STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR 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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure that residents received proper services as ordered by physician for 1 of 1 resident ' s requiring a Podiatry appointment. (Resident #61) Resident #61 was admitted to the facility on 2/15/11 with diagnoses including Diabetes Mellitus. The most recent quarterly Minimum Data Set (MDS) Assessment dated 8/10/11 assessed Resident #61 as being moderately impaired cognitively, independent with bed mobility and eating, needing limited assistance with transfers, having limited range of motion on her dominant upper and lower body, using a walker or wheelchair for mobility, having no pain and having a Stage I pressure area. The resident was identified by the facility as able to make her needs known. Review of the Request for Patient Evaluation Form dated 6/24/11 diagnosed Resident #61 with an abscess of the left great toe. The plan documented Diabetic shoes and continue current treatment	F 250	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. **Corrective Action for Resident Affected** Resident #61 was seen by a Podiatrist on 9/28/11 and was fitted for new diabetic shoes on10/6/11. **Corrective Action for Resident Potentially Affected** All residents who are diabetic are at risk for this alleged deficient practice. All residents were reviewed on 10/14/2011 by the Director of Nursing and Unit Managers to ensure no resident has a missed podiatry appointment. **Systemic Changes** All nurses (RNs and LPNs) who currently work in the facility will be in-serviced on 10/12/11 by the SDC on following physician orders with an emphasis on residents keeping podiatry appointments. Any nurse who does not receive training on 10/12/11 will not be allowed to work until in-service training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing will monitor this issue using the "Appointment Audit Tool". The monitoring will include conducting 10 chart reviews of resident appointments. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	10/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/10/11

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 250	Continued From page 1 Review of Resident #61 ' s medical record documented on 6/24/11 that the Nurse Practitioner ordered Diabetic shoes and a Podiatry consult when toes are healed . Review of the August 2011 Treatment Administration Record (TAR)documented that Resident #61's toes were healed on 8/30/11. Review of the September 2011 TAR documented that Resident #61 was to have a Podiatry consult "when toes healed.". The treatment was documented as discontinued on the September 2011 TAR. During an Interview with Nurse #3 on 9/22/11 at 8:55AM she stated that when an order is written for a Podiatry appointments the Unit Manager (UM) would get the pink copy of physician's order so that they (UM) could follow up on the order. The UM also would get a copy of the "Request for CMC patient eval form," which the physician or Nurse Practitioner completes when they see the resident. Nurse #3 stated that she was not working on this unit in June so she did not know what happened to the pink copies or the physician's visit (request for CMC patient evaluation form). Nurse #3 stated that when the issue was brought to the facility ' s attention on 9/21/11 she made Resident #61 a Podiatry appointment for the week 9/26/11. During an interview with the Administrator on 9/22/11 at 10:30AM he stated that it was his expectation that the resident appointments would be made when the physician writes an order for one. Our goal is to provide quality care for our	F 250		

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

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F 250	Continued From page 2 residents.	F 250	**Corrective Action for Resident Affected** Resident #61 was seen by a Podiatrist on 9/28/11 and was fitted for new diabetic shoes on10/6/11.	10/14/11
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to provide medically related services to attain diabetic shoes for 1 of 1 residents requiring diabetic footwear. (Resident #61). Resident #61 was admitted to the facility on 2/15/11 with diagnoses including Diabetes Mellitus and History of Cerebrovascular Accident with Hemiplegia. The most recent quarterly Minimum Data Set (MDS) Assessment dated 8/10/11 assessed Resident #61 as being moderately impaired cognitively, independent with bed mobility and eating, needing limited assistance with transfers, having limited range of motion on her dominant upper and lower body, using a walker or wheelchair for mobility, having no pain and having	F 328	**Corrective Action for Resident Potentially Affected** All residents who are diabetic are at risk for this alleged deficient practice. All residents were reviewed on 10/12/2011 by the Director of Nursing and Unit Managers to ensure all physicians' orders are being followed. **Systemic Changes** All nurses (RNs and LPNs) who currently work in the facility will be in-serviced on 10/12/11 by the SDC on following physician orders with an emphasis on residents with special needs. Included in the training will be communication protocol between nursing and social service department so residents receive their physician ordered durable medical equipment timely. Any nurse who does not receive training on 10/12/11 will not be allowed to work until in-service training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing will monitor this issue using the "Physician Order Audit Tool". The monitoring will include conducting 10 chart reviews of resident's physician orders. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate.	

