STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLINIC IDENTIFICATION NUMBER:

345330

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

03/09/2011

NAME OF PROVIDER OR SUPPLIER

THE GRAYBRIER NURS & RETIREMENT CT

STREET ADDRESS, CITY, STATE, ZIP code

118 LANE DRIVE

TRINITY, NC 27370

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

(F312) 483.25(a)(3) ADL CARE PROVIDED FOR
DEPENDENT RESIDENTS

A resident who is unable to carry out activities of
daily living receives the necessary services to
maintain good nutrition, grooming, and personal
and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff
interview, the facility failed to provide proper
incontinent care to 1 (Resident #3) of 3 sampled
residents observed. The findings include:

The facility's policy on "Perineal/Incontinent
Care" dated 9/5/07 was reviewed. The policy
read in part "10. For female resident: A. wet
washcloth and apply soap or skin cleansing
agent. B. wash perineal area, wiping from front to
back. C. separate labia and wash around
downward from front to back. D. continue to wash
the perineum moving outward to and including
thighs, alternating from side to side and using
downward strokes. E. rinse the perineum
thoroughly in the same direction, using fresh
water and a clean wash cloth. F. gently dry the
perineum. G. instruct or assist the resident to turn
on her side with her top leg slightly bent, if able.
H. rinse washcloth and apply soap or skin
 cleansing agent. I. wash the rectal area
thoroughly wiping from the base of the labia
extending to over the buttocks. J. dry area
thoroughly."

Resident #3 was admitted to the facility on
12/14/95 and was re-admitted on 12/10/09. The
resident had multiple diagnoses including

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

[Title]

DATE

[Date]

