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 _____	C 12/19/2024

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/16/24 through 12/19/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# CN6A11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/16/24 through 12/19/24. Event ID# CN6A11. The following intake was investigated: NC00225253. 1 of the 1 complaint allegation did not result in deficiency.	F 000		
F 644 SS=E	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	F 644		1/25/25

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

Electronically Signed | 01/18/2025

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 _____	C 12/19/2024

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 644	Continued From page 1 by: Based on record reviews and staff interviews, the facility failed to submit a request for an evaluation of updated Pre-Admission Screening and Resident Review (PASARR) determination for 2 of 3 residents reviewed (Resident #11 and Resident #3). The findings included: 1. Resident #11 was originally admitted to the facility on 07/02/2021 with fibromyalgia, osteoarthritis, and Post Traumatic Stress Disorder (PTSD). On 04/10/204, resident was diagnosed with Major Depressive Disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 04/28/2024 revealed Resident #11 had moderate cognitive impairment. The MDS further revealed diagnoses on 04/10/2024 of major depressive disorder. Behaviors during the look back period included feeling down, depressed or sleepy. Care plan dated 04/28/2024 revealed Resident #11 had feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/activities. A review of the Psychiatric Periodic Evaluation revealed that Resident #11 was assessed for depression. Nurse Practitioner (NP) on 04/08/2024 included major depressive disorder. NP documented to continue duloxetine (for depression and anxiety) and Wellbutrin XL (for depression), and to utilize non-pharmacological interventions.	F 644	1. On 12/18/24 during the annual facility survey, resident #11 and resident #3 did not have a level II pre-admission screening and resident review (PASARR) application or level II pre-admission screening and resident review (PASARR) on file. 2. -The facility Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. -On 1/3/2025, resident #11 and resident # 3 level II pre-admission screening and resident review (PASARR) applications were completed and submitted by the facility social worker. The system verified that they were accepted. 3. -All residents have the potential to be affected by this deficient practice. On 12/31/24, the admissions director and the social worker completed a 100% audit of all residents to ensure any resident who is eligible to be screened for a level II pre-admission screening and resident review (PASARR) was submitted. Any resident who required a new submission or revision of their pre-admission screening and resident review (PASARR) was completed and submitted. 4. 1/10/25, the Licensed Nursing Home Administrator provided education to the Director of Social Services and the Director of Admissions, on the requirements of Level I and Level II pre-admission screening and resident review (PASARRs) as outlined in the	

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 _____	C 12/19/2024

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 644	Continued From page 2 Review of medical record revealed a new application for Level II PASARR had not been completed after the diagnosis of Major Depressive Disorder. Interview with Social Worker on 12/18/2024 at 10:59 AM revealed she was responsible for notifying State Mental Health Authority of resident's new mental health condition to establish a new PASARR level and a Level II PASARR had not been completed. Social Worker explained that she must be notified by nursing of any new mental health diagnoses to submit the evaluation for screening. On 12/18/2024 at 11:20 AM, the MDS Coordinator interview revealed the NP had not notified nursing of the additional diagnoses of major depressive disorder for Resident #11. During interview with Unit Manager on 12/19/204 at 8:05 AM, it was revealed that NP no longer came to the facility and the replacement Physician Assistant (PAs) first day was today. On 12/19/2024 upon interview with the PA at 10:50 AM, it was revealed this was his first day at the facility, and he was unfamiliar with the resident's case. Interview with Interim Administrator on 12/19/2024 at 2:50 PM disclosed that she expected a Level II PASARR to be completed for residents that were diagnosed with additional mental health diagnoses. 2. Resident #3 was admitted to the facility on 10/07/202 with diagnoses, in part, of dementia and history of bipolar disease.	F 644	State Operations Manual. After 1/10/25, any newly hired Directors of Admission or Social Workers will complete in-service education during orientation. 5. -Beginning 1/13/25, the Director of Social Work and the Director of Admissions will conduct audits on 15 residents per week for 4 weeks to determine if the resident□s pre-admission screening and resident review (PASARR) is up to date. Any concerns will be corrected immediately. -The Admissions Director will screen all new admissions on the day of admission to ensure a Level II pre-admission screening and resident review (PASARR) screening application has been completed and submitted if appropriate as outlined in the State Operations Manual. 6. The Licensed Nursing Home Administrator will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review and a decision will be made if the audits will continue.	

