

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

PRINTED: 08/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2016
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(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 170 SS=C	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, the facility failed to deliver mail on Saturday to residents in the facility.</p> <p>The findings include:</p> <p>During an interview on 07/19/16 at 10:00 AM, the Resident Council President revealed she did not know who delivered mail to residents in the facility on Saturday.</p> <p>During an interview on 07/20/2016 at 4:33 PM the Activity Director revealed she delivered mail on weekdays but she did not know who delivered mail to residents on Saturday.</p> <p>During an interview on 07/20/2016 at 4:35PM the facility receptionist stated she knew the Activity Director delivered mail to residents during the week, but she did not know who delivered mail to residents on Saturday.</p> <p>During another interview on 07/20/2016 4:45 PM the facility receptionist revealed she talked to the Administrator and he told her, in the past they used to have an Activity staff person that delivered mail every weekend, but since they no longer had that person, they were in the process of finding out whether or not the mailman would</p>	F 170	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 170</p> <p>A corrective action for affected resident:</p> <p>On 08/05/2016, the Activity Director discussed the new procedure for delivering mail to residents on Saturdays with the Resident Council President. Effective 07/30/2016, the new procedure for delivering mail to residents on Saturday is that the manager on duty will retrieve all mail from the mailbox, sort, and deliver it as part of their duties on Saturdays. All current residents have the potential to be affected by the alleged deficient practice.</p>	8/12/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/05/2016

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.

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F 170	Continued From page 1 start delivering mail to the facility on weekends. During an interview on 07/20/2016 at 4:52 PM the Administrator revealed the facility had a post office box, however they were trying to get mail delivered onsite. He stated the mailman would drop off the mail and facility staff would disburse the mail.	F 170	On 08/05/2016, the Activity Director held a resident council meeting. All resident's present received information on the new procedure for delivering mail to residents on Saturdays. Systemic changes made were: On 07/30/2016, the following procedure was put in place for mail to be delivered to residents on Saturday. The manager on duty will be responsible for retrieving the mail from the mail box on Saturdays, and distributing that mail to the residents as needed. On 07/27/2016, the management team members were in-serviced by the Administrator on the new procedure for delivering mail to residents on Saturdays. The facility plans to monitor its performance by: The Social Worker will monitor this issue using the Mail Delivery Quality Assurance Tool for ensuring mail is delivered to residents according to the new procedure on Saturdays. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy,		

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F 170	Continued From page 2	F 170	HIM, Dietary Manager and the Administrator.		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to provide the physician ordered intervention for the treatment of Thrush (a fungal infection of the mouth) for 1 of 1 resident reviewed with Thrush. (Resident #183). The findings included: Resident #183 was admitted to the facility on 6/21/16 with diagnoses including Urinary Tract infection and Bacterial Infection. Review of the Admission Minimum Data Set (MDS) Assessment dated 6/28/16 identified Resident #183 as cognitively intact with a score of 15/15 on the Brief Interview for Mental Status. The resident had a surgical wound. Review of the Admitting Physician ' s orders documented Resident #183 was receiving Bactrim DS (double-strength) 800-160milligrams, two tablets, every 12 hours for a bacterial infection. Review of the Physician's Admission History and Physical dated 6/23/16 documented Resident #183 had white patches on his tongue and back</p>	F 309	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 309</p> <p>A corrective action for affected resident:</p> <p>For resident #183, the order for Diflucan was confirmed and administered to the resident on 06/26/2016 by the hall nurse.</p>	8/12/16	

