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 08/10/2017

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 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 08/10/17. Event ID# RCH411.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to obtain a physician's order to self-administer Renvela (a medication used to lower phosphorous blood levels) for 1 of 1 sampled resident receiving dialysis treatment. Resident #52. Findings included: Resident #52 was admitted to the facility on 6/24/16 with the diagnoses of major depressive disorder and end stage renal disease. A review of the most recent Minimum Data Set (MDS) dated 6/1/17 and indicated Resident #52 was cognitively intact and had no behaviors and received dialysis treatments. The care plan revealed Resident #52 received dialysis treatments three times a week. A review of the physician orders revealed Renvela 800mg, take 2 (1600mg) tabs by mouth with meals with a start date of 12/15/16.	F 176	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 176	9/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2017

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.

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F 176	Continued From page 1 During an observation made on 08/09/17 at 5:50 PM 2 large, oval tablets were in a medicine cup on the tray table in the room of Resident #52. Resident #52 was observed to swallow the tablets and continue to eat dinner. There was no nurse in the room to observe Resident #52 taking the medication. During an interview conducted on 08/09/17 at 5:50 PM, Resident #52 explained the large oval tablets were Renvela. She also explained the nurse had left the tablets in the room for her to take with her dinner meal. During an interview conducted on 08/10/17 at 11:30 AM, Nurse #1 revealed she had given Resident #52 the Renvela on 08/09/17 and left the medication in the room to be self-administered with the dinner meal. Nurse #1 also explained the facility policy to administer medications was to watch residents take their medication. Nurse #1 revealed Resident #52 was not care planned to self-administer Renevela and she made a mistake not administering and observing and leaving the medication in the room. During an interview conducted on 08/10/17 at 3:08 PM, the Medical Director (MD) revealed it was his expectation the nurses watched residents take their medication. The MD also revealed if another resident had wandered in the room and ingested the Renvela it could have a negative effect and make the phosphorous level too low. During an interview conducted on 08/10/17 at 3:27 PM, the Administrator revealed it was her expectation for nurses administering medications to observe the resident taking the medication before leaving the room.	F 176	The position of Graham Healthcare and Rehabilitation regarding the process that lead to this deficiency was that the floor nurse did not follow the correct policy and procedure for medication administration. On 8/10/17 resident # 52 had a medication self-administration assessment completed by MDS Coordinator. Resident # 52 was determined to be safe to self-administer Renvela. On 8/10/17 an order was obtained from the medical director for the resident to self-administer Renvela. On 8/10/17 a 100% audit of each resident room was completed by the Director of Nursing to be sure no pills were left in a resident room for self-administration. On 8/25/17 an audit of all residents who self-administer medications was completed by the Administrator to ensure there is a current medication self-administration assessment and physician order in place. On 8/24/17 an in-service was initiated by the Administrator for all RN's, LPN's, and medication aides (including nurse #1) related to medication administration to include observing resident's taking medications. On 8/24/17 an in-service was initiated by the Administrator for all RN's and LPN's related to residents who self-administer medications to include they must have passed a medication self-administration assessment and have a physician order. The in-services will be 100% complete by 9/07/17.	

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F 176	Continued From page 2	F 176	On 8/28/17 the Director of Nursing began auditing resident rooms to ensure medications were not left in resident room for resident to self-administer using the medication audit tool. 10 resident rooms will be audited daily 5x/week x 4 weeks then weekly x 4 weeks then monthly x 2 months. In the Director of Nursing's absence, the Staff Development Coordinator Nurse will perform this audit. The monthly QI committee will review the results of the medication audit tool monthly for 4 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that	F 278		9/7/17

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F 278	Continued From page 3 the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess 5 of 9 sampled residents utilizing the Minimum Data Set (MDS) in the area of dental (Resident #62, Resident #41, Resident #49, Resident #13, and Resident #23) and 1 of 5 sampled residents for unnecessary medication (Resident #34). The findings included: 1. Resident #62 was admitted to the facility on 03/13/15. A review of an annual Minimum Data Set (MDS)	F 278	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the	