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 _____	C 12/19/2024

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 644	Continued From page 3	F 644		

A Pre-Admission Screening and Resident Review (PASAAR) Level I was completed at the time of admission on 10/07/2020 when Resident #3 entered from the community.

On 10/22/2022, Resident #3 was diagnosed with major depressive disorder and anxiety disorder by Psychiatric Nurse Practitioner (NP).

An annual Minimum Data Set (MDS) assessment dated 08/20/2024 revealed that Resident #3 had severe cognitive impairment; was diagnosed, in part, with dementia, anxiety disorder, depression, and manic depression; and had not been evaluated by Level II PASARR.

Care plan dated 11/20/2024 disclosed that due to Resident #3's depression/anxiety, non-pharmacological interventions should be utilized such as not rushing the resident when he is speaking, approach with a soft voice, and encourage resident to express his feelings when he is feeling down.

Review of medical record revealed a new referral for a Level II PASARR evaluation had not been completed after the diagnoses of major depressive disorder and anxiety were newly identified for Resident #3 on 10/22/2022.

Interview with Social Worker on 12/18/2024 at 11:01 AM revealed she was responsible for notifying the State Mental Health Authority of resident's new mental health condition(s) to establish a new PASARR level and a referral for a Level II PASARR evaluation had not ben completed for Resident #3 after the resident was newly identified with major depressive disorder

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 _____	C 12/19/2024

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 644	Continued From page 4 and anxiety. The Social Worker explained that she had been in her role since 2010, and nursing was supposed to notify her of any new mental health diagnoses to submit the evaluation for screening. On 12/18/2024 at 11:21 AM, the MDS Coordinator interview revealed that the Psychiatric NP was responsible for notifying nursing on paper about any new mental health conditions. She reported the Psychiatric NP had not notified nursing of the additional diagnoses of major depressive disorder and anxiety disorder. During an interview with Unit Supervisor on 12/19/2024 at 8:05 AM, it was revealed that Psychiatric NP who diagnosed Resident #3 with major depressive disorder on 10/12/2022 no longer came to the facility. At 10:55 AM on 12/19/2024, an interview with the Psychiatric Physician Assistant (PA) revealed that this was his first day at the facility, and he was unfamiliar with the resident's case. On 12/19/2024 at 4:20 PM, an interview with the Interim Administrator disclosed that she expected a referral for a Level II PASARR evaluation to be completed for residents that were diagnosed with additional mental health diagnoses.	F 644		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		1/25/25

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 _____	C 12/19/2024

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 761	Continued From page 5 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff and Consultant Pharmacist interviews, the facility failed to discard expired medications from 2 of 2 medication rooms (North and South medication rooms), and 1 of 2 medication carts (South medication cart). The facility also failed to date an eye drop after opening in 1 of 2 medication carts (South medication cart). The findings included: 1.a. An observation of the North medication room refrigerator on 12/18/24 at 11:08 AM with Nurse #1 revealed five full bags of Normal Saline 250 milliliters labeled as containing Gentamicin Injection with Resident #4's name. Each bag had	F 761	1. On 12/18/24, during the facilities annual state survey the facility failed to discard expired medications in 2 of 2 medication rooms and medication carts from South medication cart. 2. -The facility Licensed Nursing Home Administrator ultimately has the responsibility to ensure that the plan of correction is implemented and followed. -On 12/18/24, the Director of Nursing and Unit Manager returned all expired medications to the pharmacy or discarded any expired medications that could not be returned under the direction of the pharmacy.	

