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 _____	C 08/24/2012

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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a resident's medication administration record was secured for 1 of 11 residents (Resident #75).	F 164	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. **F 164** **Corrective Action for Resident Affected:** For Resident # 75, the Medication Administration Record was assessed on 9/14/12 by the unit Manager and noted to have a plastic divider in place for use as a cover. **Corrective Action for Resident Potentially Affected:** All residents have the potential to be affected by the alleged deficient practice. On 9/12/14, all Medication Administration Record's and Treatment Administration Records were assessed by the Unit Managers and Support Nurses for plastic dividers to use as a cover for privacy. Any Medication Administration Record's and Treatment Administration Records noted without plastic dividers were replaced immediately by the Unit Manager and Support Nurses. This was completed on 9/14/12. **Systemic Changes** An in-service will be completed by 9/14/12 by the Staff Development Coordinator. Those who attended were all RN's and LPN's and Med Tech's, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Staff were in-serviced on 9/14/12: Maintaining confidentiality of all Medication Administration Record's and Treatment Administration Record's during the medication administration process and when treatments are being provided. The plastic dividers in the Medication Administration Records and Treatment Administration Records are to be used to cover the confidential information during the Medication Pass as well as when providing treatments to the resident's. Additional plastic dividers if needed are located in the Med Room. 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.	9/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrate | (X6) DATE: 9/14/12

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 164	Continued From page 1 Findings included: Record review indicated Resident #75 was admitted to the facility on 1/6/2011 with diagnoses which included Diabetes Mellitus. Review of a facility policy entitled "Health Information Management" dated October 2005, under section "Safety and Controls", it was indicated "Patient medical records are the property of the facility, and every effort shall be made to ensure the confidentiality of the records and to avoid release of their contents except to authorized personnel or government agencies according to HIPAA Policies and Procedures." During an observation of medication administration on 8/23/2012 at 10:25AM, Nurse #5 stood at the medication cart outside room 611 and drew up Insulin for Resident #75. The nurse then locked the medication cart and entered room 611. The nurse left the resident's Medication Administration Record (MAR) open and uncovered atop the medication cart while she was in the resident's room. The nurse stood beside the resident's wheelchair and administered the insulin into the resident's left arm. The medication cart was not visible from inside the resident's room. On return to the medication cart, the nurse was asked how the MAR should be left when out of her sight. She stated "I should have closed it or covered the page so no one could see it." In an interview with the Director of Nursing (DON) on 8/23/2012 at 1:17PM, the DON reported the expectation was a resident's MAR should be closed or covered when unattended.	F 164	**Quality Assurance** The Staff Development Coordinator will monitor the issue using the QA Monitor Privacy for monitoring that the plastic dividers are being used during medication administration and when treatments are being provided to the resident to prevent exposure of protected health information. This will be completed daily Monday thru Friday x 2 weeks then weekly x 3 months or until resolved by QOL/QA committee. See **Attachment #1.** Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Support Nurses, Social Workers, Dietary Manager and Business Office Manager.	