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F 328	Continued From page 3 a Stage I pressure area. The resident was identified by the facility as able to make her needs known. Review of Resident #61 ' s medical record documented that the Nurse Practitioner ordered Diabetic shoes on 6/24/11. Review of the Request for Patient Evaluation Form dated 6/24/11 diagnosed Resident #61 with an abscess of the left great toe. The plan documented Diabetic shoes and continue current treatment. Review of the Request for Patient Evaluation Form dated 8/9/11 documented that Resident #61 had a Stage II pressure area on her left heel. During an observation of Resident #61 ' s feet on 9/21/11 at 3:10PM, she was observed to be wearing a pair of black shoes with a brand name from a local store. The shoes were observed to be loose on the resident ' s feet. She was wearing knee high hose which were not prescription. At this time, Resident #61 stated that she would like to have special shoes to help her feet. During an interview with a Nursing Assistant # 1 on 9/21/11 at 3:10PM, she stated she was not aware that Resident #61 had any Diabetic shoes. During an interview with Nurse #1 on 9/21/11 at 3:25pm she stated that she gave a slip to the Social Worker in June, but it takes awhile for the shoe folks to come measure and then it takes another 6-8 weeks before the shoes actually get here.	F 328		

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F 328	Continued From page 4 During an interview with the Social Worker on 9//21/11 at 5:33pm she stated that she was unaware that resident had an order for diabetic shoes. She stated usually the nurse will tell me or give me the pink copy of the physician ' s orders. During an interview with Nurse #3 on 9/21/11 at 5:45pm she stated that she did not know anything about diabetic shoes for Resident #61. During an interview with the Social Worker on 9/21/11 at 5:45PM, she stated that in the Nursing Notes there was an entry documenting that (name of company) was faxed an order for diabetic shoes and " will wait a response. " Nurse #1 had signed the entry. The Social Worker further stated that when she spoke with (name of company) today, on 9/21/11, they asked that another request be faxed to them. She stated that another request was faxed. During an interview with Nurse #3 on 9/22/11 at 8:55AM she stated that when an order is written for Diabetic shoes the Unit Manager (UM) would get the pink copy of physician's order so that they (UM) could follow up on the order. The UM also would get a copy of the "Request for CMC patient eval form," which the physician or Nurse Practitioner completes when they see the resident. Nurse #3 stated that she was not working on this unit in June so she did not know what happened to the pink copies or the physician's visit (request for CMC patient evaluation form). During an interview with the Administrator on	F 328		

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F 328	Continued From page 5 9/22/11 at 10:30AM he stated that it was his expectation that the resident would have received the diabetic shoes in a timely fashion when they were ordered. Our goal is to provide quality care for our residents.	F 328	**Corrective Action for Resident Affected** Resident #199's order for Nystatin was stopped 9/26/11. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this alleged deficient practice. DON and Unit	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist interview, and staff interview, the facility failed to ensure	F 329	Managers will review all medications that require a stop date to ensure all residents are free of unnecessary medications. This will be completed by 10/14/11. **Systemic Changes** All nurses (RNs and LPNs) who currently work in the facility will be in-serviced on 10/12/11 by the SDC on following physician orders with an emphasis on keeping residents free of unnecessary medication. Also included in the education will be medications that require a stop date so nurses can alert physicians when a medication should be stopped. Any nurse who does not receive training on 10/12/11 will not be allowed to work until in-service training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing will monitor this issue using the "MAR Audit Tool". The monitoring will include conducting 10 chart reviews of resident's MAR to ensure they're free of unnecessary medications. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	10/14/11

