

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Grantsbrook Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 290 Keel Road Grantsboro, NC 28529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009</p> <p>Based on record review and staff interviews the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services for 1 of 3 residents reviewed for beneficiary protection notification who required the provision of the SNF-ABN form (Resident #40).</p> <p>Findings included:</p> <p>Resident #40 was admitted to the facility on [DATE].</p> <p>Review of CMS-R-131 (a form used to indicate Medicare Part B services are ending) revealed Resident #40's Medicare Part A skilled services ended on 2-16-24. She remained in the facility with benefit days remaining.</p> <p>Record review revealed that Resident #40 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN).</p> <p>On 4/3/24 at 1:29 PM an interview with the Social Worker (SW) indicated she provided Resident #40 with the CMS-R-131 form dated 2/14/24. She stated she must have just looked at the ABN part and printed the wrong form.</p> <p>On 4/4/24 at 9:57 AM an interview with the Administrator indicated he knew an attempt was made to provide Resident #40 with notices because she was refusing therapy services, but he was not sure what notices were provided.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468</p> <p>Based on staff interviews and record review the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment for a resident who discharged from hospice services for 1 of 1 resident reviewed for hospice care. (Resident #55)</p> <p>Findings included:</p> <p>Resident #55 was admitted to the facility on [DATE] with hospice services in place.</p> <p>Review of Resident #55's hospice discharge order dated 11/2/23 revealed Resident #55 was discharged from hospice services on 11/2/23.</p> <p>Review of Resident #55's electronic health record revealed no significant change in status Minimum Data Set assessment had been completed for Resident #55.</p> <p>During an interview on 4/3/24 at 12:07 PM the MDS Coordinator stated Resident #55 was admitted to the facility on hospice and was then discharged from hospice in November 2023. She stated she did not recall being made aware of this change in status until some point in February 2024 during a morning meeting. She stated by this time Resident #55 had been off hospice longer than the two-week window to complete a significant change in status Minimum Data Set assessment. She further stated the resident had not undergone a significant change in status herself other than the hospice discharge, so a significant change in status Minimum Data Set assessment was not completed as they had missed the window. She concluded when resident discharged from hospice, a significant change in status Minimum Data Set assessment should have been completed.</p> <p>During an interview on 4/3/24 at 12:17 PM the Director of Nursing stated during a morning meeting in November, Resident #55's hospice status was discussed by clinical staff. She stated the MDS Coordinator was in the morning meetings, and this was how staff were made aware of the change in hospice status for residents and the MDS Coordinator should have followed up to complete a significant change in status Minimum Data Set assessment.</p> <p>During an interview on 4/3/24 at 1:58 PM the Administrator stated that a significant change in status Minimum Data Set assessment should be completed when a resident elected to receive or discharge from hospices services.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468</p> <p>Based on staff interviews and record review the facility failed to accurately code the hospice status of a resident on a Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospice care. (Resident #55)</p> <p>Findings included:</p> <p>Resident #55 was admitted to the facility on [DATE] with hospice services in place.</p> <p>Review of Resident #55's hospice discharge order dated 11/2/23 revealed Resident #55 was discharged from hospice services on 11/2/23.</p> <p>Review of Resident #55's Minimum Data Set assessment dated [DATE] revealed Resident #55 was coded as receiving hospice care.</p> <p>During an interview on 4/3/24 at 12:07 PM the MDS Coordinator stated on Resident #55's Minimum Data Set assessment dated [DATE] she had incorrectly coded the resident as receiving hospice services at that time and the resident was not receiving hospice services.</p> <p>During an interview on 4/3/24 at 1:58 PM the Administrator stated hospice status should be accurately reflected in the resident's Minimum Data Set assessments.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009</p> <p>Based on observations, record review, and resident and staff interviews the facility failed to provide nail care to 1 of 2 dependent residents (Resident #167) reviewed for activities of daily living (ADL) care.</p> <p>Findings included:</p> <p>Resident #167 was admitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>A review of Resident #167's comprehensive care plan revealed in part a focus area initiated on 3/22/24 for ADL care. The goal was for Resident #167's ADL care to be completed with staff support. An intervention was 1 person assistance with personal hygiene and grooming.</p> <p>A review of Resident #167's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired. She exhibited no behaviors or rejection of care. Resident #167 required substantial/maximal assistance with personal hygiene.</p> <p>On 4/1/24 at 4:05 PM an observation of Resident #167 revealed multiple broken and jagged fingernails on both hands. In an interview with Resident #167 at that time she stated her fingernails were breaking off and needed to be clipped. She went on to say she didn't have a nail clipper and so there was nothing she could do about it. She further indicated her fingernails had been like that for a while. Resident #167 stated she got a bath every day, but no one ever offered to clip her fingernails. She went on to say she knew she should have asked someone, but she hadn't.</p> <p>On 4/2/24 at 12:02 PM an observation of Resident #167 revealed multiple broken and jagged fingernails on both hands. In an interview at that time Resident #167 stated she had not yet had her bath that day.