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F 278	Continued From page 4 assessment dated 01/25/17 indicated Resident #62 had been coded under Section L0200 B Dental as not being edentulous. On 08/08/17 at 10:35 an interview was conducted with Resident #62 who stated he wore upper dentures and chose not to wear his bottom dentures and had no problems without having lower dentures. On 08/09/17 at 4:52 PM an interview was conducted with the MDS Coordinator who stated she had coded Section L0200 B Dental on Resident #62's annual MDS assessment dated 01/25/17. The MDS Coordinator stated Resident #62 should have been coded under Section L0200 B Dental as being edentulous. The MDS Coordinator stated she had made an error in coding Resident #62's annual MDS assessment dated 01/25/17. The MDS Coordinator stated she had not received training on coding dental on the 3.0 version of the MDS. The MDS Coordinator stated the annual MDS assessment would need to be modified and submitted to accurately reflect Resident #62 was edentulous. On 08/09/17 at 5:02 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the annual MDS assessment dated 01/25/17 would have been accurately coded to reflect Resident #62 was edentulous. The DON stated her expectation was that the annual MDS assessment dated 01/25/17 would be modified and submitted to accurately reflect Resident #62 was edentulous. On 08/09/17 at 6:15 PM an interview was conducted with the Administrator who stated her expectation was that the annual MDS	F 278	Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 278 The position of Graham Healthcare and Rehabilitation regarding the process that lead to this deficiency was that the MDS Coordinator did not follow the correct coding instructions as per the RAI manual. On 8/09/17 resident #62 minimum data set (MDS) annual assessment with ARD of 1/25/17 was modified to accurately code resident # 62 dental status by the MDS nurse. On 8/09/17 resident #41 minimum data set (MDS) annual assessment with ARD of 7/1/17 was modified to accurately code resident # 41 dental status by the MDS nurse. On 8/09/17 resident #49 minimum data set (MDS) annual assessment with ARD of 10/14/16 was modified to accurately code resident # 49 dental status by the MDS nurse. On 8/09/17 resident #13 minimum data set (MDS) annual assessment with ARD of 7/07/17 was modified to accurately code resident # 13 dental status by the MDS nurse. On 8/09/17 resident #23 minimum data set (MDS) annual assessment with ARD of 12/05/16 was modified to accurately code resident	

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F 278	Continued From page 5 assessment dated 01/25/17 would have been accurately coded to reflect Resident #62 was edentulous. The Administrator stated her expectation was that the annual MDS assessment dated 01/25/17 would be modified and submitted to reflect Resident #62 was edentulous. 2. Resident #41 was admitted to the facility on 10/15/11. Review of Resident #41's medical record revealed a dental note dated 05/22/17 which indicated he was edentulous (having no teeth). The annual Minimum Data Set (MDS) dated 07/01/17 coded Resident #41 with severe impairment in cognition. The oral/dental status section of the MDS indicated there were no problems present. An observation on 08/09/17 at 8:34 AM revealed Resident #41 was edentulous. An interview conducted with the MDS Coordinator on 08/09/17 at 5:26 PM revealed she had coded the oral/dental status section of the annual MDS dated 07/01/17 for Resident #41. The MDS Coordinator confirmed Resident #41 was edentulous and acknowledged she had coded the MDS dated 07/01/17 inaccurately. The MDS Coordinator stated the annual MDS would require a correction to indicate Resident #41 was edentulous. An interview was conducted with the Administrator on 08/09/17 at 6:15 PM who stated it was her expectation the annual MDS dated 07/01/17 would have been coded to reflect Resident #41 was edentulous and would need to	F 278	# 23 dental status by the MDS nurse. On 8/09/17 resident #34 minimum data set (MDS) quarterly assessment with ARD of 5/11/17 was modified to accurately code resident # 34 anticoagulant medication by the MDS nurse. On 8/09/17 the modified assessments was accepted by the National Repository. On 8/09/17, the MDS Coordinator began auditing each resident's last comprehensive assessment to ensure dental/oral status are coded accurately. On 8/09/17, the MDS Coordinator began auditing each resident's last assessment to ensure medications are coded accurately. The audit will be completed by 8/25/17. Assessments will be modified for accuracy of coding as necessary. On 8/25/17 the MDS Coordinator, MDS nurse and Administrator were in-serviced by the Clinical Quality and Reimbursement Director on correctly coding section N (Medications) and section L (dental/oral status). On 8/28/17 the Administrator will begin auditing MDS assessments for correct resident dental status and correct medication coding using the MDS Audit Tool. 10% of completed assessments will be audited weekly x 8 weeks, then 10% of completed assessments monthly x 2months. The monthly QI committee will review the results of the MDS Audit Tool monthly for 4 months for identification of trends, actions taken, and to determine the need	

