DEPARTMENT OF HEALTH A	ND HUMAN SERVICES				FORM APPROVED
CENTERS FOR MEDICARE &	MEDICAID SERVICES			OM	B NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
	345330	B. WING _			C 08/03/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
THE GRAYBRIER NURS & RETIR	EMENT CT		116 LANE DRIVE		
			TRINITY, NC 27370		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 221 483.10(e)(1), 483.12 SS=E FROM PHYSICAL R	(a)(2) RIGHT TO BE FREE ESTRAINTS	F 2	221		9/5/17
§483.10(e) Respect	and Dignity.				
and dignity, including §483.10(e)(1) The rig physical or chemical purposes of disciplin	ight to be treated with respect g: ght to be free from any restraints imposed for e or convenience, and not resident's medical symptoms,				
neglect, misappropri and exploitation as c includes but is not lir corporal punishment	right to be free from abuse, ation of resident property, lefined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to				
(a) The facility must-					
or chemical restraint discipline or conveni required to treat the symptoms. When the indicated, the facility alternative for the lead document ongoing re restraints. This REQUIREMEN by:	e use of restraints is must use the least restrictive ast amount of time and e-evaluation of the need for T is not met as evidenced				
interviews, the facilit rails positioned in the	on, record review, and staff y utilized quarter length side e middle section of each side		Side rail assessments were 8/23/17 for the eight resident in the 2567 (residents #8, #1	ts referenced 2, #34, #52,	
	onsidering them to be a		#95, #101, #140, and #158), TITLE	by the "Side	(X6) DATE

Electronically Signed

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.

08/24/2017

OLIVILI	STOR MEDICARE &	MEDICAID SERVICES					<u>10. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	· · ·	TE SURVEY MPLETED
		345330	B. WING				C 8/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		0/03/2017
					LANE DRIVE		
THE GRAY	BRIER NURS & RETIRE	EMENT CT		TRI	NITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 221	Continued From page	a 1	F 22	21			
		a medical symptom for 8 of	1 22		Rail QA Team" that was created to		
		ts #8, #12, #34, #52, #95,			monitor side rail compliance. Member	rs of	
	· ·	8) reviewed for physical			the Side Rail QA Team consist of: the		
	restraints. The findin	, , , ,			Director of Nursing (DON), Quality		
		30			Assurance Nurse (QA Nurse), Unit		
	1. Resident #8 was a	dmitted to the facility on			Manager, Minimum Data Set Coordin	ator	
		s that included dementia,			(MDS Coordinator), Care Plan		
		insomnia, and repeated falls.			Coordinator (CPC), Therapy Manage	r,	
					and Nursing Home Administrator (NH		
	The significant chang	je Minimum Data Set (MDS)					
	assessment dated 7/4	4/17 indicated Resident #8's			The Side Rail QA Team completed side	de	
	cognition was significantly impaired. She was				rail assessments for 100% of current		
		ent on two or more staff with			residents in the facility between 8/9/2		
	-	sfers. Resident #8 was			and 8/11/2017. The initial assessment		
	-	aff for locomotion on and off			and interventions were documented i		
		ment indicated Resident #8			Electronic Medical Record (EMR). C	Dn	
		aints (defined as any manual			9/1/2017, the NHA, DON, and a		
	method or physical of	-			Corporate Representative, utilizing th		
		t attached or adjacent to the			guidance of NC DHHS and upcoming		
	-	he individual cannot remove			CMS regulation(s), met and determin	ea	
	-	freedom of movement or			that side rails would be physically		
	normal access to one	es body).			removed from all resident beds at this time. Sire rails were removed by	>	
	A review of Resident	#8's medical record			Maintenance staff on 9/1/2017.		
	revealed there had be						
		ted. Additionally, there was			Side rails were physically removed fro	om	
		e of side rails on Resident			all beds within the facility by $9/1/17$. T		
	#8's plan of care.				Side Rail QA Team will monitor qualit		
					measures (pressure ulcers, falls, falls		
	An interview was con	ducted on 7/31/17 at 2:51			major injury, loss of mobility, etc.), we		
	PM with Nurse #2. S	he stated all residents in the			for 3 months and monthly for 9 month		
	facility had quarter le	ngth side rails.			ensure resident safety, quality of care		
	An interview was can	ducted with Nurse #3 on			and mobility due to the removal of sic rails. Depending on the results of		
		She stated Resident #8 had			aforementioned monitoring, the facilit	v will	
		th side rails and was not			implement additional interventions,	y vvili	
	capable of getting ou				safe-guards, and may reconsider the		
					decision to remove all side rails base		
		conducted on 7/31/17 at 5:09			resident acuity and individualized nee		

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION		<u>D. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			. ,	PLETED
						С
		345330	B. WING		08	/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
		-MENT OT		116 LANE DRIVE		
THE GRA	YBRIER NURS & RETIR	EMENICI		TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 221	Continued From page	e 2	F 22	1		
		eeping in bed in her room		At this time, the facility int	ends to maintain	
		ne facility's cognitively		a restraint free presence;		
		ent #8 had bilateral quarter		resident safety and quality	-	
	length side rails on h	er bed. The quarter length		top priorities. Side rail ass	sessments (if	
		oned in the middle section of		side rails are utilized) will		
		(Each quarter side rail		using the aforementioned		
		6 inches in length and there		assessment tool; this will		
		oximately 26.5 inches from		only if side rail use is war	· ·	
	· ·	le rail to the top end of the ches from the bottom end of		unavoidable after other in		
		ittom end of the mattress.)		been documented and ap by a physician). Addition		
		atom end of the mattress.		that require side rails will		
	An observation was o	conducted on 8/2/17 at 4:15		assessments upon a sign		
		eeping in bed in her room.		assessment, and at least	•	
		al quarter length side rails		thereafter to determine if		
	remained in the midd	lle section of the bed.		remains indicated. Side ra	ails will be used	
				in the least restrictive man	nner possible.	
		nducted on 8/2/17 at 4:25 PM		Education will be provided		
		lursing (DON). She stated		family members where ine	dicated.	
		cility had quarter length side				
		he facility had not utilized		To ensure ongoing compl		
		nents since all residents had		three members of the Sid		
	the same quarter len	gin rais.		(members listed in paragr weekly for 3 months, then	• •	
	An interview was cor	ducted with Nursing		months to ensure side rai	-	
		8/2/17 at 4:30 PM. NA #2		been effective and that no		
		miliar with Resident #8. She		have occurred as related		
		as not able to get out of bed		quality outcomes, specific	ally related to	
		NA #2 indicated she was		the removal of side rails.	-	
	unsure why Resident	t #8's bilateral quarter length		meetings, the Side Rail Q	A Team will	
		oned in the middle section of		record quality measure m	-	
		she thought the side rails		relates to side rail use, us	-	
	-	ed as an intervention so		Rail Audit Tool," that has I		
		ble to roll out of bed. She		The team will use the Sid		
		t known how it was decided		Assessments (where med		
	-	esident's side rails were to be		quality measures, and nu determine progress with s		
		ed she just kept the side rails vere in and had not moved		compliance and resident		
	them into a different			"Side Rail Audit Tool." The		1

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/0 FORM APPI OMB NO. 0930	ROVED
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	Y
		345330	B. WING		C 08/03/20 [/]	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
				116 LANE DRIVE		
THE GRAY	BRIER NURS & RETIRE	MENICI		TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMP	(X5) PLETION DATE
F 221	at 4:35 PM. NA #3 in with Resident #8. Sh not able to get out of She reported she was bilateral quarter lengt in the middle section she thought the side is because Resident #8 prevented her from fa- revealed she had not what position each re- placed. She indicated in the position they w them into a different p An interview was con 8/2/17 at 4:40 PM. N familiar with Resident Resident #8 was una assistance. She reve how it was decided w rails on each resident staff kept the side rail day to day and had n #3 stated there were assessments. She ac no documentation in f indicated where the s positioned on each resident An interview was con Assurance (QA) Nurs She confirmed all res quarter length side rail	ducted with NA #3 on 8/2/17 dicated she was familiar e stated Resident #8 was bed without assistance. s unsure why Resident #8's h side rails were positioned of the bed. She indicated rails were in that position was at risk for falls and they alling out of bed. NA #3 known how it was decided usident's side rails were to be d she just kept the side rails ere in and had not moved position. ducted with Nurse #3 on urse #3 indicated she was t #8. She confirmed ble to get out of bed without ealed she had not known here to position the side t's bed. She indicated the is in the same position from ot repositioned them. Nurse no side rail risk dditionally stated there was the medical record that ide rails were to be	F 22		ance with	
		to position themselves they beds. She stated if the				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/06/2017 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING					C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIF	P CODE		
		MENT OF		1	16 LANE DRIVE			
THE GRA	BRIER NURS & RETIRE	MENT CI		т	RINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
F 221	Continued From page resident was not cogr resident was assesse them. She indicated to documented. The QA no documentation of s there were also no ev rails. She revealed sh for over two years and side rail risk assessm the same quarter leng rails that were position the bed for Resident 4 Nurse. She revealed the side rails on the b impaired unit had bee section of the bed. Sh follow up on this to pr A follow up interview v Nurse on 8/3/17 at 8: were 12 double occup cognitively impaired u residents resided on the The QA Nurse reporte of the bed was made. quarter side rail was a "up" position by rotatin bed which then made that was located at to indicated they had be	e 4 hitively intact then the d to see what was safest for this assessment was not A Nurse reported there was side rail assessments and aluations of risk for the side ne had worked at the facility d the facility had not utilized ents since all residents had gth rails. The bilateral side ned in the middle section of #8 was reviewed with the QA she had not known any of eds in the cognitively in positioned in the middle he stated she needed to ovide additional information. was conducted with the QA 10 AM. She indicated there bancy rooms on the		221				
	years ago). The QA I how the staff determin placed in the middle s length rails or in the to assist rails. She state	Nurse was unable to explain ned if the side rails were section of the bed as quarter op section of the bed as ed the quarter length rails er section of the bed had						

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		MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	```	G	· · ·	IPLETED
			A BOILDING			С
		345330	B. WING		08	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		MENT OF		116 LANE DRIVE		
THE GRA	YBRIER NURS & RETIRE			TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 221	Continued From page	e 5	F 22	21		
		restraints since they were	1 22	- 1		
	only quarter length ra					
	An interview was cor	nducted with NA #4 on 8/3/17				
		ted she normally worked on				
		ed unit. She reported the				
		nts on the cognitively				
		ependent on staff for ADL				
		ving) care. NA #4 was mined what position to place				
		rails and she indicated she				
		the position they were always				
		d them to a different position.				
	She reported most of	f the side rails for the				
	-	nitively impaired unit were				
		length side rails in the				
		bed. She stated this side it easier on the staff to turn				
		indicated she was familiar				
		ne stated Resident #8 was				
		bed without assistance.				
		nt #8 was able to hold onto				
		some of the strain off of the				
		epositioned in bed. She				
	side rail independent	8 was unable to move her				
		iy.				
	An interview was con	nducted with the MDS Nurse				
		M. She indicated she was				
		The MDS assessment				
		icated Resident #8 had no				
	-	as reviewed with the MDS ked what information she				
		IDS for physical restraints.				
		ed the facility had not utilized				
		sment, so she assessed the				
		the resident was able to				
		e rail. She stated if the				
	1	reach over to the side rail				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345330	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 221	she had not coded the restraint on the MDS. Resident #8 was able rail when in bed. An interview was come 8/3/17 at 11:30 AM. quarter length side rai section of the bed we The DON stated she length side rails were section of the bed. An observation was co AM with the DON of the bed with the bilateral positioned in the cent they were observed of Measurements of the DON. The bed was a length from the top er bottom end of the ma side rail was approxim and was positioned w from the top end of th the mattress and 26.5 the bottom end of the of the mattress. The attached to the bed fr instructions. A follow up interview of DON on 8/3/17 at 11: expectation was for a on an individual basis restraint. She indicate assessment for side r	e side rail as a physical The MDS Nurse indicated to reach over to the side ducted with the DON on The beds with bilateral ils positioned in the center re reviewed with the DON. had not thought the quarter positioned in the center conducted on 8/3/17 at 11:35 he model of Resident #8's quarter length side rails er section of the bed (as	F	221			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
					116 LANE DRIVE		
THE GRA	YBRIER NURS & RETIRE				TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 221	7/9/12 with diagnoses and a history of falling The quarterly Minimu assessment dated 5/2 #12's cognition was s was assessed depen- bed mobility and trans dependent on one sta the unit. The assess had no physical restra method or physical or material or equipmen resident's body that the easily which restricts normal access to one A review of Resident revealed there had be assessments comple An interview was con PM with Nurse #2. S facility had quarter len An observation was of PM of Resident #12 s that was located in th impaired unit. Reside length side rails on he side rails were position each side of the bed.	admitted to the facility on s that included Alzheimer's g. m Data Set (MDS) 24/16 indicated Resident ignificantly impaired. She dent on two or more staff for sfers. Resident #12 was aff for locomotion on and off ment indicated Resident #12 aints (defined as any manual r mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or 's body). #12's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails.	F	22			
	the top end of the sid mattress and 26.5 inc	e rail to the top end of the ches from the bottom end of ttom end of the mattress.)					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	Continued From page	8	F	221			
	with the Director of N all residents in the fac rails. She revealed th side rail risk assessm the same quarter leng An interview was con Assistant (NA) #2 on revealed she had not what position each re placed. She indicated in the position they w them into a different p An interview was con at 4:35 PM. NA #3 re how it was decided w side rails were to be p just kept the side rails and had not moved th An interview was con 8/2/17 at 4:40 PM. N not known how it was the side rails on each indicated the staff kep position from day to c them. Nurse #3 state risk assessments. Sh was no documentatio indicated where the s positioned on each re An interview was con Assurance (QA) Nurs	ducted with Nursing 8/2/17 at 4:30 PM. NA #2 known how it was decided sident's side rails were to be d she just kept the side rails ere in and had not moved position. ducted with NA #3 on 8/2/17 evealed she had not known hat position each resident's placed. She indicated she is in the position they were in hem into a different position. ducted with Nurse #3 on urse #3 revealed she had a decided where to position resident's bed. She of the side rails in the same lay and had not repositioned ed there were no side rail he additionally stated there n in the medical record that ide rails were to be esident ' s bed. ducted with the Quality we on 8/2/17 at 4:55 PM.					
	Assurance (QA) Nurs She confirmed all res						