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F 329	Continued From page 6 residents were free from medication used for excessive duration for 1 of 10 sampled residents (resident #199) reviewed for unnecessary medications. Findings include: Resident #199 was admitted to the facility 2/25/11 and readmitted on 3/11/11. Cumulative diagnoses included Dysphagia and Gastrostomy on 3/9/11. Review of the Physician Progress Note, dated 3/18/11, under the Problem list did not note thrush. Review of the resident ' s ears/nose/mouth/throat did not document any oral sores or thrush. Review of Physician ' s Orders dated 3/24/11 documented that Resident #199 was started on Nystatin 10cc (cubic centimeters) four times a day for 10 days. Nystatin belongs to the group of medicines called antifungals. The liquid forms of this medication are used to treat fungus infections in the mouth. Review of the Physician Progress Note, dated 4/1/11, noted the resident had thrush. Review of Physician ' s Orders dated 4/2/11 noted that the resident was to continue Nystatin until thrush resolved. Review of the Physician Progress Note, dated 4/16/11, noted resident continued with thrush. Documented below Assessment and Plan was to resume Nystatin Suspension four time daily with a swab to be applied to the tongue and oral cavity times 14 days. Review of Physician ' s Orders dated 4/16/11	F 329		

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F 329	Continued From page 7 read Nystatin with swab to tongue QID. The order did not specify duration of therapy. Review of the Physician Progress Note, dated 4/28/11, 5/3/11, 5/11/11, 7/9/11, 7/19/11, 8/3/11 and 9/6/11 noted under Physical Exam that the mouth and throat were normal with no ulcers present. Review of the Medication Administration Records beginning 4/16/11 through 9/21/11 documented that Resident #199 received Nystatin 100,000 units/ML (milliliter) suspension swabbed to his tongue four times per day. Review of the Pharmacy Consultants notes for May, June, July, August and September 2011 revealed no documentation addressing the need for continued antifungal use or request for evaluation by the attending physician. During an interview with Nurse #2 on 9/21/11 at 11:00AM she stated that a family member wants the Nystatin continued. She further stated that the resident began to eat pureed meals for the last several weeks and only receives his tube feeding if he eats less than 75% of his meals. During an interview with the Director of Nursing on 9/21/11 at 11:10am she stated that the facility does not have a standing order for the use of Nystatin. During an interview with the Pharmacy Consultant on 9/21/11 at 11:25am she stated that she would not have addressed the continued use of the Nystatin because the resident has a dry mouth and receiving feeding via a gastrostomy tube,	F 329		

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F 329	Continued From page 8 both of which can lead to thrush. She stated that the medication can be used prophylactically. During an interview with the Nurse Practitioner on 9/21/11 at 12:05PM she stated that she would have thought that after 8 weeks of use that it would have been re-evaluated. However, residents receiving tube feedings oftentimes have problems with thrush. This resident does have problems with a lack of moisture in his mouth and in June an order was written for Oral Moisture to the inside of his mouth three times a day. She stated the he may not need the Nystatin but there has been no harm in using it. When his primary physician in April 2011 wrote his progress note he did document to take the medication for 14days. His primary physician changed in May 2011 and if the note was in the chart when the oncoming physician read the April 2011 note stating use for 14days, the new physician may have assumed that the Nystatin was completed and did not follow up on this. The Nurse Practitioner stated that she would stop the Nystatin and see how the resident does. Review of the Physician's orders dated 9//21/11 read to discontinue Nystatin. During an interview with the Administrator on 9/22/11 at 10:30am he stated that he would expect that on the monthly review of the medications that pharmacy consultant would make recommendations of medications that should or should not be continued. He stated that he thought the facility missed this one .He further stated that he would also expect that nurses would question why a medication is still being used if the condition has resolved.	F 329		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to adequately monitor food storage in 3 of 3 kitchen refrigerators. Review of the policy entitled, " Handling of Left Food Items " read, " Left over food items are discarded after 72 hours unless otherwise indicated " . During the initial tour on 9/19/2011 beginning at 10:35 am, reach-in cooler #1 contained a plastic container of cream soup dated "9/11/11". Observation of reach- in cooler #2 revealed one container of cheese sauce dated " 9/13/11", an open plastic bag of chopped onions wrapped in aluminum foil dated " 9/13/11, and ½ pan of diet yellow Jell-O dated " 9/15/11 The walk in cooler was observed to have left over vegetable soup dated 9/13/2011 in a shallow metal pan. During an interview with the Kitchen Manager on 9/19/11 at 10:35 am it was stated foods were to be used by 3 days or discarded. He indicated	F 371	**Corrective Action for Resident Affected** All outdated food has been removed from refrigerators. **Corrective Action for Resident Potentially Affected** All residents are at risk for this alleged deficient practice. Dietary Manager or his designee will review refrigerators daily to ensure outdated food is removed timely. **Systemic Changes** All kitchen staff will be in-serviced 10/14/11 on proper food storage. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Administrator will monitor this issue using the "Food Storage Audit Tool". The monitoring will include conducting daily rounds to ensure all outdated food is properly disposed of timely. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	10/14/11