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F 309	<p>Continued From page 3</p> <p>of the throat. The physician diagnosed Resident #183 with Thrush and listed under the "Plan" to order Diflucan (anti-fungal) 200 milligrams by mouth one time daily for three days. The order was placed in the facilities computer system (Point Click Care) by the physician. Review of the eMAR (electronic medication administration record) for June 2016 documented an order for Diflucan 200 milligrams by mouth one time a day for thrush until 6/27/16. Further review of the eMAR documented the medication was started on 6/26/16 and Resident #183 was given two doses; 6/26/16 and 6/27/16. During an interview with the resident on 7/20/16 at 9:03am he stated his mouth was full of white patchy stuff. He stated he was also vomiting during those days and it was really sore and he did not eat much. He stated the Thrush had now resolved.</p> <p>During an interview with Unit Manager #2 on 7/19/16 at 2:50pm she stated nurses were in-serviced to check the eMAR every 2 hours for orders that needed to be confirmed. She stated once an order was confirmed the order would go to the pharmacy. In the computer it read the order was to start on 6/24/16 and it appeared the nurse confirmed the order on 6/26/16. She stated it should not have taken three days for the nurse to confirm the order and be started.</p> <p>During an interview with the Director of Nursing on 7/20/16 at 10:00am she stated that the staff had been in-serviced and should have been looking to see if there were orders that needed to be confirmed. The medication should have started on 6/24/16. She also stated that in the morning meetings the Administrator, herself and the unit managers ' check for outstanding orders and she did not know how this had been missed. She further stated she was not aware that the</p>	F 309	<p>All current residents have the potential to be affected by the alleged deficient practice.</p> <p>On 08/02/2016, the Nurse Consultant reviewed the orders portal in Point Click Care for any orders pending confirmation. Orders pending confirmation were confirmed by the charge nurse on 08/02/2016.</p> <p>Systemic changes made were:</p> <p>Beginning on 8/9/2016, the Staff Development Coordinator will begin in-servicing all FT, PT, and PRN Nurses on the order confirmation process, where to go to check for orders that need confirming, how often to check the orders portal, and how to confirm the order when present. Daily Monday thru Friday, the Director of Nursing will check the order portal to ensure that orders are not missed that need confirmation. Completion date for training will be 08/12/2016. This information has been integrated into the standard orientation training for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>The facility plans to monitor its performance by:</p> <p>The Director of Nursing will monitor this issue using the Orders Review Quality Assurance Tool for monitoring orders pending confirmation. This will be</p>		

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F 309	Continued From page 4 medication was started late or that a dose was missed until the State Surveyor brought this to her attention. During an interview with the Administrator on 7/20/16 at 3:40pm he stated he would expect the medication to be confirmed by the nurse timely and given as ordered.	F 309	completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to do weekly skin assessments for a resident with a neck contracture and at risk for pressure ulcers for 1 of 4 residents reviewed for pressure ulcers (Resident #140) resulting in a Stage II pressure ulcer. The findings include:	F 314	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	8/12/16	

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F 314	Continued From page 5 Resident #140 was readmitted to the facility on 5/16/14 and re-admitted on 7/29/14 with diagnoses including Anemia, Osteoporosis with vertebral compression fractures, Osteoarthritis and Coronary Artery Disease. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated 5/17/2016 identified Resident #140 as severely cognitively impaired with a score of 3 on the Brief Interview for Mental Status. Resident #140 required extensive, one person assistance with bed mobility, dressing, toilet use, personal hygiene and bathing, transferring only occurred once or twice, walking in the room and corridor did not occur, eating was independent with one person assistance, moving from a seated to standing position, walking, turning around and moving on and off the toilet did not occur. Resident #140 had no range of motion limitations of the upper extremities and had impairment to one side of the lower extremities. She did not use mobility devices. Resident #140 was always incontinent. She had no falls. She was at risk for pressure ulcer but had no unhealed pressure ulcers. Resident #140 was not receiving physical or occupational therapy. Review of the Care Area Assessments (CAAs) Summary dated 8/15/15 triggered in the area of Pressure Ulcers related to activities of daily living assistance for bed mobility was needed, frequent incontinence and the resident was at risk for developing pressure ulcers. Review of the Care Plan dated 8/15/15 documented the Focus as at risk for pressure ulcer development. Interventions in meeting the	F 314	compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 314 A corrective action for affected resident: For resident #140, on 07/20/2016, the stage 2 pressure ulcer was identified and the Nurse Practitioner was notified and treatment was initiated by the charge nurse. All current residents have the potential to be affected by the alleged deficient practice. On 07/22/2016, the hall nurses began performing head to toe skin assessments of all current residents to assess for any new areas of skin breakdown. This was completed on 08/01/2016. Systemic changes made were: On 08/04/2016, the nurse management team reset the weekly skin check UDA schedules to fire the UDA's according to the facility schedule. This will be completed on 08/04/2016. Weekly, the Director of Nursing will monitor the UDA Portal to ensure timely completion of weekly skin checks according to the facility schedule. On 08/09/2016, the Staff Development Coordinator will begin in-servicing all FT, PT, and PRN Nurses on how to complete	

