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 _____	09/05/2019

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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 survey was conducted on 9/3/19 through 9/5/19 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9D7511.	E 000		
F 000	INITIAL COMMENTS 10/07/19 Survey team deleted tag F-756 before the scheduled IDR. An amended CMS 2567 report will be provided to the facility.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 1 of 5 sampled residents reviewed for unnecessary medications (Resident # 26). Findings included: Resident #26 was admitted to the facility on 1/18/17 with multiple diagnoses including schizoaffective disorder. The quarterly Minimum Data Set (MDS) assessment dated 8/21/19 indicated that Resident #26 had severe cognitive impairment and she had received an antipsychotic medication for 7 days during the assessment period. The assessment further indicated that a gradual dose reduction (GDR) for the antipsychotic medication had not been	F 641	On 9/5/2019, the Minimum Data Set (MDS) coding error was modified by the MDS Nurse to read that a Gradual Dose Reduction (GDR) was attempted on resident #26. On 9/9/2019, the modified MDS assessment for resident #26 was re-submitted and accepted. An audit was completed by MDS Nurses (MDS Coordinator and Care Plan Coordinator), of one another's completed assessments, for all assessments completed for the current quarter to ensure GDR was coded accurately. All other MDS assessments, specific to GDR under section N: Drug Regimen Review were coded accurately. Additionally, both MDS Nurses were educated by the Administrator on 9/18/2019 of the	9/20/19

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

Electronically Signed | 09/20/2019

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F 641	Continued From page 1 attempted. Resident #26 was admitted (1/18/17) with a doctor's order for Abilify (antipsychotic medication) 2 milligrams (mgs.) by mouth at bedtime for schizoaffective disorder. On 7/6/17, the Abilify was increased to 2 mgs every 12 hours and on 7/11/19, the Abilify was increased to 5 mgs every 12 hours. On 4/8/18, there was a doctor's order to decrease the Abilify to 5 mgs at bedtime and on 10/3/18, there was an order to decrease the Abilify to 2.5 mgs daily. On 9/5/19 at 9:03 AM., the MDS Nurse was interviewed. She reviewed Resident #26's medical records and verified that Resident #26 had received a GDR on Abilify on 4/8/18 and 10/3/18. She stated that the quarterly MDS assessment dated 8/21/19 was coded wrong, a GDR had been attempted. On 9/5/19 at 2:36 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.	F 641	Resident Assessment Instrument (RAI) Manual instructions for proper coding of the MDS specific to section N0450B and N0450C, specifically to include GDR attempts since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication since the time of admission. Through root cause analysis it was determined that this deficient practice occurred as MDS nurse were coding one year versus initial admission date. A Quality Assurance (QA) tool “2019 GDR Assessment Audit Tool” was created to monitor accurate MDS coding and to maintain regulatory compliance. Each MDS Nurse will audit one another’s assessment coding, specific to GDR under section N weekly for 3 months and monthly for 3 months to ensure accurate coding and regulatory compliance. The “2019 MDS Assessment QA Team,” which consists of MDS Coordinator, Care Plan Coordinator, Director of Nursing, and Administrator will meet weekly in coordination with the currently scheduled QI meetings to discuss findings of on-going audits and corrective actions for 6 months from the date of alleged compliance to ensure deficient practice does not recur. The MDS Nurse will be responsible for ensuring compliance with the above-mentioned plan of correction elements. The above-mentioned audits and monitoring efforts will be coordinated through the facility Quality Assurance	

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F 641	Continued From page 2	F 641	process. The MDS Nurse will report findings and adjustments of audits to ensure compliance at the quarterly Executive QA meetings for the duration of the audits. The next QA meeting is scheduled October 15, 2019. The facility alleges compliance with all aspects of this portion of the plan of correction by 9/20/2019.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to prevent a resident from falling out of bed during incontinent care for 1 of 8 sampled residents reviewed for accidents (Resident #55). Findings included: Resident #55 was admitted to the facility on 8/3/16 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/12/19 indicated that Resident #55 had severe cognitive impairment and she needed two plus persons physical assist with personal hygiene and toileting.	F 689	Facility team members, specifically Administrative Nurses, have ensured the bed, mobility devices, and fall interventions in place for this resident are appropriate. Through root cause analysis, facility team members have determined the fall occurred from human error associated with staff training. Facility leaders will focus on staff training to correct the deficient practice. The Certified Nursing Assistant (CNA) responsible for care during the incident is no longer employed by the facility, therefore re-training in not an available intervention.	9/20/19

