STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 05/04/25 to conduct a recertification and complaint investigation survey and exited on 05/07/25. Additional information was obtained offsite on 05/09/25 and 05/12/25. Therefore, the exit date was changed to 05/12/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#OMEW11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 05/04/25 to conduct a recertification and complaint investigation survey and exited on 05/07/25. Additional information was obtained offsite on 05/09/25 and 05/12/25. Therefore, the exit date was changed to 05/12/25. Event ID#OMEW11. The following intakes were investigated: NC00216952, NC00219778, NC00220566, NC00223573, NC00225602, NC00227786, NC00228083, NC00228132, NC00228626. 2 of the 22 complaint allegations resulted in deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		5/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Resident, and Resident Representative interviews, the facility failed to develop and implement a comprehensive care plan for a resident with a shellfish allergy.	F 656	On 5/7/25 the Dietary Manager (DM) updated the care plan/electronic record for resident #63 to accurately reflect allergies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 2 This was for 1 of 3 residents reviewed for dietary allergies (Resident #63). The findings included: Resident #63 was admitted to the facility on 1/3/25. Resident #63's quarterly Minimum Data Set (MDS) dated 3/10/25 indicated the resident was cognitively intact. A review of Resident #63's care plan dated 1/3/25 and last revised on 3/4/25 did not include a focus area, goal or intervention for shellfish allergies. An interview with Resident #63 was conducted on 5/4/25 at 11:45 AM. Resident #63 stated he was served shrimp shortly after he moved into the facility. He told the aide he was allergic to shrimp, and she removed the meal tray. Resident #63 added, he had an allergic reaction when he was in his twenties, after eating shrimp it felt as if his throat was closing and he could not breathe. An interview with Resident #63's Resident Representative (RR) was conducted on 5/4/25 at 1:35 PM. The RR stated on 2/3/25 when she was made aware the facility had served Resident #63 shrimp, she called the facility and spoke with Nurse #1 to make sure they were aware Resident #63 had a shellfish allergy. An interview was conducted with the Regional Registered Dietician on 5/7/25 at 8:15 AM. She stated she did not know if a food allergy should be included in a care plan. An interview with the MDS Nurse was conducted	F 656	On 5/12/25 the Quality Improvement (QI) Nurse and DM initiated an audit of care plans for any resident with identified allergies to ensure resident is care planned accurately for allergies, the care plan is person-centered with measurable objectives and timeframes to meet residents needs. The Director of Nursing (DON) will address all concerns identified during the audit to include updating the care plan when indicated and/or the training of staff. The audit will be completed by 5/16/25. On 5/7/25 the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person-centered for all aspects of care with measurable objectives and timeframes to meet the residents medical, nursing and mental/psychosocial needs to include but not limited to residents allergies. In-service will be completed by 5/16/25. After 5/16/25, any nurse who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Care Plans. The QI Nurse and DM will review the care plan for 100% of admissions/ readmissions or residents with newly identified allergies to ensure care plan is person-centered for all aspects of care with measurable objectives and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 3 on 5/7/25 at 9:10 AM and revealed she would not add food allergies to the care plan, but the Dietary Manager would complete that task. The Dietary Manager was interviewed on 5/7/25 at 9:15 AM. She stated she would have been responsible for nutritional screenings and the nursing team would be assigned to discuss allergies. The nurse in charge on the day of the discussion would be tasked with adding any allergies to the care plan. An interview with the Director of Nursing (DON) on 5/7/25 at 9:20 AM revealed the Dietary Manager or any of the nurses would be responsible for adding food allergies to the care plan. She added there was not one person assigned to that task. An interview with the Administrator was conducted on 5/7/25 at 9:30 AM, he stated either the Dietary Manager or the MDS Nurse would be responsible for adding a food allergy to a care plan.	F 656	timeframes to meet residents medical, nursing, and mental/psychosocial needs to include but not limited to residents allergies weekly x 4 weeks then monthly x 1 month using the Care Plan Audit Tool. The QI Nurse and DM will address all concerns identified during the audit to include updating the care plan when indicated and/or re-training of staff. The DON will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review and determine trends and/or issues that may need further interventions put into place and determine need for further and/or frequency of monitoring.