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 01/06/2022

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THE GRAYBRIER NURS & RETIREMENT CT	**116 LANE DRIVE TRINITY, NC 27370**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/3/2022 through 1/6/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # NQGP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/3/2022 through 1/6/2022. 1 of the 6 complaint allegations were substantiated resulting in deficiency at F550. Event ID#NQGP11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		1/28/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/28/2022

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 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide a privacy cover for 1 of 3 resident reviewed for urinary catheters (Resident # 15). The findings included: Resident #15 was admitted to the facility on 5/15/2019 with diagnoses that included paraplegia and neuromuscular dysfunction of the bladder. The resident's admission Minimum Data Set (MDS) dated 10/24/2021 indicated Resident #15 was cognitively intact, had functional hearing and vision, could understand others and could be understood by others. The resident required extensive assistance with all activities of daily living, personal hygiene and toileting. Resident	F 550	The wound care nurse placed the urinary catheter bag in a privacy cover for resident #15 on 1/5/2022. Following a visual inspection on 1/5/2022, by the wound care nurse, all other residents with urinary catheters were found to have a privacy cover present. The department leaders rounds tool was updated to include checking for urinary catheter privacy covering. Direct care staff were re-educated on 1/24/2022 to visually inspect all residents with urinary catheters to confirm a privacy cover is present at all times. Education was provided to all direct-care staff. Staff will receive education prior to working his/her next scheduled shift.	

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F 550	Continued From page 2 #15 was coded for indwelling urinary catheter during the assessment period. Resident #15's comprehensive care plan updated 10/24/2021 had a focus for indwelling urinary catheter related to neuromuscular dysfunction of the bladder. The resident's medical record revealed a physician's order dated 10/24/2021 for foley catheter care every shift and an order to ensure privacy bag to foley drainage bag each shift. On 1/03/2022 at 11:34 AM the urinary drainage bag, containing urine, was observed from the hall. The drainage bag was positioned on the door side of the bed, off the floor, with no privacy cover on the drainage bag. On 1/03/2022 at 11:51 AM an interview was conducted with Resident #15. She stated she does usually have a cover over her urinary drainage bag. She was not sure why there wasn't one on the bag at that time. She stated she keeps her door closed most of the day but she does go out of the facility frequently and she would not want others to see her urinary drainage bag without a cover. During a wound care observation on 1/04/2022 at 1:51 PM, the urinary drainage bag was observed without a privacy cover. Unit manager #1 who was also the treatment nurse provided the wound care. On 1/05/22 at 3:33 PM an interview was conducted with Nurse # 9 who was assigned to Resident #15. She stated all residents should have a privacy cover on their urinary drainage	F 550	The facility Interdisciplinary team (IDT) consisting of the wound care nurse, Activity Director, Admissions Director, Administrator, Director of Nursing, Quality Assurance Nurse, and Director of Social Work, will visually check residents, at least weekly for three months to ensure urinary catheter privacy covers are present. Ongoing unannounced inspections shall be completed by the IDT. Results of weekly audits will be documented on a rounding tool and reported to the Quality Assurance and Assessment (QAA) committee. The next QAA committee meeting is scheduled 2/8/2022. The facility alleges full compliance of F550 on 1/28/2022.	

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F 550	Continued From page 3 bag. She was not aware Resident #15 did not have a privacy cover and she was not sure why Resident #15 did not have a privacy cover on her bag. She stated the resident was a very private person. On 1/05/22 at 3:34 PM an interview was conducted with Unit Manager #1. She stated all residents with urinary catheters should have a privacy cover on their urinary drainage bag. She was not certain why Resident #15 did not have one, but they did have privacy covers in the facility and they would get her one.	F 550		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		1/28/22

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F 623	Continued From page 4	F 623		

resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 5 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview with the resident or responsible party (RP) and staff, the facility failed to notify the resident or the RP in writing of the reason for the discharge to the hospital for 3 of 3 sampled residents reviewed for hospitalizations (Residents #140, #1 & # 90).	F 623	The facility provided proof of transfer documentation to the hospital for 2 of 3 residents mentioned (residents #1 and #90) to a surveyor on 1/6/2022. Resident #140 has returned to the facility; therefore, the transfer notice is not required. The	

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F 623

Continued From page 6

Findings included:

1. Resident #140 was admitted to the facility on 12/6/21. Review of the nurse's note dated 12/11/21 at 6:49 PM revealed that Resident #140's hemoglobin level was low, and she was sent to the emergency room (ER) for evaluation.

Resident #140 was readmitted back to the facility on 12/15/21.

Nurse Unit Manager #1 was interviewed on 1/06/22 at 9:48 AM. The Unit Manager stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge.

The RP of Resident #140 was interviewed on 1/06/22 at 10:01 AM. The RP stated that when the resident was discharged to the hospital, she had not received a letter notifying her of the reason for hospitalization.

Nurse # 7 was interviewed on 1/6/22 at 11:10 AM. The Nurse reported that she normally notified the RP by phone when a resident was discharged to the hospital. She added that she didn't know that she had to notify the RP in writing of the reason for the discharge to the hospital.

The Administrator was interviewed on 1/6/22 at 11:40 AM. The Administrator stated that a notice of transfer/discharge was sent to the RP when a resident was discharged. When asked for a copy of the notice, the Administrator was unable to

F 623

Administrator conducted a Root Cause Analysis (RCA) to determine why the facility process to document resident transfers was found to be missing for resident #140. Through RCA it was determined that all resident transfer paperwork was being sent to the hospital with the resident, but a copy was not also provided to Resident Representatives (RR), specifically resident #140.

