	
	nutritional problem re				Director of Nursing.	
	therapeutic diet and r	eceiving a mechanically			#37, the Nurse obtained a	
	altered diet for pleasu			reweight on 2		
		d: Observe for/record/report			ction for residents with the	
		ed for signs and symptoms iation, and sufficient weight		deficient prac	e affected by the alleged	
		1-week, greater than > 5 %			have the potential to be	
		th, or greater than $> 7.5\%$			he alleged deficient practice.	
		hs, or a 10% weight loss in			, the Nurse management	
	6-months).	-		team and die	etary manager completed a	
					current residents to identify	
		tronic medical record (eMR)			eight losses and significant	
	revealed recorded we	eights as admission weight		weight gains.	. Significant equaling a weigl	nt

Facility ID: 923329

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						MB NO	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · · · · · · · · · · · · · · · · · ·	X3) DATE COMPI	
	CONTRECTION		A. BUILDING	G			
		245040				C	
		345218	B. WING			02/1	17/2022
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MARY GR	AN NURSING CENTER				0 SOUTHWOOD DRIVE		
				CL	LINTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIC DATE
F 580	Continued From page	28	F 58	20			
			F 30		loss or gain of E% in 20 days 7 E% in 20		
	0n 01/25/22-175 lbs., 111.8 lbs.	and on 02/08/22 weight of			loss or gain of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. Residents	0	
ļ					who were noted with a significant weight	t I	
	A physician order dat	ed 02/08/22 for Resident			gain or loss had their physician and R/P		
		dent's 02/08/22 weight of			notified by the Nurse management Team		
	111.8 lbs.				This will be completed by 3/14/2022.		
					In addition to this, all current residents		
	An interview on 02/16	6/22 at 8:04 AM with the			weights over the past 60 days and order	rs	
	Registered Dietitian (RD) revealed it was her			over the past 30 days were reviewed for	-	
		be notified at least weekly of			the need of a reweight. Any resident		
		ant weight loss or gain. She			identified with a need (5 lb weight		
	-	also said she expected to be notified whenever residents' weight loss/gain was greater than 5%			discrepancy from previous weight) or		
					order for a reweight were reweighed by		
		eater than 10% weight			the CNA. This process will be completed	ו	
	-	ays so she would be able to dietary changes. RD said			by 3/14/2022. Systemic changes		
	she was not notified of				In-service education began on 2/17/2022	2	
	significant weight cha				by the Administrator and was provided to		
	Significant weight one	inge.			all full time, part time, Director of Nursing		
	An interview on 02/16	6/22 at 1:45 PM with the			Unit Manager, Support Nurse, and Dieta		
		was her expectation that she			Manager. Topics included:	,	
		se Practitioners (NP) should			" Weight policy		
		Resident #134's significant			" Nutrition, Hydration, and Supplement	nt	
		said she also expected to be			Policy		
		nt loss/gain was greater than			" Notification of the MD and R/P of		
		r greater than 10% weight			significant weight changes		
		ays so she or her NPs could			In-service education began on 3/8/2022		
	make the necessary	treatment/medication			by the Nurse Management Team and wa		
	changes.				provided to all full time, part time, and as	5	
	An interview on 02/16	6/22 at 4:00 PM with Nurse			needed Nurses, Med Aide⊡s, Med Tech⊡s, and CNA⊡s including agency		
	Practitioner (NP#1) re				staff. Topics included:		
	,	or the MD should have been			" Notification of MD and R/P of		
	-	134's significant weight loss.			significant weight changes		
		pected to be notified when			" Following MD orders for reweights		
	-	greater than 5% within a			" Weight policy for reweights		
	-	ght loss/gain within 90-days			This information has been integrated integra		
		e necessary treatment			the standard orientation training and in t		
	recommendations.				required in-service refresher courses for	-	