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 _____	C 12/19/2024

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 761	Continued From page 6 a sticker that indicated "do not use after" with the following dates: 12/9/24, 12/11/24, 12/13/24, 12/15/24, and 12/17/24. There was also another bag labeled the same way which was half full and the sticker date was to discard after 12/5/24. An interview with Nurse #1 on 12/18/24 at 11:10 AM revealed she was not sure why the bags of Normal Saline with Gentamicin were still available in the medication room refrigerator. Nurse #1 stated they were supposed to have been used to irrigate Resident #4's urinary catheter and this procedure had been scheduled for the evening shift. A phone interview with the Consultant Pharmacist on 12/18/24 at 4:14 PM revealed they had sent pre-mixed Gentamicin solution for Resident #4's urinary catheter irrigation, and the Normal Saline bags were only good for 48 hours because they had already been punctured by the pharmacy adding the Gentamicin medication into the bags of saline. She stated that any unused solution should have been discarded after two days. b. Further observation of the North medication room on 12/18/24 at 11:15 AM with Nurse #1 revealed two boxes of Bisacodyl suppositories marked with a manufacturer's expiration date of 8/31/24. One box contained 24 suppositories, and the other box contained 15 suppositories. There was also a 473 milliliter (ml) bottle of Guaifenesin marked with an expiration date of August 2024. Both medications were available for use in the North medication room. An interview with Nurse #1 on 12/18/24 at 11:18 AM revealed the nurses were responsible for checking the medication room for expired	F 761	-On 12/18/24, a bottle of Latanoprost eyedrops which did not have the open date on it was discarded and a new bottle opened and labeled appropriately. A new bottle was obtained at no charge to the resident. 3. All residents have the potential to be affected by this deficient practice. On 12/18/24, the Unit Manager and the Director of Nursing completed a 100% audit of both medication rooms and all medication carts in house to ensure there were no other expired medications. Any areas of concern were addressed immediately during the audit. 4. Beginning 1/13/25, the Staff Development Coordinator provided education to 100% of all nurses and medication aides to include agency nurses with a focus on the requirements for the labeling, storage, return, disposable of medications, and the dating of opened medications as outlined in the State Operations Manual. All in-service education will be completed by 1/20/25, any licensed nurses or medication aides to include agency nurses who have not completed education by 1/20/25 will be in serviced prior to their next shift. Any newly hired licensed nurses or medications aides to include agency nurses will receive in-service education during orientation. 5. Beginning 1/12/25, the Director of Nursing or the Assistant Director of Nursing will audit both medication rooms 2 times weekly for 4 weeks and each medication cart 2 times weekly for 4 weeks to ensure there are no expired	

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 _____	C 12/19/2024

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 761	Continued From page 7 medications. Nurse #1 stated she thought they had one of the medication aides go through the medication rooms this week. An interview with the Nurse Supervisor on 12/19/24 at 11:24 AM revealed she usually checked the medication rooms at the beginning of each month, but she did not notice any of the expired medications that were observed. An interview with the Director of Nursing (DON) on 12/19/24 at 3:27 PM revealed she did not know why there were expired medications available for use in both medication rooms and the South medication cart. The DON stated she would have thought that the supervisors would have caught them sooner and addressed them. The DON further stated that she called pharmacy and verified that the Normal Saline bags expired in two days only if they were punctured, and she did not think any of them were punctured. The DON also said that the supervisors should check the stock medications in the medication rooms, while the nurses were responsible for checking the medication carts. 2. An observation of the South medication room with Nurse #2 on 12/18/24 at 12:03 PM revealed a 236 ml unopened bottle of Multi-Vite marked with an expiration date of November 2024. An interview with Nurse #2 on 12/18/24 at 12:05 PM revealed the night shift nurses were responsible for checking the medication room for expired medications and also which ever nurse put the stock medications into the cabinets. She did not know why the expired bottle of Multi-Vite was left available for use in the South medication room.	F 761	medications. Any concerns will be addressed immediately. 6. The Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review and a decision will be made if the audits will continue.	

