STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/17/24 through 1/19/24. Event ID# 60CL11. The following intakes were investigated NC00204670, NC00211305, NC00211406, and NC00211995. 1 of the 7 complaint allegations resulted in deficiency. 2/12/24 a revision to the statement of deficiency in f689 occurred and 2567 reposted	F 000		
F 689 SS=G	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 observation, record review, and interviews of resident, staff, and physician, the facility failed to provide care in a safe manner that prevented Resident #1 from rolling out of her bed during the provision of personal care. Resident #1 fell from her bed onto the floor and sustained a hematoma to her right temple and laceration to her lower right leg. Resident #1 was sent to the Emergency Department and was diagnosed with a closed hip fracture next to her hardware from a previous hip fracgture, laceration of the right lower leg that was too wide to suture, pain, and right temple hematoma head injury. This deficient practice affected one of two sampled	F 689	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. On 12/22/2023, upon returning to the facility, resident #1 received bilateral side rails and she was upgraded to 2-person assistance for all bed mobility including	1/20/24

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

Electronically Signed | 02/06/2024

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F 689	Continued From page 1 residents (Resident#1). Findings included: Resident #1 was admitted to the facility on 8/5/22 with the diagnoses of venous insufficiency of the extremities, acute kidney failure, chronic pain, deep vein thrombosis with anticoagulant administration, diabetes, polyneuropathy, and osteoarthritis. Resident #1's quarterly Minimum Data Set dated 11/9/23 documented she had an intact cognition, a minimal hearing deficit, wore a hearing aide, had clear speech, and understands/understood. The resident was coded dependent for bathing and transfers and required substantial/maximal assist for bed mobility. Active diagnoses were diabetes, venous insufficiency of the extremities, kidney failure, osteoarthritis, and polyneuropathy. The resident had scheduled, and as needed pain medication provided. The worst pain over the past 5 days was a score of a 2 (score rating 0 to 10 with 10 being the worst). The resident had one fall since admission with minor injury. The resident was receiving an anticoagulant and opioid pain medication. Resident #1's care plan dated 11/15/23 documented she was at risk for alteration in skin integrity related to incontinence and cellulitis, chronic pain from arthritis, and falls. A review of the Facility Incident Accident Report dated 12/21/23 at 11:22 am written by Nurse #1 documented Resident #1 had a witnessed fall, reported by Nursing Assistant (NA) #1. A head-to-toe assessment was completed by Nurse #1: skin tear right lower leg with bruise/discoloration and laceration noted. NA #1	F 689	incontinence care. A nurse completed a Side Rails Evaluation to ensure sides rails for resident #1 are appropriate for resident use and to confirm side rails were not a restraint. Nursing staff members were made aware of the change through the facility Electronic Medical Record (EMR) system ADL care guide for Nurse Aide (NA) and the caregiver books at each unit. The intervention was deemed appropriate by the interdisciplinary team which consisted of the Administrator, Medical Director, a nurse, and a NA. The above-listed interventions were documented, care planned, and nursing staff were informed. On or before 12/28/2023, an audit was completed to ensure all other resident interventions are appropriate, specific to assistance provided to reduce the risk of falling out of the bed while care is being provided to prevent injuries to residents. Three residents had modified interventions, specifically, two-person assistance for bed mobility was initiated. Nursing staff members were made aware of the change through the facility Electronic Medical Record (EMR) system ADL care guide for NAs and the caregiver books at each unit. The intervention was deemed appropriate by the interdisciplinary team which consisted of the Administrator, Unit Coordinator, a nurse, and a NA. The above-listed interventions were documented, care planned, and nursing staff were informed. Beginning on 12/21/2023, following the	