Facility ID: 923329

HUMAN SERVICES EDICAID SERVICES			F	ITED: 03/21/2022 ORM APPROVED NO. 0938-0391
1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) [DATE SURVEY COMPLETED
345218	B. WING			C 02/17/2022
		STREET ADDRESS, CITY, STATE, ZIP	CODE	
		120 SOUTHWOOD DRIVE		
MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	F 58			
2 at 4:10 PM with the N) revealed she expected w their facility's weight her expectation that ant weight change on iggered a reweight and for greater than 5-lbs. from a physician should have umented weight of 111.8 2 at 10:00 AM with MDS dent #134's documented te on 02/08/22 should ne to confirm a greater rom previous weight and nd Responsible Party (RP) dent's significant weight ht policy. dmitted to the facility on s to include, in part, hypertension, and y MDS assessment dated ent had no cognitive n goals dated 12/14/21 nterventions to observe sician as needed for signs ition: which includes veight loss of 3-pound week, greater than 7.5% month, greater than 7.5%		reviewed by the Quality As process to verify that the of been sustained. Staff that received the education by not be allowed to work uni- completed. Monitoring Procedure to e- plan of correction is effect specific deficiency cited re- and/or in compliance with requirements. The Director of Nursing or monitor tag F580 using the and reweight QA tool for a physician and R/P notifical significant weight loss or g ensure reweights are obta be completed weekly x 2 v monthly x 3 months. Repo- presented to the weekly Q Assurance committee by to to ensure corrective action appropriate. Compliance v and ongoing auditing prog the weekly QA Meeting is Administrator, Director of Coordinator, Therapy, Hea	ssurance change has t have not 3/14/2022 will til it has been ensure that the ive and that emains corrected regulatory designee will e Notification auditing tions of gain and to ained. Audits will weeks then orts will be Quality the Administrator n initiated as will be monitored gram reviewed at nce Meeting. s attended by the Nursing, MDS alth Information	
	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 MENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION) 2 at 4:10 PM with the N) revealed she expected w their facility's weight her expectation that ant weight change on iggered a reweight and for greater than 5-lbs. from a physician should have umented weight of 111.8 2 at 10:00 AM with MDS dent #134's documented the to confirm a greater rom previous weight and nd Responsible Party (RP) dent's significant weight ht policy. dmitted to the facility on s to include, in part, hypertension, and y MDS assessment dated ent had no cognitive In goals dated 12/14/21 hterventions to observe sician as needed for signs ition: which includes weight loss of 3-pound week, greater than 5%	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345218 B. WING	EDICAID SERVICES 1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345218 B. WING 345218 B. WING LIDENTIFICATION NUMBER: B. WING 10 DENTIFICATION NUMBER: B. WING LIDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCIES LIDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCIES 2 at 4:10 PM with the N) revealed she expected w their facility's weight her expectation that ant weight change on iggered a reweight and for greater than 5-lbs. from a physician should have umented weight of 111.8 F 580 2 at 10:00 AM with MDS dent #134's documented e on 02/08/22 should ne to confirm a greater rom previous weight and nd Responsible Party (RP) dent's significant weight th policy. The Director of Nursing or monitor tag F580 using th and reweight loss or 0; ensure reweights are obte be completed weekly X 21 monthy X 3 months. Rep presented to the weekly CA surance commitlex by 1 to ensure corrective action appropriate. Compliance with requirements. y MDS assessment dated ent had no cognitive Administrator, Director of Coordinator, Therapy, He Manager, and the Dietary n goals dated 12/14/21 nterventions to observe ician as needed for signs tition: which includes weight loss of 3-pound week, greater than 5% months, and greater than 7.5%	HUMAN SERVICES P EDICAID SERVICES OME 1 PROVIDERSUPPLERCLA IDENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION A BUILDING (23) 345218 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 128 SOUTHWOOD DRIVE CLINTON, NC 28329 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFICATION WITH the N) revealed she expected w their facility's weight her expectation that and weight change on greater than 5-lbs, from a physician should have umented weight of 111.8 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) 2 at 4:10 PM with the N) revealed she expected w their facility's weight her expectation that and weight change on greater than 5-lbs, from a physician should have umented weight of 111.8 F 550 above mentioned staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Staff that have not received the education by 3/14/2022 will not be allowed to work until it has been completed. 2 at 10:00 AM with MDS dent #134's documented en to confirm a greater rom previous weight and drets significant weight th policy. The Director of Nursing or designee will montihy a Months. Reports will be resented to the weekly QA weight sare obtained. Audits will be completed weekly X 2 weeks then monthy, and greater than 5% month, greater than 7.5% months, and greater than 7.5% months. and greater than 7.5%