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F 314	<p>Continued From page 6</p> <p>goal of having minimized development of pressure ulcers included, in part, assist with frequent position changes and turning for pressure reduction and comfort and reporting to the nurse immediately if your note: redness, open areas, irritation of the skin.</p> <p>Review of the Weekly Skin Assessment assignment sheet documented Resident #140 was to be assessed weekly on the 11pm-7am shift on Mondays.</p> <p>Review of the Standard Assessment tab in the Point Click Care computer system documented the last skin assessment was performed on 4/12/16. The computer had, written in red, Next assessment due: weekly skin checks: 93 days overdue.</p> <p>Review of the Nursing Progress note dated 7/18/16 documented the resident had an existing area under the chin/neck that a sitter had been treating with Lanaseptic (skin protectant) and the area was not improving. The note read the nurse attempted to roll a washcloth to help support the neck and head and absorb moisture.</p> <p>Review of the Nursing Progress note dated 7/19/16 documented the area under the chin was red and tender. The note read that a telfa pad was applied under the chin to prevent rubbing.</p> <p>Review of the Nursing Note dated 7/20/16 documented the area to chin was red and moist. The resident was noted holding her chin down to her chest area. The resident was seen by the Nurse Practitioner. Antibiotics were ordered. The area was cleaned with wound cleanser and Xeroform gauze (petroleum gauze) and a dry dressing were applied. A wound consult was initiated.</p> <p>Review of the Physical Therapy (PT) evaluation dated 7/21/16 documented a diagnosis of Contracture of the muscle. The note read, in part,</p>	F 314	<p>a weekly skin UDA (User Defined Assessment) in Point Click Care. Included in the education was how to perform a head to toe skin assessment, how to enter the findings into the weekly skin check UDA, and what to do if new skin conditions are noted. The completion date for training will be 08/12/2016. This information has been integrated into the standard orientation training for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>The facility plans to monitor its performance by:</p> <p>The Staff Development Coordinator will monitor this issue using the Weekly Skin Check UDA Quality Assurance Tool for monitoring completion of the weekly skin check UDA. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.</p>		