An audit was completed by the Administrator to ensure compliance for all other residents, on 1/25/2022. For all resident transfers one month prior to the survey and since the completion of the survey, the facility is compliant with notification to the resident or the RR in writing of the reason for the discharge to the hospital.

The Administrator modified the process of communicating resident transfers. All transfers will be mailed to the RR, by the concierge, even if the resident has already returned to the facility. Transfer documentation will be scanned to the resident□s chart, by medical records clerk, with a mailed stamp following mailing of the transfer information to RR. The facility will continue sending a copy of the transfer information with the resident, at time of transfer.

The Administrator will check all transfer notice documentation for 3 months, following this period the Administrator will check a sample of at least 25% of discharge documentation for six months

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F 623 Continued From page 7
provide a proof that the RP was notified in writing of the reason for the hospitalization.

2. Resident #1 was admitted to the facility on 7/10/20. The Minimum Data Set (MDS) assessments revealed that Resident #1 was discharged to the acute hospital on 2/17/21 and 3/5/21. The quarterly MDS assessment dated 12/16/21 indicated that the resident had moderate cognitive impairment.

The nurse's notes did not have information regarding the resident's discharge/transfer to the hospital on 2/17/21 and 3/5/21.

The hospital discharge summary revealed that Resident #1 was admitted to the hospital on 2/17/21 due to gastrointestinal (GI) bleed and on 3/5/21 due to infection to the hip joint.

Resident #1 was readmitted back to the facility on 2/20/21 and 3/11/21.

Nurse Unit Manager #1 was interviewed on 1/06/22 at 9:48 AM. The Unit Manager stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP or the resident should be notified in writing of the reason for the discharge.

Resident #1 was interviewed on 1/06/22 at 10:56 AM. The resident stated that she was admitted to the hospital twice months ago, and she had not received any letter from the facility notifying her of the reason for her hospitalization.

F 623

to ensure continued compliance. Compliance percentages will be reported on a Performance Improving Project (PIP) form at QAA meetings for the duration of audits. The next QAA committee meeting is scheduled 2/8/2022. Any process improvements will be documented and modified, as needed.

The facility alleges full compliance of F623 on 1/28/2022.

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F 623	Continued From page 8	F 623		

Nurse # 7 was interviewed on 1/6/22 at 11:10 AM. The Nurse reported that she normally notified the RP by phone when a resident was discharged to the hospital. She added that she didn't know that she had to notify the RP or the resident in writing of the reason for the discharge to the hospital.

The Administrator was interviewed on 1/6/22 at 11:40 AM. The Administrator stated that a notice of transfer/discharge was sent to the RP when a resident was discharged. When asked for a copy of the notice, the Administrator provided a notice of discharge/transfer with date of transfer 2/17/21 and the reason for the transfer "it is necessary for your welfare and your needs can not be met in this facility." There was no specific reason for the transfer/discharge documented on the notice. The Administrator was unable to provide a copy of the discharge notice for the discharge date of 3/5/21.

3. Resident # 90 was admitted to the facility on 10/9/2020 with diagnoses that included hypertension (high blood pressure), diabetes type 2, and congestive heart failure.

The resident's admission Minimum Data Set (MDS) dated 10/9/2020 indicated the resident had moderately impaired cognition, required extensive assistance for activities of daily living, and received oxygen. Review of MDS assessments revealed Resident #90 was admitted to the acute hospital on 11/27/2020 through 12/3/2020 and again on 12/8/2020.

The hospital discharge summary dated 12/3/2020 revealed Resident #90 was admitted to the hospital on 11/27/2020 due to acute on chronic

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hypoxic respiratory failure (low oxygen saturation) and COVID-19 infection and was discharge back to the facility on 12/3/2021. Hospital discharge summary dated 12/29/2020 revealed the resident was admitted for acute on chronic hypoxic respiratory failure due to COVID-19 pneumonia on 12/8/2020 and discharged home on 12/29/2020.

Nurse Unit Manager #1 was interviewed on 1/06/22 at 9:48 AM. The Unit Manager stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP or the resident should be notified in writing of the reason for the discharge.

Resident #90's RP was interviewed via phone on 1/06/2022 at 10:57 AM. She stated she got a phone call from the facility notifying her of the resident's change in status, but she did not receive anything in writing from the facility regarding reason for discharge to the hospital.

On 1/06/2022 at 9:51 AM an interview was conducted with the admission and discharge coordinator. She stated she does not send out a written notice of reason for discharge when a resident goes to the hospital.

The Administrator was interviewed on 1/6/22 at 11:40 AM. The Administrator stated that a notice of transfer/discharge was sent to the RP when a resident was discharged. When asked for a copy of the notice, the Administrator provided a notice of discharge/transfer with date of transfer 11/27/2020 and the reason for the transfer "it is necessary for your welfare and your needs can

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F 623	Continued From page 10 not be met in this facility." There was no specific reason for the transfer/discharge documented on the notice. The Administrator was unable to provide a copy of the discharge notice for the discharge date of 12/8/2020.	F 623		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer a resident with a new diagnosis of mental illness to the state for Pre-Admission Screening and Resident Review (PASARR) Level 11 evaluation and determination for 1 of 2 sampled residents reviewed for PASARR (Resident #89). Findings included:	F 644	The PreAdmission Screening and Resident Review (PASRR) evaluation for resident #89 was reviewed. It was determined that the resident's primary diagnosis should be adjusted, which was confirmed and completed by the Medical Director. Once the diagnosis was adjusted, the PASRR remains a level 1, this was confirmed on 1/25/2022, by the	1/28/22