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F 278	Continued From page 6 be resubmitted with modification to accurately reflect his dental status. 3. Resident #49 was admitted to the facility on 03/23/12. Review of Resident #49's medical record revealed a dental note dated 10/07/16 which indicated he had upper and lower dentures. The annual MDS dated 10/14/16 coded Resident #49 with moderate impairment in cognition. The oral/dental status section of the MDS indicated there were no problems present. An observation on 08/07/17 at 3:32 PM revealed Resident #49 was wearing upper and lower dentures. An observation on 08/09/17 at 3:27 PM revealed Resident #49 was not wearing his dentures and was edentulous. An interview conducted with the MDS Coordinator on 08/09/17 at 5:26 PM revealed she had coded the oral/dental status section of the annual MDS dated 10/14/16 for Resident #49. The MDS Coordinator confirmed Resident #49 was edentulous and acknowledged she had coded the MDS dated 10/14/16 inaccurately. The MDS Coordinator stated the annual MDS would require a correction to indicate Resident #49 was edentulous. An interview was conducted with the Administrator on 08/09/17 at 6:15 PM who stated it was her expectation the annual MDS dated 10/14/16 would have been coded to reflect	F 278	for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 278	Continued From page 7 Resident #49 was edentulous and would need to be resubmitted with modification to accurately reflect his dental status. 4. Resident #13 was admitted to the facility on 01/11/16 with diagnoses of non-Alzheimer's disease among others. Review of the annual Minimum Data Set (MDS) dated 07/07/17 revealed Resident #13 required limited assistance with personal hygiene (including oral) and was independent with eating. There were no dental/oral concerns noted on this annual assessment with no development of a care plan. An observation of Resident #13 was made on 08/09/17 at 10:30 AM. Resident #13 was noted to be edentulous (having no natural teeth). When asked, Resident #13 stated his teeth kept on breaking off and giving him a lot of trouble so he had them all removed several years ago. An interview was conducted with the Director of Nursing (DON) on 08/09/17 at 5:02 PM. The DON stated her expectation was information in the MDS assessments would be recorded accurately to reflect each resident's dental status. The DON also acknowledged she expected the MDS would be modified to show the accuracy of the dental status for Resident #13 so a proper care plan could be developed. An interview was conducted with the MDS Nurse on 08/09/17 at 5:25 PM. The MDS Nurse stated that she had been trained to code the way she did and stated the question on the MDS was confusing and should ask directly if the resident has any natural teeth. The MDS Nurse acknowledged the MDS was miscoded for the dental section for Resident #13. The MDS Nurse	F 278		

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F 278	Continued From page 8 also submitted a corrected MDS to the state with the correct information about the status of Resident #13's teeth after the error was discussed with her. An interview was conducted the Administrator on 08/09/17 at 6:13 PM. The Administrator stated her expectation was for the MDS to be accurately coded and resubmitted with the correct information. 5. Resident #23 was admitted to the facility on 02/11/11. The most recent annual Minimum Data Set (MDS) review dated 12/05/16 revealed Resident #23 had Parkinson's disease and dysphagia (difficulty swallowing) among others. The MDS also revealed Resident #23 required extensive assistance with personal hygiene (including oral care) and supervision with eating. There were no dental/oral concerns noted on this annual assessment with no development of a care plan. An observation of Resident #23 was made on 08/09/17 at 2:24 PM. Resident #23 was noted to be edentulous and was wearing a full upper plate, but had no lower plate. An interview was conducted with the Director of Nursing (DON) on 08/09/17 at 5:02 PM. The DON stated her expectation was information in the MDS assessments would be recorded accurately to reflect each resident's dental status. The DON also acknowledged she expected the MDS would be modified to show the accuracy of the dental status for Resident #23 so a proper care plan could be developed.	F 278		

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F 278	Continued From page 9 An interview was conducted with the MDS Nurse on 08/09/17 at 5:25 PM. The MDS Nurse stated that she had been trained to code the way she did and stated the question on the MDS was confusing and should ask directly if the resident has any natural teeth. The MDS Nurse acknowledged the MDS was miscoded for the dental section for Resident #23. The MDS Nurse also submitted a corrected MDS to the state with the correct information about the status of Resident #23's teeth after the error was discussed with her. An interview was conducted the Administrator on 08/09/17 at 6:13 PM. The Administrator stated her expectation was for the MDS to be accurately coded and resubmitted with the correct information. 6. Resident #34 was admitted to the facility on 10/11/16. The quarterly Minimum Data Set (MDS) dated 05/11/17 indicated Resident #34 was cognitively intact. Section N of the quarterly MDS also indicated 0 anticoagulants (a medication used to prolong the coagulation of the blood) had been administered from 05/05/17 thru 05/11/17. A review of the physician orders from 05/01/17 thru 05/30/17 for Resident #34 revealed an order for Apixaban/Eliquis (an anticoagulant) was to be administered twice a day. A review of the Medication Administration Record for Resident #34 revealed Apixaban/Eliquis had been administered as ordered and initialed by the nursing staff during the data look back period from 05/05/17 thru 05/11/17. During an interview conducted on 08/09/17 at	F 278		