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F 689	Continued From page 3 Resident #55's care plan dated 4/12/19 was reviewed. One of the care plan problems was potential for fall related injury. The goal was for Resident #55 to have no fall with significant injury. The approaches included to encourage the resident to notify staff with need of assistance for transfer and to keep bed in low position. The care plan also revealed that on 6/9/19, Resident #55 had a witnessed fall. An Aide was providing incontinent care and the resident rolled out of bed. A hematoma and small abrasion were noted to the left side of the forehead. Resident #55's nurse's notes were reviewed. A note dated 6/9/19 at 1:53 PM written by Nurse #2 revealed that a nurse aide (NA #1) reported to writer that resident had rolled out of bed while the NA was providing care. The resident was noted on the floor between the wall and the bed. Head to toe assessment was performed and the resident was noted to have a hematoma with abrasion to the left forehead and redness to the left shoulder. Resident #55 had complained of pain to her left forehead. The physician and the responsible party (RP) were notified. The RP requested not to send the resident to the hospital and just to monitor changes at the facility. The incident report dated 6/9/19 was reviewed. The report revealed that on 6/9/19 at 11:15 AM, NA #1 reported to Nurse #2 that Resident #55 had rolled out of bed during care. The resident was observed on the floor on her back between the wall and the bed. Hematoma with abrasion was noted to her left forehead and redness to her left shoulder. On 9/5/19 at 9:05 AM, a telephone interview was conducted with NA #1. She stated that she no	F 689	Facility leaders have audited staff training compliance and are increasing the annual training required for nursing staff members that directly care for residents. Training efforts will be a combination of in-house hands-on training and external resources. The facility began using Relias Learning, an electronic training resource, in the second quarter of this year. The potential of this system is not yet fully maximized. Administrative nursing leaders will also focus on fall prevention at a minimum of one skills fair, annually. All facility CNAs will complete fall prevention training, during the next scheduled Skills Fair on October 9, 2019; there will be two additional dates in October to ensure 100% of CNAs are re-trained. Nurse aides must complete re-training at one of the scheduled Skills Fair sessions prior to returning to work. Accommodations will be made for those unable to attend the currently scheduled Skills Fair training sessions. All facility CNAs will complete fall prevention training upon hire, and at least twice annually through various resources to ensure regulatory compliance. In addition to re-training efforts, the Quality Assurance (QA) Nurse, who is responsible for investigating falls will use a “Root Cause Analysis for Falls” form that was created to investigate falls and ensure staff training is adequate through the next annual survey, at a minimum. Monitoring efforts will be conducted by the Administrator, Director of Nursing, and	

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F 689	Continued From page 4 longer worked at the facility. She stated that she was assigned to Resident #55 on 6/9/19 when the resident had a fall. She indicated that Resident #55 was stiff and was hard to turn to her sides. The resident needed two persons assist with any care since she could not hold herself when turned. NA #1 further reported that it was about lunch time and Resident #55 had to go to the dining room for lunch. She indicated that there were two NAs assigned on the hall, but one NA was assigned to assist in the dining room during lunch. She could not find anybody to help with the incontinent care, so she did the care by herself. She turned the resident to her side, and then she turned around to reach for the wash towel. When she turned around, the resident rolled out of bed. On 9/5/19 at 10:35 AM, the Quality Assurance (QA) Nurse was interviewed. She stated that she was responsible for investigating all the incidents/accidents including the falls. She reported that she investigated the fall on Resident #55 dated 6/9/19. She interviewed the NA and the Nurse. She didn't obtain written statements from the witnesses and she didn't observe how the fall had happened. The QA Nurse was unable to explain the root cause of the fall. She also stated that after the fall a bolster mattress was placed in resident's bed. On 9/5/19 at 11:15 AM, Nurse #2 was interviewed. She stated that she was assigned to Resident #55 on 6/9/19 when the resident had a fall. Nurse #2 stated that Resident #55 was stiff, and she could not move. She reported that NA #1 had reported that the resident rolled out of bed during incontinent care.	F 689	Staffing Coordinator to ensure staff have attended scheduled training for one year. Two monitoring tools “In-Service Roster” and Relias “Training Alerts” will be used to monitor compliance with assigned training. On-going staff feedback will be obtained to ensure training is adequate, appropriate, and effective. The “2019 Annual Survey QA Team” will meet weekly in coordination with the currently scheduled QI meetings to discuss findings of on-going audits and corrective actions for 6 months from the date of alleged compliance to ensure deficient practice does not recur. The Director of Nursing will be responsible for ensuring compliance with the above-mentioned plan of correction elements. The above-mentioned audits and monitoring efforts will be coordinated through the facility Quality Assurance process. The Director of Nursing will report findings and adjustments of audits to ensure compliance at the quarterly Executive QA meetings for the duration of the audits. The next QA meeting is scheduled October 15, 2019. The facility alleges compliance with all aspects of this portion of the plan of correction by 9/20/2019.	