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F 314	<p>Continued From page 7</p> <p>Resident #140 was referred to PT by Nursing due to a grade 1 or 2 pressure wound on the right anterior neck just above the medial clavicle and an area below the mental protuberance and a positioning device was necessary to improve posture. The PT noted without treatment, the resident was at risk for continued worsening of the wound and contracture.</p> <p>During observations on 7/18/16 at 11:38AM resident #140 was in bed and on her back with her head leaning downwards with her chin resting on her chest. Sitter #1 was observed in the room. Observations 7/19/16 at 9:48AM showed Resident #140 in bed lying on her back with her neck resting on chest. The head and neck was tilted downward. There was a Telfa pad observed under chin between chin and chest. Sitter #2 was observed in the room.</p> <p>Observations 7/20/16 at 2:03PM showed Resident #140 in bed, leaning forward with her neck resting on chest. Sitter #3 was observed in the room.</p> <p>During an observation 7/20/16 at 2:05PM with the Physical Therapist, Resident #140 was observed in bed, lying on her back with her head tilted downwards. Her chin was resting on her chest. Observation on 7/20/16 with Nurse #1 at 2:35PM Resident #140 was in bed on her back with her head and neck tilted downwards. The chin was observed lying on her chest. The area appeared reddened, moist and multiple areas were observed with what appeared like blisters with the tops of the skin removed.</p> <p>During an interview with Sitter #1 on 7/18/16 at 11:38AM she stated that she had sat with the resident for 3+ years. Sitter #1 stated over the past few weeks her head had been leaning more downward. Sitter#1 stated she had tried to pull her neck up and tilt it back so it would be more</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>comfortable but the resident would moan. Sitter #1 stated the resident now had an open area under her neck and chin.</p> <p>During an interview with Sitter #2 on 7/19/16 at 9:48AM she stated that she has sat with the resident over one year and she had always had " sort of a humpback " and would lean forward. Sitter #2 stated because her neck stayed down the area underneath stayed " damp " and it was irritated.</p> <p>During an interview with Sitter #3 on 7/20/16 at 2:03PM she stated the resident ' s neck had tilted lower towards her chest over the past few weeks. Sitter #3 stated the resident no longer tilted her head up to eat.</p> <p>During an interview with the Physical Therapist on 7/20/16 at 2:05PM she stated the resident had been on the PT schedule over a year ago (2014)but that she had not been seen since then. The PT stated her posture had been curved over but it was much worse now. The PT also stated in the past no braces or appliances were used because the resident could tilt her head back to eat. The PT stated it may have been positioning with her posture a year ago but now there is evidence of a contracture because the neck muscles were weak.</p> <p>During an interview with the NA #1 on 7/20/16 at 2:28PM she stated she did bathe the resident this morning and she really doesn ' t move her neck.</p> <p>During an interview with Nurse #1 on 7/20/16 at 2:35PM she stated the area affected is where the chin bone lays on the chest. Nurse #1 stated she would put a rolled up pillowcase under her chin but then that stayed wet. Nurse #1 stated this resident ' s room was assigned to the 11pm-7am</p>	F 314			

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F 314	Continued From page 9 shift for weekly skin checks every Monday. During an interview with Unit Manger #2 on 7/20/16 at 2:38PM she stated she could not find skin assessment since 4/12/2016. Unit Manager #2 stated weekly skin assessments should have been done. Unit Manager #2 stated apparently one of the sitters let the nurse know there was an open area and the sitters had been applying Lanaseptic. Unit Manager #2 stated the area was most definitely related to pressure and that she was made aware today of the issue. Interview with Treatment Nurse on 7/20/16 at 3:10PM she stated the hall nurses do all weekly assessments unless the resident had an active wound. The 11PM - 7AM nurse was unavailable for interview during the survey. During an interview with the Director of Nursing on 7/20/16 at 3:35PM she stated it would be her expectation that weekly skin checks be performed. During an interview with the Administrator on 7/20/16 at 3:40PM he stated he expected that weekly skin checks be done.	F 314			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318		8/12/16	

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F 318	<p>Continued From page 10</p> <p>Based on record review, observations and sitter and staff interviews, the facility failed to provide services to prevent a further decrease in range of motion resulting in a contracture for 1 of 4 (Resident #140) residents reviewed with diminished range of motion.</p> <p>The findings included:</p> <p>Resident #140 was admitted to the facility on 5/16/14 with diagnoses including Anemia, Osteoporosis with vertebral compression fractures, Osteoarthritis and Coronary Artery Disease and re-admitted on 7/29/14 with diagnoses including Hip Fracture from mechanical fall.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated 5/17/2016 identified Resident #140 as severely cognitively impaired with a score of 3 on the Brief Interview for Mental Status. Resident #140 required extensive, one person assistance with bed mobility, dressing, toilet use, personal hygiene and bathing, transferring only occurred once or twice, walking in the room and corridor did not occur, eating was independent with one person assistance, moving from a seated to standing position, walking, turning around and moving on and off the toilet did not occur. Resident #140 had no range of motion limitations of the upper extremities and had impairment to one side of the lower extremities. She did not use mobility devices. Resident #140 was always incontinent. She had no falls. She was at risk for pressure ulcer but had no unhealed pressure ulcers. Resident #140 was not receiving physical or occupational therapy. Section J0200 referring to should pain assessment be conducted answered</p>	F 318	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 318</p> <p>A corrective action for affected resident:</p> <p>For resident #140, the MDS Coordinator updated the residents care plan to include contractures and interventions for ROM daily with care. This was completed on 08/02/2016. In addition to this, on 07/21/2016 the resident was evaluated by OT for contracture interventions and picked up on case load.</p> <p>All current residents have the potential to be affected by the alleged deficient practice.</p> <p>Beginning on 08/06/2016, the Nursing Staff will begin assessing all current residents for contractures. If contractures are identified, the MDS Coordinator will audit the care plan to ensure the contractures are care planned and interventions included in the care plan as indicated. In addition to this, each resident identified with contractures will be</p>		