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F 278	Continued From page 10 6:03 PM, the MDS Coordinator confirmed Resident #34 had received an anticoagulant during the data look back period from 05/05/17 thru 05/11/17. She also confirmed the coding of section N of the quarterly MDS dated 05/11/17 was inaccurate and she would submit a modification to reflect anticoagulants had been administered for 7 days. During an interview conducted on 08/09/17 at 6:12 PM, the Administrator revealed the expectations of MDS coding was to be correct and if not, be modified and correctly coded to reflect Resident #34 had received anticoagulants.	F 278		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		9/7/17

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F 329	Continued From page 11 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and physician interviews, the facility failed to follow a physician's order to discontinue a medication resulting in 8 additional doses for 1 of 5 residents reviewed for unnecessary medications (Resident #45). Findings included: Resident #45 was readmitted to the facility on 10/03/16 with multiple diagnoses that included Alzheimer's disease, major depressive disorder and mood disorder. A review of the physician telephone orders for Resident #45 revealed an order dated 06/28/17 that read in part, discontinue Provera (hormone medication) 10 milligram (mg) on 08/01/17. A review of the Medication Administration Record (MAR) for Resident #45 dated 08/01/17 through	F 329	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal	

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F 329	Continued From page 12 08/31/17 revealed the following: Provera 10 mg by mouth once daily. Further review of the MAR revealed Resident #45 received Provera 10 mg on the following days: 08/01/07, 08/02/17, 08/03/17, 08/04/17, 08/05/17, 08/06/17, 08/07/17, and 08/08/17. An interview was conducted with the Director of Nursing (DON) on 08/08/17 at 5:01 PM. The DON reviewed the order dated 06/28/17 for Resident #45 and confirmed the medication should have been discontinued on 08/01/17 as ordered by the physician. She explained each MAR was checked every month by 2 separate staff members and they had neglected to transcribe the physician order onto the August MAR. The DON stated she would have expected for staff to discontinue the Provera medication for Resident #45 on 08/01/17 as ordered by the physician. AN interview was conducted with the Administrator on 08/09/17 at 6:15 PM who stated she had been informed the Provera medication for Resident #45 had not been discontinued as ordered by the physician. The Administrator added the physician had been notified and the medication had since been discontinued. She stated she would have expected for staff to discontinue the Provera medication on 08/01/17 as ordered by the physician. A telephone interview was conducted with the Medical Director (MD) on 08/10/17 at 9:36 AM who confirmed he had been notified by facility staff that Resident #45 had continued to receive Provera 10 mg after he had given the order to discontinue on 08/01/17. He added he had given new orders to discontinue the Provera mediation	F 329	appeal procedure and/or any other administrative or legal proceeding. F 329 The position of Graham Healthcare and Rehabilitation regarding the process that lead to this deficiency was that the nursing staff did not follow the MD order as written. On 8/8/17 the physician was notified of resident # 45's Provera not being discontinued on 8/1/17 as ordered. New order received at that time to discontinue Provera. On 8/28/17 a 100% audit was completed of each residents orders for the past 30 days to ensure orders to discontinue medications were discontinued from MAR accurately by the Director of Nursing, with no negative findings. On 8/08/17 the Director of Nursing began in-servicing 100% of licensed staff on correctly transcribing an order and to ensure the entire order is carried out including if a medication is discontinued that it needs to be discontinued from MAR correctly. This in-service will be completed 9/07/17. All new hires well receive in-service during new employee orientation. On 8/28/17 the Director of Nursing began auditing 100% of resident orders for accuracy using the Discontinued Medications Audit Tool. The audit will be completed by 8/28/17. The Director of Nursing will audit resident orders for accuracy using the Discontinued	

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F 329	Continued From page 13 when he had been notified of the error. The MD stated he would have expected for the medication to have been discontinued on 08/01/17 as originally ordered.	F 329	Medications Audit Tool 5x/week x 4 weeks then weekly x 8 weeks then monthly x 3 months. Any negative findings will be corrected immediately and physician will be notified. In the Director of Nursing's absence the Staff Development Coordinator Nurse will conduct the audit. The monthly QI committee will review the results of the Discontinued Medications Audit Tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to ensure that 1 of 2 residents reviewed for pressure ulcer (Resident #16) and 1	F 387	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of	9/7/17