Facility ID: 923329

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/21/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345218	B. WING			_		C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	<u> </u>	
MARY GR	AN NURSING CENTER			1:	20 SOUTHWOOD DRIVE			
				С	LINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page) 10	F	580				
	record weights on 02/ weights: 09/10/21- 20 and 02/09/22- 226.8 I significant weight gair had no documented r Physician or RP were A physician order date order to recheck Resi of 226.8 lbs. An interview on 02/16 revealed it was her ex notified at least week significant weight loss expected to be notifie weight loss/gain was month, or greater that within 90 days so she necessary dietary cha	n on 02/09/22 of 226.8 lbs., reweight or that the e notified. ed 02/10/22 revealed an ident #27's 02/09/22 weight 6/22 at 8:04 AM with the RD spectation that she be						
	Physician revealed it she or one of her two	6/22 at 1:45 PM with the was her expectation that NPs should have been 27's significant weight						
	revealed it was her ex Physcian should have #27's significant weig said she expected to loss/gain was greater greater than 10% wei	6/22 at 4:00 PM with NP #1 expectation that she or the e been notified of Resident ht loss or gain. NP #1 also be notified when weight than 5% within a month, or ght loss/gain within 90-days e necessary treatment						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/21/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				(X3) DATE COMP	SURVEY LETED
		345218	B. WING			_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MARY GR	AN NURSING CENTER				20 SOUTHWOOD DRIVE LINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page recommendations.	9 11	F	580				
	Nurse #1 revealed Re weight change on 02/ reweight and she said greater than 5-lbs. ga for the Physician and	7/22 at 10:00 AM with MDS esident #27's significant 09/22 should have had a d it was expected for weights in/loss from previous weight RP to have been notified of changes per facility weight						
	Director of Nursing (D Resident #27 on 02/1 AM with no signs or s or change from baseli Resident #27's last tw were: 02/09/22 was 2 was 201 lbs., and with the Physcian and RP 3) Resident #37 was 12/16/16 with diagnos	vo documented weights 26.8 lbs., and on 11/02/21 n this weight discrepancy, should have been notified. admitted to the facility on						
	01/01/22 revealed res impairments. Resident #37's care p listed: nutritional prob therapeutic diet and d restrictions. Nutritiona Observe for/record/re for signs or symptoms or significant weight lo	erly MDS assessment dated sident had no cognitive blan goals dated 01/06/22 lem related to receiving a loes not follow diet al interventions included: port to Physcian as needed s of malnutrition, emaciation, poss (ex: 3-lbs. in 1-week, > % in 3-months, and > 10% in						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/21/2022 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345218	B. WING			(02/	C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	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	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 12	F 58	80			
	weights listed reveale 12/04/21-195.4 lbs., 1 09/06/21-209.2 lbs. and A Registered Dietitian Resident #37 weight in body weight 178.3 lbs of 15 % in 180 days weight 178.3 lbs with a recommendation confirm last weight. An interview on 02/160 weight changes. She be notified when a weight loss/gain within could make necessary meake the necessary meake the necessary meake the necessary meaker	nd 08/10/21-211.8 lbs. note dated 02/16/22 for review revealed current a. Triggered for a weight loss with noted weight from the previous weight on to do a reweigh to 1/22 at 1:45 PM with the was her expectation that Nurse Practitioners should Resident #37's significant said she also expected to bight loss/gain was greater th, or greater than 10% n 90 days so she or her staff y treatment changes or nedication					
	#37 significant weight expected to be notifie was greater than 5% 10% weight loss/gain make the necessary t	loss. She also said she d when weight loss/gain within a month or greater within 90 days so she could reatment changes.					
	Nurse #1 revealed Re	/22 at 10:00 AM with MDS esident #37's significant 09/22 should have had a d it was expected for					