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	IPLETED
			/			С
		345330	B. WING		0	8/03/2017
NAME OF PR	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP COD		
				116 LANE DRIVE		
THE GRAY	BRIER NURS & RETIR			TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 221	Continued From page	e 9	F 22	1		
		ilized for positioning and if				
		e to position themselves they				
	had side rails on the	beds. She stated if the				
	•	nitively intact then the				
		ed to see what was safest for				
		this assessment was not				
		A Nurse reported there was side rail assessments and				
		valuations of risk for the side				
		she had worked at the facility				
		nd the facility had not utilized				
		nents since all residents had				
		gth side rails. The bilateral				
	-	ositioned in the middle				
		She revealed she had not				
		e rails on the beds in the				
	•	unit had been positioned in				
		the bed. She stated she				
	needed to follow up of	on this to provide additional				
	information.					
		was conducted with the OA				
		was conducted with the QA :10 AM. She indicated there				
	were 12 double occu					
	cognitively impaired					
		the unit. She stated 21 of				
		had the quarter length side				
	-	e center section of the bed.				
		ed this was how that model				
		 She explained that the able to be turned into the 				
	•	ing it toward the head of the				
		e the side rail an assist rail				
	that was located at to	op section of the bed. She				
		een utilizing this type of bed				
	÷	king at the facility (over 2				
	vears and) The OA	Nurse was unable to explain	1			
	years ago). The QA	Nulse was unable to explain				

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 09/06/2017 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY OMPLETED
		345330	B. WING				C 08/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	YBRIER NURS & RETIRE	MENT CT		116	LANE DRIVE		
				TR	INITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 221	length side rails or in assist rails. She state rails positioned in the had not been conside were only quarter len An interview was con at 9:30 AM. She stat the cognitively impair majority of the reside impaired unit were de (Activities of Daily Liv asked how she detern each resident's side r kept the side rails in t in and had not moved She reported most of residents on the cogr positioned as quarter center section of the rail positioning made the residents. NA #4 with Resident #12. S not able to get out of she was at risk for fal #12 had a pad alarm attempts to get out of She reported Residen the side rail and take staff when she was re indicated Resident #7 side rail independent! An interview was con on 8/3/17 at 11:02 AM the lead MDS Nurse. dated 5/24/17 that inc	section of the bed as quarter the top section of the bed as ed the quarter length side center section of the bed ered restraints since they gth side rails. ducted with NA #4 on 8/3/17 ed she normally worked on ed unit. She reported the nts on the cognitively ependent on staff for ADL ring) care. NA #4 was mined what position to place rails and she indicated she the position they were always d them to a different position. The side rails for the nitively impaired unit were length side rails in the bed. She stated this side it easier on the staff to turn indicated she was familiar the stated Resident #12 was bed without assistance and ls. She indicated Resident (used to alert staff of bed without assistance). In #12 was able to hold onto some of the strain off of the epositioned in bed. She l2 was unable to move her	F	221			

Facility ID: 953491

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/06/2017 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING			_		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	YBRIER NURS & RETIRE			11	16 LANE DRIVE			
THE GRA	I BRIER NORS & RETIRE			Т	RINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 221	utilized to code the M The MDS Nurse state a side rail risk assess side rails by seeing if	ed what information she DS for physical restraints. ed the facility had not utilized ment, so she assessed the the resident was able to	F	221				
	resident was able to r she had not coded the restraint on the MDS.	e rail. She stated if the reach over to the side rail e side rail as a physical The MDS Nurse indicated le to reach over to the side						
	8/3/17 at 11:30 AM. quarter length side ra section of the bed we The DON stated she	ducted with the DON on The beds with bilateral ils positioned in the center re reviewed with the DON. had not thought the quarter positioned in the center						
	8/3/17 at 11:35 AM of #12's bed with the bila rails positioned in the (as they were observed Measurements of the DON. The bed was a length from the top er bottom end of the ma side rail was approxin and was positioned w from the top end of th the mattress and 26.5 the bottom end of the of the mattress. The attached to the bed fr instructions.	conducted with the DON on the model of Resident ateral quarter length side middle section of the bed ed on Resident #12's bed). bed were obtained by the approximately 79 inches in nd of the mattress to the ttress. The quarter length nately 26 inches in length with 26.5 inches of open area e side rail to the top end of 5 inches of open area from side rail to the bottom end quarter length side rail was ame per the manufacturer's						

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345330	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	 was for all side rails to individual basis to def restraint. She indicat assessment for side r side rails were quarte facility had not conside to be a restraint. 3. Resident #34 was 3/26/15 with diagnose anxiety, depression, i falling. The quarterly Minimu assessment dated 6/2 #34's cognition was s was assessed as req of two or more staff w transfers. Resident # staff for locomotion of assessment indicated physical restraints (de method or physical or material or equipmen resident's body that th easily which restricts normal access to one A review of Resident revealed there had be assessments comple An interview was con PM with Nurse #2. S facility had quarter left 	She stated her expectation o be assessed on an termine if they were a ed there was no formal ails at the facility since all or length side rails and the lered this length of a side rail admitted to the facility on es that included Alzheimer's, nsomnia, and a history of m Data Set (MDS) 29/17 indicated Resident ignificantly impaired. She uiring extensive assistance ith bed mobility and 34 was dependent on one n and off the unit. The d Resident #34 had no efined as any manual mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or 's body). #34's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the	F	221			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345330	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	PM of Resident #34 s that was located in th impaired unit. Reside length side rails on he side rails were position each side of the bed. was approximately 26 was opening of appro- the top end of the side mattress and 26.5 ind the side rail to the both An interview was con- with the Director of Ni- all residents in the fact rails. She revealed the side rail risk assessment the same quarter lenge An interview was con- Assistant (NA) #2 on- revealed she had not what position each re- placed. She indicated in the position they we them into a different p An interview was con- at 4:35 PM. NA #3 re- how it was decided w side rails were to be p just kept the side rails and had not moved the An interview was con- 8/2/17 at 4:40 PM. No- not known how it was the side rails on each	Alleeping in bed in her room e facility's cognitively ent #34 had bilateral quarter er bed. The quarter length oned in the middle section of (Each quarter side rail b) inches in length and there eximately 26.5 inches from e rail to the top end of the shes from the bottom end of ttom end of the mattress.) ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side he facility had not utilized ents since all residents had gth side rails. ducted with Nursing 8/2/17 at 4:30 PM. NA #2 known how it was decided sident's side rails were to be d she just kept the side rails ere in and had not moved bosition. ducted with NA #3 on 8/2/17 evealed she had not known hat position each resident's blaced. She indicated she is in the position they were in hem into a different position.	F	22			

Facility ID: 953491

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/06/2017 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345330	B. WING			C 08/03/2017		
NAME OF PF	NAME OF PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
THE GRAYBRIER NURS & RETIREMENT CT					6 LANE DRIVE			
				TR	RINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 221	them. Nurse #3 state risk assessments. SH was no documentatio indicated where the s positioned on each re An interview was con Assurance (QA) Nurs She confirmed all res quarter length side ra the side rails were uti the resident was able had side rails were uti the resident was able had side rails on the H resident was not cogr resident was not cogr resident was assesses them. She indicated documented. The Q/ no documentation of there were also no ev rails. She revealed s for over two years an side rail risk assessm the same quarter leng side rails that were po section of the bed for with the QA Nurse. S known any of the side cognitively impaired u the middle section of needed to follow up of information. A follow up interview	lay and had not repositioned at there were no side rail he additionally stated there in in the medical record that ide rails were to be esident's bed. ducted with the Quality ie on 8/2/17 at 4:55 PM. idents in the facility had ils. The QA Nurse indicated lized for positioning and if to position themselves they beds. She stated if the hitively intact then the ed to see what was safest for this assessment was not A Nurse reported there was side rail assessments and valuations of risk for the side he had worked at the facility d the facility had not utilized nents since all residents had gth side rails. The bilateral positioned in the middle Resident #34 was reviewed She revealed she had not e rails on the beds in the unit had been positioned in the bed. She stated she on this to provide additional	F	221				
		the unit. She stated 21 of had the quarter length side						

Facility ID: 953491

If continuation sheet Page 15 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		_		C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE GRA	BRIER NURS & RETIRE	MENT CT		116 LANE DRIVE TRINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	Continued From page	9 15	F 22	1			
		center section of the bed.					
	· ·	ed this was how that model					
		She explained that the					
	-	able to be turned into the					
		ng it toward the head of the the side rail an assist rail					
		p section of the bed. She					
		en utilizing this type of bed					
		king at the facility (over 2					
	years ago). The QA I	Nurse was unable to explain					
		ned if the side rails were					
	-	section of the bed as quarter					
		the top section of the bed as					
		ed the quarter length side center section of the bed					
		red restraints since they					
	were only quarter leng	-					
		ducted with NA #4 on 8/3/17					
		ed she normally worked on					
		ed unit. She reported the					
	majority of the resider	pendent on staff for ADL					
		ing) care. NA #4 was					
	· · ·	nined what position to place					
		ails and she indicated she					
		he position they were always					
		them to a different position.					
	She reported most of						
	-	itively impaired unit were					
	· ·	length side rails in the bed. She stated this side					
		it easier on the staff to turn					
		indicated she was familiar					
		he stated Resident #34 was					
		bed without assistance and					
		ls. She indicated Resident					
	#34 had a pad alarm attempts to get out of	(used to alert staff of bed without assistance).					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		_		C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRAY	BRIER NURS & RETIRE	MENT CT		16 LANE DRIVE RINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	the side rail and take staff when she was re- indicated Resident #3 side rail independent! An interview was com- on 8/3/17 at 11:02 AM the lead MDS Nurse. dated 6/29/17 that inc physical restraints wa Nurse. She was ask utilized to code the M The MDS Nurse state a side rail risk assess side rails by seeing if reach over to the side resident was able to r she had not coded the restraint on the MDS. Resident #34 was able rail when in bed. An interview was com 8/3/17 at 11:30 AM. quarter length side ra section of the bed we The DON stated she length side rails were section of the bed. An observation was co 8/3/17 at 11:35 AM of #34's bed with the bila rails positioned in the (as they were observed Measurements of the	At #34 was able to hold onto some of the strain off of the epositioned in bed. She 44 was unable to move her y. ducted with the MDS Nurse A. She indicated she was The MDS assessment dicated Resident #34 had no s reviewed with the MDS ed what information she DS for physical restraints. ed the facility had not utilized ment, so she assessed the the resident was able to e rail. She stated if the each over to the side rail e side rail as a physical The MDS Nurse indicated e to reach over to the side ducted with the DON on The beds with bilateral ils positioned in the center re reviewed with the DON. had not thought the quarter positioned in the center onducted with the DON on the model of Resident ateral quarter length side middle section of the bed ed on Resident #34's bed). bed were obtained by the	F 221				
	(as they were observe Measurements of the DON. The bed was a	ed on Resident #34's bed).					

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				/03/2017
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	bottom end of the ma side rail was approxim and was positioned w from the top end of the the mattress and 26.5 the bottom end of the of the mattress. The attached to the bed fr instructions. A follow up interview of DON on 8/3/17 at 11: expectation was for a on an individual basis restraint. She indicat assessment for side r side rails were quarte facility had not consid to be a restraint. 4. Resident #52 was 7/27/09 with diagnose anxiety, and depressi The quarterly Minimu assessment dated 6/7 #52's cognition was s was assessed as require for locomotion on and assessment indicated physical restraints (de method or physical or material or equipment resident's body that the	ttress. The quarter length nately 26 inches in length rith 26.5 inches of open area e side rail to the top end of 5 inches of open area from side rail to the bottom end quarter length side rail was ame per the manufacturer's was conducted with the 39 AM. She stated her Il side rails to be assessed to determine if they were a ed there was no formal ails at the facility since all r length side rails and the lered this length of a side rail admitted to the facility on es that included dementia, on. m Data Set (MDS) 1/17 indicated Resident ignificantly impaired. She uiring extensive assistance rith bed mobility and 52 was dependent on staff I off the unit. The I Resident #52 had no efined as any manual r mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or	F	221			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF			
		345330	B. WING				03/2017		
NAME OF P	ROVIDER OR SUPPLIER	I		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00			
THE GRA	BRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 221	Continued From page	e 18	F	221	r l				
	A review of Resident revealed there had be assessments comple	een no side rail risk							
		ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails.							
	PM of Resident #52 s that was located in th impaired unit. Reside length side rails on he side rails were positic each side of the bed. was approximately 26 was opening of appro- the top end of the sid mattress and 26.5 inc the side rail to the bor An interview was con	ent #52 had bilateral quarter er bed. The quarter length oned in the middle section of (Each quarter side rail 6 inches in length and there oximately 26.5 inches from e rail to the top end of the ches from the bottom end of ttom end of the mattress.) ducted on 8/2/17 at 4:25 PM							
	all residents in the fact rails. She revealed the side rail risk assessment the same quarter lengt An interview was cont Assistant (NA) #2 on revealed she had not what position each re- placed. She indicated in the position they we them into a different p	ducted with Nursing 8/2/17 at 4:30 PM. NA #2 known how it was decided sident's side rails were to be d she just kept the side rails ere in and had not moved							
		evealed she had not known							

Facility ID: 953491

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						0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING	3		
		0.45000				
		345330	B. WING			03/2017
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
THE GRAY	BRIER NURS & RETIRE	EMENT CT		116 LANE DRIVE		
				TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 221	Continued From page	e 19	F 22	21		
		vhat position each resident's	1 22	- '		
		placed. She indicated she				
		s in the position they were in				
		hem into a different position.				
		·				
	An interview was con	nducted with Nurse #3 on				
		lurse #3 revealed she had				
		s decided where to position				
		resident's bed. She				
		pt the side rails in the same				
		day and had not repositioned				
		ed there were no side rail				
		he additionally stated there on in the medical record that				
	indicated where the s					
	positioned on each re					
	An interview was con	nducted with the Quality				
		se on 8/2/17 at 4:55 PM.				
		sidents in the facility had				
	quarter length side ra	ails. The QA Nurse indicated				
	the side rails were ut	ilized for positioning and if				
		e to position themselves they				
		beds. She stated if the				
	•	nitively intact then the				
		ed to see what was safest for				
		this assessment was not				
		A Nurse reported there was side rail assessments and				
		valuations of risk for the side				
		she had worked at the facility				
		id the facility had not utilized				
		nents since all residents had				
	the same quarter leng	gth side rails. The bilateral				
	side rails that were p	ositioned in the middle				
		Resident #52 was reviewed				
		She revealed she had not				
		e rails on the beds in the			1	

Facility ID: 953491

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						O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · · ·	E SURVEY IPLETED
			A. DOILDIN	<u> </u>	С	
		345330	B. WING		08	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP COD		
	YBRIER NURS & RETIRE			116 LANE DRIVE		
				TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 221	Continued From page	e 20	F 2	21		
		the bed. She stated she				
		on this to provide additional				
	Nurse on 8/3/17 at 8: were 12 double occur cognitively impaired u residents resided on the 23 resident beds rails positioned in the The QA Nurse report of the bed was made quarter side rail was "up" position by rotati bed which then made that was located at to indicated they had be since she began worl years ago). The QA how the staff determi	ollow up interview was conducted with the QA rse on 8/3/17 at 8:10 AM. She indicated there are 12 double occupancy rooms on the gnitively impaired unit and presently 23 sidents resided on the unit. She stated 21 of a 23 resident beds had the quarter length side is positioned in the center section of the bed. e QA Nurse reported this was how that model the bed was made. She explained that the arter side rail was able to be turned into the o" position by rotating it toward the head of the d which then made the side rail an assist rail at was located at top section of the bed. She licated they had been utilizing this type of bed ice she began working atthe facility (over 2 ars ago). The QA Nurse was unable to explain w the staff determined if the side rails were iced in the middle section of the bed as quarter				
	rails positioned in the	ed the quarter length side e center section of the bed ered restraints since they gth side rails.				
	at 9:30 AM. She stat the cognitively impair majority of the reside impaired unit were de (Activities of Daily Liv	ducted with NA #4 on 8/3/17 ed she normally worked on red unit. She reported the nts on the cognitively ependent on staff for ADL ring) care. NA #4 was mined what position to place				
	each resident's side r kept the side rails in t	ails and she indicated she the position they were always d them to a different position.				