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F 387	Continued From page 14 of 5 residents reviewed for unnecessary medication (Resident #23) who had been in the facility over 90 days had been seen by the physician every 60 days. The findings included: 1. Resident#16 was admitted to the facility on 03/21/05. A quarterly Minimum Data Set (MDS) assessment dated 05/09/17 indicated Resident #16 was cognitively impaired and diagnoses included diabetes mellitus, cerebral vascular accident, hemiplegia, seizure disorder, hypertension, anemia, neurogenic bladder, psychotic disorder, and depression. A review of Resident #16's medical record revealed a physician's progress note dated 03/01/17 and was signed by the physician. There was no other documentation in the medical record that indicated Resident #16 had been seen by the physician until 07/14/17. On 08/09/17 at 4:58 PM an interview was conducted with the Medical Records Nurse Aide (MRNA) who stated she was responsible for tracking physician visits to assure that the physician saw residents every 30 days for the first 90 days after admission or re-entry and every 60 days for the duration of the residents stay in the facility. The MRNA stated she generated a list each month of residents that were due to be seen by the physician and provided the list to the physician on his scheduled day. The MRNA stated if the physician did not show up to the facility on his scheduled day then she informed the Administrator who contacted the physician to	F 387	Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 387 The position of Graham Healthcare and Rehabilitation regarding the process that lead to this deficiency was that Medical Records did not communicate to the Physician which resident’s would be out of compliance regarding Physician Visits and that he would need to see the resident by a certain date. A 100% resident audit was conducted on 8/10/17 by Medical Records on all residents and no further issues were found. Medical Records was in-serviced by Administrator on 8/10/17 that residents must be seen by a physician at least once	

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F 387	Continued From page 15 schedule another time for the physician to visit residents that were due to be seen by the physician. The MRNA stated she would generate a new resident list based on the new time schedule for residents who were due to be seen by the physician. The MRNA stated the last time Resident #16 was seen by the physician was on 03/01/17 because the resident had been out of the facility on the physician's scheduled visit 04/26/17. The MRNA stated due to a documentation error she had assumed the physician had seen Resident #16 on 04/26/17 and did not place Resident #16 on the May 2017 list of residents that were due to be seen by the physician. The MRNA stated she realized that Resident #16 had not been seen in May 2017 and placed Resident #16 on the June 2017 list to be seen by the physician. The MRNA stated on 06/25/17 when the physician visited the facility Resident #16 was out of the facility during the physician's visit and missed being seen by the physician. The MRNA had not notified the Administrator that Resident #16 had not been seen in May or June 2017. The MRNA stated she placed Resident #16 on the list to be seen by the physician in July 2017 and Resident #16 was seen by the physician on 07/14/17. The MRNA verified that Resident #16 had not been seen by the physician for 134 days and had not been discharged from the facility between 03/01/17 to 07/14/17. On 08/09/17 at 6:20 PM an interview was conducted with the Administrator who stated it was the responsibility of the MRNA to generate a monthly list of residents that were due to be seen by the physician and was to provide the list to the physician. The Administrator stated the monthly physician list included dates when the physician	F 387	every 30 days for the first 90 days after admission and at least once every 60 days thereafter. A weekly audit utilizing the comprehensive patient list will be conducted weekly X 4 weeks, then monthly by Medical Records. The monthly QI committee will review the results of the medication audit tool monthly for 4 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	

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F 387	Continued From page 16 last saw the resident and included dates when the resident was required to be seen again. The Administrator stated the MRNA generated the resident list the day prior the physician's scheduled visit and was provided to the physician on his scheduled visit. The Administrator stated she was unaware that Resident #16 had not been seen by the physician from 03/01/17 to 07/14/17 which was over 120 days. The Administrator verified that Resident #16 was seen on 3/1/17 and the next visit by the physician was on 07/14/17. The Administrator stated her expectation was the MRNA would have accurately documented in the computer on 4/26/17 that Resident #16 had not been seen by the physician and would have immediately communicated with the physician a schedule to have timely visited Resident #16. The Administrator stated due to the lack of documentation in the computer and lack of communication between the MRNA and the physician Resident #16 had not been seen in April, May, and June 2017 and went over 120 days without being seen by the physician. On 08/10/17 at 9:25 AM a telephone interview was conducted with the physician who stated he saw Resident #16 on 03/01/17 and again on 07/14/17. The physician stated Resident #16 had been out of the facility in April and June of 2017 when he visited. The physician stated Resident #16 had not been on his May 2017 list of residents to be seen. The physician stated he tried to see residents at last monthly and more often depending upon the resident's medical condition.	F 387		

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2. Resident #23 was admitted to the facility on 02/11/11.

The most recent annual Minimum Data Set (MDS) review dated 12/05/16 revealed Resident #23 had diagnoses which included Parkinson's disease, Alzheimer's disease, diabetes, seizure disorder and heart failure. The MDS also revealed Resident #23 had short and long term memory problems and required extensive or total assistance with all activities of daily living (ADL's).

Review of the Medical Records Policy version date of 10/2007 indicated under Physician Progress Notes the following: "notes will be recorded by the attending physician at least every 30 days for the first 90 days after admission/re-entry and then every 60 days for the duration of the resident's stay in the facility."