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F 689	Continued From page 2 observed Resident #1's fall with injury. NA #1 informed Nurse #1 she was changing the resident's brief and bedding. The NA rolled the resident towards her when she took her hands off the resident, the resident kept rolling and fell off the bed. The resident was dependent on staff for transfers. The resident was alert and oriented to person, place, and situation. The resident had impaired hearing. The resident's blood pressure was 142/79, pulse 80 and regular, respirations 18, temperature 98.2, and oxygen saturation was 94%. A pain assessment revealed a pain score was 8 on a scale of 0 to 10 with 10 being the worst. First aid was provided to the resident' lower right leg wound with sterile dressing to cover. Emergency Medical Services were called via 911 telephone call and the resident was sent to the Emergency Department. Follow up interventions per the Supervisor investigating added side rails on both sides of the bed and a two-person assist for care. The description of the incident: Resident #1 was yelling out "help me" upon walking into the room (Nurse #1). The resident was on the floor on her back undressed from the waist down. There was a large bleeding laceration to the right lower leg, bruising above the right eye and skin tear to the left elbow was evident upon assessment. The resident complained of left side and right leg pain. On 1/18/24 at 2:40 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned to Resident #1 on 12/21/23 day shift. In the morning the nurse heard the resident yelling "help me." Nurse #1 entered the resident's room and NA #1 was coming around the bed to assist Resident #1 who had fallen off the bed onto the floor. Nurse #1 stated the resident was on the floor next to her bed and had	F 689	facility investigation, nursing staff responsible for caring for resident #1 were educated of details of the event by a Medication Aide. On or before 12/28/2023, all nursing staff caring for residents with newly implemented interventions, to prevent future events of similar nature, were provided with verbal education by administrative nursing team members. On or before 12/28/2023, the facility provided education through the facility Electronic Medical Record (EMR) system ADL care guide for NAs and the caregiver books at each unit. On 1/18/2024, additional education was provided to all nursing staff via a mass communication system and postings in the facility, with the specific purpose of collecting nursing staff signatures and to supplement previously provided education. ALL nursing staff were educated of the importance of using appropriate bed mobility to prevent residents from falling out of bed while care is being provided, specifically incontinence care, to prevent injuries to residents. Nursing staff signatures were obtained on 1/19/2024. ALL nursing staff (which includes agency nursing staff) have signed an acknowledgement and understanding of education prior to accepting his or her next scheduled shift. The interdisciplinary team consisting of the Medical Director, Administrator, Director of Nursing, Nursing support staff, and other department leaders will meet at the next scheduled quarterly Quality Assessment and Assurance (QAA) meeting to discuss the facilities	

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F 689	Continued From page 3 a large injury to the lower right leg that was bleeding, a small skin tear to the left elbow, and a hematoma on the right side of her temple. Nurse #1 stated she immediately dressed the wound with a dressing, notified the physician, and called 911 for immediate transfer to the Emergency Department. The resident was complaining of pain to the right lower leg wound. Once the resident was cared for, Nurse #1 asked NA #1 what happened when Resident #1 fell. Nurse #1 stated NA #1 informed her that during incontinence care and linen change, when the resident was rolled to her left side, the resident rolled forward and off the bed. The resident had not rolled on her own before and was able to remain side lying for care. Nurse #1 had not observed NA #1 use her phone during the shift. On 1/19/24 at 4:45 pm an interview was conducted with NA #1. NA #1 stated she was assigned to Resident #1 on 12/21/23 day shift. The resident received incontinence care in the morning. The resident had a large, loose stool that went onto the linen. The resident was rolled to her right side (window side), cleaned and linen changed. The resident was able to remain on her right side for care. The resident was then rolled to her left side (door side) to continue cleaning her of incontinence when the resident reached over the side of the bed towards the tray table and then continued rolling out of the bed onto the floor. The resident had been cared for and able to side lie on the right and left side before. The bed was elevated to waist height for care when the resident fell. Nurse #1 came into the room to assist the resident. NA #1 stated the resident was hard of hearing and the NA had to lean over the resident to be heard. NA #1 stated she was not on her phone during care provided to the	F 689	systematic approach to prevent residents from falling out of the bed while care is being provided to prevent injuries to residents. The next quarterly QAA meeting is scheduled for 1/24/2024. The Administrator will be responsible for leading up the facility Performance Improving Project (PIP) to decrease the occurrence of residents falling out of bed while care is being provided to prevent injuries to residents. The PIP initiative will continue through the remainder of the calendar year. Through the PIP, the interdisciplinary team will conduct additional audits and education to ensure an effective system to prevent residents from falling out of bed while care is being provided to prevent injuries to residents. The facility alleges compliance with this plan of correction on 1/20/2024.	

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F 689	Continued From page 4	F 689		

resident or any other care. NA #1 was trying to communicate with the resident and talked with the resident during care. The resident was looking the other way and could not see you to know you were talking to them.

The Administrator wrote a timeline documented on 12/21/23 at 11:30 am: Resident #1 had a fall from her bed during care. NA #1 was providing incontinence care, the resident reached towards the side of the bed and rolled towards her stomach and off the bed. The resident informed her assigned nurse, and another NA that NA #1 was on her phone when the resident fell off the bed.

Following the incident, NA #1 was interviewed, and documentation completed by the Director of Nursing (DON). NA #1 informed the DON she was not on her phone. Nurse #1 had not observed NA #1 use her phone during the shift. NA #1 was reapproached on 12/21/23 to clarify about earbud use and she stated "no", NA #1 was not using her phone or ear buds.