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F 644	Continued From page 11 Resident #89 was admitted to the facility on 3/9/17 with multiple diagnoses including Paranoid Schizophrenia. The annual Minimum Data Set (MDS) assessment dated 3/9/21 indicated that Resident #89 was not evaluated for PASARR Level 11. Review of the PASARR screening form revealed that a Level 1 PASARR screen was performed prior to admission to the facility. The screening form was sent by the hospital on 1/30/2017. The facility's Social Worker (SW) was interviewed on 1/6/22 at 9:10 AM. The SW stated that she just started working at the facility as a social worker. She indicated that when a resident had a new diagnosis of mental illness, a referral should have been sent to the state for Level 11 reevaluation. She reported that the last PASARR screening for Resident #89 was on 1/30/2017 and she was admitted on 3/9/17 with a diagnosis of Paranoid Schizophrenia. She stated that she didn't know why the reevaluation was not performed for the resident. The Administrator was interviewed on 1/6/22 at 11:44 AM. The Administrator stated that the previous SW might have missed to send the information to the state for a Level 11 PASARR evaluation when the resident was admitted with a diagnosis of Paranoid Schizophrenia	F 644	Director of Social Work (DSW). An audit of all resident PASRR levels was conducted by the Director of Admissions and Director of Social Work. The audit was complete on 1/25/2022, no further PASRR adjustments were required. The facility Director of Social Work (DSW) is new to the position. Through root cause analysis, the DSW had previously identified PASRR as an area of improvement through the Quality Assurance process. The DSW was performing a Performance Improving Process (PIP), prior to the survey, for the noted deficiency. The DSW will maintain compliance by ensuring accurate PASRR for residents and by adjusting, when needed, PASRR for residents based on resident admission and any change(s) in resident condition. Any PASRR adjustment(s) will be documented on an audit tool. Results of audits will be documented on a PIP form for one year; results will be communicated through the Quality Assurance and Assessment (QAA) committee. The next QAA committee meeting is scheduled 2/8/2022. The facility alleges full compliance of F644 on 1/28/2022.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		1/28/22

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F 686	Continued From page 12 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide an air mattress overlay as ordered by a physician (Resident #291) and failed to have accurate setting for air mattress (Resident #79) for 2 of 6 residents reviewed for pressure ulcers. The findings included: 1.Resident #291 was admitted to the facility on 12/31/2021 with diagnoses that included Parkinson's disease and a stage four pressure ulcer. Resident #291's admission Minimum Data Set (MDS) was not available. The resident's baseline care plan dated 12/31/2021 had a focus for impaired skin integrity. Resident #291's active order history revealed an order for air mattress overlay with a start date of 12/31/2021 and a stop date of 1/3/2022. The	F 686	Concerning the air mattress overlay for resident #291, this was a listed recommendation on the discharge summary and was not listed under the order section. An air mattress overlay was supplied, when it became available, and the resident was out of the bed for placement on 1/4/2022. The setting on the air mattress overlay for resident #79 was adjusted by the wound nurse appropriate weight range on 1/4/2022. An audit was completed for resident(s) with air mattresses to confirm settings were accurate per recommendations and patient comfort levels by the wound care nurse on 1/26/2022. All other resident air mattresses were found to be within the recommended range for their weight and/or comfort level to offload pressure. On 1/24/2022, the Director of Nursing (DON) consucted an all-nursing staff in-service was to ensure that healthcare	

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order was restarted on the same date 1/3/2022.

On 1/03/2022 at 11:12 AM an interview was conducted with Resident #291. She stated she had a wound on her bottom that was painful. She stated she was told by facility staff she would be placed on an air mattress, but she had been there several days and still was not on an air mattress. Observed resident was on a regular mattress.

On 1/04/2022 at 10:07 AM an interview was conducted with Nurse #9. She stated she was assigned to Resident #291 and confirmed the resident had a pressure injury to her sacral area. When asked about the order for the air mattress she stated the resident did have an order for an air mattress, but the resident had not been out of the bed long enough for her to get the mattress set up. Nurse #9 confirmed the order was from 12/31/2022 (4 days prior).

An interview was conducted with unit manager #1 who also served as the treatment nurse, on 1/4/2022 at 10:10 AM. She stated she was aware Resident #291 had an order for an air mattress overlay and she believed the nurse was waiting until the resident was up out of bed to put the air mattress in place. She acknowledged the order was from 12/31/2021.

01/04/22 01:53 PM during a wound care observation, the resident was observed to have a stage four pressure ulcer to the sacrum. The resident was not on an air mattress.

A second interview was conducted with Unit Manager #1 who was also the treatment nurse on 1/05/2022 at 3:30 PM. She stated she would not speculate as to why Resident #291 did not get an

F 686

professionals are aware of the guidelines for air mattress settings. Certified nursing assistants (CNA) and nurses were educated regarding appropriate settings. CNA were educated regarding appropriate notification of a nursing staff member if an air mattress overlay is noted out of appropriate setting range. Nurses were educated regarding appropriate settings and consulting the resident□s care plan for appropriate settings for the air mattress overlay. Future healthcare professionals hired for facility assistance will be trained during orientation on air mattress settings and overlay placement. All current nursing staff members shall receive re-education prior to working his/her next scheduled shift.