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 _____	C 12/19/2024

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 761	Continued From page 8	F 761		

An interview with the Nurse Supervisor on 12/19/24 at 11:24 AM revealed she usually checked the medication rooms at the beginning of each month, but she did not notice any of the expired medications that were observed.

An interview with the Director of Nursing (DON) on 12/19/24 at 3:27 PM revealed she did not know why there were expired medications available for use in both medication rooms and the South medication cart. The DON stated she would have thought that the supervisors would have caught them sooner and addressed them. The DON also said that the supervisors should check the stock medications in the medication rooms, while the nurses were responsible for checking the medication carts.

3. An observation of the South medication cart with Nurse #2 on 12/18/24 at 12:13 PM revealed a box of twelve Hemorrhoidal suppositories marked with an expiration date of September 2024 available for use. There was also an opened bottle of Latanoprost eye drops with no open date. It was marked as sent by the pharmacy on 11/7/24. The bottle had a sticker that indicated it expired six weeks after opening.

An interview with Nurse #2 on 12/18/24 at 12:15 PM revealed the nurses on the cart were responsible for going through it to check for expired medications. Nurse #2 stated she did not notice both medications because the Hemorrhoidal suppositories were no longer needed by the resident for whom it was ordered and the Latanoprost eye drops were only given at bedtime. Nurse #2 stated that whoever opened the Latanoprost eye drop bottle should have put a

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 _____	C 12/19/2024

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 761	Continued From page 9 date on it due to the expiration date being six weeks after opening. An interview with the Director of Nursing (DON) on 12/19/24 at 3:27 PM revealed she did not know why there were expired medications available for use in both medication rooms and the South medication cart. The DON stated she would have thought that the supervisors would have caught them sooner and addressed them. The DON also said that the supervisors should check the stock medications in the medication rooms, while the nurses were responsible for checking the medication carts.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		1/25/25

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 _____	C 12/19/2024

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 880	Continued From page 10 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 _____	C 12/19/2024

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 880	Continued From page 11 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to implement their infection control policy when 3 staff members (Nurse Aides #1, #2, and #3) failed to sanitize their hands in between resident contacts and contact with surfaces in the dining room during meal service. In addition, Nurse #1 failed to don Personal Protective Equipment (PPE) including a gown when providing urinary catheter care and failed to perform hand hygiene before applying gloves and after removing gloves during catheter care for Resident #4. This involved 4 of 5 staff members observed for infection control practices (Nurse Aides #1, #2, #3 and Nurse #1). The findings included: Review of the facility's policy for Handwashing dated 4/2023 indicated that the facility ensures that all employees wash hands using soap, running water, and friction in the following situations: immediately or as soon as feasible after removal of gloves or other personal protective equipment. 1.a. Nurse Aide (NA) #2 was observed on 12/16/24 at 11:51 AM touching the hands and hair of a resident in the dining room. NA #2 then walked to another resident in the dining room without washing or sanitizing her hands and then touched the resident on the hands. On 12/16/24 at 12:05 PM NA #2 was observed	F 880	1. During the facilities annual recertification and a complaint survey that occurred on December 12-16, 2025, the facility failed to implement their infection control policy. This was evidenced by the survey team noting 3 staff members (Nurse Aides #1, #2, and #3) failing to sanitize their hands in between resident contacts and contact with surfaces in the dining room during meal service. In addition, Nurse #1 failed to don Personal Protective Equipment (PPE) including a gown when providing urinary catheter care and failed to perform hand hygiene before applying gloves and after removing gloves during catheter care for Resident #4. This involved 4 of 5 staff members observed for infection control practices (Nurse Aides #1, #2, #3 and Nurse #1). 2. -All residents have the potential to be affected by this deficient practice. -On 12/18/24 the Director of Nursing and the Assistant Director of Nursing provided 100% education to Nurse Aide #1, #2, and #3 on the facility policy and procedure as outlined in the State Operations Manual for hand hygiene with a focus on meal service, donning PPE (personal protective equipment) during catheter care with focus on hand hygiene and general infection control. On 12/18/24 the Director of Nursing and the Assistant Director of	