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRA	BRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	positioned as quarter center section of the B rail positioning made the residents. NA #4 with Resident #52. S not able to get out of she was at risk for fall #52 had a pad alarm attempts to get out of She reported Resider the side rail and take staff when she was re- indicated Resident #5 side rail independent! An interview was com- on 8/3/17 at 11:02 AM the lead MDS Nurse. dated 6/1/17 that indic physical restraints wa Nurse. She was ask utilized to code the M The MDS Nurse state a side rail risk assess side rails by seeing if reach over to the side resident was able to r she had not coded the restraint on the MDS. Resident #52 was abl rail when in bed. An interview was com- 8/3/17 at 11:30 AM. T quarter length side ra section of the bed we The DON stated she	itively impaired unit were length side rails in the bed. She stated this side it easier on the staff to turn indicated she was familiar he stated Resident #52 was bed without assistance and ls. She indicated Resident (used to alert staff of bed without assistance). It #52 was able to hold onto some of the strain off of the epositioned in bed. She i2 was unable to move her	F	221			

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				03/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	BRIER NURS & RETIRE	NURS & RETIREMENT CT 116 LANE DRIVE TRINITY, NC 27370					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	 8/3/17 at 11:35 AM of #52's bed with the bills rails positioned in the (as they were observed Measurements of the DON. The bed was a length from the top error bottom end of the maside rail was approximand was positioned w from the top end of the mattress and 26.5 the bottom end of the of the mattress. The attached to the bed frinstructions. A follow up interview DON on 8/3/17 at 11: expectation was for a on an individual basis restraint. She indicat assessment for side rails were quarte facility had not consid to be a restraint. 5. Resident #95 was if facility on 1/15/15 and on 7/13/15 with diagn dementia, depression 	conducted with the DON on i the model of Resident ateral quarter length side middle section of the bed ed on Resident #52's bed). bed were obtained by the approximately 79 inches in nd of the mattress to the ttress. The quarter length nately 26 inches in length ith 26.5 inches of open area e side rail to the top end of 5 inches of open area from side rail to the bottom end quarter length side rail was ame per the manufacturer's was conducted with the 39 AM. She stated her Il side rails to be assessed to determine if they were a ed there was no formal ails at the facility since all r length side rails and the lered this length of a side rail initially admitted to the d most recently readmitted oses that included h, and a history of falling.	F	22'			
	assessment dated 5/3 #95's cognition was s	e Minimum Data Set (MDS) 30/17 indicated Resident ignificantly impaired. He uiring extensive assistance					

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				/03/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	of two or more staff w transfers. Resident # locomotion on the unia assistance of one star unit. The assessment had no physical restra method or physical or material or equipment resident's body that the easily which restricts normal access to one A review of Resident revealed there had be assessments complet An interview was com PM with Nurse #2. S facility had quarter len An observation was com PM of Resident #95 st that was located in the impaired unit. Reside length side rails on hi side rails were position each side of the bed. was approximately 26 was opening of appro- the top end of the side mattress and 26.5 ind the side rail to the both An interview was com with the Director of N all residents in the face rails. She revealed the	 with bed mobility and 95 was independent with t and required the extensive ff with locomotion off the t indicated Resident #95 aints (defined as any manual mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or 's body). #95's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. wonducted on 8/2/17 at 4:15 beleeping in bed in his room e facility's cognitively ent #95 had bilateral quarter is bed. The quarter length oned in the middle section of (Each quarter side rail concess in length and there eximately 26.5 inches from the bottom end of the one of the mattress.) ducted on 8/2/17 at 4:25 PM ursing (DON). She stated ents since all residents had 	F	221			

Facility ID: 953491

If continuation sheet Page 24 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	Continued From page		F	221			
	revealed she had not what position each re placed. She indicated in the position they w them into a different p	8/2/17 at 4:30 PM. NA #2 known how it was decided sident's side rails were to be d she just kept the side rails ere in and had not moved					
	at 4:35 PM. NA #3 re how it was decided w side rails were to be p just kept the side rails	evealed she had not known hat position each resident's placed. She indicated she is in the position they were in hem into a different position.					
	8/2/17 at 4:40 PM. N not known how it was the side rails on each indicated the staff kep position from day to o them. Nurse #3 state risk assessments. Sh						
	Assurance (QA) Nurs She confirmed all res quarter length side ra the side rails were uti the resident was able had side rails on the l resident was not cogr resident was assesses them. She indicated	ducted with the Quality te on 8/2/17 at 4:55 PM. idents in the facility had ils. The QA Nurse indicated lized for positioning and if to position themselves they beds. She stated if the hitively intact then the ed to see what was safest for this assessment was not A Nurse reported there was					

Facility ID: 953491

If continuation sheet Page 25 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/06/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		_	(08/0) 03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT		116 LANE DRIVE TRINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	there were also no ever rails. She revealed sh for over two years and side rail risk assessm the same quarter leng side rails that were por section of the bed for with the QA Nurse. So known any of the side cognitively impaired ut the middle section of needed to follow up or information. A follow up interview of Nurse on 8/3/17 at 8: were 12 double occup cognitively impaired ut residents resided on the the 23 resident beds of rails positioned in the The QA Nurse reporte of the bed was made. quarter side rail was a "up" position by rotatil bed which then made that was located at to indicated they had be since she began work years ago). The QA I how the staff determint placed in the middle so length side rails or in assist rails. She state rails positioned in the	side rail assessments and raluations of risk for the side he had worked at the facility d the facility had not utilized ents since all residents had gth side rails. The bilateral ositioned in the middle Resident #95 was reviewed the revealed she had not e rails on the beds in the init had been positioned in the bed. She stated she in this to provide additional was conducted with the QA 10 AM. She indicated there bancy rooms on the init and presently 23 the unit. She stated 21 of had the quarter length side center section of the bed. She explained that the able to be turned into the ing it toward the head of the the side rail an assist rail p section of the bed. She en utilizing this type of bed sing at the facility (over 2 Nurse was unable to explain hed if the side rails were section of the bed as quarter the top section of the bed as ed the quarter length side center section of the bed as ed the quarter length side contor section of the bed as eaction of the bed as quarter the top section of the bed as ed the quarter length side center section of the bed as eaction of the bed as quarter the top section of the bed as eact the quarter length side center section of the bed as eact the quarter length side center section of the bed as	F 22'				

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		IO. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		CON	IPLETED
		0.45000	D. MINO			С
	ROVIDER OR SUPPLIER	345330	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD		8/03/2017
NAME OF P	ROVIDER OR SUPPLIER			116 LANE DRIVE	E	
THE GRA	BRIER NURS & RETIRI	EMENT CT		TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 221	Continued From pag	e 26	F 22	1		
		o =o nducted with NA #4 on 8/3/17				
		ted she normally worked on				
		ed unit. She reported the				
		nts on the cognitively				
	-	ependent on staff for ADL /ing) care. NA #4 was				
		mined what position to place				
		rails and she indicated she				
		the position they were always				
		d them to a different position.				
	She reported most of	nitively impaired unit were				
		length side rails in the				
		bed. She stated this side				
	rail positioning made	it easier on the staff to turn				
		indicated she was familiar				
		She stated Resident #95 was bed without assistance and				
	•	s. She indicated Resident				
		(used to alert staff of				
	-	bed without assistance).				
		nt #95 was able to hold onto				
		some of the strain off of the				
		epositioned in bed. She 95 was unable to move his				
	side rail independent					
		nducted with the MDS Nurse				
		M. She indicated she was				
		The MDS assessment				
	dated 5/30/17 that in	dicated Resident #95 had no				
		as reviewed with the MDS				
		ked what information she				
		IDS for physical restraints. ed the facility had not utilized				
		sment, so she assessed the				
		the resident was able to				
	reach over to the side	e rail She stated if the				
		reach over to the side rail				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		_		C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			1	16 LANE DRIVE			
THE GRAY	BRIER NURS & RETIRE		1	RINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	Continued From page		F 221				
	restraint on the MDS. Resident #95 was ab	e side rail as a physical The MDS Nurse indicated le to reach over to the side					
	8/3/17 at 11:30 AM. quarter length side ra section of the bed we The DON stated she	ducted with the DON on The beds with bilateral ils positioned in the center re reviewed with the DON. had not thought the quarter positioned in the center					
	8/3/17 at 11:35 AM of #95's bed with the bill rails positioned in the (as they were observed Measurements of the DON. The bed was a length from the top er bottom end of the ma side rail was approxin and was positioned w from the top end of th the mattress and 26.5 the bottom end of the of the mattress. The attached to the bed fr instructions.	conducted with the DON on if the model of Resident ateral quarter length side middle section of the bed ed on Resident #95's bed). bed were obtained by the approximately 79 inches in nd of the mattress to the ttress. The quarter length mately 26 inches in length with 26.5 inches of open area e side rail to the top end of 5 inches of open area from side rail to the bottom end quarter length side rail was ame per the manufacturer's					
	DON on 8/3/17 at 11: expectation was for a on an individual basis restraint. She indicat assessment for side r side rails were quarter	was conducted with the 39 AM. She stated her Il side rails to be assessed to determine if they were a ed there was no formal rails at the facility since all r length side rails and the lered this length of a side rail					

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345330	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	8/6/14 with diagnoses anxiety, depression, i The quarterly Minimu assessment dated 7/4 was significantly impa- requiring extensive as bed mobility and exter more staff with transfit the extensive assistan in the room, walking i the unit, and locomot assessment indicated physical restraints (de method or physical or material or equipmen resident's body that th easily which restricts normal access to one A review of Resident revealed there had be assessments comple An interview was con PM with Nurse #2. S facility had quarter len An observation was of PM of Resident #101 that was located in th impaired unit. Reside quarter length side rails were section of each side of	a admitted to the facility on a that included Alzheimer's, nsomnia, and repeated falls. m Data Set (MDS) 4/17 indicated her cognition aired. She was assessed as assistance of one staff with nsive assistance of two or ers. Resident #101 required nce of one staff for walking in the corridor, locomotion on ion off the unit. The I Resident #101 had no efined as any manual mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or 's body). #101's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. conducted on 8/2/17 at 4:15 sleeping in bed in her room e facility's cognitively	F	221			

Facility ID: 953491

If continuation sheet Page 29 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	
		345330	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
THE GRA	BRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	inches from the top ei end of the mattress a bottom end of the side the mattress.) An interview was con- with the Director of Ni all residents in the fac rails. She revealed th side rail risk assessm the same quarter leng An interview was con- Assistant (NA) #2 on revealed she had not what position each re- placed. She indicated in the position they we them into a different p An interview was con- at 4:35 PM. NA #3 re- how it was decided w side rails were to be p just kept the side rails and had not moved th An interview was con 8/2/17 at 4:40 PM. N not known how it was the side rails on each indicated the staff kep position from day to d them. Nurse #3 state risk assessments. Sh	g of approximately 26.5 nd of the side rail to the top nd 26.5 inches from the e rail to the bottom end of ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side he facility had not utilized ents since all residents had gth side rails. ducted with Nursing 8/2/17 at 4:30 PM. NA #2 known how it was decided sident's side rails were to be d she just kept the side rails ere in and had not moved bosition. ducted with NA #3 on 8/2/17 evealed she had not known hat position each resident ' s blaced. She indicated she is in the position they were in hem into a different position. ducted with Nurse #3 on urse #3 revealed she had decided where to position resident's bed. She of the side rails in the same ay and had not repositioned d there were no side rail he additionally stated there n in the medical record that ide rails were to be	F	221			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		_		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	16 LANE DRIVE			
THE GRA	YBRIER NURS & RETIRE	MENT CT	т	RINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	Continued From page	e 30	F 221				
	Assurance (QA) Nurs She confirmed all res quarter length side ra the side rails were uti the resident was able had side rails on the b resident was not cogr resident was assesses them. She indicated documented. The QA no documentation of there were also no ev rails. She revealed si for over two years any side rail risk assessm the same quarter leng side rails that were po section of the bed for reviewed with the QA had not known any of the cognitively impair in the middle section needed to follow up o information. A follow up interview Nurse on 8/3/17 at 8: were 12 double occup cognitively impaired u residents resided on the The QA Nurse reporte of the bed was made. quarter side rail was a "up" position by rotati	d to see what was safest for this assessment was not A Nurse reported there was side rail assessments and valuations of risk for the side he had worked at the facility d the facility had not utilized ents since all residents had gth side rails. The bilateral ositioned in the middle Resident #101 was Nurse. She revealed she the side rails on the beds in ed unit had been positioned of the bed. She stated she in this to provide additional was conducted with the QA 10 AM. She indicated there pancy rooms on the					

