STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	10/19/2018

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GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

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F 000	INITIAL COMMENTS A recertification survey was conducted on 10/16/18 through 10/19/18. Past non-compliance was identified at: CFR 483.25 at tag F 689 at a scope and severity of J. The tag F689 constituted substandard quality of care. An extended survey was conducted.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		11/8/18

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

Electronically Signed | 11/12/2018

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure a bed mattress, blanket, a wheelchair cushion, and cover were clean and free from a strong odor resembling urine for 1 of 1 resident reviewed for environment (Resident #32). The findings included: Observations on 10/16/18 at 4:03 PM revealed when entering the room of Resident #32, a strong odor resembling urine was noted. The wheelchair seat cushion, cover, and a brown blanket placed on the top of the resident's bed had a strong odor resembling urine. On 10/18/18 at 7:09 AM a brown blanket placed on top the bed continued to have a urine odor. During an interview on 10/18/18 at 7:17 AM, Nurse Aide (NA) #1 and NA #2 explained	F 584	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal	

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F 584	Continued From page 2 Resident #32's room had an odor resembling urine. They explained bed linens were changed every time a resident gets a shower and when visibly soiled. NA #2 smelled the brown blanket and confirmed it had an odor resembling urine. She stripped all linen off the bed and indicated they would be replaced. NA #2 revealed Resident #32's most recent shower day was 10/17/18 and the brown blanket should've been replaced. On 10/18/18 at 3:19 PM the wheelchair cushion and cover continued to have a strong odor resembling urine. A review of the facility's daily wheelchair cleaning sheet read in part: 11 PM to 7 AM shift please remember that wheelchair cleaning must be done adequately, meaning get the chair 100% clean, allow to dry, then place clean cushions back once dry. Do not simply wipe. May take the wheelchair to the shower room to clean. Resident #32's wheelchair was scheduled to be cleaned every Thursday and should have been cleaned on 10/18/18 between the hours of 11:00 PM to 7:00 AM. During an observation on 10/19/18 at 6:45 AM, Resident #32's room continued to have a strong odor resembling urine. The Director of Nursing (DON) was in the room and confirmed the room continued to have a strong odor resembling urine. She identified Resident #32's bed mattress, wheelchair cushion, and cover as having a strong odor resembling urine. During an interview on 10/19/18 at 6:45 AM, the DON revealed it was her expectation when a resident's care equipment or furniture had a strong odor resembling urine it would be cleaned.	F 584	appeal procedure and/or any other administrative or legal proceeding. F 584 The position of Graham Healthcare and Rehabilitation regarding the process that lead to this deficiency was that the facility staff did not follow the correct policy and procedure for cleaning and maintenance of resident□s mattress, wheelchair and equipment. On 10/19/18 resident # 32 bed linen was removed and replaced with clean linen, the mattress was sanitized by Housekeeping staff, the wheelchair was cleaned by nursing staff and the wheelchair cushion was removed and replaced with a new one. On 10/25/18 an in-service was initiated by the Staff Facilitator Nurse by the direction of the Administrator, for all nursing and housekeeping staff regarding the correct procedure for cleaning of resident□s rooms, mattresses, wheelchairs and equipment. The in-service will be 100% complete by 11/08/18. On 10/25/18 the Director of Nursing began auditing resident wheelchairs and equipment to ensure that these items are clean and free of odor using the wheelchair and equipment audit tool. Ten percent of resident wheelchair and equipment will be audited daily 5x/week x 4 weeks then biweekly for 4 weeks, then weekly for 4 weeks then monthly for 3 months. In the Director of Nursing□s	