During a record review on 08/09/17 at 10:09 AM of the most recent physician visit for Resident #23, it was discovered a general exam occurred on 05/03/17 and it was not until 07/24/17 Resident #23 was seen by a physician in the facility.

During an interview with the Medical Records Aide (MRA) on 08/10/17 at 10:22 AM the MRA stated she kept up with the scheduling for the residents regarding how often they saw the doctor. The MRA verified and produced a list which had Resident #23's name on it to be seen by the physician on 06/25/17 but the MRA did not know why Resident #23 was not seen by the

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physician on this date. Resident #23 was again scheduled to see the physician on 07/14/17 but was again not seen. The next physician visit for Resident #23 was on 7/24/17. The MRA acknowledged this was greater than the 60 day timeframe in which the physician had to make a visit for this resident.

During an interview with the Director of Nursing (DON) on 08/10/17 at 10:31 AM the DON stated they were currently working on better communication and finding a way to make sure all the residents were being seen in their proper timeframes by the physician. The DON also stated the MRA should be making sure all residents were seen within the proper timeframes and if they were not the MRA should be contacting the physician to schedule the appointments timely. The DON further stated her expectations were for every resident to be seen at least once every 60 days and as needed and this was not acceptable if they were not seen within this time frame.

During an interview with the Administrator (ADM) on 08/10/17 at 10:38 AM the ADM stated her expectation was that the physician would communicate with the MRA and let her know if there was a resident on the list to be seen but was unable to be seen on the original date scheduled. The ADM also stated her expectation was for each resident to be seen every 60 days per protocol.

During a telephone interview with the physician (MD) on 08/10/17 at 11:15 AM the MD stated Resident #23 was on his list to be seen on 06/25/17 and 07/14/17 but on both occasions they were unable to find her in her room or the

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F 387	Continued From page 19 activity room. The MD also stated the facility did a good job of keeping up with his visits to make sure they were in the regulatory timeframe and he actually tried to see each resident at least once every 30 days. The MD further stated "this is on me" and it was not the facility's fault the timeframe had exceeded 60 days. The MD also stated he would be looking for a better system to track the residents to make sure they were being seen timely.	F 387		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		9/7/17

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F 431	Continued From page 20 (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 appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (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. (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 observation, record review, and staff interviews the facility failed to remove 3 expired pneumococcal vaccine vials from 1 of 2 medication storage refrigerators. Findings included: A review of the manufacturer's instructions for Pneumococcal Vaccine Polyvalent Pneumovax indicated for storage and handling that all vaccine must be discarded after the expiration date.	F 431	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's	

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F 431	Continued From page 21 On 08/10/2017 at 1:37 PM 3 vials of Pneumococcal Vaccine Polyvalent Pneumovax single dose 0.5 milliliter (ml) vials with manufacturer expiration date of 06/27/17 were observed in 1 of 2 medication refrigerators in a clear plastic zip lock bag with an expiration date written on the outside of the bag as 09/06/17. On 08/10/17 at 1:37 PM an interview was conducted with Nurse #1 who verified 3 vials of Pneumococcal Vaccine had expired on 06/27/17 and were in the medication refrigerator ready for resident use and were stored in a clear plastic zip lock bag dated 09/06/17. Nurse #1 immediately removed the 3 vials of expired Pneumococcal Vaccine from the medication refrigerator. On 08/10/17 at 1:39 PM an interview was conducted with the Director of Nursing (DON) who verified that 3 vials of Pneumococcal Vaccine 0.5 ml single dose vials were expired on 06/27/17 and were located in a clear plastic zip lock bag dated 09/06/17 and were in the medication refrigerator ready for resident use. The DON stated it was the responsibility of the night shift nurse to check for expired medication in the medication refrigerator. The DON stated it was her expectation that the clear plastic zip lock bag dated 09/06/17 would have been opened and the 3 vials of Pneumococcal Vaccine would have been examined for an expiration date. The DON stated moving forward she would designate a specific nurse to check for expired medication in the medication refrigerator. On 08/10/2017 at 3:11 PM an interview was conducted with the Administrator who stated her expectation was that the nursing staff would have opened the clear plastic zip lock bag dated	F 431	response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 431 The position of Graham Healthcare and Rehabilitation regarding the process that lead to this deficiency was that the nursing staff did not follow the correct policy and procedure regarding the checking of expired medications. On 8/10/17 the three expired vials of pneumococcal vaccine in the refrigerated were removed and discarded of by the nurse. A 100% audit was completed on 8/10/17 by the Director of Nursing to ensure all medication vials to include pneumococcal vaccine are properly stored, dated, and labeled. All identified areas of concern were immediately corrected by the Director of Nursing on 8/10/17. An in-service was initiated with 100% of all license nurses regarding the dating of and expiration of medications including Pneumovac vials by the Director of Nursing on 8/17/17. The in-service will be 100% completed by 9/01/17. All newly	