Facility ID: 923329

If continuation sheet Page 13 of 26

	MENT OF HEALTH AN S FOR MEDICARE & I				FOF	ED: 03/21/2022 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345218	B. WING		0	C 2/17/2022
NAME OF P	ROVIDER OR SUPPLIER		SI	TREET ADDRESS, CITY, STATE, 2	· · · · · ·	
MARY GR	AN NURSING CENTER			20 SOUTHWOOD DRIVE LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 580 F 692 SS=E	weights greater than \$ previous weight for the been notified of the si- per facility weight poli An interview on 02/16 DON revealed she ex follow their facility's w was her expectation the significant weight cha have triggered a rewer reweights greater than weight to have the ME Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted rr (Includes naso-gastric both percutaneous endosc enteral fluids). Based comprehensive assess ensure that a resident §483.25(g)(1) Maintai of nutritional status, si desirable body weight balance, unless the re demonstrates that this preferences indicate of §483.25(g)(2) Is offerent maintain proper hydra §483.25(g)(3) Is offerent	5-lbs. gain/loss from e Physcian and RP to have gnificant weight changes cy. /22 at 4:10 PM with the pected her nursing staff to eight policy. DON said it hat Resident #37's nge on 02/09/22 should ight and for all significant n 5-lbs. from a previous D notified. atus Maintenance (3) nutrition and hydration. c and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and i on a resident's esment, the facility must f- ns acceptable parameters uch as usual body weight or c range and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to tion and health; ed a therapeutic diet when roblem and the health care	F 580			3/14/22

If continuation sheet Page 14 of 26

						NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	ATE SURVEY
			A. BUILDING	3		0
		345218	B. WING			C
		545210				02/17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
MARY GR	AN NURSING CENTER			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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 692	Continued From page	e 14	F 69	92		
	by:					
	Based on record revi	iew, staff interviews,		The statements made on thi	s plan of	
	Physician, Nurse Pra			correction are not an admiss	ion to and do	
		(RD) interviews, the facility		not constitute an agreement	with the	
	-	assess significant weight		alleged deficiencies.		
		ificant weight loss (Resident		To remain in compliance with		
		gh and assess significant		and state regulations the fac	-	
		nt's significant weight gain ailed to obtain a reweight for		or will take the actions set fo plan of correction. The plan of		
		ocumented as having a		constitutes the facility s alle		
		s (Resident #37) for 3 of 4		compliance such that all alle	-	
	residents observed for	,		deficiencies cited have been	•	
				corrected by the dates indica		
	Findings included:			F692		
	0			A corrective action for the fac	cility failing to	
	1) Resident #134 wa	s admitted to the facility on		reweigh and assess significa	int weight	
	01/24/22 and was re-	admitted from the hospital		loss of resident's significant	weight loss	
	on 02/07/22 with a cu			(Resident #134), failed to rev	•	
		crum ulcer, diabetes (DM),		assess significant weight gai		
	dementia, anemia, dy	vsphagia, and gastrostomy.		resident's significant weight	-	
				(Resident #27), and failed to		
		y Minimum Data Set (MDS)		reweight for a resident who w		
		led resident was severely		documented as having a sign		
		and required total assistance t #134 was coded as having		weight loss (Resident #37) for residents observed for nutriti		
		r more in the last month or		For resident #134, a reweigh		
		n last 6-months and was		obtained on 2/16/2022 by the		
		ic and mechanically altered		Registered Dietician assesse		
	diet.			residents weight loss and ma		
				recommendations on 2/17/20		
	Resident #134's care	plan goals dated 02/07/22		For resident #27, a reweight		
		nutritional problem related to		on 2/17/2022 by the Nurse.	The PCP was	
	receiving therapeutic			informed of the weight gain of		
	-	diet for pleasure eating.		4 weights and assessed the		
	Care plan intervention			weight gain with recommend	ations on	
		nysician as needed for signs		2/17/2022.		
		nutrition, emaciation, and		For resident #37, the Nurse	obtained a	
	sufficient weight loss	(ex: 3-pounds in 1-week,		reweight on 2/16/2022.		