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F 584	Continued From page 3 The bed mattress should be sanitized and if the odor continued it was replaced. She also identified the wheelchair cushion and cover had an odor resembling urine and expected the cushion and cover would be cleaned or replaced. She confirmed the bed mattress, wheelchair cushion, and cover were not adequately cleaned. She also revealed it was her expectation bed blankets be removed when noted to have a strong odor resembling urine.	F 584	absence, the Administrator will perform this audit. On 10/25/18 the Housekeeping Supervisor began auditing resident rooms for cleaning of the room and mattress to ensure the room and mattress are clean and free of odor using the room and mattress audit tool. Ten percent of resident wheelchair and equipment will be audited daily 5x/week x 4 weeks then biweekly for 4 weeks, then weekly for 4 weeks then monthly for 3 months. In the Housekeeping Supervisor□s absence, the Administrator will perform this audit. On 11/06/18 a QAPI meeting was held involving the Facility Department Heads and the Medical Director regarding the deficiency along with corrective action put in place to correct deficiency. The monthly QA committee will review the results of both the wheelchair and equipment and the room and mattress audit tools monthly for 4 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or Director of Nursing will present the findings and recommendations of the monthly QA committee to the quarterly executive QAPI committee for further recommendations and oversight.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/5/18

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F 689	Continued From page 4 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to provide supervision for a cognitively impaired resident who exited the facility while unsupervised for 1 of 3 sampled residents (Resident #6). Resident #6 was discovered outside of the facility 48 feet from the facility's front entrance without supervision and was assessed by a nurse to have no injuries upon his return to the facility. The findings included: Resident #6 was admitted to the facility 10/05/11 with diagnoses including cerebral palsy (lesions on the brain that affect the ability to move and can make communication skills difficult) and aphasia (loss of ability to understand or express speech) among others. Review of the notes of a Wandering Resident Meeting (WRM) on 05/24/18 revealed Resident #6 was discussed. The resident behavior documentation and Minimum Data Set (MDS) assessments were reviewed and no wandering behavior was noted. The determination was made that his alarm bracelet could be removed. The Interdisciplinary Team (IDT) progress notes gave no indication of any attempts by Resident #6	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 5 to exit the facility unsupervised. The annual Minimum Data Set (MDS) dated 07/03/18 revealed Resident #6 had short and long term memory problems. The MDS further indicated Resident #6 had no wandering behavior during the 7 day assessment period. The MDS also indicated Resident #6 had severe cognitive impairment. There was no care plan addressing Resident #6 being at risk for wandering prior to exiting the facility on 07/09/18 unsupervised. Observations of Resident #6 throughout the survey revealed he was mobile in his wheelchair by using his legs only. He was observed going up and down the hallway and into his room slowly, but with little difficulty. Review of a nurse's note from Nurse #3 dated 07/09/18 revealed Resident #6 had "an unwitnessed elopement from the building this AM and was found in the parking lot by the Maintenance Supervisor, returned to facility with no injuries and is currently on continuous supervisor watch with a staff member." During an interview with the Receptionist on 10/18/18 at 9:45 AM, she stated part of her job was to watch who comes in and leaves the facility. She also stated a Receptionist was available 7 days a week from 9:00 AM to 7:00 PM to observe who came in and left from the facility. She further stated whenever she took a break the front door was always monitored by another staff member, usually the Accounts Receivable (AR) Manager.	F 689		

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During an interview with the Maintenance Director on 10/18/18 at 9:51 AM, he stated he had been outside the front of the building on 07/09/18 when he saw Resident #6 in his wheelchair propelling himself backwards with his legs. The Maintenance Director also stated he brought Resident #6 back into the building and stopped by the Administrator's office to let her know what happened before returning Resident #6 to the nurses' station on the hall where he resided and he was assessed by the nurse to have no injuries. During the interview the Maintenance Director showed where he found Resident #6 in the facility's parking lot on 07/09/18. The Maintenance Director utilized a measuring tape and measured the location where he saw Resident #6 in the parking lot and determined it was 48 feet from the front entrance and a total of 70.5 feet from where the parking lot began sloping down to the driveway.

During an interview with the AR Manager on 10/18/18 at 10:00 AM, she stated on 07/09/18 the therapy manager came to her office and shut the door behind her. The AR Manager also stated the receptionist was not present that day and she was watching the front, so for about 20 minutes while she was completing the Medicare billing with the therapy manager, no one was watching the front door. She also stated she was educated by the Administrator that she could no longer close the door anymore and her first concern when she was watching the front was to see who was coming and going. She further stated when the receptionist took a break now, she actually went to the receptionist office and observed who came and went from the facility.