The wound care nurse will be responsible for ensuring continued compliance. The wound nurse will audit the air mattress settings during weekly wound rounding and will document her findings. Results of the audits will be recorded on a Performance Improving Project (PIP) form. The PIP forms shall be reported to the Quality Assurance and Assessment (QAA) committee for a period of one year. The next QAA committee meeting is scheduled 2/8/2022.

The facility alleges full compliance of F686 on 1/28/2022.

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F 686	Continued From page 14	F 686		

air mattress on admission 12/31/2021.

A phone interview was conducted with the medical director on 1/06/2022 at 10:44 AM. He stated he would have expected the resident to have been placed on an air mattress on her admission date, 12/31/2022 or shortly after due to her stage four pressure ulcer. He was not sure why that would not have been done.

2.Resident # 79 was admitted to the facility on 7/30/2014. The resident had a diagnosis of stage four pressure ulcer.

The resident's significant change Minimum Data Set (MDS) dated 12/11/2021 indicated the resident was mildly cognitively impaired and total dependent for bed mobility and all activities of daily living. She had a stage four pressure injury during the assessment period.

Resident #79's comprehensive care plan, update on 12/17/2021 had a focus for alteration in skin integrity.
Active orders for Resident #79 included an order for an air mattress overlay with a start date of 9/7/2021 and an order for wound care consult with a start date of 9/21/2021.

Resident #79's medical record revealed she was evaluated by a wound care physician every 4-6 weeks. The wound care physician's most recent assessment dated 12/7/2021 indicated the wound was much larger, most likely due to protein malnutrition and pressure.

On 1/04/2022 at 10:05 AM observed Resident #79's air mattress was set on 550 pounds (lbs).

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F 686	Continued From page 15 The residents most recent documented weight was 241 lbs. on 12/2/2022. A wound care observation was conducted on 1/04/2022 at 11:03 AM. Resident #79 had a large stage four sacral wound. On 1/04/2022 at 11:10 AM immediately following wound care, an interview was conducted with the treatment nurse. She stated the air mattress should be set according to the resident's weight. She acknowledged the mattress was set on 550lbs. She further stated she was not sure of the resident's most recent weight, but she was certain the resident was not 550lbs. When asked who sets up the air mattresses, she stated the nursing staff were responsible for placing the mattress on the bed and ensure proper settings and function. An interview was conducted with Nurse #11 on 1/04/2022 at 4:11 PM. She stated she checked the mattress to make sure it was inflating but she had not looked at the settings.	F 686		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		1/28/22

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§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, and staff, Nurse Practitioner and Medical Director interviews, the facility failed to hold blood pressure medications as ordered for 2 of 13 residents whose medications were reviewed (Residents #50 and #83).

The findings included:

1) Resident #50 was admitted to the facility on 12/30/20 with diagnoses that included hypertension.

Review of Resident #50's physician orders included an order dated 8/18/21 for Hydralazine (used to treat hypertension) 50 milligrams (mg) 1 tablet by mouth three times a day. Hold for systolic blood pressure less than or equal to 110 or diastolic blood pressure less than or equal to 60.

The annual Minimum Data Set (MDS) assessment dated 11/8/21 indicated Resident #50 was alert and oriented.

The November 2021 and December 2021

Residents #50 and #83 were found to have no adverse reactions following medication administration as noted during the survey. Following receipt of the survey results, responsible staff were re-educated for medication administration expectations.

The Director of Nursing and the Medical Director audited all resident blood pressure medications for a previous period of two month and the pharmacy consultant notes were reviewed. 100% of medications were audited on 1/20/2022 to identify medications with hold/administer parameters. Medications were reviewed with the Medical Director and subsequent medication adjustments were made for 11 out of 14 residents on blood pressure medications. Medication adjustments were made to ensure residents were on regimens to sustain blood pressures within acceptable range per the Medical Director.

Healthcare professionals responsible for

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F 757	Continued From page 17 Medication Administration Records (MARs) were reviewed and revealed Resident #50 had received Hydralazine, despite the systolic blood pressure (SBP) below 110 or diastolic blood pressure (DBP) below 60 on the following dates: - 11/13/21- DBP was 55 - 11/14/21- SBP was 101 and DBP was 59 - 11/22/21- DBP was 59 - 12/7/21- DBP was 58 - 12/11/21- SBP was 106 and DBP was 53 - 12/16/21- SBP was 103 - 12/30/21- DBP was 58 An interview occurred with Nurse #2 on 1/6/22 at 9:25 AM, who was assigned to Resident #50 on 12/7/21. Nurse #2 indicated she was aware the resident had parameters to hold the Hydralazine. She reported the blood pressure was taken by the nursing assistants (NAs) and recorded on the MAR. Nurse #2 reviewed the December 2021 MAR, verified the Hydralazine was administered despite the DBP being below 60 when it should have been withheld and responded it was an oversight. On 1/6/22 at 10:22 AM, a phone interview occurred with Nurse #3 who was assigned to Resident #50 on 11/13/21 and 11/14/21. The November 2021 MAR was reviewed with her and she stated even though the NA's obtained vital signs to include blood pressure, she manually checked Resident #50's blood pressure before administering Hydralazine due to the hold parameters ordered. She was unable to recall why the Hydralazine was administered outside the parameters other than to say it was an error on her part and the medication should have been withheld.	F 757	medication administration were re-educated of facility expectation regarding medication administration, specific to blood pressure medications and parameters to administer or hold on 1/23/2022, by the Director of Nursing (DON). All staff will receive re-education prior to working his/her next scheduled shift. The facility initiated a Performance Improving Project (PIP) regarding medication administration, specific to blood pressure medications. The DON and Administrative Nursing team will audit, daily, beginning 1/26/2022 to ensure that HCP training is on-going and effective. Auditing and re-education shall be documented on the PIP form and reported to the Quality Assurance and Assessment (QAA) committee. The next QAA committee meeting is scheduled 2/8/2022. The facility alleges full compliance of F757 on 1/28/2022.	