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F 318	<p>Continued From page 11</p> <p>yes. There were no answers to the pain assessment interview documented.</p> <p>Review of the Care Area Assessments (CAAs) Summary dated 8/15/15 triggered in the area of Activities of Daily Living (ADL) function related to decreased ADLs due to decreased functional mobility, pathological fractures of the vertebrae along with osteoporosis which causes the resident not to be able to do some things for herself. Problems listed in which resident was at risk for because of her functional decline included: complications of immobility, such as contractures.</p> <p>Review of the Care Plan, dated 8/21/15, documented the Focus as having an ADL Self Care Performance deficit related to a decrease functioning related to a hip fracture. Interventions in maintaining the current level of functioning included, in part, refer to Physical/Occupational therapy as needed, monitor, document and report to the physician as needed any changes and declines in function and report any redness, broken areas or irritation noted on the skin to the nurse immediately.</p> <p>Review of the Care Plan, dated 9/24/15 documented the Focus as using ½ length side rails and Geri-chair with increased risk for associated complications and injuries. Interventions in minimizing the risk for complications related to using ½ side rails included, in part, observe for, document and report to the physician changes regarding effectiveness of the device, contracture formation and skin breakdown.</p> <p>Review of the resident ' s most recent care plans</p>	F 318	<p>screened by OT for the need of additional interventions. This process will be completed by 08/12/2016.</p> <p>Systemic changes made were:</p> <p>On 08/08/2016, the Interdisciplinary Care Plan Team will be in-serviced by the Nurse Consultant on care planning requirements, and updating care plans when risk are identified through the CAA process. On 08/11/2016, the Staff Development Coordinator will in-service all FT, PT and PRN nurses and CNA's on the referral process for referring residents to nursing and therapy for evaluation of new and worsening contractures. Completion date for training is 08/12/2016. This information has been integrated into the standard orientation training for MDS Coordinators and hall nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>The facility plans to monitor its performance by:</p> <p>The Support Nurse will monitor this issue using the Contracture Care Quality Assurance Tool for monitoring residents with contractures for appropriate interventions. This will be completed weekly for 4 weeks monitoring 5 residents then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective</p>		

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F 318	<p>Continued From page 12</p> <p>revealed no problems identified for contractures or decreased range of motion.</p> <p>Review of the Quarterly Nursing Assessment dated 5/12/16 documented Resident #140 ' s mobility was very limited and she could make occasional slight changes in body or extremity position but was unable to make frequent or significant changes independently.</p> <p>Review of the Physician progress note dated 6/21/16 had no documentation of a contracture.</p> <p>Review of the Nursing Progress note dated 7/18/16 documented the resident had an area under the chin/neck and the sitter had been treating the area with Lanaseptic and the area was not improving. The note documented that the Nurse #1 attempted to roll a washcloth to help support the neck and head and absorb the moisture.</p> <p>Review of the Nursing Progress note dated 7/19/16 documented the area under the chin was red and tender. A telfa pad was applied under the chin to prevent rubbing.</p> <p>Review of the Nursing Progress note dated 7/20/16 documented Physical Therapy (PT) was given an order to evaluate for an appliance to lift the chin and stabilize the neck.</p> <p>Review of the Physical Therapy evaluation dated 7/21/16 documented a diagnosis of Contracture of the muscle. The note read, in part, Resident #140 was referred to PT by Nursing due to a grade 1 or 2 pressure wound on the right anterior neck just above the medial clavicle and an area below the mental protuberance and a positioning device was necessary to improve posture. The therapist noted without treatment, the resident was at risk for continued worsening of the wound and contracture.</p>	F 318	<p>action initiated as appropriate.</p> <p>Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.</p>		