Facility ID: 923329

		MEDICAID SERVICES				1	NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	ATE SURVEY
							С
		345218	B. WING			()2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	20 SOUTHWOOD DRIVE		
MARTGR	AN NURSING CENTER			C	LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 692	Continued From page	e 15	F 6	i92			
		weight loss in 3-months, or a			Corrective action for residents with the	2	
	10% weight loss in 6-				potential to be affected by the alleged	-	
	-				deficient practice.		
	Resident #134's elec				All residents have the potential to be		
	, ,	orded weights as admission			affected by the alleged deficient practi	ce.	
	weight on 01/25/22-1 weight of 111.8 lbs.	75 lbs. and on 02/08/22			On 3/8/2022, the Nurse management	•	
	weight of 111.6 lbs.				team and dietary manager completed review of all current residents to identi		
	A physician order dat	ed 02/08/22 for Resident			significant weight loss and significant	ıy	
		dent's 02/08/22 weight of			weight gain. Significant equaling a wei	ight	
	111.8 lbs.	C C			loss or gain of 5% in 30 days, 7.5% in	-	
					days, and 10% in 180 days. Residents		
		6/22 at 8:04 AM with the			who were noted with a significant weig	ght	
		RD) revealed a significant			gain or loss will be assessed by the		
		defined as whenever /gain was greater than 5%			Registered Dietician by 3/9/2022. In addition to this, all current residents		
		eater than 10% weight			weights over the past 60 days and ord		
	loss/gain within 90 da				over the past 30 days were reviewed f		
	An interview on 00/40				the need of a reweight. Any resident		
		6/22 at 1:45 PM with the was her expectation that			identified with a need (5 lb weight discrepancy from last weight) or order		
	•	lined a rewight for Resident			from the provider for a reweight were		
		ight change. The Physician			reweighed by the CNA. This process v	was	
		d for all residents with			completed by 3/14/2022.		
	weight changes great	ter than 5-lbs. from a			Systemic changes		
	previous weight.				In-service education began on 2/16/20		
					by the Administrator and was provided		
		6/22 at 4:00 PM with Nurse			all full time, part time, Director of Nurs	•	
	Practitioner (NP#1) re	dent #134's significant			Unit Manager, Support Nurse, and Die Manager. Topics included:	etary	
	-	n 02/08/22 should of had a			" Weight policy		
	-	said a reweight must be			" Nutrition, Hydration, and Supplem	nent	
		ghts greater than 5-lbs. from			Policy		
		or when weight loss/gain was			" Notification of the MD and R/P of		
	-	in a month, or greater 10%			significant weight changes		
	weight loss/gain withi	in 90-days.			In-service education began on 3/8/202	22	
	An interview on 02/17	7/22 at 10:00 AM with the			by the Nurse Management Team and		
	MDS Nurse #1 revea				provided to all full time, part time, and		

Facility ID: 923329

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			()(0)			NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY
			A. BUILDIN	G		С
		345218	B. WING)2/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				120 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER			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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 692	Continued From page	e 16	E G	0.2		
1 032			F 6			
	documented significa	ant weight change on e had a reweight done to		needed Nurses, Med Aide Tech s, and CNA s include		
		n 5 lbs. weight loss from		staff. Topics included:	any agency	
		ording to facility's weight		" Notification of MD and	R/P of	
	policy.			significant weight changes		
				" Following MD orders f		
	An interview on 02/17	7/22 at 11:05 AM with		" Weight policy for rewe	ights	
	Restorative Aide (RA	.) #1 said she was assigned		This information has been	integrated into	
		weekly resident weights.		the standard orientation tra		
		ompleted all the weights she		required in-service refresh	er courses for	
		weights to the hall nurse		all the above-mentioned st		
	-	for entering weights into		reviewed by the Quality As		
		ng system. RA #1 said at		process to verify that the c been sustained. Staff that	•	
	-	hall nurse's responsibility to their electronic medical		received the education by		
	-	f a reweight was needed.		not be allowed to work unti		
		a forfolgin nao noododi		completed.		
	An interview on 02/17	7/22 at 11:40 AM with MDS		Monitoring Procedure to er	nsure that the	
	Nurse #1 revealed sh	ne was the nurse who		plan of correction is effectiv		
	electronically entered	l Resident #134's weight on		specific deficiency cited rel	mains corrected	
	02/08/22 of 111.8 lbs	. MDS Nurse #1 said she		and/or in compliance with r	regulatory	
		t numbers turned red when		requirements.		
	she entered resident			The Director of Nursing or		
		nt's weight was significant		monitor tag F692 using the		
	-	vas needed to verify the		change QA tool for auditing		
	weight.			residents with significant w		
	Review of Resident +	#134's electronic medical		weight gain are assessed l Registered Dietician and re	-	
	record revealed Resi			obtained as indicated. Aud	-	
		s 175 lbs Resident #134		completed weekly x 2 wee		
	-	n 01/28/22 through 02/07/22,		x 3 months. Reports will be		
		e-admitted back to the facility		the weekly Quality Assurar		
		ght was documented as		by the Administrator to ens		
		2. An admitting Physcian		action initiated as appropri		
		ht to be done on 02/08/22 to		Compliance will be monitor		
		34's admission weight of		ongoing auditing program		
		eview revealed a reweight		weekly Quality Assurance	-	
		irm the discrepancy between		weekly QA Meeting is atter		
	ine two weights 175	lbs. and 111.8 lbs. Resident		Administrator, Director of N	iursina. MDS	

