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 03/27/2013

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 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide activities for one (1) of one (1) cognitively impaired residents confined to bed. (Resident #4). The findings include: Resident #4 was originally admitted to the facility on 6/14/10 and was readmitted on 6/5/12, with diagnoses including Late Effect Hemiplegia, Severe Intellectual Disability, Dementia with Behavior Disturbance, Psychosis, Osteoporosis, Osteoathrosis, History of Circulatory Disease, Abnormality of Gait and Muscle Weakness-General. According to the most recent Minimum Data Set (MDS) dated 2/2/13 Resident # 4 had long and short term memory deficits and severely impaired decision making. She required extensive to total assistance in all activities of daily living. Review of Resident #4's Care Plan in the area of activities, last reviewed on 2/1/13, read in part, " I am noted to not want to participate in my favorite activity. Intervention: Ask about my activity preference and help me plan. I prefer small group activities. Please assist me to get to activity, I choose. Help me visit with my friends and family in private location."	F 248	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 dates indicated. **F 248** **Corrective Action for Resident Affected:** On April 11, 2013 Resident #4's RP was contacted by Activity's Assistant to review her interests. Her activity plan was updated based on these interests. **Corrective Action for Resident Potentially Affected:** All bed fast residents were potentially affected. On April 23, 2013 all bedfast residents activity plans were reviewed and updated by the care plan team which consist of the RN MDS Coordinator, Activities Coordinator, Social Worker and Dietary Manager to meet their activity needs and interest. **Systemic Changes** Our Activities Director and Activities Assistant will be in-serviced 4/23/13 by the Administrator on developing an Activities Program for bedfast residents. When activity plans are updated, the Activity Director will contact the RP's for input and to include any changes they request.	4/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4/19/13

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 248	Continued From page 1 An activity note written by the Activity Coordinator on 1/31/13 at 1:08 PM read in part, "Activity Note: Quarterly- Patient is alert x1. Stays in bed due to personal preference according to nursing staff. Patient's TV is on in room for RO for patient." Review of Activity Notes for February and March, 2013, revealed the Activity Coordinator provided in room activities for Resident #4, twice a week in February and once a week in March. The activities consisted of in-room visits by the Activity Coordinator. During an observation on 3/26/13 at 2:00 PM Resident #4 was lying in bed awake. There was no music or television on in the resident's room. During an observation on 3/26/13 at 3:44 PM Resident #4 was lying in bed awake looking up at the ceiling and out of her window. She did not respond when spoken to. There was no music or television on in the resident's room. During an interview on 3/26/13 at 4:32 PM, Nursing Assistant (NA) # 1 stated she assisted Resident #4 with feeding, turning and keeping her dry. She revealed Resident #4 could not ring her call bell. She stated Resident #4 required total care every day. NA # 1 stated Resident #4 was in bed when she came in to work second shift, (3:00 PM to 11:00 PM) and she did not get her out of bed on second shift. She stated Resident #4 hollered out and screamed ever so often. NA # 1 stated Resident #4 did not attend activities in the evening and she was not sure if she attended activities during the day. During an observation on 3/26/13 at 4:45 PM, Resident #4 was lying in bed awake with no television or music on in her room. She looked out of the window and at the ceiling. During an observation on 3/27/13 at 10:00 AM,	F 248	**Quality Assurance** The Administrator or designee will monitor this issue using the Activity Audit QA Tool for monitoring 1:1 resident activities. This will be completed five times a week then weekly x 3 months or until resolved by QOL/QA committee. **See Attachment A.** Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	

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F 248	Continued From page 2 Resident #4 was in bed awake, hollering in her room in bed. There was no music or television on in her room. A singing activity was being held in the facility during this time period. During an observation on 3/27/13 at 10:15 AM, Resident #4 was awake in bed. She did not respond when spoken to and no television or music was on in her room. During an observation on 3/27/13 at 11:35 AM, Resident #4 was hollering sporadically in her room. She was lying in bed dressed in a red outfit and she was awake looking out of her window. There was no television or radio on in Resident # 4's room. During an observation on 3/27/13 at 11:55 AM, Resident #4 was hollering sporadically in her room. She was lying in bed awake looking up at the ceiling and out of her window. There was no music, television or any other forms of stimulating activity in her room. During an observation on 3/27/13 at 12:10 PM, Resident # 4 was hollering in her room sporadically. She was lying in bed awake, no television or music playing. Resident continued to look out of her window. During an observation on 3/27/13 at 12:25 PM, Resident # 4 continued to holler in her room sporadically. She was looking out of her window and there was no television or music playing in her room. Resident #4 was observed raising her head up from her pillow, she had one knee propped up on her bed, as if she was wanted to get out of bed. Resident # 4's lunch tray was in her room next to her bed. During an interview on 3/27/13 at 2:05 PM, Nursing Assistant (NA) # 2 stated she fed Resident # 4 breakfast, lunch and a snack. She revealed she bathed, changed and turned	F 248		