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide oral care (Resident #50), and routine nail care (Resident #80 and #85) for 3 of 13 sampled residents requiring extensive to total assistance for activities of daily living (ADLs). The findings include: 1. Resident # 80 was admitted to the facility on 3/7/2011 with diagnoses of diabetes and dementia. The Minimum Data Set (MDS) dated 6/08/12 noted the resident as being severely impaired for cognition and daily decision making. The resident was also noted to have long and short term memory problems. The MDS also indicated the resident required extensive assistance with all ADLs .The MDS did not indicate the resident resisted care. The resident care plan updated 6/9/2012, included a problem/need of requiring assistance with ADLs, but did not mention resident refusing care. A review of nurse notes from July 1, 2012 to the present found no documentation of the resident refusing care. An observation of the resident ' s fingernails having dark brown matter underneath was made	F 312	~~F 312~~ **A corrective action for Resident #3 has been accomplished by:** Resident #50, oral care was provided 9/7/12 by Nursing Assistant. Resident's # 80 and 85, nails were cleaned and trimmed 9/7/12 by Nursing Assistant. **A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All resident's have the potential to be affected by the alleged deficient practice. All residents were assessed for the need of oral and nail care by the Unit Managers and Support nurse using the Oral and Nail care audit tool. This was completed on 9/14/12. Residents that were identified as needing oral and/or nail care had care provided to them by their assigned CNA. This was completed by 9/14/12. **See Attachment #2.** **Systemic changes made were:** On 9/14/12 a nursing in-service was held for all Full-time and Part-time RN's, LPN's, CNA's and Med Tech's. The Staff Development Coordinator reviewed a power point with the staff regarding providing oral hygiene and nail care. Also discussed were the schedule for CNA's trimming non-diabetic resident's nail's and the schedule for nurses to clean diabetic resident's nails. **See attachment #3.** The facility specific in-service was sent to each Hospice Provider whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until 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.	9/14/12

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F 312	Continued From page 3 on 8/22/12 at 4:20PM. The resident was also observed on 8/23/12 at 9:30 AM with dark brown matter underneath the fingernails. In an interview on 8/23/2012 at 10:50AM, NA #1 stated that resident nail care was done daily and more often if needed. An observation was made on 8/23/12 at 3:30 PM of the resident sitting at a table in the dining room; the resident had dark brown matter under her fingernails. The resident was observed at 9:30 AM on 8/24/12 as having brown matter under the fingernails while the resident was in bed. On 8/24/12 at 9:35 AM in an interview, nurse #1 stated that the resident was known to put her hands in her brief and get feces on her hands and fingernails then could be combative when staff tried to clean them. Nurse #1 stated that on 8/23/12, she and two NAs tried to get the resident to let them clean her nails, and the resident refused. On 8/24/12 at 9:45 AM in an interview, the unit manager, stated that the diabetic nail care was done by a nurse, but that if the nails are dirty, they needed to be cleaned whenever they appeared to be dirty. In an interview with the Director of Nursing on 8/23/12 at 3:10 PM, the DON indicated that her expectations were that the basic daily care for residents would include hair care, oral care, nail care, bath and dressing. 2. Resident (#50) was admitted 6/5/12. The care	F 312	**The facility plans to monitor its performance by:** The Unit Managers will monitor this issue using the Oral and Nail Care QA Tool for monitoring oral and nail care. This will be completed 5 days a week x 2 weeks then weekly x 3 months or until resolved by QOL/QA committee. **See Attachment #4.** Reports will be given to the weekly Quality of Life Committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Support Nurses, Social Workers, Dietary Manager and the Business Office Manager.	

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F 312	Continued From page 4 plan, dated 6/6/12, noted that resident needed assistance for all ADLs. The Minimum Data Set (MDS) dated 7/3/12 noted that the resident was cognitively intact, and required total to extensive assistance with all activities of daily living (ADLs). No mention of dental status was revealed in a review of the nurse notes from 7/31/12 to present. On 8/22/12 at 3:00 PM the resident's teeth were observed as being brown. The resident stated that she did not brush her teeth and that staff did not brush her teeth. When asked if she could brush her own teeth, the resident replied "I guess I could if they put the toothbrush in my hand, and propped my arm up. "Resident was observed to have bilateral contractures of her hands. On 8/23/12 at 2:55PM, NA #2 stated that she had just completed cares for the resident. She stated that she had not done any oral care. NA #2 was unable to find a toothbrush in the bedside table top drawer. During the interview the resident's toothbrush was located in the second drawer of the bedside table in the plastic packaging, unopened. NA #2 stated that she was a float, but had taken care of the resident in the past. The NA also stated that when she had taken care of the resident in the past, that she had given her mouthwash then, but had not brushed her teeth. In an interview with the Staff Development coordinator on 8/23/2012 at 3:30 PM the nurse stated that as part of orientation, the NAs were expected to pass off a checklist of resident cares, particular to the shift that they worked. For the day shift, which was 7AM to 3PM, the expectation included daily mouth care, and denture care.	F 312		