Review of investigation documents: The day of the accident, 12/21/23, the family member called the Administrator. The family member requested NA #1 no longer care for Resident #1 and that the resident was larger and care would have been physically impossible for one staff member. On 12/22/23 the resident stated she had not seen NA #1 on the phone but heard her talking to someone. The resident was hard of hearing. NA #1 was removed from work since a resident injury had occurred. The resident returned from the hospital on 12/22/23. Orders were obtained for 2-person assistance for care and bilateral (both sides) bed rails for bed mobility.

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F 689	Continued From page 5	F 689		

A hand-written statement dated 12/21/23 documented by NA #1: NA #1 went into Resident #1's room to perform incontinence care. The resident's brief and bedding was soiled with stool. Resident #1's bed was raised to NA #1's waist height for changing. NA #1 rolled the patient (Resident #1) to the left side. The resident was rolled and stopped on her side. The resident was nervous and went to reach towards that side and rolled further towards her stomach and onto the floor.

Resident #1's hospital Emergency Department record and discharge summary visit dated 12/22/23 documented the Resident fell off the bed during care at the facility. She sustained multiple closed right hip fractures next to her hardware from a previous hip fracture, a hematoma to the right temple area, and a large laceration/evulsion that was 18 centimeters long by 15 centimeters wide. The physician was unable to approximate the wound edges to close/suture because the skin was so fragile, and the wound was too wide. The resident complained of acute pain of the right lower leg wound. There was frank bleeding that stopped. A non-adherent dressing was applied, and care was to be followed up at the facility. The hip fracture was non-surgical and had minimal pain. The head scan revealed there was no bleeding inside.

Resident #1's physician progress note dated 12/22/23 documented a right lower extremity wound and for Resident #1 to follow up at the wound clinic. Antibiotics were ordered at the Emergency Department for cellulitis. The resident had severe pain and Tramadol 50

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F 689	Continued From page 6	F 689		

milligrams was ordered and ineffective. The Tramadol was increased to 100 milligrams and Oxycodone 5 milligrams every 6 hours as needed was ordered. The Pregabalin was increased to 50 milligrams twice a day (for neuropathy pain).

On 1/17/24 at 6:12 pm an interview was conducted with the Physician. He stated the facility had informed him of Resident #1's fall and the Emergency Department (ED) visit. The Physician stated he was not informed of the particulars of how the resident fell and the NA's role. The Quality Assurance members had not discussed this accident/incident yet. He stated he was following the resident's right lower leg wound. The physician stated he saw the wound on 12/21/23 and it was very bad, large, and bleeding. The Emergency Department physician could not close the wound, it was too wide. The Physician stated the wound was getting better but because the resident was bedbound, had diabetes, heart disease, very fragile skin, and was on chronic blood thinner, the wound would take a long time to heal. Since the resident had been bedbound for some time, she was at a high risk of fracture with falls.

On 1/17/24 at 3:55 pm an observation and interview was done of Resident #1. She was in her bed in a hospital gown. The resident no longer had the bruise to the right forehead. She was lying on a large, air mattress bed with bilateral side rails. The bed had an air mattress and was the same bed/mattress the resident fell out of. The side rails were added after the fall and fit the bed with no gap. The resident had a dressing to the right lower leg that covered most

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F 689	Continued From page 7	F 689		

of her calf in place. The resident was interviewed and able to state that she fell out of bed. The NA rolled her off the bed during care and she fell to the floor (before side rails were placed). The resident stated she was in a lot of pain after falling and her lower right leg had a bad injury that was currently open, not healing, and very painful with the dressing change. The resident had not remembered reaching while being rolled for care. The resident stated she was concerned about the size of the wound and what would happen to her leg. The resident commented she was receiving her pain medication. The resident also commented at present, the resident had no pain from the wound just her "usual arthritis."

On 1/18/23 at 12:30 pm an observation of Resident #1's wound assessment and care by the Wound Nurse was done. The dressing was removed, and yellow and serous drainage was present on the dressing. The wound appeared large and took up more than half of the calf in length and three quarters of the calf in width on the outer side of the leg. The outer edges of the wound were granulating, and the center appeared to be approximately 2 to 3 centimeters deep with uneven tissue and 3 areas of black tissue. The area around the wound was light pink. The Wound Care Nurse commented that the black tissue was bruising from a hematoma that developed in the wound, not necrotic tissue.

On 1/18/24 at 2:05 pm an interview was conducted with the Medication Aide. The Medication Aide stated she was not aware of nursing staff being informed of the accident, how it happened, or education/in-service provided. The interventions added were bed rails at the

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F 689	Continued From page 8 resident's request to hold on for bed mobility and two staff for bed mobility and care.	F 689		