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ND PLAN OF C	DVIDER OR SUPPLIER BRIER NURS & RETIRE SUMMARY STJ (EACH DEFICIENC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345330 EMENT CT	```	STREET ADDRESS, CITY, STATE, ZIP COD	Сом 08	E SURVEY IPLETED
NAME OF PRO	DVIDER OR SUPPLIER BRIER NURS & RETIRE SUMMARY STJ (EACH DEFICIENC	345330 MENT CT		STREET ADDRESS, CITY, STATE, ZIP COD	08	С
THE GRAYE	BRIER NURS & RETIRE SUMMARY STJ (EACH DEFICIENC		B. WING	STREET ADDRESS, CITY, STATE, ZIP COD		
THE GRAYE	BRIER NURS & RETIRE SUMMARY STJ (EACH DEFICIENC		B. WING	STREET ADDRESS, CITY, STATE, ZIP COD		100/0047
THE GRAYE	BRIER NURS & RETIRE SUMMARY STJ (EACH DEFICIENC					3/03/2017
	SUMMARY ST/ (EACH DEFICIENC					
	SUMMARY ST/ (EACH DEFICIENC			116 LANE DRIVE		
(X4) ID	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES		TRINITY, NC 27370		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 221 (Continued From page	2 31	F 22	21		
		p section of the bed. She	1 22			
		en utilizing this type of bed				
	-	king at the facility (over 2				
		Nurse was unable to explain				
		ned if the side rails were				
		section of the bed as quarter				
		the top section of the bed as				
	-	ed the quarter length side				
		center section of the bed				
	-	ered restraints since they				
	were only quarter len	-				
	An interview was con	ducted with NA #4 on 8/3/17				
		ed she normally worked on				
		ed unit. She reported the				
	majority of the resider	-				
		ependent on staff for ADL				
		, ring) care. NA #4 was				
		mined what position to place				
		ails and she indicated she				
		he position they were always				
	-	them to a different position.				
	She reported most of					
1	residents on the cogn	itively impaired unit were				
	positioned as quarter	length side rails in the				
0	center section of the I	bed. She stated this side				
1	rail positioning made	it easier on the staff to turn				
t	the residents. NA #4	indicated she was familiar				
		She indicated Resident #101				
		(used to alert staff of				
		bed without assistance).				
		#101 had tried to get up				
		t. She reported Resident				
		d onto the side rail and take				
		of the staff when she was				
	-	She stated Resident #101				
	-	ut of bed without assistance				
		or falls. She indicated nable to move her side rail				

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345330	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	on 8/3/17 at 11:02 AM the lead MDS Nurse. dated 7/4/17 that indi- physical restraints wa Nurse. She was ask utilized to code the M The MDS Nurse state a side rails by seeing if reach over to the side resident was able to r she had not coded the restraint on the MDS. Resident #101 was al rail when in bed. An interview was con 8/3/17 at 11:30 AM. quarter length side ra section of the bed we The DON stated she length side rails were section of the bed. An observation was co 8/3/17 at 11:35 AM of #101's bed with the b rails positioned in the (as they were observed Measurements of the DON. The bed was a length from the top er bottom end of the ma	e 32 ducted with the MDS Nurse A. She indicated she was The MDS assessment cated Resident #101 had no s reviewed with the MDS ed what information she DS for physical restraints. ed the facility had not utilized ment, so she assessed the the resident was able to e rail. She stated if the each over to the side rail e side rail as a physical The MDS Nurse indicated one to reach over to the side ducted with the DON on The beds with bilateral ils positioned in the center re reviewed with the DON. had not thought the quarter positioned in the center re nodel of Resident ilateral quarter length side middle section of the bed ed on Resident #101's bed). bed were obtained by the pproximately 79 inches in ad of the mattress to the ttress. The quarter length nately 26 inches in length	F	221			
	and was positioned w	e side rail to the top end of					

Facility ID: 953491

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM): 09/06/2017 APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345330	B. WING		_	08/0	C 03/2017
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE GRAYBRIER NURS & RETIRE	MENT CT		16 LANE DRIVE RINITY, NC 27370			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 the bottom end of the of the mattress. The of attached to the bed frainstructions. A follow up interview w DON on 8/3/17 at 11:3 expectation was for al on an individual basis restraint. She indicate assessment for side rais were quarter facility had not conside to be a restraint. 7. Resident #140 was 10/31/16 and readmitt diagnoses that include depression, insomnia, The quarterly Minimur assessment dated 7/1 was significantly impa requiring extensive as mobility and the limiter transfers. Resident #1 assistance of one staf walking in the corridor and locomotion off the indicated Resident #1 restraints (defined as a physical or mechanica equipment attached or body that the individual for the	inches of open area from side rail to the bottom end quarter length side rail was ame per the manufacturer's was conducted with the 39 AM. She stated her I side rails to be assessed to determine if they were a ed there was no formal ails at the facility since all r length side rails and the ered this length of a side rail admitted to the facility on ted on 4/6/17 with ed Alzheimer 's, anxiety, , and repeated falls. m Data Set (MDS) 3/17 indicated her cognition ired. She was assessed as isistance of one staff for 140 required the extensive f for walking in the room, r, locomotion on the unit, e unit. The assessment 40 had no physical any manual method or al device, material or r adjacent to the resident's al cannot remove easily m of movement or normal	F 221				

Facility ID: 953491

If continuation sheet Page 34 of 83

CENTER STATEMENT	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		FORM OMB NC (X3) DATE	0: 09/06/2017 1 APPROVED 0. 0938-0391 SURVEY LETED
		345330	B. WING				
	ROVIDER OR SUPPLIER	540000		STREET ADDRESS, CITY, ST		08/	03/2017
	NOVIDER OR SOLT EIER			116 LANE DRIVE	IATE, ZII CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT		TRINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	A review of Resident a revealed there had be assessments complet An interview was com- PM with Nurse #2. Si facility had quarter len An observation was co- PM of Resident #140 that was located in the impaired unit. Reside quarter length side rai length side rails were section of each side co- side rail was approxim and there was openim inches from the top ei- end of the mattress a bottom end of the side the mattress.) An interview was com- with the Director of Ne all residents in the fac rails. She revealed the side rail risk assesses the same quarter lenge An interview was com- Assistant (NA) #2 on revealed she had not what position each re placed. She indicated in the position they we them into a different p An interview was com-	#140's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. onducted on 8/2/17 at 4:15 sleeping in bed in her room e facility's cognitively ent #140 had bilateral ils on her bed. The quarter positioned in the middle of the bed. (Each quarter nately 26 inches in length g of approximately 26.5 nd of the side rail to the top nd 26.5 inches from the e rail to the bottom end of ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side he facility had not utilized ents since all residents had gth side rails. ducted with Nursing 8/2/17 at 4:30 PM. NA #2 known how it was decided sident's side rails were to be d she just kept the side rails ere in and had not moved	F 22'				

Facility ID: 953491

If continuation sheet Page 35 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 09/06/2017 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE ODA		MENT OF		11	6 LANE DRIVE		
THE GRAT	BRIER NURS & RETIRE	MENT CI		TF	RINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	side rails were to be p just kept the side rails and had not moved th An interview was con 8/2/17 at 4:40 PM. N not known how it was the side rails on each indicated the staff kep position from day to o them. Nurse #3 state risk assessments. Sh was no documentation indicated where the s positioned on each re An interview was con Assurance (QA) Nurs She confirmed all res quarter length side rai the side rails were uti the resident was able had side rails on the I resident was not cogr resident was assesses them. She indicated documented. The Q/ no documentation of there were also no ev rails. She revealed s for over two years an side rail risk assessm	that position each resident's placed. She indicated she is in the position they were in hem into a different position. ducted with Nurse #3 on urse #3 revealed she had a decided where to position in resident's bed. She but the side rails in the same lay and had not repositioned ed there were no side rail he additionally stated there in in the medical record that ide rails were to be esident's bed. ducted with the Quality se on 8/2/17 at 4:55 PM. idents in the facility had lized for positioning and if to position themselves they beds. She stated if the hitively intact then the ed to see what was safest for this assessment was not A Nurse reported there was side rail assessments and valuations of risk for the side he had worked at the facility d the facility had not utilized uents since all residents had	F	221			
	side rails that were po section of the bed for reviewed with the QA had not known any of	ofth side rails. The bilateral ositioned in the middle Resident #140 was Nurse. She revealed she f the side rails on the beds in ed unit had been positioned					

Facility ID: 953491

If continuation sheet Page 36 of 83

						O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
						С
		345330	B. WING		30	3/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	BRIER NURS & RETIRE	EMENT CT		116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 221	Continued From page	e 36	F 22	21		
		of the bed. She stated she				
		on this to provide additional				
	•	was conducted with QA 10 AM. She indicated there				
	were 12 double occu					
	cognitively impaired u					
		the unit. She stated 21 of				
		had the quarter length side				
		e center section of the bed. ed this was how that model				
	-	. She explained that the				
	-	able to be turned into the				
		ng it toward the head of the				
		e the side rail an assist rail op section of the bed. She				
		en utilizing this type of bed				
		king at the facility (over 2				
	, ,	Nurse was unable to explain				
		ned if the side rails were				
		section of the bed as quarter the top section of the bed as				
		ed the quarter length side				
		center section of the bed				
		ered restraints since they				
	were only quarter len	gth side rails.				
	An interview was con	ducted with NA #4 on 8/3/17				
		ed she normally worked on				
	the cognitively impair	ed unit. She reported the				
	majority of the reside					
		ependent on staff for ADL				
		ring) care. NA #4 was mined what position to place				
		ails and she indicated she				
		he position they were always				
		them to a different position.				
	She reported most of					

Facility ID: 953491

If continuation sheet Page 37 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	positioned as quarter center section of the B rail positioning made the residents. NA #4 with Resident #140. S was not able to get ou and she was at risk for Resident #140 had a staff of attempts to get assistance). She rep able to hold onto the st repositioned in bed. S was unable to move h An interview was com- on 8/3/17 at 11:02 AM the lead MDS Nurse. dated 7/13/17 that inc no physical restraints Nurse. She was ask utilized to code the M The MDS Nurse state a side rail risk assess side rails by seeing if reach over to the side resident was able to r she had not coded the restraint on the MDS. Resident #140 was al rail when in bed. An interview was com- 8/3/17 at 11:30 AM. T quarter length side ra section of the bed we The DON stated she	itively impaired unit were length side rails in the bed. She stated this side it easier on the staff to turn indicated she was familiar She stated Resident #140 ut of bed without assistance or falls. She indicated pad alarm (used to alert et out of bed without orted Resident #140 was side rail and take some of	F	221			

Facility ID: 953491

If continuation sheet Page 38 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
			A. BUILDI	NG .			C
		345330	B. WING			08/	03/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRAY	BRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 221	8/3/17 at 11:35 AM of #140's bed with the b rails positioned in the (as they were observe	onducted with the DON on the model of Resident ilateral quarter length side middle section of the bed ed on Resident #140's bed).	F	221			
	DON. The bed was a length from the top er bottom end of the ma side rail was approxin and was positioned w from the top end of th the mattress and 26.5 the bottom end of the of the mattress. The	bed were obtained by the approximately 79 inches in nd of the mattress to the ttress. The quarter length nately 26 inches in length ith 26.5 inches of open area e side rail to the top end of 5 inches of open area from side rail to the bottom end quarter length side rail was ame per the manufacturer's					
	DON on 8/3/17 at 11: expectation was for a on an individual basis restraint. She indicate assessment for side r side rails were quarte facility had not consid to be a restraint.	was conducted with the 39 AM. She stated her Il side rails to be assessed to determine if they were a ed there was no formal rails at the facility since all r length side rails and the lered this length of a side rail					
	4/30/17 with diagnose	admitted to the facility on es that included Alzheimer's, nsomnia, and a history of					
	assessment) indicate	mum Data Set (MDS) 28/17 (a thirty day MDS d Resident #158's cognition aired. She was assessed as					

Facility ID: 953491

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	
		345330	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00,	00/2011
	YBRIER NURS & RETIRE	MENT OT			116 LANE DRIVE		
THE GRA	I DRIEK NURS & RETIRE	MENTOT			TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	requiring extensive as bed mobility and trans required the extensive walking in the room, w locomotion on the uni unit. The assessmen had no physical restra method or physical or material or equipment resident's body that the easily which restricts normal access to one A review of Resident for revealed there had be assessments complet An interview was complet An interview was complet An observation was complet M with Nurse #2. St facility had quarter len An observation was complet facility had quarter len An observation was complet impaired unit. Reside quarter length side ra length side rails were section of each side co side rail was approxim and there was openim inches from the top en end of the mattress an bottom end of the side the mattress.) An interview was com- with the Director of Na all residents in the face	ssistance of one person with afers. Resident #158 e assistance of one staff for valking in the corridor, t, and locomotion off the t indicated Resident #158 aints (defined as any manual mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or ' s body). #158's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. onducted on 8/2/17 at 4:15 sleeping in bed in her room e facility's cognitively	F	22'			

Facility ID: 953491

If continuation sheet Page 40 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345330	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
					116 LANE DRIVE		
THE GRA	BRIER NURS & RETIRE	MENTCI			TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	the same quarter leng An interview was con Assistant (NA) #2 on revealed she had not what position each re placed. She indicated in the position they we them into a different p An interview was con at 4:35 PM. NA #3 re how it was decided w side rails were to be p just kept the side rails and had not moved th An interview was con 8/2/17 at 4:40 PM. N not known how it was the side rails on each indicated the staff kep position from day to d them. Nurse #3 state risk assessments. Sh was no documentatio indicated where the s positioned on each re An interview was con Assurance (QA) Nurs She confirmed all res quarter length side ra the side rails on the h resident was not cogr resident was assessed	ents since all residents had gth side rails. ducted with Nursing 8/2/17 at 4:30 PM. NA #2 known how it was decided sident's side rails were to be d she just kept the side rails ere in and had not moved bosition. ducted with NA #3 on 8/2/17 evealed she had not known hat position each resident's blaced. She indicated she is in the position they were in nem into a different position. ducted with Nurse #3 on urse #3 revealed she had a decided where to position resident's bed. She of the side rails in the same lay and had not repositioned ed there were no side rail he additionally stated there n in the medical record that ide rails were to be esident's bed. ducted with the Quality we on 8/2/17 at 4:55 PM. idents in the facility had ils. The QA Nurse indicated lized for positioning and if to position themselves they beds. She stated if the	F	22			

Facility ID: 953491

If continuation sheet Page 41 of 83

		MEDICAID SERVICES				<u>10. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING	3		
		245220				С
		345330	B. WING			8/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
THE GRA	BRIER NURS & RETIR	EMENT CT		116 LANE DRIVE		
-				TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 221	Continued From pag	e 41	F 22	1		
1 22 1			F 22			
		A Nurse reported there was side rail assessments and				
		valuations of risk for the side				
		she had worked at the facility				
		nd the facility had not utilized				
	-	nents since all residents had				
		gth side rails. The bilateral				
	-	ositioned in the middle				
	section of the bed for					
		A Nurse. She revealed she				
		of the side rails on the beds in				
		red unit had been positioned				
		of the bed. She stated she				
		on this to provide additional				
	information.	F				
	•	was conducted with the QA				
		:10 AM. She indicated there				
	were 12 double occu					
		unit and presently 23				
		the unit. She stated 21 of				
		had the quarter length side				
		e center section of the bed.				
	-	ted this was how that model				
		 She explained that the able to be turned into the 				
		ing it toward the head of the				
		e the side rail an assist rail				
		op section of the bed. She				
		een utilizing this type of bed				
	-	king at the facility (over 2				
		Nurse was unable to explain				
		ined if the side rails were				
		section of the bed as quarter				
	-	the top section of the bed as				
	-	ted the quarter length side				
		e center section of the bed				
	-	ered restraints since they				
				1		1