Facility ID: 923329

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION		TE SURVEY
		345218	B. WING			C)2/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
MARY GR	AN NURSING CENTER			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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 692	134's ordered reweig 02/16/22 and was not	e 17 ht was later completed on ted to be 182.8 lbs. with of the reweight on 02/17/22.	F 69	D2 Coordinator, Therapy, Health Manager, and the Dietary Ma		
	at 10:00 AM. An interview on 02/16/22 at 4:10 PM with the Director of Nursing (DON) revealed she expected her nursing staff to follow the facility's weight policy. Resident #134's significant weight change on 02/08/22 should have triggered a reweight and the nurse should have done the reweight with that discrepancy.					
	09/09/21 with a cumu	admitted to the facility on lative diagnosis including re, diabetes and dementia.				
	12/17/21 revealed Re	erly MDS assessment dated esident #27 had no cognitive uired total assistance with				
	revealed weight loss for signs or symptoms includes emaciation, 3-pound weight loss of than 5% weight loss than 7.5% weight loss	olan goals dated 12/14/21 with interventions to observe s of malnutrition: which significant weight loss of or gain in 1-week, greater or gain in 1-month, greater s or gain in 3-months, and ight loss or gain in 6-months.				
	record weights on 02/	#27's electronic medical /14/22 revealed the following 00 lbs., 11/02/21- 201 lbs., lbs.				
		ed 02/10/22 revealed an ident #27's 02/09/22 weight				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 03/21/2022 MAPPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345218	B. WING			_		C 17/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
MARY GR	AN NURSING CENTER				20 SOUTHWOOD DRIVE			
				_				0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	18	F	692				
	An interview on 02/16	/22 at 8:04 AM with the						
		RD) revealed it was her						
	expectation that she b	e notified at least weekly						
		ificant weight loss or gain.						
	She also said she exp	ected to be notified eight loss/gain was greater						
		th, or greater than 10%						
		n 90 days so she would be						
	able to make the nece	essary dietary changes.						
	Physician revealed it is she or one of her two should have been not significant weight char have been done for w from a previous weigh was her expectation for facility's policy on weigh care plan protocols. An interview on 02/16 Practitioner (NP#1) re expectation that a rew weights greater than 5	nge and for a reweight to eights greater than 5-lbs. at. The Physcian added it or nursing staff to follow the ghts and to follow resident's /22 at 4:00 PM with Nurse						
	loss/gain was greater	than 5% within a month, or in within 90-days so she						
	Nurse #1 revealed Re weight change on 02/ reweight done. She s	/22 at 10:00 AM with MDS esident #27's significant 09/22 should have had a aid it was expected for 5-lbs. gain from previous eight.						