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 _____	C 12/19/2024

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 880	Continued From page 12 assisting a resident with meal set up while wearing gloves, then immediately assisted another resident with meal set up without removing the gloves. NA #2 then helped cut the resident's food and touched the resident's bread while wearing the same gloves. NA #2 was interviewed on 12/16/24 at 12:50 PM. She stated she would wash and sanitize her hands after delivering meals to each resident and after assisting a resident with eating before assisting another resident with a meal. NA #2 said her usual procedure was to wash her hands after removing gloves or replacing them and after touching hair or other areas of the body. NA #2 said she did not wash or sanitize her hands for every occasion needed when she assisted residents in the dining room. b. On 12/16/24 at 11:59 AM NA #1 was observed adjusting a residents clothing protector with his hands, then immediately serve another resident a meal tray without sanitizing or washing his hands. On 12/16/24 at 12:20 PM NA #1 was observed touching and readjusting a resident's clothing protector and then immediately assisted another resident with their meal. NA #1 did not wash or sanitize his hands before assisting the resident with their meal. NA #1 was interviewed on 12/26/24 at 12:56 PM. He stated he usually would wash or sanitize his hands after he helped set a resident up for a meal and after touching a resident. NA #1 stated he overlooked washing and sanitizing his hands between assisting residents with meals and after touching clothing protectors.	F 880	Nursing also provided education to Nurse #1 on the facility policy and procedure for donning PPE (personal protective equipment) during catheter care with a focus on understanding EBP (Enhanced Barrier Precautions), hand hygiene, and general infection control. -On 1/16/25, the nurse consultant from Regional Infection Prevention Support (RIPS) performed an initial assessment of the infection control practices in the facility with the Director of Nursing and the Unit Manager. She observed general infection control throughout the facility, handwashing during meal service and during care, don/doff of PPE (personal protective equipment) for a resident on EBP (Enhanced Barrier Precautions, and overall infection control during meal service on the halls and in the dining room. 3. -The facility Licensed Nursing Home Administrator ultimately has the responsibility to ensure that the plan of correction is implemented and followed. -On 1/16/25, the Director of Nursing/IP (Infection Preventionist) observed Nurse #1 don/doff PPE (personal protective equipment, perform handwashing, appropriately observe infection control precautions for a resident on EBP (Enhanced Barrier Precautions) while following the facility policy and procedure as outlined in the State Operations Manuel. -On 1/16/25, the Director of Nursing/IP (Infections Preventionist) observed Nurse Aides #1, #2, and #3 appropriately	