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F 371	Continued From page 10 kitchen staff are to check daily for outdated foods and discard any found. The Kitchen Manager discarded all the outdated items found in the refrigerator. A cook was interviewed on 9/19/ AM at 11:45 am. She stated the soup was left over from the weekend. She revealed one resident liked to have a bowl of vegetable soup at night so kitchen staff saved the soup all week for the resident. The Kitchen Manager stated on 9/21/11 at 2:35 pm the kitchen makes vegetable soup one day each week and keeps it for one resident who likes soup at night. He stated staff discard any left over soup when they make the next pot.	F 371	**Corrective Action for Resident Affected** All trash was placed in the dumpster and the dumpsters were sprayed for yellow jackets. **Corrective Action for Resident Potentially Affected** All residents are at risk for this alleged deficient practice. Housekeeping Supervisor will review the dumpsters daily for proper trash disposal. Supervisor will also search for yellow jackets and inform Maintenance Department if spray is needed. **Systemic Changes** All housekeeping staff will be in-serviced 10/14/11 on proper trash disposal. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Administrator will monitor this issue using the "Trash Disposal Audit Tool". The monitoring will include conducting daily rounds to ensure all trash is disposed of properly and if spray is needed for yellow jackets. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to ensure garbage was stored to prevent the harborage of insects and failed to have the area around the dumpsters free of debris for 4 of 4 dumpsters. Findings include: The dumpster area behind the kitchen was observed on 9/19/2011 at 1:40 pm. Scattered pieces of paper and boxes were observed around the four trash dumpsters. Yellow Jackets were noted to be swarming around the outside walls,	F 372		10/14/11

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F 372	Continued From page 11 massing on the doors, and flying inside all four trash dumpsters. A second observation was made on 9/20/2011 at 2:30 pm while first shift workers were taking trash out to the dumpsters. The dumpsters were in the same condition. A third observation on 9/21/2011at 2:45PM revealed three of four trash dumpster doors were closed and had no yellow jackets. The first dumpster had an open door and yellow jackets were observed to be in the dumpster and around the outside of the door. In an interview with the Kitchen Manager on 9/21/2011 at 2:50 pm he stated maintenance sprayed for insects at the facility. On 9/22/2011@ 10:25 am Maintenance Employee #1 stated they spray all the time. He indicated the spray used was like fly spray. He revealed the spray did some good for a while but then the yellow jackets were back. Maintenance Employee #1 stated staff go back and spray again whenever someone complains. Maintenance employee #1 reported the facility had a contract with (name of pest control company), Inc who visited the facility two times a month or as needed. He said they have called (name of pest control company) about the yellow jackets. During a phone interview with the Branch Manager of (name of pest control company) on 9/22/2011 at 11:30 Am he stated they typically do not spray dumpsters unless there is an issue reported. He revealed he did not ever recall	F 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328

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F 372	Continued From page 12 having to spray the dumpsters at the facility. He stated any time the facility needed a service or had an area of concern they noted it in the log book provided by (name of pest control company). The service man then completed the service requested. The Branch Manager stated the pest control company had some pesticides that would be extremely toxic to yellow jackets. He stated the treatment would take about 5 minutes to complete. He indicated it was important for staff and residents not to be exposed to yellow jackets. The Branch Manager revealed many people are allergic to yellow jacket stings and it could be a big health issue for employees and residents if they were stung. During an interview with Housekeeping employee #2 on 9/22/2011 at 1:00 pm he stated he had been at the facility for 5 years. The employee revealed the yellow jackets were present several months every year when it was hot and humid. He indicated the insects disappeared when the weather gets colder. An interview was conducted with Housekeeping employee #3 on 9/22/2011 at 2:40 pm. She stated she had been at the facility for 3 months and took trash out every day. The employee indicated the insects had been there every day since she started working. The Housekeeper revealed she had heard Maintenance sprayed for the yellow jackets. The employee stated she threw the bags of trash into the dumpster as fast as she could and ran back so she would not be stung.	F 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328