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	-	D HUMAN SERVICES					FORM): 03/21/2022 MAPPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	LETED
		345218	B. WING			_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
				12	20 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER			С	LINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	An interview on 02/17 Director of Nursing (D Resident #27 on 02/1 AM with no signs or s or change from baseli Resident #27's last tw were: 02/09/22 - 226.4 Ibs. DON said it was h weight discrepancy be would have expected done a reweight. An interview on 02/17 Restorative Aide (RA) to complete all daily/w She said when she co would give the list of w who was responsible their electronic chartin never knew if any of th or not since only the r residents' previous we also the hall nurse's re weights as well as asl 3) Resident #37 was 12/16/16 with a cumu anemia, congestive he (DM), and gastroesop (GERD). Resident #37's Quarte 01/01/22 revealed res impairments. Residen to supervision with ea Resident #37's care p	 7/22 at 10:15 AM with the PON revealed she observed 7/22 from 9:00 AM - 9:30 ymptoms of excessive fluid ine. DON confirmed vo documented weights 8 lbs., and on 11/02/21 - 201 her expectation that with the etween the two weights she her nursing staff to have 7/22 at 11:05 AM with 0 #1 said she was assigned veekly resident weights. Sompleted all the weights she weights to the hall nurse for entering weights into ag system. RA #1 said she was esponsibility to enter k for a reweight if needed. admitted to the facility on lative diagnosis including: eart failure (CHF), diabetes shageal reflux disease erly MDS assessment dated sident had no cognitive at needed limited assistance ting. 	F	692				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/21/2022 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345218	B. WING		_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1:	20 SOUTHWOOD DRIVE			
MARY GR	AN NURSING CENTER		с	LINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	restrictions. Nutritional observe for signs or s emaciation, or signific 1-week, > 5% in 1-ma and > 10% in 6-month A review of Resident record (eMAR) docum 02/09/22-178.3 lbs., 1 11/06/21-198.6 lbs., 0 08/10/21-211.8 lbs. F percentages from 08/ were 9.59% last 3 mo loss in past 6-months An interview on 02/16 Physcian revealed it v Resident #37 to have 11/06/21 and 02/09/2 5-lbs. weight loss from a weight loss was gree or greater than 10% v so she or her staff cool treatment or medication An interview on 02/16 Practitioner (NP#1) re expectation that rewe done on all weights g previous weight or wh than 5% within a mon weight loss within 90 the necessary treatmon A Registered Dietitian Resident #37 weight f	al interventions included to symptoms of malnutrition, cant weight loss (ex: 3-lbs. in onth, > 7.5% in 3-months, ns). #37's electronic medical nented weights: 12/04/21-195.4 lbs., 19/06/21-209.2 lbs. and Resident #37's weight loss 10/21 through 02/09/22 onths and 18.79 % weight 5/22 at 1:45 PM with the was her expectation for been reweighed on both 2 due to having greater than in a previous weight or when eater than 5% within a month weight loss within 90 days; uld make necessary on changes. 5/22 at 4:00 PM with Nurse evealed it was her ights should have been reater than 5-lbs. from nen weight loss was greater ith, or greater than 10% days, so she could make ent changes.	F 692				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/21/2022 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345218	B. WING		_		C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
MARY GR	AN NURSING CENTER			20 SOUTHWOOD DRIVE CLINTON, NC 28329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	reweigh to confirm lass An interview on 02/17 Nurse #1 revealed Revelop the change on 02/ reweight change on 02/ reweight done. She sevelop to obtain previous weight to obtain previous weight to obtain weekly weights. RA # the assigned weights. RA # the assigned weights here responsible for obtain weekly weights. RA # the assigned weight she responsible for electron into the eMAR. She to nurse's responsibility for a reweight if needed An interview on 02/17 Restorative Aide (RA) responsible for reside said after she comple would enter the weight after she entered the responsible for verifyi if a reweight was need 02/09/22 the hall nurs reweight on Resident An interview on 02/17 Director of Nursing (D Resident #37's signifi- have had reweights d	a recommendation to do a st weight. /22 at 10:00 AM with MDS seident #37's significant 09/22 should have had a said it was expected for a 5-lb. gain/loss from the tain a reweight. /22 at 11:05 AM with #1 said she was ing residents daily and #1 said when she completed she would give the set to the hall nurse who was onically entering the weights hen said it was the hall to verify weights and to ask ed. /22 at 11:20 AM with #2 revealed she was nts' monthly weights. RA #2 ted the monthly weights she its into the eMAR. She said weights the hall nurse was ng the weights and checking ded or not. RA #2 said on e did not ask her to do a #37. /22 at 10:15 AM with the /ON) revealed all of cant weight changes should	F 692				
		ght to obtain a reweight and					

Facility ID: 923329

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345218	B. WING				C 17/2022
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 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 761 SS=D	CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle: appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci- biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The faci- locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when the package drug distribut quantity stored is min- be readily detected. This REQUIREMENT by: Based on observation record review, the faci- unattended medication store an opened box of accordance with the readily detected.	(1)(2) of Drugs and Biologicals or used in the facility must be a with currently accepted s, and include the y and cautionary expiration date when of Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cality must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced ns, staff interviews, and illity failed to: 1) keep an in cart locked; 2) date and of nebulizer vials in manufacturer's instructions; and box of nebulizer vials f 2 medication carts	F	76		ıl ken	3/14/22
	The findings included	:			constitutes the facility⊡s allegation of compliance such that all alleged		