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F 689	Continued From page 5 On 9/5/19 at 2:36 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to prevent resident from falling during care.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to store a nebulizer mask in a sealed bag when not in use for Resident #72. This was for 1 of 3 residents reviewed for respiratory care. The findings included: Resident #72 was admitted on 3/22/16 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Resident #72's significant change Minimum Data Set (MDS) dated 7/30/19 indicated she was cognitively intact and exhibited no behaviors. Review of Resident #72's care plan revised 8/21/19 read she had alteration in respiratory status. Interventions included changing her nebulizer mask weekly and storing the nebulizer mask in a storage bag per facility policy.	F 695	Through root cause analysis it was determined that the resident removes her own nebulizer mask. The resident has a Brief Interview for Mental Status (BIMS) score of 13 of 15, meaning she is mentally intact. The resident was educated of the importance to return the nebulizer mask to the storage bag. In addition to allowing this resident to maintain independence of removing her mask, the facility has also re-educated nurses staff responsible for caring for this resident. Nurses are aware to check and ensure nebulizer mask was replaced once treatment is complete. The Physician's Order for the nebulizer treatment was revised to include staff returning the nebulizer mask to the bag once treatment is complete. A RN, Unit Coordinator completed an	9/20/19

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F 695	Continued From page 6 Review of Resident #72's September 2019 Physician orders included an order for Ipratropium-Albuterol (inhalation medication used to control symptoms of COPD) nebulizer treatments twice daily. The Physician orders also included changing her nebulizer mask weekly and storing the nebulizer mask in a storage bag per facility policy. Review of Resident #72's Medication Administration Record (MAR) for September 2019 indicated she received her nebulizer treatments as ordered. Review of Resident #72's Treatment Administration Record (TAR) for September 2019 indicated staff last changed her nebulizer mask on 9/2/19 and the nebulizer mask was to be stored in a storage bag (Ziplock) per facility policy. In an observation on 9/3/19 at 10:45 AM, Resident #72's nebulizer mask was lying on top of the nebulizer machine that was sitting on top of her over the bed table. The nebulizer mask was not sealed in a storage bag. Resident #72 stated she received breathing treatments daily using the nebulizer mask. In an observation on 9/4/19 at 2:20 PM, Resident #72's nebulizer mask was partially lying on top of the nebulizer machine on her over the bed table. Also observed was an unopened Ziplock bag lying on the over the bed table. In an observation on 9/5/19 at 8:45 AM, Resident #72's nebulizer mask was partially lying on top of the nebulizer machine on her over the bed table.	F 695	audit for all residents with nebulizers on 9/17/2019 to ensure masks were found being stored in the appropriate bag, there were 9 of 24 masks found improperly stored. On 9/20/2019 a follow up audit was conducted by the Unit Coordinator; all nebulizer masks were stored properly. The Administrator created a nebulizer cleaning and storage procedure to reflect regulatory expectations and standard precautions for infection control. All nurses were educated of the new nebulizer cleaning and storage procedure on 9/20/2019. Nurses must acknowledge the new procedure prior to working his/her next scheduled shift. Additionally, new nebulizer storage bags have been ordered; these bags will be affixed to the resident's nightstand or bedside table to ensure a bag is available and in a universal location for nurses to store equipment appropriately. A Quality Assurance (QA) tool, "2019 Nebulizer Mask Audit Tool" was created to monitor nebulizer mask storage for all appropriate residents and to maintain regulatory compliance. Utilizing the QA tool, monitoring will be completed for all residents with a nebulizer stored in his/her room. Audits will be conducted by a Unit Coordinator, weekly for 3 months and monthly for 3 months. The "2019 Annual Survey QA Team," which consists of the Director of Nursing, Unit Coordinators, and Administrator will meet weekly in coordination with the currently scheduled QI meetings to discuss findings of on-going audits and corrective actions for	