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F 372	Continued From page 13 A review of the facility pest control log book dated from 6/4/2011 - 9/9/2011 showed no entries indicating the yellow jackets were present at the dumpsters nor any request for services to remove them.	F 372	**Corrective Action for Resident Affected** Resident #199's order for Nystatin was stopped 9/26/11. **Corrective Action for Resident Potentially Affected** All residents are at risk for this alleged deficient practice. DON and Unit Managers will review all medications that require a stop date to ensure all residents are free of unnecessary medications. DON & Unit Managers will review Pharmacy Consultant reports monthly to ensure medications are not given for an excessive duration. This will be completed by 10/14/11. **Systemic Changes** All nurses (RNs and LPNs) who currently work in the facility will be in-serviced on 10/12/11 by the SDC on following physician orders with an emphasis on keeping residents free of unnecessary medication. Also included in the education will be medications that require a stop date so nurses can alert physicians when a medication should be stopped. Any nurse who does not receive training on 10/12/11 will not be allowed to work until in-service training has been completed. The Pharmacy Manager will in-service Pharmacy Consultant on ensuring medications are not given for an excessive duration. This will be completed by 10/14/11. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing will monitor this issue using the "MAR Audit Tool". The monitoring will include conducting 10 chart reviews of resident's MAR to ensure they're free of unnecessary medications. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate.	
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 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist interview, and staff interview, the facility failed to ensure the consultant pharmacist identified medication given for excessive duration for 1 of 10 sampled residents (resident #199). Findings include: Resident #199 was admitted to the facility 2/25/11 and readmitted on 3/11/11. Cumulative diagnoses included Dysphagia and Gastrostomy on 3/9/11. Review of the Physician Progress Note, dated 3/18/11, under the Problem list did not note thrush. Review of the resident ' s ears/nose/mouth/throat did not document any oral sores or thrush.	F 428		

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	345218	A. BUILDING _____ B. WING _____	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR 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 14 Review of Physician ' s Orders dated 3/24/11 documented that Resident #199 was started on Nystatin 10cc (cubic centimeters) four times a day for 10 days. Nystatin belongs to the group of medicines called antifungals. The liquid forms of this medication are used to treat fungus infections in the mouth. Review of the Physician Progress Note, dated 4/1/11, noted the resident had thrush. Review of Physician ' s Orders dated 4/2/11 noted that the resident was to continue Nystatin until thrush resolved. Review of the Physician Progress Note, dated 4/16/11, noted resident continued with thrush. Documented below Assessment and Plan was to resume Nystatin Suspension four time daily with a swab to be applied to the tongue and oral cavity times 14 days. Review of Physician ' s Orders dated 4/16/11 read Nystatin with swab to tongue QID. The order did not specify duration of therapy. Review of the Physician Progress Note, dated 4/28/11, 5/3/11, 5/11/11, 7/9/11, 7/19/11, 8/3/11 and 9/6/11 noted under Physical Exam that the mouth and throat were normal with no ulcers present. Review of the Medication Administration Records beginning 4/16/11 through 9/21/11 documented that Resident #199 received Nystatin 100,000 units/ML (milliliter) suspension swabbed to his tongue four times per day.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	09/22/2011