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/06/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	IREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	EMENT CT			I6 LANE DRIVE RINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	Continued From page	e 42	F	221			
	at 9:30 AM. She stat the cognitively impair majority of the reside impaired unit were de (Activities of Daily Liv asked how she detern each resident's side r kept the side rails in t in and had not moved She reported most of residents on the cogr positioned as quarter center section of the rail positioning made the residents. NA #4 with Resident #158. was not able to get of and she was at risk for Resident #158 had a staff of attempts to ge assistance). She rep able to hold onto the the strain off of the st repositioned in bed. was unable to move f An interview was con on 8/3/17 at 11:02 AM the lead MDS Nurse. dated 5/28/17 that ind no physical restraints Nurse. She was ask utilized to code the M The MDS Nurse state a side rail risk assess side rails by seeing if	ependent on staff for ADL ring) care. NA #4 was mined what position to place rails and she indicated she the position they were always d them to a different position. The side rails for the nitively impaired unit were length side rails in the bed. She stated this side it easier on the staff to turn indicated she was familiar She stated Resident #158 ut of bed without assistance or falls. She indicated pad alarm (used to alert et out of bed without orted Resident #158 was side rail and take some of					

Facility ID: 953491

If continuation sheet Page 43 of 83

	-	D HUMAN SERVICES //EDICAID SERVICES					FORM): 09/06/2017 APPROVED). 0938-0391
STATEMENT OF DEF AND PLAN OF CORF	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING			_		C 03/2017
NAME OF PROVID	ER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRAYBRIE	ER NURS & RETIRE	MENT CT			6 LANE DRIVE RINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
resid she rest Res rail An i 8/3/ qua sect The leng sect An o 8/3/ #15 rails (as DOI leng bott side and from the the the of th atta instr A fo DOI exp on a rest asso	had not coded the traint on the MDS. sident #158 was at when in bed. interview was cond (17 at 11:30 AM. T inter length side rai tion of the bed were to DON stated she h gth side rails were tion of the bed. observation was co (17 at 11:35 AM of i8's bed with the bi is positioned in the they were observe asurements of the N. The bed was a gth from the top en tom end of the mat e rail was approxim I was positioned wi in the top end of the mattress and 26.5 bottom end of the mattress. The of inched to the bed fra ructions.	43 each over to the side rail e side rail as a physical The MDS Nurse indicated ole to reach over to the side ducted with the DON on The beds with bilateral ls positioned in the center re reviewed with the DON. had not thought the quarter positioned in the center onducted with the DON on the model of Resident lateral quarter length side middle section of the bed ed on Resident #158's bed). bed were obtained by the pproximately 79 inches in d of the mattress to the tress. The quarter length th 26.5 inches in length th 26.5 inches of open area e side rail to the top end of inches of open area from side rail to the bottom end quarter length side rail was ame per the manufacturer's was conducted with the 39 AM. She stated her I side rails to be assessed to determine if they were a ed there was no formal ails at the facility since all rength side rails and the	F 2	221				

Facility ID: 953491

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				PRINTED: 09/06/2017 FORM APPROVED OMB NO. 0938-0391
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
	345330	B. WING		C 08/03/2017
ROVIDER OR SUPPLIER	I	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
BRIER NURS & RETIRE	MENT CT			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
		F 221		
		F 278		9/5/17
each assessment wit	h the appropriate			
· · •				
assessment must sig	n and certify the accuracy of			
(1) Under Medicare a	nd Medicaid, an individual			
resident assessment	is subject to a civil money			
and false statement in subject to a civil mon	n a resident assessment is ey penalty or not more than			
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER BRIER NURS & RETIRE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page facility had not consic to be a restraint. 483.20(g)-(j) ASSESS ACCURACY/COORE (g) Accuracy of Assee must accurately reflect (h) Coordination A registered nurse must each assessment wit participation of health (i) Certification (1) A registered nurse must each assessment wit participation of health (i) Certification (1) A registered nurse must subject of the assessment penalty for Falsific (i) Certifies a material resident assessment penalty of not more thas assessment; or (ii) Causes another in and false statement in subject to a civil mon- \$5,000 for each asses (2) Clinical disagreen	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345330 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 facility had not considered this length of a side rail to be a restraint. 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 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	S FOR MEDICARE & MEDICAID SERVICES PEPICIENCIES CORRECTION (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CA A. BUILDING 345330 B. WING STRE BRIER NURS & RETIREMENT CT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 facility had not considered this length of a side rail to be a restraint. 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 the assessment must sign and certify the accuracy of that portion of the assessment. (i) Certification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (ii) 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 III 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.	S FOR MEDICARE & MEDICAID SERVICES IP DEFICIENCIES (X1) PROVIDERSUPPLIERCIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE IGENER NURS & RETIREMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE IGENE NURS & RETIREMENT OF DEFICIENCIES PRETX IEACH DEFICIENCY MUST BE PRECIDED BY FULL PRETX REGULATORY OR LSC DENTIFYING INFORMATION) PRETX Continued From page 44 F 221 facility had not considered this length of a side rail to be a restraint. F 278 ACCURACY/COORDINATION/CERTIFIED F 278 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. F 278 (h) Cordination A registered nurse must sign and certify that the assessment must sign and certify tha accuracy of that portion of the assessment. IDENTIFICATION (INCERTIFIED) (i) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- IDENTIFICATION (INCERTIFIED) (i) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- IDENTIFICATION (INCERTIFIED) (i) Certifies a material and false stat

Facility ID: 953491

If continuation sheet Page 45 of 83

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		IO. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED
		345330	B. WING		0	C 8/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				116 LANE DRIVE		
THE GRA	BRIER NURS & RETIRE			TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 278	Continued From page	o 45	F 2	70		
1 270			F Z	78		
	by:	Γ is not met as evidenced				
		on, record review, and staff		The MDS assessments r		
		/ failed to code the Minimum		2567 for residents #8, #1		
	· · /	rately in the areas of r 8 of 8 residents		#101, #140, and #158 ha modified/coded correctly		
		95, #101, #140, and #158)		the Minimum Data Set (N		
		residents (Residents #150		MDS nurse made signific	,	
		The findings included:		of prior assessments for t		
				residents. The MDS asse	essment for	
		idmitted to the facility on		resident #150 was modifi		
	•	s that included dementia,		correctly, related to corre	-	
	anxiety, depression,	insomnia, and repeated falls.		was changed to "yes"). F		
	The significant chang	ge Minimum Data Set (MDS)		received a quarterly asse 8/4/2017 and the MDS ha		
		4/17 indicated Resident #8's		accurate for vision device		
		cantly impaired. She was				
		ent on two or more staff with		As of 9/5/17, all MDS ass	essments in the	
	bed mobility and tran	sfers. Resident #8 was		facility are coded correctly	y for side rail	
		aff for locomotion on and off		usage (including restraint	s) and vision	
		ment indicated Resident #8		devices.		
		aints (defined as any manual				
		r mechanical device, It attached or adjacent to the		Additional education was Director of Nursing to the		
		he individual cannot remove		Department, to appropria		
	-	freedom of movement or		rails as restraints. Educat		
	normal access to one			from "The Long Term Car	•	
		#8 's medical record		specific to side rails and r	•	
	revealed there had b			additional education was	provided from	
	assessments comple	eted.		the RAI manual specific to	-	
	An interview	duated on 7/04/47 -1 0 54		MDS assessments relate		
		iducted on 7/31/17 at 2:51		The Director of Social Wo		
	facility had quarter le	She stated all residents in the nother side rails		Work Assistant were educ Corporate Executive Assi		
	adding had quarter le			proper coding of vision de		
	An interview was cor	nducted on 7/31/17 at 3:04		assessments. A 100% in		
		She stated Resident #8 had		been completed by the D		
		th side rails and was not		to ensure MDS Staff accu	-	
	capable of getting ou	t of bed on her own.		residents for restraints an	id that MDS	

Facility ID: 953491

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		AND HUMAN SERVICES <u> MEDICAID SERVICES</u>				RM APPROVI IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY IPLETED
		345330	B. WING		0	C 8/03/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD	E	
				116 LANE DRIVE		
THE GRAY	BRIER NURS & RETIF	REMENT CI		TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 278	Continued From pa	ge 46	F 27	8		
		-		assessments, care plans, CA	As, and	
	An observation was	conducted on 7/31/17 at 5:09		progress notes match specific		
	PM of Resident #8	sleeping in bed in her room		use. A 100% in-service has t		
		the facility's cognitively		completed by the Corporate E		
		lent #8 had bilateral quarter		Assistant to ensure Social We		
		her bed. The quarter length		accurately assess residents f		
		tioned in the middle section of		devices and that MDS assess		
		d. (Each quarter side rail		plans, CAAs, and progress no		
		26 inches in length and there		the residents function related		
		roximately 26.5 inches from ide rail to the top end of the		devices. The MDS Coordinate	-	
	•	nches from the bottom end of		MDS responses for MDS ass using the "MDS Restraint Auc		
		pottom end of the mattress.)		has been created, to ensure I		
				assessments are coded accu		
	An interview was co	onducted on 8/2/17 at 4:25 PM		Director of Nursing will audit t		
	with the Director of	Nursing (DON). She stated		ensure accurate coding and o		
		acility had quarter length side		as related to restraint use. Ad	•	
	rails. She revealed	the facility had not utilized		the facility created an audit to	ol, the	
		ments since all residents had		"Vision Devices Audit Tool" to		
	the same quarter le	ngth rails.		vision devices are properly as		
				coded on the MDS assessme		
		onducted with NA #4 on 8/3/17		Director of Social Work or So		
		ated she normally worked on		Assistant will complete the log		
		aired unit. She reported the lents on the cognitively		be audited by the Corporate I Assistant to ensure accurate		
		dependent on staff for ADL		for vision devices.		
		iving) care. NA #4 was				
		ermined what position to place		The MDS Restraint Audit Too	l and the	
		e rails and she indicated she		Vision Devices Audit Tool will		
		n the position they were always		ensure MDS assessments an	e completed	
		ed them to a different position.		accurately, specifically in refe		
		of the side rails for the		restraint use and vision devic		
		gnitively impaired unit were		above listed QA tools (for side		
		er length side rails in the		rails/restraints and vision dev		
		e bed. She stated this side		completed for all MDS assess		
		e it easier on the staff to turn		the next 6 months from the da		
		t4 indicated she was familiar She stated Resident #8 was		corrective action. The Directo and Executive Assistant will u	-	
	WILL RESIDENT #8. S	DUE SIAIEO RESIDENT#8 WAS	1	and executive assistant will be	ise the audit	1

Facility ID: 953491

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N (X3) DATE SURVEY COMPLETED C 08/03/2017 S, CITY, STATE, ZIP CODE 08/03/2017 7370 (X5) ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE PREFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) urately prior to being locked and (; any discrepancies will be the MDS Coordinator, prior to on of MDS assessments. The dinator and/or Director of Social eport any findings of miscoded assments (related to restrain use Image: Completion of the system of the
08/03/2017 3, CITY, STATE, ZIP CODE 7370 (X5) COMPLETION H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (X5) COMPLETION DATE DEFICIENCY) Urrately prior to being locked and (; any discrepancies will be the MDS Coordinator, prior to on of MDS assessments. The dinator and/or Director of Social eport any findings of miscoded assments (related to restrain use
A CITY, STATE, ZIP CODE 7370 ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE COMPLETION DEFICIENCY) Arrately prior to being locked and (x5) COMPLETION DATE DEFICIENCY) Arrately prior to being locked and (x6) COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE DEFICIENCY) COMPLETION DATE COMPLETION DATE COMPLETION DATE DATE DEFICIENCY) COMPLETION DATE DATE DATE COMPLETION DATE
Available for the set of the set
ACVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE SREFERENCED TO THE APPROPRIATE DEFICIENCY) Arrately prior to being locked and ; any discrepancies will be the MDS Coordinator, prior to on of MDS assessments. The dinator and/or Director of Social eport any findings of miscoded assments (related to restrain use
A CORRECTIVE ACTION SHOULD BE COMPLETION DEFICIENCY) Arately prior to being locked and (; any discrepancies will be the MDS Coordinator, prior to on of MDS assessments. The dinator and/or Director of Social eport any findings of miscoded assents (related to restrain use
; any discrepancies will be the MDS Coordinator, prior to on of MDS assessments. The dinator and/or Director of Social eport any findings of miscoded assents (related to restrain use
; any discrepancies will be the MDS Coordinator, prior to on of MDS assessments. The dinator and/or Director of Social eport any findings of miscoded assents (related to restrain use
devices) at the quarterly QA Committee meetings for 6 m the date of corrective action. xecutive QA Committee scheduled October 17, 2017. alleges full compliance with correction as of 9/5/2017.

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMF	SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	had no physical restra method or physical or material or equipment resident's body that the easily which restricts normal access to one A review of Resident revealed there had be assessments complet An interview was complet An interview was complet An observation was complete An observation was complete An observation was complete An observation was complete assessments complete An observation was complete An observation was complete An observation was complete assessments complete assessments complete An observation was complete was opening of appro- the top end of the side mattress and 26.5 incomplete An interview was com- with the Director of Ne all residents in the fact rails. She revealed the side rail risk assessment the same quarter lenge An interview was complete An intervie	aints (defined as any manual rechanical device, t attached or adjacent to the he individual cannot remove freedom of movement or 's body). #12's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the high side rails. onducted on 8/2/17 at 4:15 leeping in bed in her room e facility's cognitively ent #12 had bilateral quarter er bed. The quarter length ined in the middle section of (Each quarter side rail 6 inches in length and there eximately 26.5 inches from e rail to the top end of the shes from the bottom end of tom end of the mattress.) ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side he facility had not utilized ents since all residents had gth side rails.	F	278	8		

Facility ID: 953491

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		_		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT		16 LANE DRIVE FRINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	residents on the cogn dependent on staff for Living) care. NA #4 determined what posi- side rails and she indi- in the position they we moved them to a differ most of the side rails cognitively impaired u quarter length side ra- the bed. She stated to made it easier on the NA #4 indicated she w #12. She stated Resi- out of bed without ass for falls. She indicate alarm (used to alert si- bed without assistance #12 was able to hold some of the strain off repositioned in bed. Si was unable to move fr An interview was com- on 8/3/17 at 11:02 AM the lead MDS Nurse at the accurate completi The quarterly MDS as that indicated Resider restraints was review. She was asked what code the MDS for phy Nurse stated the facili risk assessment, so si- by seeing if the resider the side rail. She staff to reach over to the si-	itively impaired unit were r ADL (Activities of Daily	F 278				