Event ID: 508O11

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						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	ATE SURVEY DMPLETED
			A. BUILDING	3		С
		345218	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		02/17/2022
				120 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER			CLINTON, NC 28329		
()(1) ID		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETIO DATE
F 761	Continued From page	e 23	F 76	31		
				deficiencies cited have l	been or will be	
	Manufacturer's guide			corrected by the dates i	ndicated.	
		I sulfate solution revealed:		F761		
		in within the foil pouch at all		A corrective action for fa		
	-	sed, use individual vials		unattended medication		
	within 2 weeks, prote	ct from light.		date and store an opene vials in accordance with		
	An observation of the	200 Hall medication cart		manufacturer's instruction		
		at 10:37 AM. The cart was		the opened box of nebu		
		all next to the 200 Hall		the cart for 1 of 2 medic		
	nurse's station. The c			observed (200 Hall cart		
	unlocked, with the pu	sh-in lock in the out position.		The nurse consultant re		
		nembers in sight. An opened		undated nebulizer vials	from a top the	
		omide 0.5 mg and albuterol		medication cart and disc		
	-	n solution nebulizer vials was		immediately locked the		
		e cart with the foil pouch		affected. This was comp	pleted on	
		posed to light. There was no		2/16/2022.		
	opened date on the fo	oil pouch.		Corrective action for res		
	During the observation	on on 2/16/22 at 10:37 AM,		potential to be affected deficient practice.	by the alleged	
	-	Consultant was noted in the		All residents have the p	otential to be	
	-	ed to the medication cart.		affected by the alleged of		
		was unlocked. She placed		On 3/8/22, the Nurse ma		
		side the cart and locked the		completed an audit obse		
	cart at that time.			medication carts for the	•	
				observed to ensure the	medication cart	
	An interview was con	ducted on 2/16/22 at 10:42		was locked, audited to e	ensure no	
		en she returned to the cart.		medications were left ur		
	She acknowledged th			cart, and audited to ens		
		she had been called away		vials were dated when o	-	
		st have forgotten to put the		inside of the medication		
		in the medication cart and urther stated she didn't		completed by the RN U	nin wanager.	
		d to be protected from light		In-service education be	nan on 2/16/2022	
	and discarded 14 day			and was provided to all	-	
				and as needed nurses,	-	
	An interview with the	Director of Nursing (DON)		and Medication Tech S		
		at 10:49 AM. She stated she		" Medication cart mu	-	
		tion carts to be locked at all		when out of sight of the		

Facility ID: 923329

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY	
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		. ,	COMPLETED	
					С	
		345218	B. WING		02	2/17/2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI		-
				120 SOUTHWOOD DRIVE		
WART GR	AN NURSING CENTER			CLINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 761	Continued From page	> 24	F 76	31		
1 /01	times when not in direct sight of the nurse. She			or Med Tech		
	further stated medications should not be left			" Medications cannot	be left unattended	
	unattended on top of the medication cart. She			on top of the medication		
		er vial package should be		" Dating nebulizer via	2	
	dated when opened a	and unused vials discarded		and discarding according	to manufacturer	
	14 days after exposu	re.		instructions and proper s		
				This information has bee		
		d with the Administrator on		the standard orientation		
	2/17/22 at 3:25 PM. She stated she expected the medication carts to be locked when not in direct			required in-service refres		
	sight of the nurse. She further stated medications			all nurses, Medication Ai Medication Tech⊡s and v		
	should be stored according to manufacturer's			by the Quality Assurance		
	guidelines inside the medication cart.			that the change has been		
	g			that have not received th		
				3/14/22 will not be allowe	•	
				has been completed.		
				Monitoring Procedure to plan of correction is effect		
				specific deficiency cited i		
				and/or in compliance with		
				requirements.	·······································	
				The Director of Nursing of	or designee will	
				monitor tag F761 using t		
				tool for auditing medicati		
				when not attended by a r		
				aide, or medication tech.		
				audit for medications bei unattended on the medic	•	
				dating nebulizer medicat		
				opened and proper stora		
				completed weekly x 2 we	-	
				x 3 months. Reports will	-	
				the weekly Quality Assur		
				by the Administrator to e		
				action initiated as approp		
				Compliance will be monit		
				ongoing auditing program	n reviewed at the	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM / FORM									
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		C 02/17/2022					
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
MARY GRAN NURSING CENTER	2		120 SOUTHWOOD DRIVE CLINTON, NC 28329						
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION					
F 761 Continued From pa	ge 25	F 761		IDS					

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