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 _____	C 12/19/2024

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 880	Continued From page 13 c. On 12/16/24 at 12:10 PM NA #3 was observed placing gloves in her coat pocket and washing her hands. NA #3 then removed the gloves from her coat pocket, placed them on her hands and touched a resident's sandwich. NA #3 was interviewed 12/16/24 at 12:39 PM. NA #3 stated she would wash or sanitize her hands before and after she passed meals to each resident, after she touched clothing, and after she removed gloves. NA #3 said she did forget to sanitize and wash when she used gloves and after touching residents clothing before assisting another resident. The Director of Nursing (DON) stated on 12/19/24 at 3:39 PM the NAs and Nurses should have washed or sanitized their hands in-between assisting residents with meals. The DON stated hands should be washed or sanitized after touching their own clothing, residents clothing, hair, face, and after removing gloves. The Administrator was interviewed on 12/19/24 at 4:08 PM and stated Nurses and NAs should have sanitized hands in-between assisting residents with meals. She stated hands should have been sanitized after touching hair, clothing and before they assisted a resident with eating. 2. Review of the facility's policy for Enhanced Barrier Precautions (EBP) revised on 6/13/24 indicated Enhanced Barrier Precautions will be utilized by staff for all residents with a known CDC (Centers for Disease Control and Prevention) targeted MDRO (multidrug-resistant organism) infection or colonization (when contact precautions are not indicated) and/or residents without known MDRO who have wounds and/or	F 880	observe infection control precautions to include handwashing during the lunch meal service while following the facility policy and procedure as outlined in the State Operations Manuel. 4. Beginning 1/10/25, the Staff Development Coordinator provided education to 100% of all nursing staff to include agency staff on the facility policy and procedure with a focus on the requirements for handwashing; using hand sanitizer or soap and running water following the removal of gloves; proper use of PPE (personal protective equipment) and precautions requirements for EBP (Enhanced Barrier Precautions) as outlined in the State Operations Manuel. All in-service education will be completed by 1/20/25, any staff to include agency who have not completed the in-service education by 1/20/25 will receive in-service prior to their next shift. Any newly hired nursing staff members to include agency nurses who have not received the in-service education will receive it during their orientation. -The RIPS (Regional Infection Prevention and Support) nurse will present the following live in-services to the staff in the facility: Chain of infection for all staff 1/23/25 @ 7am, standard precautions: PPE for all staff 1/30/25 @ 7am, standard precautions: hand hygiene for all staff 2/6 @ 7am, transmission-based precautions for clinical staff, standard precautions: environmental cleaning for housekeeping. The first in-service is scheduled for 1/23/25 at 7am. Staff members who are unable to attend will be able to watch a	

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 _____	C 12/19/2024

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 880	Continued From page 14 implanted medical devices. An observation on 12/18/24 at 10:29 AM revealed Resident #4 had signage for EBP posted on his door. The signage indicated all healthcare personnel must wear gloves and gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use to include urinary catheter, and wound care. Nurse #1 entered Resident #4's room to provide urinary catheter care without wearing a gown for the procedure. Nurse #1 put gloves on both hands without performing hand hygiene and obtained soapy water in a kidney basin from Resident #4's bathroom sink faucet. Nurse #1 placed the kidney basin on Resident #4's bedside table, uncovered Resident #4, and pulled open his brief. Nurse #1 wiped Resident #4's urinary catheter insertion site with a washcloth soaked in the soapy water from the kidney basin. She removed both gloves and without performing hand hygiene, she proceeded to put on a new set of gloves to both hands. She reached inside her shirt pocket and obtained a tube of antibiotic ointment. Nurse #1 squeezed the contents of the tube into a medicine cup and placed the cup on Resident #4's bedside table. Nurse #1 changed her gloves without doing hand hygiene. She applied the ointment onto Resident #4's urethral meatus (passage or opening leading to the interior of the body). Nurse #1 removed her gloves and put on a new pair of gloves to both hands. She wiped the rest of Resident #4's urinary catheter, discarded any unused supplies, removed her gloves and washed her hands. An interview with Nurse #1 on 12/18/24 at 10:36	F 880	recorded presentation of each class. All staff who have not attended the previous in-service education will do so at the beginning of their next scheduled shift. The Licensed Nursing Home Administrator has requested a schedule of every Thursday until the sessions are completed. Three dates have been scheduled thus far. The others will be based on the availability of the nurse consultant from RIPS (Regional Infection Prevention Support). 5. Beginning 1/12/25, the Director of Nursing/Infection Preventionist, the Unit Manager, and the Assistant Director of Nursing will conduct infection control surveillance and monitoring rounds 5 times weekly for 8 weeks with a focus on hand washing, meal service, don/doff PPE (personal protective equipment) while taking care of residents on EBP (Enhanced Barrier Precautions), and general infections control practices per the facility policy and procedure and as outlined in the State Operations Manual. 6. The Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review and a decision will be made if the audits will continue.	