Facility ID: 953491

If continuation sheet Page 50 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345330	B. WING				C 103/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	A follow up interview w 8/3/17 at 11:42 AM. S was for all side rails to individual basis to det restraint and for the M 3. Resident #34 was a 3/26/15 with diagnose anxiety, depression, it falling. The quarterly Minimu assessment dated 6/2 #34's cognition was s was assessed as requ of two or more staff w transfers. Resident # staff for locomotion or assessment indicated physical restraints (de method or physical or material or equipment resident's body that th easily which restricts normal access to one A review of Resident # revealed there had be assessments complet An interview was com- PM with Nurse #2. S facility had quarter ler An observation was c PM of Resident #34 s that was located in the impaired unit. Reside	was conducted with DON on She stated her expectation o be assessed on an ermine if they were a IDS to be coded accurately. admitted to the facility on es that included Alzheimer's, nsomnia, and a history of m Data Set (MDS) 29/17 indicated Resident ignificantly impaired. She uiring extensive assistance ith bed mobility and 34 was dependent on one n and off the unit. The I Resident #34 had no efined as any manual mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or 's body). #34's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. onducted on 8/2/17 at 4:15 leeping in bed in her room	F	278	8		

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OLITEI		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	ECONSTRUCTION	· · ·	E SURVEY IPLETED
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		COM	
						С
		345330	B. WING		08	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	YBRIER NURS & RETIRI	MENT CT	1	16 LANE DRIVE		
THE GRA	I BRIER NORS & RETIR		1	RINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From pag	e 51	F 278			
	each side of the bed. was approximately 2 was opening of appro the top end of the sid mattress and 26.5 in	oned in the middle section of (Each quarter side rail 6 inches in length and there oximately 26.5 inches from le rail to the top end of the ches from the bottom end of ttom end of the mattress.)				
	An interview was conducted on 8/2/17 at 4:25 PM with the Director of Nursing (DON). She stated all residents in the facility had quarter length side rails. She revealed the facility had not utilized side rail risk assessments since all residents had the same quarter length side rails.					
	stated she normally wimpaired unit. She re- residents on the cogridependent on staff for Living) care. NA #4 determined what pos- side rails and she inco- in the position they wimoved them to a diffe	8/3/17 at 9:30 AM. She worked on the cognitively eported the majority of the nitively impaired unit were or ADL (Activities of Daily				
	cognitively impaired of quarter length side ra the bed. She stated made it easier on the NA #4 indicated she #34. She stated Res out of bed without as for falls. She indicated alarm (used to alert s	unit were positioned as ails in the center section of this side rail positioning e staff to turn the residents. was familiar with Resident sident #34 was not able to get sistance and she was at risk ed Resident #34 had a pad staff of attempts to get out of ce). She reported Resident				

Facility ID: 953491

If continuation sheet Page 52 of 83

DEPARTMENT OF HE						FORM	APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345330	B. WING				C 03/2017
NAME OF PROVIDER OR SUP	PLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRAYBRIER NURS	& RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
PREFIX (EACH I	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
 was unable to An interview on 8/3/17 at the lead MDS the accurate The quarterly that indicated restraints was She was ask code the MD Nurse stated risk assessmed by seeing if the side rail. To reach over the side rail at A follow up in 8/3/17 at 11: was for all side individual bases for all side individual bases are straint and 4. Resident # 7/27/09 with anxiety, and The quarterly assessment #52's cognitive was assessed of two or moto transfers. Reference of the comparison of the comp	in bed. o move h was con 11:02 AN S Nurse is completi y MDS as d Reside s review the facil bent, so s he reside S for phy the facil bent, so s he reside S for star r to the s as a phys de rails to de rails to d	She indicated Resident #34 her side rail independently. ducted with the MDS Nurse A. She indicated she was and she was responsible for on of MDS assessments. assessment dated 6/29/17 int #34 had no physical ed with the MDS Nurse. information she utilized to vsical restraints. The MDS ity had not utilized a side rail the assessed the side rails ent was able to reach over to ted if the resident was able ide rail she had not coded sical restraint on the MDS. was conducted with DON on She stated her expectation termine if they were a MDS to be coded accurately.	F	278			

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345330	B. WING _				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRA	YBRIER NURS & RETIRE	MENT CT			16 LANE DRIVE RINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 278	method or physical or material or equipmen resident's body that the easily which restricts normal access to one A review of Resident revealed there had be assessments complet An interview was con PM with Nurse #2. S facility had quarter len An observation was of PM of Resident #52 st that was located in the impaired unit. Reside length side rails on he side rails were position each side of the bed. was approximately 26 was opening of appro- the top end of the side mattress and 26.5 indo- the side rail to the bod An interview was con with the Director of Na all residents in the face rails. She revealed the side rail risk assesses the same quarter lenge An interview was con Assistant (NA) #4 on stated she normally we impaired unit. She revealed the states and she normally we impaired unit.	 mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or 's body). #52's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. onducted on 8/2/17 at 4:15 eleeping in bed in her room e facility's cognitively ent #52 had bilateral quarter er bed. The quarter length oned in the middle section of (Each quarter side rail) b) inches in length and there eximately 26.5 inches from e rail to the top end of the end of the mattress.) ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side rails inches since all residents had gth side rails. 	F2	278			

Facility ID: 953491

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		_	(08/	C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER		- T	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				116 LANE DRIVE			
THE GRAY	BRIER NURS & RETIRE	MENT CT		TRINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Living) care. NA #4 w determined what posi side rails and she indi- in the position they we moved them to a differ most of the side rails cognitively impaired u quarter length side ra- the bed. She stated to made it easier on the NA #4 indicated she w #52. She stated Resi out of bed without ass for falls. She indicate alarm (used to alert si bed without assistance #52 was able to hold some of the strain off repositioned in bed. Si was unable to move h An interview was como on 8/3/17 at 11:02 AM the lead MDS Nurse at the accurate completi The quarterly MDS as indicated Resident #50 was reviewed with the asked what information MDS for physical rest stated the facility had assessment, so she a seeing if the resident the side rail. She state to reach over to the si the side rail as a physical	r ADL (Activities of Daily was asked how she tion to place each resident's icated she kept the side rails ere always in and had not rent position. She reported for the residents on the nit were positioned as ils in the center section of his side rail positioning staff to turn the residents. vas familiar with Resident dent #52 was not able to get sistance and she was at risk d Resident #52 had a pad taff of attempts to get out of e). She reported Resident onto the side rail and take of the staff when she was She indicated Resident #52 her side rail independently. ducted with the MDS Nurse 1. She indicated she was and she was responsible for on of MDS assessments. sessment dated 6/1/17 that 2 had no physical restraints e MDS Nurse. She was on she utilized to code the raints. The MDS Nurse not utilized a side rail risk issessed the side rails by was able to reach over to red if the resident was able ide rail she had not coded sical restraint on the MDS.	F 27		DEFICIENCY)		
	the side rail. She stat to reach over to the si the side rail as a phys	ed if the resident was able de rail she had not coded					

Facility ID: 953491

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345330	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	 8/3/17 at 11:42 AM. S was for all side rails to individual basis to def restraint and for the M 5. Resident #95 was in facility on 1/15/15 and on 7/13/15 with diagon dementia, depression The significant chang assessment dated 5/3 #95's cognition was s was assessed as requipation on the unitic assistance of one station on the unitic assistance of one station on the unitic assistance of one station on the unitic method or physical restration material or equipment resident's body that the easily which restricts normal access to one A review of Resident to revealed there had be assessments completed An interview was completed An interview was completed An observation was completed A	She stated her expectation o be assessed on an eermine if they were a 1DS to be coded accurately. Initially admitted to the d most recently readmitted oses that included , and a history of falling. e Minimum Data Set (MDS) 30/17 indicated Resident ignificantly impaired. He uiring extensive assistance ith bed mobility and 95 was independent with t and required the extensive ff with locomotion off the t indicated Resident #95 aints (defined as any manual e mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or 's body). #95's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the noth side rails. onducted on 8/2/17 at 4:15 leeping in bed in his room	F	278	8		

Facility ID: 953491

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>′</i>	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>		
		0.45000				С
		345330	B. WING			8/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
THE GRA	YBRIER NURS & RETIRI	EMENT CT		116 LANE DRIVE		
				TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From pag	e 56	F 27	70		
1 270			F 27	ð		
		oned in the middle section of				
		. (Each quarter side rail 6 inches in length and there				
		oximately 26.5 inches from				
		le rail to the top end of the				
	· ·	ches from the bottom end of				
		ottom end of the mattress.)				
	An interview was cor	nducted on 8/2/17 at 4:25 PM				
		Iursing (DON). She stated				
		cility had quarter length side				
		he facility had not utilized				
		nents since all residents had				
	the same quarter len					
	An interview was cor	nducted with Nursing				
		8/3/17 at 9:30 AM. She				
		worked on the cognitively				
	impaired unit. She re	eported the majority of the				
	residents on the cogi	nitively impaired unit were				
	dependent on staff for	or ADL (Activities of Daily				
	Living) care. NA #4	was asked how she				
	-	sition to place each resident's				
		dicated she kept the side rails				
		vere always in and had not				
		erent position. She reported				
		for the residents on the				
		unit were positioned as				
		ails in the center section of this side rail positioning				
		e staff to turn the residents.				
		was familiar with Resident				
		sident #95 was not able to get				
		sistance and he was at risk				
		ed Resident #95 had a pad				
		staff of attempts to get out of				
		ce). She reported Resident				
		onto the side rail and take				
		f of the staff when she was				

Facility ID: 953491

If continuation sheet Page 57 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345330	B. WING				C 103/2017
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 278	repositioned in bed. was unable to move h An interview was con on 8/3/17 at 11:02 AM the lead MDS Nurse at the accurate completi The significant chang 5/30/17 that indicated physical restraints way Nurse. She was ask utilized to code the M The MDS Nurse state a side rail risk assess side rails by seeing if reach over to the side resident was able to r she had not coded the restraint on the MDS. A follow up interview 1 8/3/17 at 11:42 AM. was for all side rails to individual basis to del restraint and for the M 6. Resident #101 was 8/6/14 with diagnoses anxiety, depression, i The quarterly Minimu assessment dated 7/4 was significantly impa- requiring extensive as bed mobility and exter more staff with transfe the extensive assistant	She indicated Resident #95 his side rail independently. ducted with the MDS Nurse A. She indicated she was and she was responsible for ion of MDS assessments. e MDS assessment dated I Resident #95 had no is reviewed with the MDS ed what information she DS for physical restraints. ed the facility had not utilized ment, so she assessed the the resident was able to e rail. She stated if the reach over to the side rail e side rail as a physical was conducted with DON on She stated her expectation to be assessed on an termine if they were a MDS to be coded accurately. a admitted to the facility on that included Alzheimer's, nsomnia, and repeated falls. m Data Set (MDS) 4/17 indicated her cognition aired. She was assessed as assistance of one staff with nsive assistance of two or ers. Resident #101 required nce of one staff for walking n the corridor, locomotion on	F	278	3		

Facility ID: 953491

If continuation sheet Page 58 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345330	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER	L		Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	assessment indicated physical restraints (de method or physical or material or equipmen resident's body that th easily which restricts normal access to one A review of Resident revealed there had be assessments comple An interview was con PM with Nurse #2. S facility had quarter len An observation was of PM of Resident #101 that was located in th impaired unit. Reside quarter length side rai length side rails were section of each side of side rail was approxir and there was openin inches from the top e end of the mattress a bottom end of the sid the mattress.) An interview was con with the Director of N all residents in the fac rails. She revealed th side rail risk assessm the same quarter lengt	A Resident #101 had no efined as any manual r mechanical device, t attached or adjacent to the he individual cannot remove freedom of movement or 's body). #101's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. conducted on 8/2/17 at 4:15 sleeping in bed in her room e facility's cognitively ent #101 had bilateral ils on her bed. The quarter positioned in the middle of the bed. (Each quarter nately 26 inches in length og of approximately 26.5 nd of the side rail to the top nd 26.5 inches from the e rail to the bottom end of ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side he facility had not utilized tents since all residents had gth side rails.	F	278	3		

Facility ID: 953491

If continuation sheet Page 59 of 83

						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · · ·	E SURVEY IPLETED
			A. BUILDING			С
		345330	B. WING		0	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/03/2017
				116 LANE DRIVE	-	
THE GRAY	BRIER NURS & RETIRE	EMENT CT		TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 278	Continued From page	e 59	F 27	8		
	stated she normally w	vorked on the cognitively				
		eported the majority of the				
		nitively impaired unit were				
	dependent on staff for	or ADL (Activities of Daily				
	Living) care. NA #4	was asked how she				
		ition to place each resident's				
		licated she kept the side rails				
		ere always in and had not				
		erent position. She reported				
		for the residents on the				
		unit were positioned as				
	· •	ails in the center section of				
		this side rail positioning				
		staff to turn the residents.				
		was familiar with Resident				
		Resident #101 had a floor				
	,	lert staff of attempts to get				
		sistance). She stated				
		ied to get up unassisted in				
		ed Resident #101 was able				
		rail and take some of the				
		when she was repositioned				
		esident #101 was not able to tassistance and she was at				
	0	icated Resident #101 was				
		ide rail independently.				
	An interview was con	ducted with the MDS Nurse				
		M. She indicated she was				
		and she was responsible for				
		ion of MDS assessments.				
	-	ssessment dated 7/4/17 that				
	indicated Resident #					
		ed with the MDS Nurse.				
		information she utilized to				
		ysical restraints. The MDS				
	-	lity had not utilized a side rail				
		she assessed the side rails				

Facility ID: 953491

If continuation sheet Page 60 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345330	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	BRIER NURS & RETIRE	MENT CT			16 LANE DRIVE RINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	to reach over to the s the side rail as a physical or nechanics mobility and the limited transfers. Resident #1 assessment attached of and locomotion off the assessment state of an estate walking in the corrido and locomotion off the indicated Resident #1 restraints (defined as physical or mechanics equipment attached of body that the individu which restricts freedo access to one's body A review of Resident An interview was con	ted if the resident was able ide rail she had not coded sical restraint on the MDS. was conducted with DON on She stated her expectation be assessed on an termine if they were a MDS to be coded accurately. admitted to the facility on ted on 4/6/17 with ed Alzheimer's, anxiety, , and repeated falls. m Data Set (MDS) 13/17 indicated her cognition aired. She was assessed as assistance of one staff for ed assistance of one staff for e	F	278			

Facility ID: 953491

If continuation sheet Page 61 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345330	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRA	BRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 278	Continued From page	9 61	F	278	3		
	PM of Resident #140 that was located in the impaired unit. Reside quarter length side ra length side rails were section of each side of side rail was approxim and there was openin inches from the top ei end of the mattress a bottom end of the side the mattress.) An interview was con- with the Director of Ne all residents in the fac rails. She revealed th	ent #140 had bilateral ils on her bed. The quarter positioned in the middle of the bed. (Each quarter nately 26 inches in length ig of approximately 26.5 nd of the side rail to the top nd 26.5 inches from the e rail to the bottom end of ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side he facility had not utilized ents since all residents had					
	stated she normally w impaired unit. She re- residents on the cogn dependent on staff for Living) care. NA #4 determined what posi- side rails and she ind in the position they we moved them to a differ most of the side rails cognitively impaired u quarter length side ra the bed. She stated to made it easier on the	8/3/17 at 9:30 AM. She vorked on the cognitively ported the majority of the itively impaired unit were r ADL (Activities of Daily					