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F 312	Continued From page 5 During an interview on 8/23/12 at 3:10 PM, the Director of Nursing (DON) stated that her expectation for basic care was nail care, oral care, bath and dressing. 3. Resident #80 was readmitted to the facility on 10/8/2012 with cumulative diagnosis of dementia, mental disorder, muscle weakness, failure to thrive and quadriparesis due to a cerebral vascular accident. Review of the Minimum Data Set dated 8/14/2012 of resident #80 indicated the resident had severe cognitive impairment and was totally dependent of staff for personal hygiene and bathing. The MDS indicated the resident had range of motion impairment of both upper and lower extremities. Review of resident #80 care plan dated 8/16/2011 with updates indicated a problem area of the resident had needed extensive to total assistance from the staff for all activities of daily living due to a history of a cerebral vascular accident with approaches of the staff to provide personal hygiene daily, and to monitor the finger nails daily for need for trimming and cleaning. On 8/21/2012 through 8/24/2012 several observations had been made daily of resident #80 ' s fingernails being long, jagged and thick. On 8/24/2012 at 10:41 am resident #80 ' s fingernails were brought to the attention of nurse #1 who at the time filed the nails and provided nail care. On 8/24/2012 an interview with the treatment aide	F 312		

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F 312	Continued From page 6 indicated that finger nail care for a resident had been done by the nurse if the resident had a diagnosis of diabetes and nursing assistants other wise. The treatment aide indicated finger nail care was expected to be done with daily personal care which included cutting of the nails. On 8/24/2012 at 10:11 am an interview with nurse #4 indicated that primary finger nail care had been the responsibility of the 3pm to 11 pm nursing assistants if the resident was not a diabetic. The Nurse #1 indicated resident #80 had a history of long thick finger nails. On 8/24/2012 at 10:57 am an interview with nurse aid #3 indicated that nail care for the resident ' s was to be done daily and if needed cutting and filing of the nail. On 8/24/2012 at 10:50 am an interview the unit Nurse Manager #1 indicated her expectation was that all nursing staff could have done nail care. The manager indicated nursing assistants on the 3 pm to 11 pm shift are responsible for cutting and trimming the nails, but any staff member could do nail care if needed.	F 312	**F 371** **A corrective action for Steam Table and Lids has been accomplished by:** All warming lids have been washed by the Housekeeping Staff. The warming unit has been cleaned and painted by the Maintenance staff. This was completed on 9/10/12 **A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** This has the potential to affect all residents. All warming lids have been washed by the Housekeeping Staff. The warming unit has been cleaned and painted by the Maintenance staff. This was completed on 9/10/12 **Systemic changes made were:** The Dietary Manager, DM, will in-service all Cooks and Dietary Aides on 9/18/12. The DM will educate staff on following cleaning schedules and reviewed new Quality Assurance tool to monitor the cleaning of warming lids and warming units. **See Attached.** **The facility plans to monitor its performance by:** The Dietary Manager will monitor this issue by using the Steam Table Audit Tool. This will be completed 5 days a week x 2 weeks then weekly x 3 months or until resolved by Quality of Life/Quality Assurance committee. **See Attachment.** Reports will be given to the weekly Quality of Life Committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Support Nurses, Social Workers, Dietary Manager and the Business Office Manager.	9/18/12
F 371 SS=D	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			

