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	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Graybrier Nurs & Retirement CT	116 Lane Drive Trinity, NC 27370

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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35122 Based on record review and staff interviews, the facility failed to update the Do Not Resuscitate (DNR) status for 1 of 32 residents reviewed for Advanced Directives (Resident #10). The findings included: Resident #10 had been admitted on [DATE]. Resident #10's admission Minimum Data Set assessment dated [DATE] indicated she had severe cognitive impairment. A Care Plan with an initiation date of [DATE] and a review date of [DATE] indicated Resident #10 had a Full Code status. The care plan goal was to honor the Full Code status. Interventions included staff will follow the Advanced Directives as written. On [DATE] Resident #10's electronic medical record (EMR) was observed to have Full Code status indicated on the resident dashboard (information banner). In the Advanced Directive section, a scanned copy of a goldenrod Do Not Resuscitate (DNR) form was observed, signed by the physician dated [DATE]. An Advance Directives form was also included noting allow natural death (Do Not Resuscitate [DNR]; no CPR (cardiopulmonary resuscitation) will be given in the event of cardiopulmonary arrest [when the heart stops beating and there is no breathing]) This form was signed by Resident #10's Responsible Party on [DATE] and by her physician on [DATE]. The hard copies of both forms, the goldenrod DNR and the Advance Directives, both of which documented Resident #10 was a DNR, were filed in the Code Status notebook for Resident #10's hallway located at the nurses' station. This notebook contained each resident's face sheet (demographic information), goldenrod form (code status form signed by the physician), and their Advance Directives form. An interview with Nurse #1 was conducted on [DATE] at 10:05 AM. The Nurse stated each resident's code status was noted in the EMR and also in the Code Status notebook located at each nursing station. (continued on next page)

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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Medical Records Clerk was conducted on [DATE] at 10:28 AM. She stated that after the physician signed the forms (goldenrod DNR and Advance Directives forms), she scans them into the EMR and then places the hard copies into the Code Status notebook at the nurses' station. She explained that each nurses' station had a book with each resident's face sheet, goldenrod and advance directives forms. An interview with Nurse Aide #1 was conducted on [DATE] at 11:08 AM. She stated she regularly cared for Resident #10. She explained the residents' code status could be found in the Code Status notebook at the nurses' station. An interview with the Social Work Assistant was conducted on [DATE] at 3:23 PM. She explained the DNR status and care plans were reviewed quarterly and updated as needed. After reviewing the EMR information for Resident #10, the goldenrod DNR form, the Advance Directives form, and the care plans, she stated the information should match but didn't. During an interview on [DATE] at 9:54 AM the Social Worker (SW) stated she was unsure how the resident's EMR being updated to reflect Resident #10's DNR status had been missed. She explained Resident #10's dashboard had indicated Full Code status, and she used that information to develop and update the Code Status care plan. She also explained that during care plan meetings with Resident #10's family, she would ask if there was any change in the code status but did not clarify what the status was. She stated she was unsure who updated the resident dashboard. During an interview with the Administrator on [DATE] at 10:12 AM he stated upon entry, residents were considered Full Code until the Code Status was determined. He explained he thought the paperwork for Resident #10's Code Status had been completed and scanned into the EMR but the administrative nurse who updated the dashboard didn't see the paperwork. The Administrator also explained the SW developed the care plan with the information on the resident's dashboard. During an interview with Nurse #4 on [DATE] at 10:35 AM she stated any nurse could update the Code Status information. She explained that upon admission Resident #10 had a Full Code status and several days after admission her family signed paperwork for the DNR status. She explained that updating the EMR Code Status update had been missed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415 Based on observation, record review, and interviews with the Medical Director and staff, the facility failed to obtain an order to delay the removal of sutures until the wound was healed for 1 of 2 residents reviewed for professional standards (Resident #62). The findings included: Resident #62 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and dementia. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #62 was severely cognitively impaired without mood or behavioral concerns. Review of the nurses' notes revealed an entry dated [DATE] that Resident #62 had a witnessed fall on [DATE]. Resident #62 was taken to the local emergency room for evaluation where she received sutures for a wound to the right side of her forehead. Review of the emergency room discharge paperwork dated [DATE] revealed Resident #62 was supposed to be scheduled for a follow up appointment to have her sutures removed in seven days. Review of the physician's orders transcribed in the chart for Resident #62 uncovered an expired order for suture removal on [DATE]. There was no documentation in the nurse's notes that explained why the order had expired without being completed. There were no further orders or physicians follow up notes regarding suture removal noted in the chart. Review of Resident #62's [DATE] Treatment Administration Record (TAR) revealed the expired order for suture removal but no further orders for removal were documented. The order to remove the sutures was not signed off as completed and left blank. The nurses' notes reviewed for [DATE] contained a note from the night shift nurse who documented Resident #62 had a clean dry dressing over the right brow area with light greenish-yellow bruising. There were no other nurses' notes or documentation about the sutures discovered in the record. A note written by the Wound Care nurse dated [DATE] at 4:40 PM documented Resident #62 had sutures present on her forehead with improved bruising. There was no mention of obtaining an order to remove the sutures. An interview was conducted with Nurse #2 on [DATE] at 12:15 PM. She stated there was an order for suture removal for Resident #62 on [DATE]. She stated she was not working that day, and she was unaware why the sutures had not been removed. The Wound Care Nurse was interviewed on [DATE] at 2:56 PM. She stated on [DATE] the provider noted Resident #62's wound looked wet and soft so the order to remove sutures was extended due to the wound's appearance. The Wound Care Nurse did not write a new order for suture removal. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #5 was interviewed on [DATE] at 9:32 AM. Nurse #5 stated she had worked the morning shift on [DATE]. She verbalized on [DATE] the hospice agency nurse had visited Resident #62, and they jointly assessed her sutures that day. Nurse #5 stated the hospice nurse told her she didn't think the wound looked good enough to remove the sutures and she agreed with her. Nurse #5 indicated she had decided not to remove the sutures, but she did not notify the NP or Medical Director of the wound's condition to obtain a new order because she thought the hospice nurse was going to contact the provider instead. An observation on [DATE] at 12:10 PM revealed Resident #62 had sutures on the right side of her forehead. The laceration's edges were clean, dry and approximated. Minimal pale pink discoloration was noted around the site. The Nurse Practitioner (NP) was interviewed on [DATE] at 3:34 PM. She stated that she had not assessed Resident #62 previously because residents who received hospice care were followed by the facility's Medical Director. She stated that the resident was added to her list to be seen on[DATE] for evaluation for suture removal. The Medical Director was interviewed on [DATE] at 10:50 AM. He stated that Resident #62 had fallen and suffered a laceration on [DATE]. He stated he had told the Wound Care nurse to leave the sutures in place for at least ten days during one of his daily phone calls with her, but he was unsure of the exact date. He stated that he was unsure why the order was not changed for Resident #62.