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A phone interview occurred with the Nurse Practitioner (NP) on 1/6/22 at 10:30 AM and stated if the resident had received a few dosages of Hydralazine outside of the parameters it would not have caused any serious harm. The NP added she would have expected the nurses to follow the orders for Hydralazine parameters as written though.

The Director of Nursing (DON) was interviewed on 1/6/22 at 12:19 PM and stated she expected the nurses to follow doctor's orders including blood pressure medications with parameters to hold. The DON further stated she expected the nurses to check the blood pressure right before administering the medication.

2) Resident #83 was admitted to the facility on 9/13/21 with diagnoses that included hypertension.

Review of Resident #83's physician orders included an order dated 10/13/21 for Lisinopril (used to treat hypertension) 1 tablet by mouth one time a day. Hold for systolic blood pressure (SBP) less than 100, diastolic blood pressure (DBP) less than 60 or heart rate (HR) less than 60.

A quarterly Minimum Data Set (MDS) assessment dated 12/17/21 indicated Resident #83 was alert and oriented.

The November 2021, December 2021, and January 2022 Medication Administration Records (MARs) were reviewed and revealed Resident #83 had received Lisinopril, despite the SBP below 100 or DBP below 60 on the following

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F 757	Continued From page 19 dates: - 11/1/21 DBP was 55 - 11/7/21 DBP was 55 - 11/8/21 DBP was 58 - 11/11/21 DBP was 55 - 11/19/21 DBP was 59 - 11/30/21 DBP was 54 - 12/1/21 DBP was 54 - 12/10/21 DBP was 57 - 12/19/21 DBP was 58 - 12/20/20 SBP was 97 and DBP was 53 - 12/22/21 DBP was 57 - 12/26/21 DBP was 55 - 12/28/21 DBP was 58 - 1/3/22 SBP was 96 and DBP was 60 An interview occurred with Medication Aide (MA) #1 on 1/5/22 at 12:38 PM. She was assigned to Resident #83 on 11/8/21, 11/11/21, 11/30/21, 12/1/21, 12/20/21, 12/22/21, 12/26/21, 12/28/21 and 1/3/22. MA #1 indicated she was aware the resident had parameters to hold the Lisinopril. She reported she rechecked Resident #83's blood pressure prior to administering the medication but put in the values provided by the nursing assistants (NAs) and didn't document what she obtained. MA #1 reviewed the November 2021, December 2021 and January 2022 MARs and verified the Lisinopril appears to have been administered despite the SBP below 100 and DBP below 60. She added the medication should have been withheld and stated it was an oversight. On 1/6/22 at 8:40 AM, a phone call was placed to Nurse #4 who had been assigned to Resident #83 on 12/10/21, 12/19/21 and 12/26/21. A message was left for a return call that was not received during the course of the survey.	F 757		

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Nurse #5 was interviewed on 1/6/22 at 9:24 AM, who was assigned to Resident #83 on 11/19/21. She was aware the resident had parameters to hold the blood pressure medications. After reviewing the November 2021 MAR, she verified the resident's DBP was documented as 59, should have withheld the Lisinopril and felt like it was an oversight.

An interview occurred with Nurse #2 on 1/6/22 at 9:25 AM, who was assigned to Resident #83 on 11/7/21. After reviewing the November 2021 MAR, she verified the resident had parameters to hold the blood pressure medication, the documented DBP was 55 requiring the medication to be held and felt it was an error on her part.

A phone interview occurred with the Medical Director on 1/6/22 at 10:33 AM and stated he would have expected the nursing staff to have followed the orders regarding Lisinopril blood pressure parameters, however he felt there was no serious harm caused as he monitored her lab work very closely.

The Director of Nursing (DON) was interviewed on 1/6/22 at 12:19 PM and stated she expected the nurses to follow doctor's orders including blood pressure medications with parameters to hold. The DON further stated she expected the nurses to check the blood pressure right before administering the medication.

F 757

F 758 SS=D

Free from Unnec Psychotropic Meds/PRN Use
CFR(s): 483.45(c)(3)(e)(1)-(5)

F 758 — 1/28/22

§483.45(e) Psychotropic Drugs.