Facility ID: 953491

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345330	B. WING		-		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT		116 LANE DRIVE FRINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 278	 #140. She stated Reget out of bed without risk for falls. She indipad alarm (used to allout of bed without ass Resident #140 was all and take some of the she was repositioned Resident #140 was unindependently. An interview was conton 8/3/17 at 11:02 AN the lead MDS Nurse at the accurate completine The quarterly MDS as that indicated Resider restraints was review. She was asked what code the MDS for phy Nurse stated the facill risk assessment, so s by seeing if the reside the side rail. She state to reach over to the side the side rail as a physe A follow up interview 8/3/17 at 11:42 AM. Swas for all side rails to restraint and for the New Sa. Resident #158 was 4/30/17 with diagnose 	sident #140 was not able to assistance and she was at cated Resident #140 had a ert staff of attempts to get sistance). She reported ole to hold onto the side rail strain off of the staff when in bed. She indicated hable to move her side rail ducted with the MDS Nurse 1. She indicated she was and she was responsible for on of MDS assessments. assessment dated 7/13/17 ht #140 had no physical ed with the MDS Nurse. information she utilized to rsical restraints. The MDS ity had not utilized a side rail he assessed the side rails ent was able to reach over to ted if the resident was able ide rail she had not coded sical restraint on the MDS. was conducted with DON on She stated her expectation o be assessed on an	F 278				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/06/2017 MAPPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		PLETED
		345330	B. WING				C 103/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	The most recent Mininassessment dated 5/2 assessment) indicated was significantly imparequiring extensive as bed mobility and trans required the extensive walking in the room, w locomotion on the uni- unit. The assessment had no physical restra- method or physical or material or equipment resident's body that the easily which restricts normal access to one A review of Resident a revealed there had be assessments complete An interview was com- PM with Nurse #2. St facility had quarter lent An observation was com- PM of Resident #158 that was located in the impaired unit. Reside quarter length side rails were section of each side co- side rail was approxim and there was openin inches from the top en-	mum Data Set (MDS) 28/17 (a thirty day MDS d Resident #158's cognition aired. She was assessed as ssistance of one person with sfers. Resident #158 e assistance of one staff for walking in the corridor, it, and locomotion off the ti indicated Resident #158 aints (defined as any manual r mechanical device, t attached or adjacent to the ne individual cannot remove freedom of movement or t's body). #158's medical record een no side rail risk ted. ducted on 7/31/17 at 2:51 he stated all residents in the ngth side rails. conducted on 8/2/17 at 4:15 sleeping in bed in her room e facility's cognitively	F	278			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/06/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345330	B. WING				C /03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GRAY	BRIER NURS & RETIRE			116	6 LANE DRIVE		
				TR	RINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	with the Director of N all residents in the fact rails. She revealed the side rail risk assessment the same quarter lengt An interview was com Assistant (NA) #4 on stated she normally we impaired unit. She re- residents on the cogre dependent on staff fo- Living) care. NA #4 determined what posi- side rails and she ind in the position they we moved them to a differ most of the side rails cognitively impaired u quarter length side ra- the bed. She stated for made it easier on the NA #4 indicated she we #158. She stated Re- get out of bed without risk for falls. She indi- pad alarm (used to al- out of bed without ass Resident #158 was a and take some of the she was repositioned Resident #140 was u- independently. An interview was com- on 8/3/17 at 11:02 AM	ducted on 8/2/17 at 4:25 PM ursing (DON). She stated cility had quarter length side he facility had not utilized tents since all residents had gth side rails. ducted with Nursing 8/3/17 at 9:30 AM. She vorked on the cognitively eported the majority of the hitively impaired unit were r ADL (Activities of Daily	F	278			
		and she was responsible for ion of MDS assessments.					

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 09/06/2017 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345330	B. WING				C 18/03/2017
NAME OF P	ROVIDER OR SUPPLIER	L		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	BRIER NURS & RETIRE	MENT CT			16 LANE DRIVE		
_				TF	RINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	She was asked what code the MDS for phy Nurse stated the facil risk assessment, so s by seeing if the reside the side rail. She sta to reach over to the s the side rail as a phys A follow up interview 8/3/17 at 11:42 AM. S was for all side rails to individual basis to de restraint and for the M 8b. Resident #158 was 4/30/17 with multiple Alzheimer 's disease Data Set (MDS) asse indicated that Reside impairment and she H assessment further in was not wearing any day MDS assessment that Resident #158 has was not wearing any On 8/2/17 at 10:45 Al observed up in wheel eye glasses. On 8/3/17 at 9:10 AM Resident #158, was i Resident #158 was w	At dated 5/28/17 that 158 had no physical ed with the MDS Nurse. information she utilized to ysical restraints. The MDS ity had not utilized a side rail she assessed the side rails ent was able to reach over to ted if the resident was able ide rail she had not coded sical restraint on the MDS. was conducted with DON on She stated her expectation o be assessed on an termine if they were a MDS to be coded accurately. as admitted to the facility on diagnoses including e. The admission Minimum essment dated 5/7/17 nt #158 had severe cognitive has adequate vision. The indicated that Resident #158 corrective lenses. The 30 it dated 5/28/17 revealed ad impaired vision and she corrective lenses. M. Resident #158 was Ichair and she was wearing	F	278			

Facility ID: 953491

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345330	B. WING				。 03/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRAY	BRIER NURS & RETIRE	MENT CT			16 LANE DRIVE FRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	at bedside. On 8/3/17 at 9:40 AM was interviewed. She responsible for compl the MDS assessment the resident as having because during her at not wearing eye glass able to read the regul She further stated tha the resident was weat SW had no explanation was coded impaired was able to read regular p On 8/3/17 at 11:31 AM (DON) was interviewed she expected the MD accurate. 9. Resident #150 was 3/22/17. Cumulative syndrome of bilateral degeneration. A social worker progre	 4158 was wearing eye , Resident #158 was eye glasses was observed , the Social Worker (SW) #1 e stated that the SW was eting section B (vision) of . She stated that she coded g no corrective lenses ssessment the resident was as print on the newspaper. at she did not ask the staff if ring eye glasses or not. The on as to why the resident was rint. M, the Director of Nursing ed. The DON stated that 	F	278			
		ion for Resident #150 dated. nt #150 was referred for dry le related macular					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	
		345330	B. WING				03/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	BRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	over the counter read A Significant Change (MDS) dated 5/24/17 impaired vision and d A social worker note of Resident #150 had im able to read regular p print. The note stated not have glasses. A Care Area Assessm 5/26/17 stated Reside visual function. He w large prints in magazi On 8/2/17 at 10:30AM observed sitting in his station. Resident #150 On 8/3/17 at 8:00AM conducted with NA#1 for Resident #150. Sh reading glasses and w On 8/3/17 at 9:02 AM conducted with Socia did not remember if s vision before complet CAA should contain th MDS. She stated it m typographical error or On 8/3/17 at 11:31 AM	An interview was who provided care routinely be stated Resident #150 had id not wear any glasses. Adated 5/25/17 stated spaired vision and was not rint but could read large d Resident #150 said he did thent (CAA) for vision dated ent #150 was triggered for ore glasses and could see nes. A Resident #150 was s wheelchair at the nursing 50 was wearing glasses. , an interview was who provided care routinely be stated Resident #150 had wore them most of the time. , an interview was I Worker #1 who stated she he reviewed the MDS for ing the CAA. She stated the he same information as the hust have been a in the CAA. M, an interview was irector of Nursing who stated	F	278			
		irector of Nursing who stated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345330	B. WING			08/03/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
THE GRAY	BRIER NURS & RETIRE	MENT CT		116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	
F 280 F 280 SS=D	Continued From page 483.10(c)(2)(i-ii,iv,v)(3 PARTICIPATE PLANN 483.10 (c)(2) The right to part and implementation o plan of care, including (i) The right to particip including the right to in be included in the plan request meetings and revisions to the perso (ii) The right to particip expected goals and o amount, frequency, an other factors related to plan of care. (iv) The right to receiv included in the plan of care. (c)(3) The facility shal	e 68 3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP ticipate in the development of his or her person-centered g but not limited to: bate in the planning process, dentify individuals or roles to nning process, the right to a the right to request n-centered plan of care. pate in establishing the utcomes of care, the type, nd duration of care, and any o the effectiveness of the we the services and/or items f care. e care plan, including the ificant changes to the plan Il inform the resident of the his or her treatment and dent in this right. The	F 28 F 28	30		9/5/17
	(i) Facilitate the inclus resident representativ(ii) Include an assessing strengths and needs.					

Facility ID: 953491

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345330	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRAY	BRIER NURS & RETIRE	MENT CT			116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 280	 483.21 (b) Comprehensive C (2) A comprehensive C (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lime (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practicable for the resident and their resident report for the resident of the participation must for the participation of the	esident's personal and in developing goals of care. Fare Plans care plan must be- 7 days after completion of ssessment. Terdisciplinary team, that hited to 7 vician. Te with responsibility for the responsibility for the I and nutrition services staff. Eticable, the participation of resident's representative(s). The included in a resident's participation of the resident resentative is determined to development of the staff or professionals in ined by the resident's needs e resident.	F	280			
		vised by the interdisciplinary ssment, including both the					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/06 FORM APPR OMB NO. 0938	OVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345330	B. WING		C 08/03/201	7
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COL		
	BRIER NURS & RETIRE	MENT CT		116 LANE DRIVE		
				TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPL E APPROPRIATE DA	ETION
F 280	Continued From page	e 70	F 28			
	comprehensive and c		1 200			
	assessments.					
		is not met as evidenced				
	by:					
		n, medical record review,		On 8/24/2017, the Minimum		
		erviews, the facility failed to		Coordinator reviewed and up		
		e care plan for dialysis site for		plans for specific residents m		
	one of one residents	for vision for one of three		the 2567 for: dialysis services #123 "right" arm AV shunt wa		
		or vision (Resident #150).		"left" arm AV shunt) and for v		
	The findings included			(resident #150 "contacts" was		
				"glasses").	o onangou to	
	1. Resident #123 wa	is admitted to the facility on		3,		
	1/18/17 and last read	mitted on 6/22/17.		An audit was completed on 8	/24/2017, by	
	-	s included: dependence on		the Minimum Data Set Coord		
	renal dialysis and end	d stage renal disease.		other residents receiving dial		
				and for residents that require		
		al dated 1/19/17 indicated diagnosis of end stage renal		devices to ensure accurate p No additional adjustments we		
		ialysis. Resident #123 had		necessary for residents recei		
		alized for a clotted left AVF		services and vision devices.		
		used for dialysis). A				
		cal procedure used to		Care plans will continue to be	e updated by	
		vas attempted by internal		the Care Plan team, which in	cludes:	
	•••	d in rupture requiring stent.		Minimum Data Set Coordinat	tor, Care Plan	
		as not salvageable and a		Coordinator, Director of Socia		
		atheter was placed on		Director of Activities, or Certif	-	
	1/11/17.			Manager and Front Line Staf The Care Plan team will cont		
	A Significant Change	/ 5 day Minimum Data Set		care plan meetings for reside		
		ed Resident #123 was		resident's representative, we		
		in cognition. Dialysis was		plan meetings are scheduled		
		een received during the		upon admission, at least qua		
	assessment period.	-		more frequent as needed. Re	esidents	
				and/or resident representativ		
	A Care Area Assessn			required to attend. The Direc		
		ng) dated 6/30/17 stated		Services will maintain a log o	-	
		ved dialysis 3 x week and		meetings that are offered to r		
	nad both an AV(arter	iovenous) graft to left upper		log is created by the Concier	ge.	

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		MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		. ,	MPLETED
			A. BUILDING	·		С
		345330	B. WING		c	8/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				116 LANE DRIVE		
THE GRA	YBRIER NURS & RETIRE			TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From page	e 71	F 28	50		
	arm and a dialysis ca chest due to ESRD.	theter to the right upper		Accommodations will be residents are aware of th of care.		
	#123 had a diagnosis and had a dialysis ca chest and AV shunt to fistula was placed to included, in part, 7/3/ and thrill. Assess AV symptoms of infection On 7/31/17 at 3:11 Pl conducted with Resid stated she went to dia She was observed to the right upper chest upper arm and a ban just above the elbow she had a new area of going to be used for of On 8/2/17 at 3:30 PM conducted with Nurse center stated the left and the left AV shunt Dialysis used the dial She said the dialysis the new AV site locat and staff should now	M, an interview was dent #123. Resident #123 alysis three times a week. In have a dialysis catheter in area, an AV fistula in the left dage on the right upper arm area. Resident #123 said under the bandage that was dialysis. 1, an interview was e #1 who stated the dialysis AV shunt clotted in February did not have a thrill or bruit. lysis catheter for treatments. center stated they checked ed in the right arm on 8/2/17 begin checking for thrill and		A check list, the "Care P has been created to ens are completed accuratel current information that if the coding on the reside assessment. The MDS C Care Plan Coordinator w tool; the tool will be used prevent care plan discre least 12 months (weekly then monthly for 9 month Plan Team (members lis audit and record care pla The MDS Coordinator w of the audits to the Exect committee at quarterly in duration of the audits (12 next scheduled Executive meeting is scheduled Oct The facility alleges full co this plan of correction as	y and reflect is consistent with nt's MDS Coordinator or vill complete the d to monitor and pancies for at r for 3 months, hs). The Care ted above) will an adjustments. vill report findings cutive QA neetings for the 2 months). The ve QA Committee ctober 17, 2017.	
	the care plan for Res stated the care plan s and updated. The re	arm.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345330	B. WING				C 103/2017
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRAYBRIER NURS & RETIREMENT CT					116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACT CROSS-REFERENCED TO			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 280	the left AV shunt shou On 8/3/17 at 11:31 AN conducted with the Di she expected the care contain accurate infor #123.	interventions that referred to ild have been removed. M, an interview was irector of Nursing who stated e plan to be accurate and mation regarding Resident	F	280			
	3/22/17. Cumulative syndrome of bilateral degeneration. A consult eye evaluat 5/8/17 stated Resider eye syndrome and ag degeneration. The co over the counter read A Significant Change (MDS) dated 5/24/17 impaired vision and d A social worker note of Resident #150 had im able to read regular p print. The note stated not have glasses. A Care Area Assessm 5/26/17 stated Reside	Minimum Data Assessment stated Resident #150 had id not wear any glasses. dated 5/25/17 stated npaired vision and was not rint but could read large d Resident #150 said he did ment (CAA) for vision dated ent #150 was triggered for					
	large prints in magazi A Care plan dated 5/2	26/17 stated Resident #150 of macular degeneration.					