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F 428	Continued From page 15 Review of the Pharmacy Consultants notes for May, June, July, August and September 2011 revealed no documentation addressing the need for continued antifungal use or request for evaluation by the attending physician. During an interview with Nurse #2 on 9/21/11 at 11:00AM she stated that the family wants the Nystatin continued. She further stated that the resident began to eat pureed meals for the last several weeks and only receives his tube feeding if he eats less than 75% of his meals. During an interview with the Director of Nursing on 9/21/11 at 11:10am she stated that the facility does not have a standing order for the use of Nystatin. During an interview with the Pharmacy Consultant on 9/21/11 at 11:25am she stated that she would not have addressed the continued use of the Nystatin because the resident has a dry mouth and receiving feeding via a gastrostomy tube, both of which can lead to thrush. She stated that the medication can be used prophylactically. During an interview with the Nurse Practitioner on 9/21/11 at 12:05PM she stated that she would have thought that after 8 weeks of use that it would have been re-evaluated. However, residents receiving tube feedings oftentimes have problems with thrush. This resident does have problems with a lack of moisture in his mouth and in June an order was written for Oral Moisture to the inside of his mouth three times a day. She stated the he may not need the Nystatin but there has been no harm in using it. When his primary physician in April 2011 wrote his progress note he	F 428		

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F 428	Continued From page 16 did document to take the medication for 14days. His primary physician changed in May 2011 and if the note was in the chart when the oncoming physician read the April 2011 note stating use for 14days, the new physician may have assumed that the Nystatin was completed and did not follow up on this. The Nurse Practitioner stated that she would stop the Nystatin and see how the resident does. Review of the Physician's orders dated 9//21/11 read to discontinue Nystatin. During an interview with the Administrator on 9/22/11 at 10:30am he stated that he would expect that on the monthly review of the medications that the pharmacy consultant would make recommendations of medications that should or should not be continued. He stated that he thought the facility missed this one .He further stated that he would also expect that nurses would question why a medication is still being used if the condition has resolved.	F 428		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 370 CLINTON, NC 28328

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K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: corridor wall located on 300 hall near soiled utility room had a unsealed opening greater than 2 inches. Rating of wall be maintain to meet construction type of facility. 42 CFR 483.70(a)	K 017	K17 Unsealed opening in our 300 hall corridor repaired. 10/17/11 All corridor walls reviewed for openings. This will be added to Maintenance Department's Preventative Maintenance logs for monitoring. Any deficient practice will be reviewed by QA Comm. K29 Self Closing mechanism added to Med Records storage door. 10/18/11 This is the potential to affect all residents. This will be added to Maintenance Department's Preventative Maintenance logs for monitoring. Any deficient practice will be reviewed by QA Comm.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/4/11

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.

GW

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K 029	Continued From page 1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: door to Med. Records is not self closing.	K 029		
K 038 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: doors to PT and Med. Records require two motions of hand to open door to corridor.	K 038	K38 1 lock removed from PT & Med Room doors. This has the potential to affect all residents. This will be added to Maintenance Department's monthly PM logs for monitoring. Any deficient practice will be reviewed by QA Comm.	10/18/11

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	345218	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 2 42 CFR 483.70(a)	K 038		
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: on activation of fire alarm, strobe in Unit 1 dining room did not work.	K 051	K51 Strobe light in Unit 1 Dining Room replaced. This has the potential to affect all residents. This will be added to Maintenance Department's monthly PM logs for monitoring. Any deficient practice will be reviewed by QA Comm.	11/5/11

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	345218	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2011

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K 051	Continued From page 3 42 CFR 483.70(a)	K 051		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: riser room located in Central supply room is not sprinkled. Also storage with in 18 inches of sprinkler head in Med. Record room. 42 CFR 483.70(a)	K 056	K56 Storage is Med Records room is below 18 inches of sprinkler head. All storage rooms have been reviewed so all material is 18 inches below sprinkler head. This will be added to Maintenance Department's monthly PM logs for monitoring. Any deficient practice will be reviewed by QA Comm.	10/14/11

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	348218	A. BUILDING 02 - BUILDING 02 B. WING	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: chapel door requires two motion of hand to open door to exit corridor. 42 CFR 483.70(a)	K 038		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 8.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: multi plug taps are being used in rooms 202,204 and 806 for use to plug TV into. 42 CFR 483.70(a)	K 147	K147 Plug taps were removed from rooms 202, 204 & 806. All plug taps were removed from other resident rooms. This will be added to Maintenance Department's weekly PM logs for monitoring. Any deficient practice will be reviewed by QA Comm.	11/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/4/11

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.