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 10/17/2024

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
E 000	Initial Comments An unannounced complaint and recertification survey's were conducted on 10/14/24 through 10/17/24 . The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID C61311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/14/24 through 10/17/24. Event ID# C61311. The following intake was investigated NC00220985. 1 of the 2 complaint allegations resulted in a deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		10/25/24

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

Electronically Signed | 11/05/2024

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F 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the Do Not Resuscitate (DNR) status for 1 of 32 residents reviewed for Advanced Directives (Resident #10). The findings included: Resident #10 had been admitted on 3/23/24. Resident #10's admission Minimum Data Set assessment dated 3/29/24 indicated she had severe cognitive impairment. A Care Plan with an initiation date of 4/5/24 and a review date of 10/10/24 indicated Resident #10 had a Full Code status. The care plan goal was to honor the Full Code status. Interventions included staff will follow the Advanced Directives as written.	F 578	Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. Through root cause analysis, it was determined that the family for resident #10 changed the code status after admission. The updated code status was scanned to the chart, but not processed through the nursing department, therefore adjustments were not updated to the resident dashboard (information banner). Resident orders determine the code	

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F 578	Continued From page 2 On 10/14/24 Resident #10's electronic medical record (EMR) was observed to have Full Code status indicated on the resident dashboard (information banner). In the Advanced Directive section, a scanned copy of a goldenrod Do Not Resuscitate (DNR) form was observed, signed by the physician dated 3/29/24. An Advance Directives form was also included noting "allow natural death (Do Not Resuscitate [DNR]; no CPR (cardiopulmonary resuscitation) will be given in the event of cardiopulmonary arrest [when the heart stops beating and there is no breathing])" This form was signed by Resident #10's Responsible Party on 3/29/24 and by her physician on 4/8/24. The hard copies of both forms, the goldenrod DNR and the Advance Directives, both of which documented Resident #10 was a DNR, were filed in the Code Status notebook for Resident #10's hallway located at the nurses' station. This notebook contained each resident's face sheet (demographic information), goldenrod form (code status form signed by the physician), and their Advance Directives form. An interview with Nurse #1 was conducted on 10/15/24 at 10:05 AM. The Nurse stated each resident's code status was noted in the EMR and also in the Code Status notebook located at each nursing station. An interview with the Medical Records Clerk was conducted on 10/15/24 at 10:28 AM. She stated that after the physician signed the forms (goldenrod DNR and Advance Directives forms), she scans them into the EMR and then places the hard copies into the Code Status notebook at the	F 578	status that is listed on the resident dashboard (information banner). Resident care plans for code status are updated based on the resident dashboard (information banner). On 10/14/2024, the physician order for advanced directive for resident #10 was updated to accurately reflect a code status of Do Not Resuscitate (DNR) within all areas of the electronic medical record (EMR), including the scanned DNR, DNR in the Code Status notebook, resident dashboard (information banner), and care plan. On 10/14/2024, the Quality Assurance Nurse conducted a code status audit of all residents in the building. One resident received an adjustment with their code status, to accurately reflect a code status of Do Not Resuscitate (DNR) within all areas of the electronic medical record (EMR), including the scanned DNR, DNR in the Code Status notebook, resident dashboard (information banner), and care plan. The facility has updated the written process for code status updates within the EMR and resident information books used by the nursing department. When a code status is changed, it will be routed through the nursing department to make necessary adjustments to the EMR system. Additionally, the facility will implement code status audits at time of admission, when a code status changes, and quarterly through the care planning process. These code status audits will	

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F 578	Continued From page 3	F 578		

nurses' station. She explained that each nurses' station had a book with each resident's face sheet, goldenrod and advance directives forms.

An interview with Nurse Aide #1 was conducted on 10/15/24 at 11:08 AM. She stated she regularly cared for Resident #10. She explained the residents' code status could be found in the Code Status notebook at the nurses' station.

An interview with the Social Work Assistant was conducted on 10/16/24 at 3:23 PM. She explained the DNR status and care plans were reviewed quarterly and updated as needed. After reviewing the EMR information for Resident #10, the goldenrod DNR form, the Advance Directives form, and the care plans, she stated the information should match but didn't.

During an interview on 10/17/24 at 9:54 AM the Social Worker (SW) stated she was unsure how the resident's EMR being updated to reflect Resident #10's DNR status had been missed. She explained Resident #10's dashboard had indicated Full Code status, and she used that information to develop and update the Code Status care plan. She also explained that during care plan meetings with Resident #10's family, she would ask if there was any change in the code status but did not clarify what the status was. She stated she was unsure who updated the resident dashboard.

During an interview with the Administrator on 10/17/24 at 10:12 AM he stated upon entry, residents were considered Full Code until the Code Status was determined. He explained he thought the paperwork for Resident #10's Code Status had been completed and scanned into the

improve code status accuracy to ensure that the deficient practice will not recur.

Results of above-mentioned audits will be documented on an “Advanced Directive Audit Tool” used by the team to document care plan meetings. Staff that are involved with care plan updates, which include the Director of Nursing, MDS Nurse, Administrative Nurses, Social Work, and Medical Records will monitor results of the above-mentioned audits weekly for eight weeks and monthly for six months. Process changes and results of the audits will be evaluated for effectiveness through the quarterly QAPI meetings for the duration of audits. The next scheduled QAPI meeting is January 21, 2025.

The facility alleges compliance with this plan on or before October 25, 2024.