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F 758	Continued From page 21 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 22 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observation and physician and staff interview, the facility failed to ensure residents on antipsychotic medications had adequate indication for its use documented in the medical records for 3 of 10 sampled residents reviewed for antipsychotic medications (Residents # 85, #140 & #76). Findings included: 1. Resident # 85 was admitted to the facility on 12/13/21 with multiple diagnoses including metabolic encephalopathy. The admission Minimum Data Set (MDS) assessment dated 12/20/21 indicated that Resident #85 had severe cognitive impairment and he displayed physical, verbal, and other behavioral symptoms and rejection of care which occurred 1 to 3 days during the assessment period. The hospital discharge summary with the admission date of 12/8/21 and discharge date of 12/13/21 was reviewed. The discharge medications included Seroquel (an antipsychotic medication) 25 milligrams (mgs.) by mouth at bedtime as needed (PRN) for up to 30 days for agitation and combative behavior. Resident #85's admission doctor's orders dated 12/13/21 included Seroquel 25 mgs by mouth at	F 758	Through root cause analysis (RCA), the antipsychotic interdisciplinary team (a-IDT) consisting of the Pharmacy Consultant, Medical Director, and Director of Nursing, has determined that the facility is in full compliance with F758. Adequate indications for antipsychotic medications were located in the charts for resident #85, #140, and #76. The a-IDT reviewed the medical record for resident #85 and determined that the resident admitted with the diagnosis Acute metabolic encephalopathy with hyperactive delirium as stated in the hospital discharge summary dated 12/13/2021. Review of the nurse□s notes from 12/13/2021 show that the resident was started on daily Seroquel due to physical aggression with the staff. Further review of the medical record showed that the Medical Director initiated Risperdal 0.5mg BID on 12/14/2021 after the resident had a full 24-hour period without sleep. The facility was following Medical Director orders to reduce the effects of hospital induced delirium exacerbated by his transition to the facility. The a-IDT reviewed the medical record for	

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F 758	Continued From page 23 bedtime for restlessness and agitation (written by Nurse #8). Review of the nurse's notes, there was no documented indication for the start of Seroquel daily instead of PRN as ordered from the hospital. On 12/14/21, there was a doctor's order to start Risperdal 0.5 mgs by mouth twice a day for delirium (written by Nurse Unit Manager #1). Review of the nurse's notes, there was no documented indication for the start of the Risperdal. The Pharmacy Consultant drug regimen review dated 1/2/22 indicated that Risperdal 0.5 mgs twice a day was added for delirium on 12/14/21. There was no rationale for the resident to be on 2 atypical antipsychotics and delirium was transitory (not permanent). Nurse Unit Manager (UM) #1 was interviewed on 1/5/22 at 3:04 PM. The UM verified that she transcribed the order for the Risperdal given by the physician on 12/14/21. She indicated that Resident #85 was restless, hitting /kicking and had bitten a staff member on 12/13/21. She called the doctor on 12/14/21 and he ordered for Risperdal. She reported that she was aware that the resident was already on Seroquel. When asked for the indication for the use of Risperdal, she replied for delirium. Nurse #2, assigned to Resident #85, was interviewed on 1/6/22 at 9:15 AM. She stated that the resident was quite most of the time in bed but could be combative during care at times. Resident #85 was observed in bed with his eyes closed on 1/6/22 at 9:16 AM.	F 758	resident #140 and determined that the resident admitted with the diagnosis Late onset Alzheimer's as per FL2 and behavioral disturbances as per nurse practitioner note dated for 9/20/2021. Per FL2 and then hospital discharge summary dated 12/11/2021, resident was to be admitted on Seroquel 25mg daily. Upon review of the medical record, the a-IDT has determined that resident #140 did have adequate indication for use of antipsychotic medication. Furthermore, review of the nurse□s notes from admission on 12/6/2021 through 1/6/2022, increased dosing was justified as evidenced by residents ongoing physical aggression with staff, agitation, and tearful behavior. The a-IDT reviewed the medical record for resident #76 and determined that this resident was on antipsychotic medications for dementia with severe behavioral disturbances. The nurse□s notes were reviewed through 7/2021 and ongoing use through 1/2022 was deemed necessary and increased dosing was appropriate. The Medical Director and the Psychiatric Nurse Practitioner did evaluate the patient due to physical aggression with the staff and deemed it necessary to adjust medication dosing in 8/2021. Review of the nurse□s notes for the previous seven months did show multiple instances of physical aggression towards staff. Furthermore, surveyor did witness wound care with resident #76 and did see the ongoing physical aggression still displayed, improved as reported by	

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Nurse #8 was called on 1/5/22 at 3:45 PM and on 1/6/22 at 10:11 AM but was unsuccessful. On 1/6/22 at 6:18 PM, Nurse #8 had called back. When interviewed, she could not remember why she transcribed the order for Seroquel daily instead of PRN as ordered from the hospital. She also could not remember the indication for the use of the Seroquel.

The Attending Physician was interviewed on 1/6/22 at 10:40 AM. He stated that he was aware that the facility had high number of psychotropic drug use and he agreed that he should start looking into it. He stated that Resident #85 had behaviors such as agitation and he expected nursing to document the rationale when a psychotropic medication was started, added, or increased in dose.

Nurse Aide (NA) #1, assigned to Resident #85, was interviewed. She stated that she worked at the facility for 3 years and had known the resident. She stated that the resident did not have any behaviors at all.

The Director of Nursing (DON) was interviewed on 1/6/22 at 12:20 PM. The DON stated that she was officially the DON on 1/3/22. She agreed that some orders for the antipsychotic medications did not have adequate indication for its use documented in the medical records. She also verified that delirium, restlessness, dementia, and Alzheimer's alone were not appropriate indication for the use of antipsychotic drugs. The DON agreed that nursing should document in the medical records the adequate indication when a psychotropic drug was started, added, or increased in dose.

F 758

long-term staff from 7/2021.

The a-IDT and Administrative Nurses completed an audit of all residents with prescribed psychotropic medications by 1/24/2022. The a-IDT and Administrative Nurses found adequate indication for use of psychotropic medications for all residents receiving these medications.