During an interview with the Administrator on

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10/18/18 at 10:28 AM, she stated she was always present for the monthly wandering resident meetings. She also stated she was present on the day Resident #6 was discussed back in May 2018 and they had looked back over several months of notes and determined he had no exit seeking behaviors or periods of aimless wandering in his wheelchair. She further stated the determination was made to remove his alarm bracelet. The Administrator acknowledged a root cause analysis had been completed and it was determined that the Accounts Receivable Bookkeeper had not monitored the front door as assigned. The Administrator stated she did not believe Resident #6 was capable of opening the door independently.

During an interview with the MDS Coordinator on 10/18/18 at 1:42 PM, she indicated she remembered when Resident #6 came to her door in his wheelchair on the morning of 07/09/18. She also stated he was attempting to speak to her, but then left and headed down the hallway in the opposite direction of the front door. She further stated about 10 minutes after this occurred, the medication nurse for Resident #6 came to her office to tell her he had been found outside by the Maintenance Director. The MDS Coordinator stated she then left her office to check on Resident #6 to make sure he was alright and found that he had already been assessed to be okay and had a one to one sitter with him. She then went to find the Maintenance Director and asked him what happened. She also stated she was very surprised to find out he had been outside the front of the facility because he had always been complacent and had never talked about leaving the facility or been observed pushing on exit doors.

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F 689	Continued From page 8 The facility provided a plan of correction with a correction date of 07/16/18. The plan of correction included the following: Root Cause: Accounts Receivable Bookkeeper did not monitor the door as assigned. What measures did the facility put in place for the resident affected? On 5/24/18 during wandering resident meeting, resident #6 was discussed, resident behavior documentation and MDS assessments were reviewed and no wandering behaviors were noted. It was determined to be safe to remove wander guard and resident #6 was care planned for this change. On 7/9/18 at approximately 10:30am resident #6, who is cognitively impaired, self-propelled out of facility in wheelchair without staff being aware. Was noted approximately 48ft from front door in the front parking lot of facility by maintenance director and was assisted back into facility. Resident #6 was outside for approximately 3-5 minutes. On 7/9/18 resident #6 was assessed by facility staff nurse with no injuries or concerns found. Physician and resident responsible party were notified on 7/9/18 by facility nurse. On 7/9/18 all exit doors were checked by facility staff, all doors were locked and alarming appropriately.	F 689		

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F 689	Continued From page 9 On 7/9/18 a Wandering Risk Assessment, which includes questions regarding exit seeking behaviors, was completed for resident #6 and the care plan for the resident was updated to reflect at risk for wandering with interventions. On 7/9/18 a wander guard was placed on resident #6 by facility staff. On 7/9/18 resident #6 was placed on one on one supervision and wander guard was placed on resident #6. Care plan was updated to reflect interventions. On 7/16/18 one to one supervision was stopped when resident #6 was moved to room 33B across from the nurse's station. On 7/16/18 resident #6 care plan was updated to reflect intervention change. Once resident #6 was moved across from nurses station one to one supervision was stopped because resident #6 was in a room that allowed for closer monitoring of location. What measures were put in place for residents having the potential to be affected? On 7/09/18 a 100% complete head count was completed for all residents by facility nurses. No residents were unaccounted for. On 7/09/2018 scheduling was changed so that a facility receptionist is assigned to monitor the facility front door 7 days per week from 9am to 7pm. The front is locked from 7PM until 9AM. The receptionist is scheduled and posted on a biweekly basis in the receptionist area on the	F 689		

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phone list schedule and part of the receptionist duties are to watch the facility front door while doors are unlocked. On 7/09/2018 receptionists were notified of this responsibility by the Administrator and Director of Nursing.

On 7/10/18, the facility nurses completed a wandering risk assessment on all current residents. Any resident assessed at risk, will be reviewed by the interdisciplinary (IDT) team to ensure the care plan, and interventions are in place and current.

On 7/9/18 the facility consultant reviewed risk management reports for the past 90 days to identify any trends related to exit with no trends noted.

An in-service was started on 7/9/18 by the Director of Nursing for all facility nurses on completion of the wandering risk assessment including implementation of interventions for residents at risk. No licensed nurse will be allowed to work after 7/9/18 until in-service is complete. The in-service was completed by 7/16/2018.