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

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interviews the facility failed to maintain sanitary condition of one of two steam tables (in the dining room). On 8/21/2012 at 11:56 am, 8/22/2012 at 11:00 am and 3:30 pm, 8/23/2012 at 9:30 am and 2:30 pm, and 8/24/2012 at 9:57 am an observation was made of the steam table unit in the dining room to have dried food and sticky brown substance on the individual lids to the warming units, and a sticky brown substance between each warming unit, down the front of the unit and on the bottom shelf. On 8/24/2012 at 10:00 am an interview with the Dietary Manager indicated it was the expectation of the person serving the food from the steam table to clean the table after each serving with the supplied Quat-10 cleaning solution. The Manager indicated it had been the facility protocol to run the lids of the individual warming units through the dishwasher on the weekends. The manager at this time observed the unit and viewed the dried food on the lids and the sticky brown substance on the warming unit and lids. The manager indicated he had expected the steam table unit should have been cleaned after each use. The Manager was observed to take the lids to the kitchen and clean the unit with the Quat-10 solution.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from	F 412		

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F.412	Continued From page 8 an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to ensure a resident received dental services for 1 of 3 residents (resident #30). Findings included: Record review indicated Resident #30 was admitted to the facility on 3/14/2012. Review of a physician progress note dated 3/22/12 revealed "Significant problem with her mouth. She has studs in her lower jaw to hold her dentures, however her dentures were not fitting correctly and she couldn ' t wear them, and the studs have caused ulcerations in her mouth. She has been seeing Clinton Family Dentistry regularly for her mouth problem and they are trying to adjust her dentures. " Review of a progress note dated 4/26/12 revealed "She was seen at (name of local dentist), and they referred her to (name of dental school). The dental school will see her when her nutrition issues have resolved. "	F 412	**F 412** **Corrective Action for Resident Affected:** Resident #30 was seen by UNC Chapel Hill Dental School on 09/11/12. **Corrective Action for Resident Potentially Affected:** All residents with orders for a dental consult have the potential to be affected by the alleged deficient practice. On 9/12/12 all residents current Physician orders, past 6 months of consults and progress notes were reviewed for orders for a dental consult and it was then verified that the appointment has been scheduled or obtained. **See Attachment #5.** This was completed by the Unit Managers and Support Nurse on 9/14/12. **Systemic Changes** An in-service will be completed by 9/14/12 by the Staff Development Coordinator. Those who attended were all Unit Managers and Support Nurses FT and PT. Any staff member who did not receive in-service training will not be allowed to work until training has been completed. Staff was in-serviced on obtaining appointments for dental consults. When an order is received for a dental consult, if an appointment is not obtained within 72 hours of receiving the order, the Director of Nursing will be notified and consulted for next steps in obtaining the appointment. **See Attachment #6.** Notification will be discussed daily as needed in the Daily Quality of Life meeting x 3 months or until resolved by the Quality of Life Committee. 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.	9/14/12

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F 412	Continued From page 9 Review of a nursing note dated 6/19/2012 at 3:26PM indicated "(name of dental school) called by this nurse in response to message left with phone #. Stated they had faxed referral form to (name of local dentist) to be completed since referral was made from there and were still awaiting it back. This nurse also requested a form to complete to see if it would help process be completed so patient could have appointment made, stated she would fax a form to this nurse and facility fax and phone number given. Will await form, complete and send back to (name of dental school). " In an interview on 8/21/2012 at 4:11PM, the resident reported she had dental issues and she was waiting for an appointment to address them. She indicated she had metal studs on her bottom jaw which held her dentures in place. She indicated her dentures did not fit properly on the studs anymore, and they were trying to get her a dental appointment to have the problem fixed. She indicated the studs bothered her now, and she hoped it would be fixed soon. She reported when she was admitted into the facility, she had mouth ulcers which were caused by the metal studs and indicated the ulcers were healed. She revealed she was being seen by a local dentist prior to admission to the nursing facility, and that office had referred her to a different dental office for further treatment. The resident reported she was not sure what the hold up was for her dental appointment. In an interview with Nurse Manager #2 on 8/24//12 at 1150AM, the nurse reported resident #30 had a referral from a local dentist to a dental	F 412	**Quality Assurance** The Director of Nursing will monitor this issue using the QA Tool Dental Consult. This will be completed daily Monday thru Friday x 2 weeks then weekly x 3 months. **See Attachment #7.** Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Support Nurses, Social Workers, Dietary Manager and Business Office Manager.	