Through ongoing a-IDT reviews, monthly reviews of patient medical records will continue to ensure that residents remain free of unnecessary medications. The a-IDT will report findings of reviews to the Quality Assurance and Assessment (QAA) committee. The next QAA committee meeting is scheduled 2/8/2022.

The facility alleges full compliance of F757 on 1/28/2022.

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2. Resident # 140 was originally admitted to the facility on 12/6/21 and was readmitted on 12/11/21 with multiple diagnoses including Alzheimer's Disease and Dementia without behavioral disturbances. The significant change in status Minimum Data Set (MDS) assessment dated 12/22/21 indicated that the resident had severe cognitive impairment and had displayed physical behavioral symptoms and rejection of care which occurred 1 to 3 days during the assessment period.

The hospital discharge summary dated 12/11/21 was reviewed. The discharge medications included Seroquel (an antipsychotic medication) 25 milligrams (mgs) by mouth daily at 5 PM.

Resident #140's admission doctor's orders dated 12/11/21 were reviewed. The orders included Seroquel 25 mgs by mouth at bedtime for dementia without behavioral disturbances.

On 12/22/21, a new order for Seroquel 25 mgs by mouth in AM was added and the bedtime dose was increased to 50 mgs. The indications for the use of the Seroquel were Alzheimer's Disease and Dementia without behavioral disturbances.

The nurse's note dated 12/22/21 was reviewed. There was no documented indication for the change/increase in dose of the Seroquel.

There was no documentation of behavior monitoring from 12/6/21 to 1/6/22.

The Pharmacy Consultant drug regimen review dated 1/2/22 revealed that Seroquel was

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increased to 25 mgs in AM and 50 mgs at bedtime. The nurse's notes indicated exit seeking, agitated with physical aggression at times.

Resident #140 was observed in bed on 1/5/22 at 2:30 PM and on 1/6/22 at 9:05 AM. She did not display any behaviors during the observation.

Nurse # 7, assigned to the resident, was interviewed on 1/6/22 at 9:00 AM. She verified that she transcribed the physician's order for the Seroquel on 12/22/21. She reported that she thought she had documented the resident's behavior in the nurse's notes. She stated that the resident's behaviors were mostly agitation, yelling wanting to go home and was found at the exit door that day (12/22/21).

Nurse Aide (NA) #2, assigned to Resident #140, was interviewed on 1/6/22 at 9:12 AM. The NA stated that the resident was quite most of the time but agitated at times calling out names.

The Attending Physician was interviewed on 1/6/22 at 10:40 AM. He stated that he was aware that the facility had high number of psychotropic drug use and he agreed that he should start looking into it. He stated that Resident #140 had behaviors such as agitation and he expected nursing to document the rationale when a psychotropic medication was started, added, or increased in dose.

The Director of Nursing (DON) was interviewed on 1/6/22 at 12:20 PM. The DON stated that she was officially the DON on 1/3/22. She agreed that some orders for the antipsychotic medications did not have adequate indication for its use

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documented in the medical records. She also verified that delirium, restlessness, dementia, and Alzheimer's alone were not appropriate indication for the use of antipsychotic drugs. The DON agreed that nursing should document in the medical records the adequate indication when a psychotropic drug was started, added, or increased in dose.

3. Resident # 76 was admitted to the facility on 10/11/17 with multiple diagnoses including restlessness and agitation. The quarterly Minimum Data Set (MDS) assessments dated 9/13/21 and 12/10/21 indicated that Resident #76 had memory and decision- making problems and he did not have any behaviors or rejection of care during the assessment period.

Resident #76 had a doctor's order dated 7/16/20 for Seroquel (an antipsychotic drug) 50 milligrams (mgs) by mouth three times a day for vascular dementia with behavioral disturbances.

On 8/27/21, there was a doctor's order for Seroquel 50 mgs by mouth two times a day and 75 mgs by mouth at bedtime.

Review of the behavior monitoring from August 2021 through December 2021, there were no behaviors documented.

Review of the nurse's note dated 8/27/21, there was no indication to support for the increase in dose of the Seroquel.

The Pharmacy Consultant drug regimen review dated 9/2/21 indicated that Seroquel was increased from 50 mgs three times a day to 50

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mgs twice a day and 75 mgs at bedtime with no behaviors to substantiate for the increase in dose. The review indicated that the resident was cooperative for the last 30 days.

Resident #76 was observed on 1/5/22 at 9:15 AM and on 1/6/22 at 9:20 AM. He was in bed with his eyes closed.

Nurse # 2, assigned to Resident #76, was interviewed on 1/6/22 at 9:15 AM. The Nurse stated that Resident #76 could get agitated during care, and he yelled at times.

The Attending Physician was interviewed on 1/6/22 at 10:40 AM. He stated that he was aware that the facility had high number of psychotropic drug use and he agreed that he should start looking into it. He stated that Resident #76 had behaviors such as agitation and he expected nursing to document the rationale when a psychotropic medication was started, added, or increased in dose.

Nurse Aide (NA) #1, assigned to Resident #76 was interviewed on 1/6/22 at 11:01 AM. The NA stated that Resident #76 was quiet when not bothered but could be combative during care.