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F 431	Continued From page 22 09/06/17 and looked at the expiration date on the 3 vials of Pneumococcal Vaccine and discarded the expired medication that was ready for resident use. The Administrator stated nurses were responsible for checking for expired medication in the medication refrigerator. The Administrator stated no specific nurse had been designated to check the medication refrigerator for expired medication.	F 431	hired license nurses will be in-serviced regarding dating of and expiration of medication vials during new employee orientation. The Director of Nursing will check all medication carts and medication rooms weekly x 4 weeks then biweekly x 8 weeks, then monthly x 3 months to ensure each cart and medication room including medication refrigerators are free from expired medications to include Pneumovac vials using the expired medications audit tool. Audits will include ensuring vials of medications are properly dated and stored. All identified areas of concern will be immediately corrected. In the absence of the Director of Nursing, the Staff Development Coordinator Nurse will perform the audit. The monthly QI committee will review the results of the expired medications audit tool monthly for 4 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		9/7/17

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 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

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F 441	Continued From page 23 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (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	F 441		

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F 441	Continued From page 24 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 review and staff interviews the facility failed to ensure staff followed infection control procedure by not performing hand hygiene between resident to resident contact or when exiting residents' rooms after obtaining vitals (Room #'s 4, 6, 7, 9, 33, 35, and 52) during 2 of 2 observations. Findings included: Review of the facility's "Hand washing Procedure," with a revised date of 12/18/12, read in part, you should wash your hands before and after contact with residents.	F 441	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the	

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F 441	Continued From page 25 Review of the facility's "Alcohol Hand Sanitizer Procedure," with a revised date of 12/18/12, stated "an alcohol-based hand sanitizer may be used unless the hands are visibly soiled." 1. During a continuous observation on 08/08/17 starting at 4:26 PM, Nurse Aide (NA) #1 was observed entering room #4 with the equipment cart to obtain vitals on a resident. At 4:33 PM, NA #1 was observed leaving room #4, immediately entering room #6 and obtaining vitals on a resident without performing hand hygiene. At 4:37 PM, NA #1 was observed leaving room #6, immediately entering room #7 and obtaining vitals on a resident without performing hand hygiene. At 4:40 PM, NA #1 was observed leaving room #7, immediately entering room #9 and obtaining vitals on a resident without performing hand hygiene. At 4:42 PM, NA #1 was observed leaving room #9, immediately entering room #52 and obtaining vitals on a resident without performing hand hygiene. During an interview on 08/08/17 at 5:33 PM, NA #1 confirmed she was supposed to perform hand hygiene when leaving a resident's room whenever care was provided which included vitals. NA #1 acknowledged she had not performed hand hygiene when leaving rooms #4, #6, #7, #9, and #52 after she had obtained vitals on each of the residents. During an interview on 08/09/17 at 5:01 PM the Director of Nursing (DON) stated staff were expected to perform hand hygiene when leaving residents' rooms anytime care had been provided.	F 441	Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 441 The position of Graham Healthcare and Rehabilitation regarding the process that lead to this deficiency was that the nursing staff did not follow the facility's infection control policy and procedure. All staff were in-serviced beginning 8/24/17 by Administrator and will be completed by 9/01/17 regarding facility handwashing policy and handwashing procedure. A handwashing audit will be performed by the Director of Nursing regarding proper handwashing policy and procedure by staff 5X/week for 4 weeks, weekly for 4 weeks and then monthly for 3 months. In the absence of the Director of Nursing, the Staff Development Coordinator Nurse will perform the audit. The monthly QI committee will review the results of the Infection Control/Handwashing Audit Tool monthly for 4 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations	

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F 441	Continued From page 26 During an interview on 08/10/17 at 3:18 PM the Administrator stated it was her expectation staff would follow the facility's infection control procedure for hand hygiene when exiting residents' rooms after providing care or obtaining vitals. 2. During a continuous observation on 08/09/17 starting at 2:37 PM, NA #2 was observed entering room #33 and obtaining vitals on both residents in the room without performing hand hygiene in between resident contact. At 2:42 PM, NA #2 was observed leaving room #33 without performing hand hygiene, immediately entering room #35 and obtaining vitals on both residents in the room without performing hand hygiene in between resident contact. During an interview on 08/09/17 at 2:50 PM, NA #2 confirmed she was supposed to perform hand hygiene when leaving a resident's room whenever care was provided which included vitals. NA #2 stated she had "forgot" to perform hand hygiene "but should have" before leaving rooms #33 and #35 after she had obtained the residents' vitals. During an interview on 08/09/17 at 5:01 PM the DON stated staff were expected to perform hand hygiene when leaving residents' rooms anytime care had been provided. During an interview on 08/10/17 at 3:18 PM the Administrator stated it was her expectation staff would follow the facility's infection control procedure for hand hygiene when exiting residents' rooms after providing care or obtaining vitals.	F 441	for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345355	MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	DATE SURVEY COMPLETE: 8/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTEI	**811 SNOWBIRD ROAD ROBBINSVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 162	483.10(f)(11)(i)-(iii) LIMITATION ON CHARGES TO PERSONAL FUNDS