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F 318	<p>Continued From page 13</p> <p>The PT note of 7/21/16 further read, Resident #140 ' s joint alignment was assessed. The assessment documented Resident #140 ' s neck extension was initiated to hold the head up with minimal movement noted. The PT documented a poor non-fixed to fixed contracture of the neck in the right antero-lateral flexed posture and chronic shortening of the anterior neck muscle secondary to poor posture and prolonged immobility. A neck pillow was to be placed at the neck area for an hour or as tolerated with 30 to 60 minutes break, and then applied again.</p> <p>The clinical impression on 7/21/16 documented the " Impact on Burden of Care/Daily Life " as having complicating factors, including long-term neck right, anterior-lateral flexion posture resulting in a worsened neck contracture; Precautions: Grade 1 to 2 pressure ulcer on area below the mental protuberance and right anterior neck above the medial clavicle.</p> <p>During observations on 7/18/16 at 11:38AM resident #140 was in bed and on her back with her head leaning downwards with her chin resting on her chest. Sitter #1 was observed in the room.</p> <p>Observations 7/19/16 at 9:48AM showed Resident #140 in bed lying on her back with her neck resting on chest. The head and neck was tilted downward. Sitter #2 was observed in the room.</p> <p>Observation 7/20/16 at 2:03PM showed Resident #140 in bed, leaning forward with her neck resting on chest. Sitter #3 was observed in the room.</p> <p>During an observation 7/20/16 at 2:05PM with the Physical Therapist, Resident #140 was observed in bed, lying on her back with her head tilted downwards. Her chin was resting on her chest.</p> <p>Observation on 7/20/16 with Nurse #1 at 2:35PM Resident #140 was in bed on her back with her head and neck tilted downwards. The chin was</p>	F 318			

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F 318	<p>Continued From page 14</p> <p>observed lying on her chest. The area appeared reddened, moist and multiple areas were observed with what appeared like blisters with the tops of the skin removed.</p> <p>During an interview with Sitter #1 on 7/18/16 at 11:38AM she stated that she had sat with the resident for 3+ years and over the past few weeks her head had been leaning more downward. The sitter stated that she had tried to pull her neck up and tilt it back so it would be more comfortable but the resident would moan. Sitter #2 stated the resident did not reposition herself in bed and the resident now had an open area under her neck and chin.</p> <p>During an interview with Sitter #2 on 7/19/16 at 9:48AM she stated that she had sat with the resident over one year and the resident had always had " sort of a humpback " and would lean forward. Sitter #2 stated that because her neck stayed down the area underneath stayed " damp " from drooling and it was irritated.</p> <p>During an interview with Sitter #3 on 7/20/16 at 2:03PM she stated the resident ' s neck had tilted lower towards her chest over the past few weeks. Sitter #3 stated the resident no longer tilted her head up to eat.</p> <p>During an interview with the Physical Therapist on 7/20/16 at 2:05PM she stated the resident had been on the PT schedule years ago (2014) for rehabilitation for a fractured hip but that she had not been seen since then. The Physical Therapist stated her posture had been curved but it was much worse now. The Physical Therapist also stated in the past no braces or appliances were used because the resident could tilt her head back to eat. The Physical Therapist further stated that it may have been positioning with her posture a year ago but now there was evidence of a</p>	F 318			