The Director of Nursing (DON) was interviewed on 1/6/22 at 12:20 PM. The DON stated that she was officially the DON on 1/3/22. She agreed that some orders for the antipsychotic medications did not have adequate indication for its use documented in the medical records. She also verified that delirium, restlessness, dementia, and Alzheimer's alone were not appropriate indication for the use of antipsychotic drugs. The DON agreed that nursing should document in the

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F 758	Continued From page 29 medical records the adequate indication when a psychotropic drug was started, added, or increased in dose.	F 758		
F 842 SS=B	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	F 842		1/28/22

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F 842	Continued From page 30 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 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 record reviews and staff interviews, the facility failed to maintain accurate medical records in the area of medication management for 2 of 13 residents' whose medications were reviewed (Residents #50 and #83).	F 842	Residents #50 and #83 were found to have no adverse reactions following medication administration as noted during the survey. Following receipt of the survey results, responsible staff were re-educated for medication administration	

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The findings included:

1) Resident #50 was admitted to the facility on 12/30/20 with diagnoses that included hypertension.

Review of Resident #50's physician orders included an order dated 8/18/21 for Hydralazine (used to treat hypertension) 50 milligrams (mg) 1 tablet by mouth three times a day. Hold for systolic blood pressure less than or equal to 110 or diastolic blood pressure less than or equal to 60.

The annual Minimum Data Set (MDS) assessment dated 11/8/21 indicated Resident #50 was alert and oriented.

The November 2021, December 2021, and January 2022 Medication Administration Records (MARs) were reviewed and revealed there was no documented blood pressure to indicate the reason why Hydralazine was withheld on the following:
" 11/1/21 at 2:00 PM
" 11/27/21 at 8:00 PM
" 12/12/21 at 2:00 PM
" 12/15/21 at 8:00 PM
" 12/20/21 at 8:00 PM
" 12/21/21 at 8:00 PM
" 12/22/21 at 8:00 PM
" 12/27/21 at 8:00 PM
" 12/28/21 at 8:00 PM
" 1/2/22 at 8:00 PM
" 1/3/22 at 8:00 PM
" 1/4/22 at 8:00 PM

A phone call was placed to Nurse #10 on 1/6/22 at 8:42 AM, who was assigned to Resident #50

F 842

expectations.

Medications were reviewed with the Medical Director and subsequent medication adjustments were made for 11 out of 14 residents on blood pressure medications. Medication adjustments were made to ensure residents were on regimens to sustain blood pressures within acceptable range per the Medical Director.

Healthcare professionals responsible for medication administration were re-educated of facility expectation regarding medication administration, specific to blood pressure medications and parameters to administer or hold on 1/23/2022. All nursing staff were educated by the Director of Nursing (DON) on 1/24/2022 regarding the necessity to document blood pressures when requested per physician order, in the resident□s medical record. All nurses will receive re-education prior to beginning his/her next scheduled shift.

The facility initiated a Performance Improving Project (PIP) regarding medication administration, specific to blood pressure medications. The Administrative Nursing Team, consisting of the DON and Unit Coordinators, will conduct daily monitoring beginning on 1/28/2022 to ensure that HCP training is on-going and effective, for a period of six months. Auditing and re-education shall be documented on the PIP form and reported to the Quality Assurance and

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on 11/27/21 and 1/2/22. A message was left for a return call which was not received during the survey.

A phone interview occurred with Nurse #1 on 1/6/22 at 3:00 PM. She was assigned to Resident #50 on 12/15/21, 12/20/21, 12/21/21, 12/22/21, 12/27/21, 12/28/21, 1/3/22 and 1/4/22. She reported she most likely held the blood pressure medication due to the parameters to withhold. She was unable to state why she didn't document the blood pressure value on the MARs.

The Director of Nursing (DON) was interviewed on 1/6/22 at 12:19 PM and stated she expected the nurses to obtain and document blood pressure values on the MARs when indicated and per physician orders.

2) Resident #83 was admitted to the facility on 9/13/21 with diagnoses that included hypertension.

Review of Resident #83's physician orders included an order dated 10/13/21 for Lisinopril (used to treat hypertension) 1 tablet by mouth one time a day. Hold for systolic blood pressure (SBP) less than 100, diastolic blood pressure (DBP) less than 60 or heart rate (HR) less than 60.

A quarterly Minimum Data Set (MDS) assessment dated 12/17/21 indicated Resident #83 was alert and oriented.

The November 2021 and December 2021 Medication Administration Records (MARs) were

F 842

Assessment (QAA) committee, to ensure regulatory compliance. The next QAA committee meeting is scheduled 2/8/2022.

The facility alleges full compliance of F842 on 1/26/2022.

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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	Continued From page 33 reviewed and revealed there was no documented blood pressure or heart rate to indicate the reason why Lisinopril was withheld on 11/26/21, 12/6/21, 12/8/21, 12/15/21 and 12/16/21. An interview occurred with Medication Aide (MA) #1 on 1/5/22 at 12:38 PM, who was assigned to Resident #83 on 12/6/21. MA #1 reviewed the December 2021 and verified there was no blood pressure or heart rate documented to indicate the reason why Lisinopril was withheld and stated it was an oversight. A phone interview was conducted with Nurse #6 on 1/6/22 at 9:55 AM. She was assigned to Resident #83 on 12/8/21, 12/15/21 and 12/16/21. After reviewing the December 2021 MAR with her she stated she had recently started at the facility within the last few months and was still trying to learn the Electronic Medical Record (EMR) system. Nurse #6 added she obtained Resident #83's blood pressure and heart rate before administering the medication and felt the medication was withheld due to the parameters. She acknowledged the incomplete documentation on the MAR and stated it was an error on her part. The Director of Nursing (DON) was interviewed on 1/6/22 at 12:19 PM and stated she expected the nurses to obtain and document blood pressure values on the MARs when indicated and per physician orders	F 842		