(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:

(A) Nursing services as required at §483.35.

(B) Food and Nutrition services as required at §483.60.

(C) An activities program as required at §483.24(c).

(D) Room/bed maintenance services.

(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.

(F) Medically-related social services as required at §483.40(d).

(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.

(ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone, including a cellular phone.

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GRAHAM HEALTHCARE AND REHABILITATION CENTEI	**811 SNOWBIRD ROAD ROBBINSVILLE, NC**

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(B) Television/radio, personal computer or other electronic device for personal use.

(C) Personal comfort items, including smoking materials, notions and novelties, and confections.

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

(E) Personal clothing.

(F) Personal reading matter.

(G) Gifts purchased on behalf of a resident.

(H) Flowers and plants.

(I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).

(J) Non-covered special care services such as privately hired nurses or aides.

(K) Private room, except when therapeutically required (for example, isolation for infection control).

(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.

(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.

(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.

(iii) Requests for items and services.

(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.

(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345355	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 8/10/2017
NAME OF PROVIDER OR SUPPLIER **GRAHAM HEALTHCARE AND REHABILITATION CENTEI**	STREET ADDRESS, CITY, STATE, ZIP CODE **811 SNOWBIRD ROAD ROBBINSVILLE, NC**		

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F 162	Continued From Page 2

(C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
This REQUIREMENT is not met as evidenced by:
Based on record review and resident and staff interviews the facility failed to ensure residents were given the option to receive a monthly haircut provided by facility staff at no additional cost as allowed by Medicaid for 1 of 1 sampled resident reviewed for personal funds (Resident #63).

Findings included:

Review of the medical record revealed Resident #63 was admitted to the facility on 06/30/15. The annual Minimum Data Set (MDS) dated 07/04/17 coded Resident #63 with intact cognition and able to make her needs known.

During an interview on 08/07/17 at 1:08 PM Resident #63 stated she had been charged for a haircut she had recently received at the facility and the cost had been deducted from her personal funds account.

During an interview on 08/09/17 at 4:46 PM the Bookkeeper indicated she had been in her current position with the facility for two years and was responsible for entering charges into the residents' personal funds accounts, such as beauty and barber services. She explained the hairdresser submitted weekly invoices of services received by each resident and the cost for the services were entered into each resident's personal funds account to be deducted from their balance. She was unaware that residents who received Medicaid were eligible to receive one haircut per month at no additional cost. The Bookkeeper reviewed Resident #63's personal funds account and verified the costs for haircuts performed by the hairdresser on 02/20/17, 04/10/17, 06/12/17, and 07/19/17 had been deducted from her personal funds account.

During an interview on 08/09/17 at 6:15 PM the Administrator stated residents were informed upon admission to the facility that beauty and barber services, such as haircuts, performed by the hairdresser were billable to the resident. She added facility staff were able to provide residents with a haircut when requested at no additional charge. The Administrator was unaware if Resident #63 had been given the option of receiving a haircut from facility staff free of charge.

During an interview on 08/10/17 at 10:14 AM Resident #63 stated staff had never been informed she could receive a haircut at no additional cost when provided by facility staff. Resident #63 added she had never been given any other option but to see the hairdresser when she had needed a haircut.

During a follow-up interview on 08/10/17 at 3:18 PM the Administrator explained staff had provided residents with a free haircut whenever they noticed the resident needed one or the resident had specifically requested. She acknowledged there was no system in place that monitored when or how often haircuts were offered to eligible residents or identified the specific staff who could provide haircuts at no additional cost. The Administrator stated she would expect for staff to give residents the option of receiving a haircut from facility staff or the hairdresser each time services were requested.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345355	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 8/10/2017
NAME OF PROVIDER OR SUPPLIER **GRAHAM HEALTHCARE AND REHABILITATION CENTEI**	STREET ADDRESS, CITY, STATE, ZIP CODE **811 SNOWBIRD ROAD** **ROBBINSVILLE, NC**		

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