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F 248	Continued From page 3 Resident # 4 every two hours. She stated she used a mechanical lift to transfer Resident # 4 and she showered her every Tuesday and Thursday. NA # 2 stated Resident # 4 did not resist care and she did not exhibit any other behaviors except hollering. She stated she usually got Resident # 4 out of bed before lunch and 3:00 PM. She revealed when Resident # 4 was out of bed, she was up in her geri chair because of the way she was contracted. NA # 2 stated Resident #4 did not usually attend activities. She revealed Resident #4 went to a singing activity during Christmas. She revealed Resident # 4 hollered while up in the geri chair. During an observation on 3/27/13 at 2:15 PM Resident # 4 was lying in bed, awake. She had been hollering sporadically. A pillow had been moved from behind her head. There was no television or music playing in her room. She looked out of her window and at the ceiling. During an interview on 3/27/13 at 2:30 PM, the Activity Coordinator stated Resident # 4 was mostly bed bound. She stated she was alert and she yelled. The Activity Coordinator revealed she played music for Resident # 4 and when she was up she took her to personal touch to do her nails. She stated if Resident # 4 was not out of bed, she would do her nails in her room one to two times per week. The Activity Coordinator stated Resident # 4 responded by staring and she was not verbal. She revealed if Resident # 4 hollered during an activity she would provide stimulating activities such as rubbing her arms and doing things to calm her. During an interview on 3/27/13 at 3:15 PM, Staff Nurse # 1 stated Resident #4 liked certain music, listening to the radio, rather than television. She revealed the radio seemed to calm her. She	F 248		

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F 248	Continued From page 4 revealed there were days Resident # 4 hollered more than others. During an interview on 3/27/13 at 4:41 PM, the Director of Nursing revealed Resident #4 experienced periods of psychosis and she did not know how playing music or television in her room would affect her psychosis. She stated her expectation would be some type of stimulation in her room.	F 248	**Corrective Action for Resident Affected:** For Resident #4, the residents care plan was reviewed and *updated* to reflect her current status. This was completed on 4/19/13 by the Care Plan Team which consist of the RN MDS Coordinator, Activities Coordinator, Social Worker and Dietary Manager.	4/24/13
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to update/revise a	F 280	**Corrective Action for Resident Potentially Affected:** All resident's have the potential to be affected by the alleged deficient practice. On 4/22/13 to 4/24/13 all residents care plans will be reviewed by the Care Plan Team which consist of the RN MDS Coordinator, Activities Coordinator, Social Worker and Dietary Manager and their care plans will be reviewed for any needs or changes. **Systemic Changes** On 4/23/13, the Corporate MDS Consultant will in-service the Care Plan Team on reviewing and updating care plans. **Quality Assurance** The Director of Nursing or designee will monitor this issue using the Care Plan Audit QA Tool for monitoring changes and care plan updates. This will be completed five times a week for two weeks then weekly x 3 months or until resolved by QOL/QA committee. **See Attachment A.** Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	

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F 280	Continued From page 5 comprehensive care plan for one (1) of four (4) sampled residents reviewed. (Resident #4). The findings include: Resident #4 was originally admitted to the facility on 6/14/10 and was readmitted on 6/5/12, with diagnoses including Late Effect Hemiplegia, Severe Intellectual Disability, Dementia with Behavior Disturbance, Psychosis, Osteoporosis, Osteoathrosis, History of Circulatory Disease, Abnormality of Gait and Muscle Weakness-General. According to the most recent Minimum Data Set (MDS) dated 2/2/13, Resident # 4 had long and short term memory deficits and severely impaired decision making. Resident #4 required extensive to total assistance in all activities of daily living. Review of Resident #4's Care Plan dated 2/1/13 read, in part, "I require extensive total assistance with activities of daily living secondary to poor cognition. Goal: Resident will assist with activities of daily living skills as condition allows as evidenced by their participation x 90 days. If resident becomes resistant to care then attempt to determine cause and address, maintain safety and leave and approach later. Encourage resident to participate in activities of daily living as she is able. Provide task segmentation and praise for participation. Assist resident in choosing clothing to wear every day. Assist resident to perform oral hygiene every AM and as needed. Encourage patient each shift to sit up on edge of bed and try to stand or walk." Review of Resident #4's Care Plan, in the area of elopement, last reviewed on 2/1/13 read in part, " I am at risk for elopement attempt in the facility due to being able to move around the facility. I have a wander guard intact. Intervention: Notify Nurse of any change in mental status. Redirect	F 280		