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F 318	Continued From page 15 contracture because the neck muscles were weak. The Physical Therapist stated usually when changes are noted the nursing staff will complete a screening referral. The Physical Therapist stated if the resident ' s neck had been evaluated and treated it may not have progressed like it did; however she stated, it was now probably too late to change the position. The Physical Therapist stated she was unaware of this issue. During an interview with the NA #1 on 7/20/16 at 2:28PM NA #1 stated the resident was bathed this morning and the resident really doesn ' t move her neck. NA #1 stated the resident would hold on the side rail when staff turned her , but she could not turn herself. During an interview with Nurse #1 on 7/20/16 at 2:35PM Nurse #1 stated the area affected was where the chin bone laid on the chest. Nurse #1 stated she would put a rolled up pillowcase under her chin but then that stayed wet. Nurse #1 stated that one of the sitter ' s had been applying Lanaseptic to the area and when it was not getting better the sitter informed the nursing staff. Nurse #1 stated this resident ' s room was assigned to the 11pm-7am shift for weekly skin checks every Monday. During an interview with the Director of Nursing (DON) on 7/20/16 at 3:35pm she stated it would be her expectation if nursing determined there was a need for a therapy referral that that would have been done. During an interview with the Administrator on 7/20/16 at 3:40pm he stated he would have expected a therapy referral to have been made for Resident #140.	F 318			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		8/12/16	

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F 329	<p>Continued From page 16</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacist interviews, the facility failed to obtain an abnormal involuntary movement assessment for 1 of 5 sampled resident reviewed for unnecessary medications (Resident #47).</p> <p>Findings included:</p> <p>Resident #47 was admitted to the facility on 5/9/16 with a diagnosis to include Alzheimer's</p>	F 329	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged</p>		

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F 329	<p>Continued From page 17</p> <p>dementia with behavioral disturbances and psychosis.</p> <p>Review of the Physician's admission orders dated 5/9/16 revealed an order for Risperdal (an antipsychotic medication that can cause side effect of jerky movements) 0.25 mg (milligrams) by mouth twice daily for psychosis. The order was changed on 5/7/16 to Risperdal 0.5 mg by mouth at bedtime and Risperdal 0.25 mg by mouth every morning for Psychosis.</p> <p>Review of the monthly Pharmacist Consultant review documented request on 5/18/16, 6/21/16 and 7/14/16 for an AIMS (Abnormal Involuntary Movement Scale) to be done. The pharmacy note of 5/18/16 had a (N) placed next to the recommendation.</p> <p>During an interview with the Unit Manger #1 on 7/20/16 at 10:05 am she stated she did not see an AIMS in the medical record.</p> <p>During an interview with the Director of Nursing on 7/20/16 at 10:13 am she stated the AIMS should be done when a resident was on anti-psychotic medication, usually on initiation of the medication or on admission to the facility if the resident was admitted on an anti-psychotic medication.</p> <p>During an interview with the Administrator on 7/20/16 at 10:46 am he stated when the pharmacist recommended an AIMS to be done, the Unit Manager should have acted on the recommendation and completed the AIMS.</p> <p>During an interview on 7/20/16 at 3:45pm with the Consultant Pharmacist she stated it was her</p>	F 329	<p>deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F329</p> <p>Corrective Action for Resident Affected</p> <p>On 07/20/2016, an AIMS assessment was completed for resident # 47 by the Support Nurse.</p> <p>All current residents receiving an antipsychotic or Reglan have the potential to be affected by the alleged deficient practice.</p> <p>All residents receiving antipsychotics and Reglan medications have the potential to be affected by this practice. On 08/02/2016, a report was generated from Point Click Care (PCC) of all residents receiving anti-psychotic and Reglan medications. The Nurse Management Team audited all identified residents for the most recent completed AIMS assessment to ensure an AIMS assessment had been completed within the past 6 months. This was completed on 08/02/2016.</p> <p>Systemic Changes made were: On 08/08/2016, Nurse Consultant in-serviced the Director of Nursing, Staff Development Coordinator, Unit Manager, MDS Nurse, and Support Nurse on the requirements for completion of AIMS assessment on residents that receive an antipsychotic medication or Reglan. An AIMS assessment must be completed on</p>		

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F 329	Continued From page 18 expectation for the AIMS to be completed on admission. She stated the (N) on the pharmacy recommendation meant the recommendation was done and given to the Nursing Unit Manager to complete the AIMS.	F 329	admission if the resident is on an antipsychotic or Reglan, when an antipsychotic or Reglan is initiated, and every 6 months thereafter. This information has been integrated into the standard orientation training for all Directors of Nursing, Staff Development Coordinator, Unit Manager, MDS Nurse, and Support Nurse and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The MDS Nurse will be responsible for auditing five residents receiving anti-psychotic or Reglan for compliance with AIMS completion q six months. This will be done weekly for one month then monthly times two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		8/12/16	