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F 578	Continued From page 4 EMR but the administrative nurse who updated the dashboard didn't see the paperwork. The Administrator also explained the SW developed the care plan with the information on the resident's dashboard. During an interview with Nurse #4 on 10/17/24 at 10:35 AM she stated any nurse could update the Code Status information. She explained that upon admission Resident #10 had a Full Code status and several days after admission her family signed paperwork for the DNR status. She explained that updating the EMR Code Status update had been missed.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with the Medical Director and staff, the facility failed to obtain an order to delay the removal of sutures until the wound was healed for 1 of 2 residents reviewed for professional standards (Resident #62). The findings included: Resident #62 was admitted to the facility on	F 684	Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	11/7/24

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F 684	Continued From page 5 7/18/24 with diagnoses that included Alzheimer's disease and dementia. The admission Minimum Data Set (MDS) dated 7/25/24 indicated Resident #62 was severely cognitively impaired without mood or behavioral concerns. Review of the nurses' notes revealed an entry dated 10/03/24 that Resident #62 had a witnessed fall on 10/3/24. Resident #62 was taken to the local emergency room for evaluation where she received sutures for a wound to the right side of her forehead. Review of the emergency room discharge paperwork dated 10/03/24 revealed Resident #62 was supposed to be scheduled for a follow up appointment to have her sutures removed in seven days. Review of the physician's orders transcribed in the chart for Resident #62 uncovered an expired order for suture removal on 10/10/24. There was no documentation in the nurse's notes that explained why the order had expired without being completed. There were no further orders or physicians follow up notes regarding suture removal noted in the chart. Review of Resident #62's October 2024 Treatment Administration Record (TAR) revealed the expired order for suture removal but no further orders for removal were documented. The order to remove the sutures was not signed off as completed and left blank. The nurses' notes reviewed for 10/10/24 contained a note from the night shift nurse who	F 684	Through root cause analysis, it was determined that on 10/10/2024 Nurse #5 should have obtained a physician order to delay suture removal for resident #62. A physician order was received on 10/16/2024 to remove sutures for Resident #62 on 10/17/2024. Resident #62 sutures were removed on 10/17/2024. On 10/17/2024, the Wound Care Nurse conducted a suture removal order audit of all residents in the building. No other residents had sutures, therefore there was no potential for any further deficient practice. On 11/7/2024, Nurse #5 has been re-educated of the facility expectation to follow physician orders, or to receive a new physician order when a change in care is medically indicated. The Director of Nursing has scheduled all nursing staff education on 11/11/2024. The facility expectation to follow physician orders, or to receive a new physician order when a change in care is medically indicated will be reviewed at this mandatory meeting. The Wound Care Nurse will begin to audit all suture orders for timely removal using the “Suture Compliance Tool.” Audits will be conducted to ensure compliance and to allow for timely correction of care, as needed. The Wound Care nurse will be responsible for over-seeing timely removal of sutures. Results of above-mentioned audits will be documented on the “Suture Compliance	

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F 684	Continued From page 6	F 684		

documented Resident #62 had a clean dry dressing over the right brow area with light greenish-yellow bruising. There were no other nurses' notes or documentation about the sutures discovered in the record.

A note written by the Wound Care nurse dated 10/14/24 at 4:40 PM documented Resident #62 had sutures present on her forehead with improved bruising. There was no mention of obtaining an order to remove the sutures.

An interview was conducted with Nurse #2 on 10/15/24 at 12:15 PM. She stated there was an order for suture removal for Resident #62 on 10/10/24. She stated she was not working that day, and she was unaware why the sutures had not been removed.

The Wound Care Nurse was interviewed on 10/15/24 at 2:56 PM. She stated on 10/10/24 the provider noted Resident #62's wound looked wet and soft so the order to remove sutures was extended due to the wound's appearance. The Wound Care Nurse did not write a new order for suture removal.

Nurse #5 was interviewed on 10/17/24 at 9:32 AM. Nurse #5 stated she had worked the morning shift on 10/10/24. She verbalized on 10/10/24 the hospice agency nurse had visited Resident #62, and they jointly assessed her sutures that day. Nurse #5 stated the hospice nurse told her she didn't think the wound looked good enough to remove the sutures and she agreed with her. Nurse #5 indicated she had decided not to remove the sutures, but she did not notify the NP or Medical Director of the wound's condition to obtain a new order because she thought the

Tool." The Director of Nursing will monitor results of the above-mentioned audits weekly for eight weeks and monthly for six months. Results of the audits will be evaluated for effectiveness through the quarterly QAPI meetings for the duration of audits. The next scheduled QAPI meeting is January 21, 2025.

The facility alleges compliance with this plan on or before November 7, 2024.

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F 684	Continued From page 7	F 684		

hospice nurse was going to contact the provider instead.

An observation on 10/15/24 at 12:10 PM revealed Resident #62 had sutures on the right side of her forehead. The laceration's edges were clean, dry and approximated. Minimal pale pink discoloration was noted around the site.

The Nurse Practitioner (NP) was interviewed on 10/16/24 at 3:34 PM. She stated that she had not assessed Resident #62 previously because residents who received hospice care were followed by the facility's Medical Director. She stated that the resident was added to her list to be seen on10/16/24 for evaluation for suture removal.

The Medical Director was interviewed on 10/17/24 at 10:50 AM. He stated that Resident #62 had fallen and suffered a laceration on 10/3/24. He stated he had told the Wound Care nurse to leave the sutures in place for at least ten days during one of his daily phone calls with her, but he was unsure of the exact date. He stated that he was unsure why the order was not changed for Resident #62.