</p> <p>On 4/2/24 at 2:18 PM an observation of Resident #167 revealed multiple broken and jagged fingernails on both hands.</p> <p>On 4/2/24 at 2:33 PM an interview with Nurse Aide (NA) #1 indicated she was familiar with Resident #167. She stated Resident #167 had never refused any care that she was aware of. She went on to say she provided Resident #167 with a complete head to toe bed bath earlier that day which included washing Resident #167's hands. NA #1 stated she had access to nail care supplies. She went on to say she was able to provide nail care to residents as long as the weren't diabetic or on a blood thinner. NA #1 stated in that case, she would ask the nurse. She further indicated if she noticed a resident's fingernails were dirty or had any roughness, she would ask the resident if they wanted nail care because she wouldn't want them to scratch themselves. NA #1 stated Resident #167 had not requested nail care and she had not noticed Resident #167 having any broken or jagged fingernails during her bath that day. She went on to say she had not asked the nurse about Resident #167's fingernails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 2:47 PM an observation of Resident #167's fingernails with the Director of Nursing (DON) revealed multiple broken and jagged fingernails on both hands. During an interview at that time the DON stated Resident #167's fingernails had a few rough places and looked like they needed to be filed. On 4/4/24 at 8:26 AM in a follow-up interview the DON stated the only thing she could say was that she had not really been able to see the jaggedness of Resident #167's fingernails just standing by her bed, until she got up close. She further indicated if someone had seen Resident #167's fingernails they should have addressed them.</p> <p>On 4/3/24 at 1:38 PM an interview with Nurse Aide (NA) #2 indicated she provided Resident #167 with a complete bed bath that included washing Resident #167's hands during her shift on 4/1/24. She stated Resident #167 had never refused any care that she was aware of. She went on to say if she noticed a resident had broken or jagged fingernails, she had access to a nail file to file or shape them. NA #2 stated she had not noticed Resident #167 having any broken or jagged fingernails on 4/1/24 when she provided her bath around 9:30 AM. She went on to say Resident #167 had not requested nail care.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48295</p> <p>Based on observation and staff interviews, the facility failed to remove an expired food item stored for use in 1 of 1 refrigerated walk-in storage cooler. This practice had the potential to affect food served to residents.</p> <p>Findings included:</p> <p>During the initial tour of the kitchen on [DATE] at 9:59 am through 10:35 am, the Dietary Manager was present during the inspection the walk-in cooler was observed with a 1-gallon container of salad dressing that was ,d+[DATE] full dated as opened [DATE].</p> <p>The Dietary Manager was interviewed during the initial tour on [DATE] at 9:59 am through 10:35 am. She stated that staff were trained on food storage to include dating, labeling, and discarding outdated foods. She further stated that the refrigerated coolers were checked daily for outdated foods and outdated foods should have been discarded at that time. Opened foods were marked with the date opened and should have been discarded 7 days after that date. She disposed of the food item listed above.</p> <p>In a follow-up interview with the Dietary Manager on [DATE] 3:15 pm she stated that the salad dressing was used to make tomato and cucumber salad and it was last used about 3 months ago. She stated that she was responsible for checking the refrigerated coolers daily and she last checked the cooler this morning and the dressing should have been discarded but she overlooked it.</p> <p>During an interview with the Nutrition Consultant on [DATE] at 3:18 PM revealed the salad dressing should have been discarded 7 days after it was opened.</p> <p>In an interview with the Administrator on [DATE] at 9:59 am he stated that the salad dressing was too old and should have been discarded prior to now. He further indicated he did not know how long it could be kept but knew that you could not keep it for months.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>41009</p> <p>Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint investigation survey of 10/28/21, and the recertification and complaint investigation survey of and 3/22/23. This was for re-cited deficiencies in the areas of Medicaid/Medicare Coverage/Liability Notices (F582) and Accuracy of Assessments (F641) The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>The findings included:</p> <p>This tag is cross referenced to:</p> <p>F582: Based on record review and staff interviews the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services for 1 of 3 residents reviewed for beneficiary protection notification who required the provision of the SNF-ABN form (Resident #40).</p> <p>On the 3/22/23 recertification and complaint investigation survey the facility was cited for failing to provide a completed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF-ABN)</p> <p>In an interview on 4/4/24 at 10:01 AM the Administrator stated last year the problem was the notices were incomplete. He went on to say this year the form was incorrect. He further indicated he felt like these were different issues.</p> <p>F641: Based on staff interviews and record review the facility failed to accurately code the hospice status of a resident on a Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospice care. (Resident #55)</p> <p>On the 10/28/21 recertification and complaint investigation survey the facility was cited for failing to accurately code the Minimum Data Set (MDS) assessment.</p> <p>In an interview on 4/4/24 at 10:01 AM the Administrator stated it was hard to go back 3 years to look at things. He went on to say the while the QAA Committee did track things like this, he felt the situations were different. He further indicated it would be hard to track the whole process.</p>