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 _____	C 12/19/2024

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 880	Continued From page 15 AM revealed that she did not notice the sign for EBP on Resident #4's door and stated that the sign must have just been put up. Nurse #1 indicated she was supposed to have put on a gown when she provided catheter care to Resident #4. Nurse #1 stated that she had washed her hands prior to entering Resident #4's room, and she would normally wash her hands prior to putting gloves on but Resident #4 was agitated and wanted to get up, so she was trying to hurry. Nurse #1 further stated that she had not heard that she was supposed to sanitize her hands after removing gloves and before applying new ones. Nurse #1 stated that she had received education on hand hygiene and EPB, and that she knew what she was supposed to do, but she could not explain why she hadn't donned a gown or perform hand hygiene after removing her gloves. Nurse #1 stated that there was no excuse. An interview with Director of Nursing (DON) who also served as the facility's Infection Preventionist on 12/19/24 at 3:27 PM revealed staff was supposed to wash their hands and apply PPE when going into rooms on EBP. The DON stated Nurse #1 should have worn a gown and gloves while providing catheter care to Resident #4. The DON also stated that Nurse #1 should have done hand hygiene after removing her gloves. She shared that Nurse #1 had been educated on the facility's infection control policies and should have known what to do.	F 880		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies	F 887		1/25/25

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 _____	C 12/19/2024

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 887	Continued From page 16	F 887		

and procedures to ensure all the following:
(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;
(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19

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 _____	C 12/19/2024

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 887	Continued From page 17 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 3 of 6 residents reviewed for infection control (Resident #2, Resident #11, and Resident #18). The findings included: 1. Resident #2 was admitted to the facility on 04/30/2018. The quarterly Minimum Data Set (MDS) dated 11/22/2024 revealed that Resident #2's cognition was severely impaired. The electronic immunization record revealed that Resident #2 received the COVID-19 immunization on 10/16/2024. A review of Resident #2's medical record revealed there was no information documented in	F 887	1. During the facilities annual survey, the facility failed to provide proof of documentation to show that 3 residents (Resident #2, Resident #11, and Resident #18) or their responsible party had been provided education for the COVID-19 vaccine. 2. -The facility Licensed Nursing Home Administrator ultimately is responsible for ensuring the plan of correction is implemented and followed. -All residents have the potential to be affected by this deficient practice. On 1/10/25, the Director of Nursing reviewed the COVID-19 vaccine information/education sheet with resident numbers 2, 11, and 18's responsible parties. All parties signed and verified understanding. 3. On 1/15/25, the Director of Nursing and the Minimum Safety Data Set (MDS)	

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 _____	C 12/19/2024

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 887	Continued From page 18 Resident #2's medical record that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 vaccine. During an interview with the Interim Assistant Director of Nursing (ADON) on 12/18/2024 at 7:54 AM, she stated that she had been at this facility since the second week of November 2024. The ADON stated that she served as Staff Development Coordinator (SDC) and Quality Improvement (QI) nurse. She stated that she was responsible for resident and staff immunizations with consents and was "catching up" with the administration of the vaccines. At 1:00 PM on 12/19/2024, The Director of Nursing (DON) and the Regional Director were asked for documentation of the education provided for Resident #2 regarding the benefits and potential side effects of the COVID-19 immunization. The information was not received. The Director of Nursing (DON) who was interviewed on 12/19/2024 at 3:40 PM revealed that she was responsible for resident immunizations and acknowledged that she did not have documentation about providing education about benefits and potential side effects of COVID-19 immunization. The Interim Administrator was interviewed on 12/19/2024 at 4:25 PM and stated that she expected staff to educate and document education provided regarding benefits and potential side effects of COVID-19 immunizations. 2. Resident #11 was originally admitted to the	F 887	nurse completed a 100% audit of all residents to ensure COVID-19 education had been provided to residents or their responsible party as appropriate and as outlined in the State Operations Manual. 4. Beginning 1/10/25, the Staff Development Coordinator provided education to all Licensed nurses to include agency nurses on the requirements of providing education for the COVID-19 vaccine as outlined in the State Operations Manual. All In-service education will be completed by 1/20/25. Any licensed nurse to include agency nurses who have not completed education by 1/20/25 will be in-serviced prior to their next shift. Any newly hired licensed nurses to included agency nurses will receive the education during orientation. 5. Beginning 1/12/25, the Director of Nursing or the Assistant Director of Nursing will conduct audits of 3 residents per week for 4 weeks as well as review any new admissions for the week to ensure education has been provided and is documented by the resident or their responsible party in relation to the COVID-19 vaccine as outlined in the State Operations Manual. Any concerns observed will be addressed immediately. 6. The Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review and a decision will be made if the audits will continue.	