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F 695	Continued From page 7 Also observed was an unopened Ziplock bag lying on the over the bed table. Nurse #1 reached for the nebulizer mask in preparation to administer Resident #72's breathing treatment. Nurse #1 was stopped and asked where the nebulizer mask was to be stored when not in use. He stated the mask should be stored inside the provided Ziplock bag lying on the over the bed table when it was not in use. Nurse #1 stated it must have been an oversight and stated the rationale for storing the nebulizer mask in a sealed bag was to prevent contamination and control infections. In an interview on 9/5/19 at 11:45 AM, the Administrator stated the facility did not have a policy regarding the storage of nebulizer mask when not in use and only recently instituted the storing of the nebulizer mask in Ziplock bag. He stated it was his expectation Resident #72's nebulizer mask be stored in a sealed bag when not in use.	F 695	6 months from the date of alleged compliance to ensure deficient practice does not recur. The Director of Nursing will be responsible for ensuring compliance with the above-mentioned plan of correction elements. The above-mentioned audits and monitoring efforts will be coordinated through the facility Quality Assurance process. The Director of Nursing will report findings and adjustments of audits to ensure compliance at the quarterly Executive QA meetings for the duration of the audits. The next QA meeting is scheduled October 15, 2019. The facility alleges compliance with all aspects of this portion of the plan of correction by 9/20/2019.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 7/12/18	F 867	This deficiency, which is due to a repeated issue specific to F689, was analyzed and determined that human error, specific to failure to follow facility expectations and staff training resulted in	9/20/19

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F 867	Continued From page 8 recertification survey. This was for a recited deficiency in the area of Accidents (F689). This deficiency was cited again on the current recertification survey of 9/5/19. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F689 Accidents: Based on record review and staff interview, the facility failed to prevent a resident from falling out of bed during incontinent care for 1 of 8 sampled residents reviewed for accidents (Resident #55). During the recertification survey of 7/12/18 the facility was cited at F689 for failing to prevent a resident from falling out of bed during care. An interview was conducted with the Administrator and the Director of Nursing (DON) on 9/5/19 at 2:37 PM. They both reported they were aware that F689 was a repeat citation from the previous recertification survey. They indicated the Plan of Correction for the 7/12/18 deficiency focused on Nursing Assistants (NA) following the instructions specified on their electronic care guide when providing residents with Activities of Daily Living (ADL) assistance. The Administrator and DON indicated that they believed this deficiency was different from the previous recertification ' s deficiency as the staff member had implemented the electronic care guide interventions. The DON indicated that although the root cause of this deficiency was different than the 7/12/18 deficiency, that she expected the staff to prevent residents from	F 867	regulatory non-compliance. Facility leaders have re-evaluated the staff training program specific to fall prevention. More robust training efforts will be initiated to ensure regulatory compliance. In addition to training that occurs at time of hire and at least annually, the facility will implement hands-on skills fair training annually and additional training identified by staff performance evaluations. The facility submitted a plan of correction in 2018 that was accepted and followed. As noted in surveyor comments, facility leaders believe this deficiency has differences from the previous deficiency, although it is in the same category, F689. The Administrator will update the current QAPI plan and Facility Assessment to address repeated deficient practice and to identify other potentially deficient practice by the next scheduled Executive QA Meeting, October 15, 2019. The facility will initiate Performance Improving Project(s) (PIP) as appropriate to ensure corrective action and to maintain regulatory compliance. The Administrator met with all department leaders on 9/6/2019 to discuss department improvements following notification of F867 on 9/5/2019. Results of this feedback will able coordinated through the next scheduled Executive QA Meeting, October 15, 2019. Monitoring this Plan of Correction (POC) for F689 and other identified potentially deficient practice will be recorded by all	

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F 867	Continued From page 9 falling out of bed during care.	F 867	facility departments utilizing the facility PIP form and tools mentioned in the POC for F689. At a minimum, updates will be given to the Administrator at each Executive QA meeting through the next annual recertification survey. The facility created a QA team, “2019 Annual Survey QA Team,” which consists of the Administrator, Director of Nursing, QA Nurse, Unit Coordinators, MDS Nurses, Therapy Manager, and Social Work. The “2019 Annual Survey QA Team” will meet at least monthly in coordination with the currently scheduled QI meetings to discuss findings of on-going audits and corrective actions through the next annual recertification survey to ensure deficient practice does not recur. The Administrator will be responsible for ensuring compliance with the above-mentioned plan of correction elements. The above-mentioned audits and monitoring efforts will be coordinated through the facility Quality Assurance process. The Administrator will report findings and adjustments of audits to ensure compliance at the quarterly Executive QA meetings for the duration of the audits. The next QA meeting is scheduled October 15, 2019. The facility alleges compliance with all aspects of this portion of the plan of correction by 9/20/2019.	