Low deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days along 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.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 312 | Continued From page 1  
Epilepsy with seizure history, End Stage Dementia, History of multiple Stroke, Peripheral Neuropathy, Osteoarthritis, Gastro esophageal Reflux and Chronic Anxiety Disorder. The MDS assessment dated 01/10/11 indicated that the resident had a severe cognitive impairment. The assessment also indicated that the resident was frequently incontinent of bowel and bladder and totally dependent on the staff for personal hygiene.  
The care plan dated 01/10/11 was reviewed. One of the problems was " requires total assist with care, incontinent b/u(bowel/urine). The approaches included " provide incontinent care and skin monitoring.  
On 03/08/11 at 2:30 PM, Resident #3 was observed during the incontinent care. The resident was observed to have 2 disposable pads soaked with urine. NA #1 (Nursing Assistant) was observed to instruct NA #2 to wet a washcloth with water. Na #1 was then observed to turn the resident to her right side and proceeded to clean the resident's buttocks and the rectal area with the wet washcloth and then dried the area using a towel. Na #1 was observed to apply an ointment to the resident's buttocks. Then, she proceeded to roll the pads soaked with urine and apply 2 new disposable pads under the resident. The resident was turned to her left side and NA #2 was observed to remove the soaked disposable pads and straightened the new pads underneath the resident. The 2 NAs covered the resident with the blanket and left the room.  
On 03/08/11 at 2:45 PM, NA #2 was interviewed. | F 312 | reviewed the policy and received verbal instruction from the Director of Nursing on proper perineal/incontinent care for males and females during a mandatory in-service. Staff signatures were obtained for verification that they had received the new policy. These signatures were filed within the facility as well as each staff member receiving their own copy of the revised Policy for them to periodically review. The revised policy was placed on each Nursing Unit in the Nursing Policy and Procedure Manuals.  
CNA's will continue to be evaluated on their ability to provide proper Perineal/Incontinent care on an annual basis during Skills Fairs and their Performance Evaluations (Administrative Nurses (RN's including the Director of Nursing, Assistant Director of Nursing, Unit Manager, Quality Assurance Nurse, and MDS Coordinator) perform a "Skills Checklist" as a part of each CNA's annual evaluation).  
An audit tool has been developed and will be utilized by the Quality Assurance Nurse or designee to observe perineal/incontinent care of one random resident on a weekly basis for a period of six months. This audit tool and monitoring technique will be utilized on all shifts and units. The rotation of shifts and units will be chosen randomly. These audits will be integrated into the Quality Assurance program and ensure that proper perineal/incontinent care is being provided to the residents. | 3-16-11 | 3-31-11 |
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 312</td>
<td>Continued From page 2 She stated that she was orientating with Na #1. She stated that she was taught to do incontinent care by washing the perineal area by spreading both legs, open the vagina and clean it from front to back, then the buttocks area. On 03/08/11 at 2:50 AM, NA #1 was interviewed. She stated that she normally cleans the perineal area by sticking her fingers between the resident's thighs while the resident is turned to the sides. She also stated that she only spread the legs and open the labia to clean the perineal area when the resident had a stool.</td>
<td>F 312</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>(X5) COMPLETION DATE</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>K 029</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong>&lt;br&gt;One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system&lt;br&gt;option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or&lt;br&gt;field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</td>
<td>K 029</td>
<td>1) The obstruction of the kitchen dry storage door was removed; staff members were informed that doors must remain free of&lt;br&gt;obstructions.&lt;br&gt;2) A self-closing device was installed on the oxygen storage room door to ensure that it will&lt;br&gt;close, latch, and seal.&lt;br&gt;3) Self-closing devices were installed on the two corridor doors in laundry to ensure they&lt;br&gt;will close, latch, and seal.&lt;br&gt;4) A self-closing device was installed on the east wing trash room door to ensure it will&lt;br&gt;close, latch, and seal tightly in its frame.</td>
<td>3/29/11</td>
</tr>
<tr>
<td></td>
<td>This STANDARD is not met as evidenced by:&lt;br&gt;Surveyor: 26594&lt;br&gt;Based on observation on Wednesday 3/29/31 between 9:00 AM and 1:00 PM the following was noted:&lt;br&gt;1) The dry storage room in the kitchen was found&lt;br&gt;tied open and would not close.&lt;br&gt;2) The oxygen storage room was not equipped&lt;br&gt;with a self-closing device.&lt;br&gt;3) The two corridor doors to the laundry room did&lt;br&gt;not close, latch and seal.&lt;br&gt;4) The trash room in east wing did not close and&lt;br&gt;seal tight in its frame.&lt;br&gt;42 CFR 483.70(a)</td>
<td></td>
<td>All corridor and storage room doors were inspected throughout the facility. Using proper&lt;br&gt;hardware and self-closing devices, repairs were made where necessary, to ensure doors close, latch, and seal tightly.</td>
<td>4/12/11</td>
</tr>
<tr>
<td>K 061</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong>&lt;br&gt;Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</td>
<td>K 061</td>
<td>The Maintenance Director and/or Maintenance&lt;br&gt;Assistant will make monthly rounds to examine&lt;br&gt;all corridors and self-closing devices&lt;br&gt;throughout the facility to ensure all of them&lt;br&gt;will operate, latch, and seal tightly; additionally, they&lt;br&gt;will check to ensure no further obstructions&lt;br&gt;exist.</td>
<td>4/2/11</td>
</tr>
<tr>
<td></td>
<td><strong>RECEIVED</strong>&lt;br&gt;APR 20 2019</td>
<td></td>
<td>The Maintenance Director will utilize the &quot;2011 Life Safety Plan of Correction Audit Tool.&quot;&lt;br&gt;This tool has been created to log necessary&lt;br&gt;findings and repairs when needed. The audit&lt;br&gt;tool will be completed monthly, for six months.&lt;br&gt;Results will be reviewed in the quarterly&lt;br&gt;Quality Assurance (QA) meetings, successively&lt;br&gt;for six months.</td>
<td>4/29/11</td>
</tr>
</tbody>
</table>

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 discardable 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 discardable 14 days following the date the documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
2011 Life Safety Plan of Correction Audit Tool

The purpose of this audit tool is to serve as a written account of the continued efforts of GrayBrier personnel to correct deficiencies and maintain regulatory compliance regarding the Life Safety Survey conducted by Roger Fortman, Building System Engineer, on 3/29/2011.

1. Corridor, storage room, and trash room doors throughout the facility were inspected to ensure that all of them are in working order and will close, latch, and seal properly. In addition, self-closing devices were inspected and doors were free of obstruction.

Date of Inspection: ________________

Personnel Conducting the Inspection: _______________________________________

Notes about Inspection (include any correction made):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Electronically supervised tamper alarm is checked to be in working order should the value become closed on the automatic sprinkler system.

Date of Inspection: ________________

Personnel Conducting the Inspection: _______________________________________

Notes about Inspection (include any correction made):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________