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F 428	<p>Continued From page 19 pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and consultant pharmacist interview, the facility failed to act on pharmacy recommendations requesting an abnormal involuntary movements (AIMS) assessment for 1 of 5 residents reviewed for unnecessary medications (Resident #47).</p> <p>Findings included:</p> <p>Resident #47 was admitted to the facility on 5/9/16 with a diagnoses to include Alzheimer ' s Dementia with behavioral disturbances and Psychosis.</p> <p>Review of the Physician ' s admission orders dated 5/9/16 revealed an order for Risperdal 0.25milligrams by mouth twice daily for Psychosis. The order was changed on 7/15/16 to Risperdal 0.5milligrams by mouth at bedtime and Risperdal 0.25milligrams by mouth every morning for Psychosis.</p> <p>Review of the monthly Pharmacy Review documented requests on 5/18/16, 6/21/16 and 7/14/16 for an AIMS to be done. The note had a (N) placed next to the recommendation.</p>	F 428	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 428</p> <p>Corrective Action for Resident Affected</p> <p>On 07/20/2016, an AIMS assessment was completed for resident # 47 by the Support Nurse.</p> <p>All current residents have the potential to be affected by the alleged deficient practice.</p> <p>All current residents have the potential to be affected by the alleged deficient</p>		

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F 428	<p>Continued From page 20</p> <p>During an interview with the Unit Manger #1 on 7/20/16 at 10:05am she stated she did not see an AIMS in the medical record.</p> <p>During an interview with the Director of Nursing on 7/20/16 at 10:13am she stated the AIMS should be done when a resident is on anti-psychotic medications, usually on initiation of the medication or on admission to the facility if the resident is admitted on an anti-psychotic medication.</p> <p>During an interview with the Administration on 7/20/16 at 10:46am he stated when the pharmacist recommended an AIMS to be done, the Unit Manager should have acted on the recommendation and completed the AIMS.</p> <p>During an interview on 7/20/16 at 3:45pm with the Consultant Pharmacist she stated it was her expectation for the AIMS to be completed on admission. She stated the (N) on the pharmacy recommendation meant the recommendation was done and given to nursing.</p>	F 428	<p>practice. On 08/02/2016 a chart audit was initiated for all current residents for staff pharmacy recommendations that have not been carried out. This will be completed by comparing the last three months of staff pharmacy recommendation reports to the residents chart. Any discrepancies noted will be corrected by the Nurse Management Team. This audit was completed on 08/12/2016.</p> <p>Systemic Changes made were:</p> <p>Effective 08/12/2016, the following procedure was incorporated for following up on the monthly pharmacy recommendations for staff. When the Monthly Pharmacist Report is delivered to the Director of Nursing (DON), the DON will assign a copy of the Monthly Pharmacist Recommendations to the Unit Manager and Support Nurse within 48 hours. The staff recommendations will then be followed up within 14 days of receiving the report. The procedure for responding to the monthly pharmacy staff recommendations will be as follows: The staff recommendations will be addressed as indicated and a response written in the column titled "Follow-Through". Once all staff recommendations are responded to, the report will be given to the Director of Nursing and filed in the Monthly Pharmacy Recommendations Notebook. The Nurse Management Team (DON, Staff Development Coordinator and Unit Manager) received education on this new procedure by the Nurse Consultant on 08/08/2016. This information has been</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2016
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(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 428	Continued From page 21	F 428	<p>integrated into the standard orientation training for all Directors of Nursing, Staff Development Coordinator, Unit Manager, MDS Nurse, and Support Nurse and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>The facility plans to monitor its performance by:</p> <p>The QA Nurse Consultant will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Pharmacist Recommendations. The monitoring will include verifying that the monthly pharmacy review report recommendations were carried out as outlined above. This will be completed on a sample of 10 resident's a month for 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.</p>		