An in-service was started on 7/9/18 by the Director of Nursing for all facility staff on monitoring of residents locations to include if assigned to watch the front door, you must physically be in line of sight of door at all times. No staff will be allowed to work after 7/9/18 until in-service is complete. The in-service was completed by 7/16/2018. Information regarding residents at risk for wandering will continue to be left in the receptionist area in the Wandering Residents Book, which is updated by the QI Nurse and Medical Records. Regardless of

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resident behavior, all staff are to contact the nurse on duty before a resident exits the front door, unless assisted by staff or Emergency Management Services.

What systems were put in place to prevent the deficient practice from reoccurring?

On admission, quarterly, and with significant change in condition a resident will have a wandering risk assessment completed. If resident is determined by assessment to be at risk, resident will be reviewed by the IDT team to ensure the care plan, and interventions are in place and current. The QI Nurse was in-serviced regarding this process on 7/09/18 by the Administrator and explained that she will oversee this process.

How the facility will monitor systems put in place:

The director of nursing (DON), administrator, social worker and/or staff facilitator will review risk management reports 5 x weekly x 4 weeks to ensure no exits occurred. If occurred actions taken were appropriate, including interventions. This audit will be documented on the Risk Management audit tool. The administrator and/or DON will present the findings and recommendations of the monthly (Quality Improvement) QI committee and to the quarterly executive Quality Assurance Performance Improvement (QAPI) committee for further recommendations and oversight. The Risk Management reports include a description in incident location which was reviewed to ensure no further incidents related to staff failure to monitor front door occurred. Ongoing monitoring of residents assessed to be at risk for wandering

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are reviewed monthly during Wandering at Risk QA meeting and reviewed during the Quarterly Quality Assurance Performance Improvement committee and there have been no additional negative findings related to staff monitoring of front door.

Beginning 7/09/18, the Administrator is given a copy of the biweekly receptionist schedule. Staff were in-serviced beginning 7/09/18 by the Administrator and Director of Nursing that if the receptionist is unable to work her schedule, receptionist is to inform the Administrator. If the receptionist must leave the receptionist area, they must ensure that another staff member relieves them before they leave this area. In-service was completed on 7/16/2018.

The QAPI Meeting was held on 8/23/2018 with Facility Department Heads and the Medical Director in which the incident and four point plan was reviewed.

Validation:
The facility's plan of correction and correction date of 07/16/18 was validated on 10/18/18 and 10/19/18. Validation of the facility's plan of correction included the following:

Verification of wandering risk assessments completed for all residents, receptionist schedule verification of front door coverage from 9:00 AM to 7:00 PM daily, an in-service for all facility nurses of completing the wandering risk assessment and an in-service for all facility staff on the monitoring of residents location if assisted to watch the front door and an update of resident information for those at risk for wandering is

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	345355	A. BUILDING _____ B. WING _____	10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 689	Continued From page 13 updated with the information for Resident #6. The care plan updated for 07/09/18 indicated Resident #6 was at risk for "wandering and/or at risk for unsupervised visits from facility related to attempts to leave unit/building." The goal for Resident #6 was to have "no episodes of unsupervised exits from facility through next review." Some of the interventions included "check daily to ensure resident has an alarm bracelet on and that it is functioning properly" and "document episodes of wandering." During an interview with Nurse #2 on 10/18/18 at 11:19 AM, she stated all residents with an alarm bracelet are visually inspected by the nurses at 6:00 AM and 6:00 PM and this is documented on the Medication Administration Record (MAR) daily. Nurse #2 also stated they have a nursing assistant (NA) who goes to all those residents with a mechanical device that checks the alarm bracelets to make sure they will alarm. During an interview with nursing assistant (NA) #4 on 10/18/18 at 11:29 AM, she stated she worked 6 days a week and uses a scanner tool to check all residents with wanderguards to ensure they are functioning correctly each morning. NA #4 further stated that the alarm bracelet for Resident #6 was on his left ankle and she had checked and signed off that it was working as of this morning.	F 689		