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F 412	Continued From page 10 school when she was admitted to the facility. The nurse also reported issues over the last several months between the local dentist, the dental school and the facility. The nurse further reported she had not involved any other staff with assistance in getting the appointment set up. In an interview with the resident's physician on 8/24/2012 at 12:15 PM, he reported the facility sent him a fax on 4/3/2012 with information about the resident needing to be seen at (name of dental school). He also reported he misunderstood information in the fax, and he initially thought the dental school was concerned with the resident's nutritional status and wanted that resolved before an appointment was made. He reported he understood now that was not the case and it was the nurse at the facility who was concerned about the resident's nutritional status. In an interview with the Director of Nursing(DON) on 8/24/2012 at 12:55PM, the DON reported the expectation was dental appointments and referrals be made in a timely manner. The DON further reported five months was not timely in regard to Resident #30.	F 412	**431** **Corrective Action for Resident Affected:** No residents were identified as having been affected by this alleged deficient practice. **Corrective Action for Resident Potentially Affected:** All residents have the potential to be affected by the alleged deficient practice. On 9/14/12 all medication rooms on Units 1-4 were audited for expired medications. **See Attachment #7.** This audit was completed by the Supply Clerk on 9/14/12. **Systemic Changes** An in-service will be completed on 9/14/12 by the Staff Development Coordinator. Those who attended were all RN's and LPN's, and the Supply Clerk FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Staff was in-serviced on proper disposal of expired medications. Medical Supplies Clerk will review Med Rooms weekly for expired medications. **See Attachment #7.** 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.	9/14/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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 _____	C 08/24/2012

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 431	Continued From page 11 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record, the facility failed to ensure that there were no expired items in one of four medication storage rooms (300 hall). Findings included: On 8/23/12 at 3:00PM, accompanied by nurse #3, an observation was made of the medication storage room on the 300 hall nurses station. In a basin marked prn (when necessary) breathing treatments, there were 3 zip top gallon bags with packages of albuterol solution (used to treat	F 431	**Quality Assurance** The Staff Development Coordinator will monitor this issue using the Expired Med Quality Assurance Tool for monitoring the Medication Rooms for expired Meds and signatures on the nightly audit tool. This will be completed Monday thru Friday x 2 weeks then weekly x 3 months or until resolved by Quality of Life/Quality Assurance committee. **See Attachment #8.** Reports will be given to the weekly Quality of Life- Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life/Quality Assurance Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Support Nurses, Social Workers, Dietary Manager and Business Office Manager.	

PRINTED: 11/26/2012
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	11/16/2012

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
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	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.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: By observation on 11/16/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; the fire alarm system would not silence upon activation of a pull station, except by resetting the device. Testing in multiple zones was not observed.	K 052	K052 Silencer was repaired on the fire alarm system. This was added to monthly PM program so it tested on a regular basis going forward. Any deficient practice will be reported to the monthly QA program. K211 Hand sanitizer was moved from area near the light switch in the 400 hall shower room and placed within the shower room at an appropriate location. All hand sanitizers were reviewed to ensure they were not placed within 6 inches of a light switch. Hand sanitizer review will be added to monthly PM program going forward. Any deficient practice will be reported to the monthly QA program.	12/10/12 11/16/12
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR)	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/4/12

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.

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

PRINTED: 11/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 211	Continued From page 1 dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 11/16/12 at approximately noon the following Alcohol Based Hand Rub (ABHR)dispenser was non-compliant, specific findings include; an alcohol based hand rub was located with six inches of the light switch in the unit 2, 400 hall shower room.	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING 02 - BUILDING 02 B. WING _____	11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

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

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.