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DATE COMF		
		345330	B. WING			08/03/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	•		
THE GRA	YBRIER NURS & RETIRE	MENT CT			ANE DRIVE TY, NC 27370			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 280 F 356 SS=C	Interventions included with placement of corr were clean and in good On 8/2/17 at 10:30 AN observed sitting in his station. Resident #150 On 8/3/17 at 8:00 AN conducted with NA#1 for Resident #150. Sh reading glasses and w She stated Resident # contacts. On 8/3/17 at 8:20 AM conducted with the M the Social Worker dev Resident #150 and sh plan. She stated Res contacts and that sho in the interventions. I On 8/3/17 at 11:31 AN conducted with the Di she expected the care contain accurate infor #150. 483.35(g)(1)-(4) POS INFORMATION 483.35 (g) Nurse Staffing Info	d, in part, to assist resident tracts. Assure contacts od repair. M, Resident #150 was wheelchair at the nursing 0 was wearing glasses. A, an interview was who provided care routinely the stated Resident #150 had wore them most of the time. #150 did not have/ wear , an interview was DS Coordinator who stated veloped the care plan for the signed off on the care ident #150 did not have uld not have been included t was overlooked. M, an interview was rector of Nursing who stated e plan to be accurate and mation regarding Resident TED NURSE STAFFING	F 2				8/24/17	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				
		345330	B. WING			C 08/03/2017		
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
THE GRAYBRIER NURS & RETIREMENT CT					116 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)			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 356	Continued From page (ii) The current date. (iii) The total number by the following categ unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. (2) Posting requirement (i) The facility must per specified in paragraph daily basis at the begin (ii) Data must be post (A) Clear and readable (B) In a prominent pla residents and visitors	e 74 and the actual hours worked pories of licensed and aff directly responsible for t: s. I nurses or licensed defined under State law) des. ents. post the nurse staffing data in (g)(1) of this section on a inning of each shift. ted as follows: le format. ace readily accessible to		356	DEFICIENCY)			
	The facility must, upo make nurse staffing d for review at a cost no standard. (4) Facility data retent facility must maintain	n oral or written request, lata available to the public of to exceed the community tion requirements. The the posted daily nurse						
	stanning data for a min	imum of 18 months, or as						

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STATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345330	B. WING		•	8/03/2017	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
THE GRAY	BRIER NURS & RETIRI	EMENT CT		116 LANE DRIVE TRINITY, NC 27370			
		TATEMENT OF DEFICIENCIES		-	N OF CORRECTION	0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 356	Continued From pag	e 75	F3	356			
		, whichever is greater.					
		T is not met as evidenced					
		on, staff interview, and record		The Staffing Hours Po	sting Form was		
		led to post an accurate daily		adjusted to reflect nurs			
	staff posting with all i	required information for 4 of		shift on the posting for			
	•	1/17 through 8/3/17). The		Hours Posting Form wa			
	findings included:			re-posted immediately interview with the surve			
	During the initial tour	of the facility on 7/31/17 at					
	-	taff posting indicated there		Staffing hours have be	en posted daily,		
		urses (RNs) for a total of 40		using the revised form			
	hours, 11 Licensed F	ractical Nurses (LPNs) for a		include: facility name; f	the current date; the		
		nd 32 Certified Nurse Aides		total number and the a			
		rs. This posting had not		by RNs, LPNs, and CN	As; and resident		
	separated the number by shift.	er of staff and the total hours		census, per shift.			
				The facility adjusted th	•		
		M a review was conducted		posting staffing hours.			
	•	ing from 7/31/17 through		Posting Form has been			
		he nurse staffing sheets		Concierge (Receptioni	<i>,</i> .		
		. The postings from all fours		as provided from the S	•		
		ated the number of staff and d by shift. Additionally, the		Staffing hours for Satu Monday, will be posted			
		rs and RN total hours		of business on Friday.	-		
	worked on the daily s			Tuesday, Wednesday,			
	-	the daily staff schedules.		Friday will be posted th			
		-		close of business. Holi			
	An interview was cor	nducted with the Front Office		posted in advance, as			
		8/3/17 at 10:10 AM. She		will be adjusted, as nee	-		
		sponsible for completing the		the most current staffin	ng hours and facility		
		the stated she had been		census.			
		for several months. She		Stoffing hours for and	dov will be		
		utilized combined all shifts umber of staff and total hours		Staffing hours for each maintained for at least			
		She confirmed the number		facility record retention	-		
		hours worked were not		regulation. Staffing hou			
		The FOM stated she posted		reviewed by the Admin			
		h morning and had not		responsible for ensurin			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AF OMB NO. 0	PPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345330	B. WING	C 08/03/	2017	
	ROVIDER OR SUPPLIER Y BRIER NURS & RETIRE	EMENT CT		STREET ADDRESS, CITY, STATE, ZIP CODE 116 LANE DRIVE TRINITY, NC 27370		2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) OMPLETION DATE
F 356 F 371 SS=D	She also stated she p Fridays at the end of weekend and this pos- revised/updated over occurred. An interview was con Administrator on 8/3/ revealed RN staff wh care were regularly in staff and RN staff hou the MDS Nurses, Qu Nurse #1 (Unit Manae staffing numbers rega they had not provided An interview was con Nursing (DON) on 8/3 indicated her expecta posting to be complet required. 483.60(i)(1)-(3) FOOI STORE/PREPARE/S (i)(1) - Procure food f considered satisfacto authorities. (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p	bosting if there were is or to the staffing numbers. posted the daily staffing on her work day for the entire sting was not the weekend if changes had ducted with the 17 at 10:30 AM. He o had not provided direct necluded in the RN number of urs worked. He stated that ality Assurance Nurse, and ger) were all included in the ardless of whether or not d direct care to residents. ducted with the Director of 3/17 at 11:29 AM. She ation was for the daily staff ted accurately and as D PROCURE, ERVE - SANITARY rom sources approved or rry by federal, state or local cood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable	F 35	this area, weekly for 6 months to daily staffing hours were posted, maintained, and accurate. Any fir un-posted or incorrectly posted s hours will be corrected and repor Executive QA Committee meeting duration of weekly reviews. The r Executive QA Committee meeting scheduled October 17, 2017. The facility alleges full complianc this plan of correction as of 8/24/2	ndings of taffing ted in the gs for the next g is e with 2017.	30/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/06/2017 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345330	B. WING _	B. WING			C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	16 LANE DRIVE		
THE GRA	THE GRAYBRIER NURS & RETIREMENT CT			т	RINITY, NC 27370		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 371	Continued From page	2 77	F	371			
		es not preclude residents s not procured by the facility.					
	(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.						
	foods brought to resid visitors to ensure safe handling, and consun	garding use and storage of lents by family and other a and sanitary storage, aption. is not met as evidenced					
	by: Based on record revi	ew, observation and staff ailed to date the thickened n 1 of 1 refrigerator			Juices were opened for breakfast mea service on 8/3/2017; opened and unlabeled items were labeled following surveyors notification to the facility on		
	was conducted. The stored in the refrigera 1/4 full of 48 ounce (oz dated 7/7/17 2/3 full of 48 oz. hone 7/18/17 2/3 full 48 oz. honey th 7/18/17 3/4 full 48 oz. honey th 7/14/17 1/2 full 46 oz. honey th 7/18/17 The manufacturer's in cartoon of the thicken when opened and to a	:.) honey thick orange juice by thick orange juice dated hick apple juice dated ick apple juice dated ick grape juice dated istruction written on the led juices indicated to date			 8/3/2017. Following an inspection of the kitchen I facility staff and the consultant Registe Dietician on 8/16/2017, all opened food items were found to be dated and labe properly. The facility has implemented more frequent process for monitoring the kitchen; the kitchen will be audited by the Administrator and a dietary managemer representative on a weekly basis, for the remainder of the calendar year. The Administrator and/or designee will ther audit the kitchen at least monthly with a dietary management representative, unless otherwise directed by the corporexpectation. To prevent future problems in the 	red led a he he ent he a	
	opening. Interview with the Exe	ecutive Chef was conducted			identified dietary areas, the facility initia a 100% re-training in-service with dieta		

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 09/06/2017 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345330	B. WING		0	C B/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRAY	THE GRAYBRIER NURS & RETIREMENT CT			116 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)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 371	dates written on the k and not opened dates did not know that the dated when opened a opening. He added t the expiration date. Interview with the Die conducted on 8/3/17 stated that they had n	AM. The Chef stated that the boxes were delivery dates s. He further stated that he thickened juices had to be and discarded 10 days after hat he was always going by etary Manager (DM) was at 10:50 AM. The DM not been dating the n opened and she did not ued juices had to be	F 3	71 personnel for dating and labeling items and other potentially defici practice(s). This in-service was by the facility's executive chef. Retraining and monitoring of corwill be under the direction of a monter of a monter of the data and the direction of a monter of the data and the direction of a monter of the data and the direction of a monter of the data and the direction of the data and	ent directed npliance ewly xperience his rator, r, a egistered o of 3 of will meet ar, to tion. The complete o monitor ection for tioned QA tified in e meet ection. d at that y areas unds will and will This QA e NHA will mittee. ee 7, 2017. ce with	
	7/02 00) Previous Versions Ob	solate Event ID: D770		this plan of correction as of 8/30	/2017.	at Daga 70 of 82

Event ID: DZZC11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/06/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION			SURVEY
	CONTRACTION		A. BUILD	ING .		C	
		345330	B. WING			08/	/03/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRA	THE GRAYBRIER NURS & RETIREMENT CT				116 LANE DRIVE TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520 SS=E		ERS/MEET	F	520			9/5/17
	(g) Quality assessme	nt and assurance.					
	(1) A facility must mai and assurance comm minimum of:	ntain a quality assessment ittee consisting at a					
	(i) The director of nur	sing services;					
	(ii) The Medical Direc	tor or his/her designee;					
	staff, at least one of w	a board member or other					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evaluate	respect to which quality					
		ement appropriate plans of ified quality deficiencies;					
	Secretary may not rec records of such comn such disclosure is rela	mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this					
	(i) Sanctions. Good fa committee to identify						

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/06 FORM APPRO OMB NO. 0938-	OVE
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345330	B. WING		C 08/03/2017	7
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRAY	BRIER NURS & RETIRE	EMENT CT		116 LANE DRIVE TRINITY, NC 27370		
	CLIMMADY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE	ETION
F 520	Continued From page	e 80	F 520			
		be used as a basis for				
	sanctions.					
	This REQUIREMENT	Γ is not met as evidenced				
	by:					
		view and staff interviews, the		Areas of deficient practice as i		
		essment and Assurance led to maintain implemented		during the most recent annual the areas of F278, F356, and F		
		itor these interventions that		been corrected.	37 Thave	
	•	to place following the 8/31/16				
		. The recited deficiencies		New Quality Assurance Teams	and Tools	
	were in the areas of a	assessment accuracy		have been created (MDS Rest	raint Audit	
		e staffing (F356), and food		Tool, Vision Devices Audit Tool	-	
		leficiencies were cited again		Hours Posting Form, and Dieta		
		fication survey of 8/3/17.		Experience QA Team) were cre		
		e of the facility during two cord show a pattern of the		where needed to both obtain a regulatory compliance of the a		
		sustain an effective Quality		specific to F278, F356, and F3		
		surance Program. The				
	findings included:			Quality Assurance efforts have	improved	
				as evidence by an increase of	-	
	This tag is cross refe			Assurance teams and Quality I		
		bservation, record review,		(MDS Restraint Audit Tool, Visi		
		the facility failed to code the MDS) accurately in the areas		Audit Tool, Staffing Hours Post and Dietary Experience QA Tea	-	
	of physical restraints	· ·		to F278, F356, and F371. This		
		#34, #52, #95, #101, #140,		intended to not only obtain reg		
	and #158) and vision			compliance but to prevent regu	-	
	(Residents #150 and			non-compliance issues in the a	areas	
				referenced in this plan of corre	ction.	
	-	tion survey of 8/31/16, the				
	code the MDS asses	8 for failing to accurately		Moving forward, the Nursing H Administrator will proactively st		
		ning and Resident Review		process of assessing and dete		
		the current recertification		need for additional QA/QI effor		
		facility failed to code the		outlined in Phase 2 of the CMS		
		e areas of restraints and		Requirements of Participation.		
	vision.			Administrator will complete and		
				a facility assessment of strengt		
	2. F356 - Based on o	bservation, staff interview,		weaknesses no later than Nove	ember 27,	

Facility ID: 953491

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		MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		<u>3 NO. 0938-03</u> DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G	. ,	COMPLETED	
		345330	B. WING		-	08/03/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRAYBRIER NURS & RETIREMENT CT			116 LANE DRIVE TRINITY, NC 27370				
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO	
F 520	Continued From page	e 81	F 52	20			
		e facility failed to post an		2017. The docume	nted results of this		
		osting with all required		facility assessment			
	information for 4 of 4	days reviewed (7/31/17		QAPI efforts, will be	e communicated to the		
	through 8/3/17).				anaging the facility by		
	•	tion survey of 8/31/16, the			er 2017. At that time,		
		6 for failing to post the			will review, direct, and		
	•	or 1 of 5 days of the survey 6 to 8/31/16. On the current			f the final version of the for 2017. This should		
		of 8/3/17 the facility failed to			n of annually starting		
		ly staff posting for 4 of 4			17 unless documented		
	days.			or directed otherwis	se by the Executive QA		
				Team or regulatory	entities.		
		ecord review, observation					
		ne facility failed to date the			compliance with this		
	thickened juices whe refrigerator observed	-		plan of correction a	is of 9/5/2017.		
	During the recertifica	tion survey of 8/31/16, the					
		1 for multiple food items not					
		ad expired and brown-soiling					
		On the current recertification					
	refrigerated thickened	facility failed to date the d liquids.					
	An interview was con	nducted with the					
		17 at 11:15 AM. The					
		he was the head of the					
		surance Committee. The					
		ed the committee consisted					
		Director of Nursing (DON),					
		nimum Data Set (MDS) ions Director, Social Worker,					
		stated the committee met					
		strator indicated he was					
	aware assessment a	ccuracy and staff posting					
	were repeat citations						
		. The Administrator stated					
	the implemented prev	• •					
	correction included a	n MDS assessment checklist					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/06/2017 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345330	B. WING			_		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
THE GRA	YBRIER NURS & RETIRE	MENT CT			16 LANE DRIVE FRINITY, NC 27370			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 520	to be used for a year. would be completed to Staff Coordinator 's in and Monday staff rost posted prior to close of There was a retraining dietary personnel in the practice. The Administ were to audit the kitch quarter then monthly assurance group was	A new staff posting tool by the receptionist from the information. The weekend ter would be completed and of business on Friday. g, in-service for 100% of the areas of deficient strator and Dietary manager	F	520				

Facility ID: 953491

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