STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

(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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		5/31/18

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

Electronically Signed | 06/01/2018

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F 842	Continued From page 1 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to maintain complete and accurate records for pain medication administration for one of three residents reviewed for accurate and complete medical records (Resident #8). The findings included: Resident #8 was admitted to the facility 9/15/17 and discharged to the community 10/16/17. Cumulative diagnoses included diabetes, foot ulcer and other chronic pain.	F 842	Based on conversations with the surveyor, during the survey, the facility administrative team reviewed the potentially deficient practice on 5/16/2018. A preliminary plan of correction was in place as of 5/17/2018 to address missing medication documentation. The resident referenced under the deficiency is no longer a resident of the facility. Additionally, the specific staff member responsible for the deficient practice is no	

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F 842	Continued From page 2 An Admission Minimum Data Set (MDS) dated 9/22/17 indicated Resident #8 was cognitively intact. A care plan dated 9/15/17 stated Resident #8 had a diagnosis or condition likely to cause pain and Resident was taking pain medication. Interventions included to administer pain medication as ordered. Physician orders were reviewed and revealed the following order for PRN (as needed) pain medication: 9/15/17 oxycodone-APAP (Acetaminophen) 5-325 milligrams every four hours PRN pain. A review of the Controlled Drug Receipt/Record/disposition forms dated 9/16/17 through 10/16/17 documented Resident #8 received oxycodone-APAP 5-325 milligrams administered by Nurse #1 on the following dates: 9/16/17 at 2:30 AM, 9/21/17 at 10:00 PM, 9/22/17 at 7:30 PM, 9/23/17 at 7:30 PM, 9/24/17 at 7:30 PM, 9/24/17 at 11:30 PM, 9/25/17 at 7:30 PM, 9/26/17 at 11:30 PM, 9/27/17 at 7:30 PM, 9/27/17 at 11:20 PM, 9/28/17 at 7:50 PM, 9/28/17 at 11:50 PM, 9/29/17 at 3:50 AM, 9/29/17 at 6:45 AM, 9/30/17 at 7:00 AM, 10/5/17 at 7:45 PM, 10/5/17 at 11:50 PM and 10/7/17 at 12:05 AM. A review of the electronic PRN medication record and nursing notes revealed no documentation that Resident #8 received oxycodone-APAP 5-325 milligrams on the above dates and times. Nurse #1 no longer worked at the facility and could not be reached.	F 842	longer employed with the facility; therefore correcting the specific documentation errors as cited will not be attained. Through root cause analysis, it was found that the nurse was inadequately documenting medication administration, more specifically PRN medication administration. The nurse was documenting medications in the controlled substance declining count sheets and was documenting the medications as administered on most scheduled medication orders; however, she was only documenting some PRN medications as ordered. The process for documenting scheduled medications and PRN medications differs slightly, but it is believed that this staff member was not utilizing the computer system adequately. Results of audits (mentioned below) will now show if missing medication documentation is isolated to one or few staff members or if it is a more universal systematic issue; both isolated and/or universal issues will be addressed to ensure facility remains within regulatory compliance. Staff in-services were provided to all Nurses and Medication Aides beginning 5/17/2018; every Nurse and Medication Aide will be expected to acknowledge receipt and understanding of the medication documentation in-service prior to working his/her next scheduled shift. In-services directed from the administrative nurses/QA team instructed staff that medication administration documentation must match on the	

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F 842	Continued From page 3 On 5/17/18 at 4:00 PM, an interview was conducted with the Director of Nursing. She stated she and the Administrator had reviewed the documentation of the oxycodone-APAP 5-325 milligrams on 5/16/17 and realized that what was recorded on the Controlled Drug Receipt/Record/ disposition form was not completely documented on the electronic PRN medication record. Some of the doses of oxycodone-APAP 3-325 milligrams had not been documented on the electronic PRN medication record or in the nursing notes. She said the nursing notes were automatically generated when the medication was signed out on the electronic PRN medication record. The Director of Nursing stated her expectation was that the narcotic medication be documented and administered at the same time it was signed out on the control sheet and the documentation should match with times and dates on the control sheet, the electronic PRN medication record and the nursing notes. On 5/17/18 at 4:35 PM, an interview was conducted with the Administrator and the Director of Nursing. The Administrator also stated his expectation was for the control sheet, prn documentation and nursing notes to be accurate and complete.	F 842	declining count sheet and the eMAR documentation. An audit was initiated by the QA team on 5/16/18 and completed on 5/17/2018 to establish a baseline count of all controlled substances within the facility on this date. Daily audits began on 5/17/2018 of all scheduled and PRN controlled substances; audits will be completed daily for 30 days by the Administrative Nursing team. Following the 30 day daily audits, audits will become weekly for all PRN medications as PRN documentation was determined to be the primary issue through root cause analysis. Weekly PRN medication audits will be completed for 6 months at a minimum. If documentation discrepancies are noted, specific to declining count sheet, eMAR, and medication administration, the nurse or Medication Aide will be educated of facility expectations and procedures. If documentation discrepancies continue, the facility will utilize progressive discipline, re-training, or other measures to ensure accurate and complete documentation. The Director of Nursing Services will be responsible for directing POC elements and ensuring thorough and complete medication documentation of controlled substances; controlled substance medication documentation must match in the declining count sheet, eMAR, and resident medication administration. Documentation issues, discrepancies, and staff education will be reported to the facility Administrator and documented in the staff members personnel file. The	

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F 842	Continued From page 4	F 842	Director of Nursing will be responsible for monitoring, analyzing and reporting the results and progress of on-going audits through the Executive QA committee at quarterly meetings for the duration of daily and weekly audits. The next scheduled Executive QA meeting is scheduled 7/31/2018. The Director of Nursing Services will be responsible for directing POC elements and ensuring thorough and complete medication documentation. Through the above mentioned elements the facility alleges full compliance with this plan of correction as of 5/31/2018.	