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me when exit seeking behavior is noted. Engage me in conversation re: why or what I am seeking. Monitor for side effects of medications. Consult MD for changes in condition. All staff should notify the charge Nurse if resident begins to verbalize the desire to leave, sitting or standing at doors for prolonged periods or trying to exit doors.

Review of Resident #4's Care Plan in the area of wandering, last reviewed 2/1/13, read in part, " I like to safely wander in facility but I am at risk for injury and elopement due to being in wheelchair and becoming more mobile. Intervention: Reassure resident that needs will be met and provide assistance as needed with those needs. Gradually try to redirect resident if wandering becomes unsafe. Wander guard transmitter. Encourage her to do other things when rolling in wheelchair such as visiting other residents or sitting at nurse's station. Provide diversional activities, dolls, coloring, and other activities of interests.

In the area of activities, the Care Plan, read, " I am noted to not to want to participate in my favorite activities. Intervention: Ask about my activity preference and help me plan. I prefer small group activities. Please assist me to get to activities I choose. Please remind me when activities are scheduled. Help me visit with my friends and family in private location.

Resident #4's Care Plan in the area of communication, read, " I have difficulty making myself understood. One of the interventions included, " Make sure my glasses are clean and available at all times."

In the area of being at risk for recurrent skin breakdown secondary to urinary incontinence and poor appetite, an intervention was, " to be out of

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F 280	Continued From page 7	F 280		

bed daily to her wheelchair."
During two days of the investigation from 3/26/13 through 3/27/13, Resident # 4 was observed in bed or lying in a geri chair in the hallway. Observations revealed Resident #4 was not wearing glasses, was not sitting on the edge of her bed to stand, could not assist with oral hygiene and she could not wander or elope from the facility. In addition, Resident #4 was not out of bed daily in her wheelchair and she did not attend group activities.
During an interview on 3/26/13 at 4:32 PM, Nursing Assistant (NA) # 1 stated she assisted Resident #4 with feeding, turning and keeping her dry. She revealed Resident #4 could not ring her call bell. She stated Resident #4 required total care every day. NA # 1 stated Resident #4 was in bed when she came in to work second shift, (3:00 PM to 11:00 PM) and she did not get her out of bed on second shift. She stated Resident #4 hollered out and screamed ever so often.
During an interview on 3/27/13 at 2:05 PM, Nursing Assistant (NA) # 2 stated she fed Resident # 4 breakfast, lunch and a snack. She revealed she bathed, changed and turned Resident # 4 every two hours. She stated she used a mechanical lift to transfer Resident # 4 and she showered her every Tuesday and Thursday. NA # 2 stated Resident # 4 did not resist care and she did not exhibit any other behaviors except hollering. She stated she usually got Resident # 4 out of bed before lunch and 3:00 PM. She revealed when Resident # 4 was out of bed, she was up in her geri chair because of the way she was contracted.
During an interview on 3/27/13 at 4:04 PM, the Minimum Data Set (MDS) Coordinator stated Resident #4's Care Plan needed to be updated.

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F 280	Continued From page 8 She revealed Resident #4 went through periods of talking and started to go downhill. She revealed the resident's Care Plan was updated every three months. She said every Comprehensive Assessment had to be updated. She revealed within the last six months there had been a change in Resident #4's condition. She stated Care Plan meetings were held, they talked about the resident and had clinical meetings daily. During an interview on 3/27/13 at 4:37 PM, the Director of Nursing revealed that her expectation would be for Resident #4's Care Plan to be updated. During an interview on 3/27/13 at 5:00 PM, the facility Social Worker stated she did not know where Resident #4's wheelchair was located. She revealed Resident # 4 had a wheelchair in the past. The Social Worker stated Resident #4 was usually in bed. She revealed the resident was out of bed sometimes, but not very often. She said she did not know the reason Resident #4 was in bed. The Social Worker also revealed she thought Resident #4 used to wear glasses, but she had not seen her wear glasses lately.	F 280		