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 _____	C 12/19/2024

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 887	Continued From page 19	F 887		

facility on 12/27/19 and was readmitted on 9/14/2020.

Review of quarterly Minimum Data Set (MDS) assessment dated 04/28/2024 revealed Resident #11 had moderate cognitive impairment.

A review of the electronic immunization record revealed that Resident #11 refused the COVID-19 immunization in 2024 without a documented date.

On 09/25/2024, a note was authored by the Assistant Director of Nursing (ADON) who was no longer employed at the facility and stated that Resident and legal representative refused the COVID vaccine.

During an interview with the Interim ADON on 12/18/2024 at 7:54 AM, she stated that she had been at this facility since the second week of November 2024. The ADON also that she served as Staff Development Coordinator (SDC) and Quality Improvement (QI) nurse. She stated was responsible for resident and staff immunizations with consents and was "catching up" with the administration of the vaccines.

At 11:05 AM on 12/18/2024, Resident #11 was interviewed. She remembered refusing the COVID-19 vaccine this fall and stated that she did not recall being educated about the benefits and potential side effects of the vaccine.

At 1:00 PM on 12/19/2024, The Director of Nursing (DON) and the Regional Director were asked for documentation of the education provided for Resident #11 regarding the benefits and potential side effects of the COVID-19 immunization. The information was not received.

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 _____	C 12/19/2024

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 887	Continued From page 20	F 887		

The DON who was interviewed on 12/19/2024 at 3:40 PM revealed that she was ultimately responsible for resident immunizations and acknowledged that she did not have documentation about providing education about benefits and potential side effects of COVID-19 immunization.

The Interim Administrator was interviewed on 12/19/2024 at 4:25 PM and stated that she expected staff to educate and document education provided regarding benefits and potential side effects of COVID-19 immunizations.

3. Resident #18 was admitted to the facility on 07/02/2021.

Review of quarterly Minimum Data Set (MDS) assessment dated 04/28/2024 revealed Resident #18 had moderate cognitive impairment.

A review of the electronic immunization record revealed that Resident #18 refused the COVID-19 immunization for 2024 without a documented date.

On 09/25/2024, a note was authored by the former Assistant Director of Nursing (ADON) who was no longer employed at the facility and stated that Resident and legal representative refused the COVID vaccine.

During an interview with the Interim ADON on 12/18/2024 at 7:54 AM, she declared that she had been at this facility since the second week of November 2024. The ADON also that she served as Staff Development Coordinator (SDC) and

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 _____	C 12/19/2024

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 887	Continued From page 21	F 887		

Quality Improvement (QI) nurse. She sated was responsible for resident and staff immunizations with consents and was "catching up" with the administration of the vaccines.

At 11:05 AM on 12/18/2024, Resident #18 was interviewed. She remembered refusing the COVID-19 vaccine this fall and stated that she did not recall being taught about the benefits and potential side effects of the vaccine.

At 1:00 PM on 12/19/2024, The Director of Nursing (DON) and the Regional Director were asked for documentation of the education provided for Resident #18 regarding the benefits and potential side effects of the COVID-19 immunization. The information was not received.

The Director of Nursing (DON) was interviewed on 12/19/2024 at 3:40 PM, revealed that she was responsible for vaccine and acknowledged that she did not have documentation about providing education about benefits and potential side effects of COVID-19 immunization.

The Interim Administrator was interviewed on 12/19/2024 at 4:25 PM and stated thatshe expected staff to educate and document education provided regarding benefits and potential side effects of COVID-19 immunizations.