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		5/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 4 by: Based on record reviews, and interviews with the Resident, Resident Representative, and staff, the facility failed to obtain a resident's dietary allergies prior to serving food to a resident that would create an allergic reaction. This was for 1 of 3 residents (Resident #63) reviewed for food allergies and preferences. Findings included: Resident #63 was admitted to the facility on 1/3/25. There were no allergies listed on the discharge paperwork from the hospital. Resident #63's quarterly Minimum Data Set (MDS) dated 3/10/25 indicated the resident was cognitively intact. An interview with Resident #63 was conducted on 5/4/25 at 11:45 AM. Resident #63 stated he was served shrimp shortly after he moved into the facility. He told the aide he was allergic to shrimp, and she removed the meal tray. Resident #63 added, he had an allergic reaction when he was in his twenties, after eating shrimp it felt as if his throat was closing and he could not breathe. An interview with Resident #63's Resident Representative (RR) was conducted on 5/4/25 at 1:35 PM. The RR stated on 2/3/25 when she was made aware the facility had served Resident #63 shrimp, she called the facility and spoke with Nurse #1 to make sure they were aware Resident #63 had a shellfish allergy. A progress note dated 2/3/25 and written by Nurse #1 revealed the RR and Resident	F 806	On 5/7/25 the Director of Nursing (DON) repeated a food preference/allergy review with resident #63 and/or resident representative and confirmed that the electronic record for identified allergies was correct. On 5/7/25 the Quality Improvement (QI) Nurse and Dietary Manager (DM) initiated questionnaires with all alert and oriented residents regarding allergies. These questionnaires identified all allergies and ensured the electronic record and care plan were updated for identified allergies to include but not limited to food allergies. The DM and QI Nurse addressed all concerns identified during the questionnaires to include updating the electronic record when indicated. The audit was completed 5/16/25. On 5/7/25 the Social Worker (SW) and Admissions Coordinator (AC) initiated questionnaires with resident representatives for residents unable to report. These questionnaires identified all allergies and ensured the electronic record and care plan were updated for identified allergies including but not limited to food allergies. The DM and QI Nurse addressed all concerns identified during the questionnaires including updating the electronic record as indicated. The audit was completed 5/16/25. On 5/7/25 the QI Nurse and DM initiated questionnaires with all alert and oriented residents regarding allergies. These	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 5 discussed with dietary that he had a shellfish allergy and the allergy had been added to his medical record. An interview was conducted with Nurse #1 on 5/6/25 at 8:30 AM. She stated she did not remember if Resident had been served shellfish. She further stated the RR called on 2/3/25 and told her the resident was allergic to shellfish. Nurse #1 revealed typically new residents meet with the dietary team within 24 hours of admission to discuss likes, dislikes and allergies if they do not come into the facility with that information. An interview was conducted with Cook #1 on 5/4/25 at 11:00 AM. He stated the food allergies and preferences are listed on the tray slips that are used to prepare trays for meal service. An interview with the Dietary Manager was conducted on 5/5/25 at 1:15 PM. She revealed part of her role is to meet with the family at the preadmission meeting and talk with the resident within 36 hours of admission. She went on to say she did not remember meeting with Resident #63's family. An interview with the Nurse Supervisor was held on 5/5/25 at 1:30 PM. He stated the admitting nurse would put allergies into the resident's record upon admission. He was the admitting nurse for Resident #63 and there was not an allergy listed on the discharge summary from the hospital. An interview with the Director of Nursing was conducted on 5/6/25 at 9:15 AM. She revealed her expectation would have been that the	F 806	questionnaires identified all allergies and ensured the electronic record and care plan were updated for identified allergies to include but not limited to food allergies. The DM and QI Nurse addressed all concerns identified during the questionnaires to include updating the electronic record when indicated. The audit was completed 5/16/25. On 5/7/25 the SW and AC initiated questionnaires with resident representatives for residents unable to report. These questionnaires identified all allergies and ensured the electronic record and care plan were updated for identified allergies including but not limited to food allergies. The DM and QI Nurse addressed all concerns identified during the questionnaires including updating the electronic record as indicated. Audit was completed 5/16/25. The DM and QI Nurse will complete an audit of 100% admissions/readmissions or residents with newly identified allergies weekly x 4 weeks then monthly x 1 month. This audit is to ensure the resident and/or resident representative is interviewed by dietary/nursing staff regarding allergies and to ensure the electronic record is updated to accurately reflect resident allergies. The QI Nurse and DM will address all concerns identified during the audit to include obtaining and updating the electronic record for identified allergies and/or the retraining of staff. The QI Nurse will review the Allergy Audit Tool weekly x 4 weeks then monthly x 1 month	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 6 admission nurse or hall nurse would add allergies to the record if the information was included in the admission paperwork. She went on to say family/resident preadmission meetings were held with each facility department represented. If there was not a family/resident preadmission meeting each facility department manager should meet with the family or resident within 24 hours of admission. The admission nurse would be responsible for adding allergies to the medical record. An interview conducted with the Regional Registered Dietician on 5/7/25 at 8:15 AM. She stated she would expect food allergies to be reviewed by the Dietary Manager and the nursing team would make a notation on the medical record within 48 hours of admission. An interview with the Administrator was conducted on 5/6/25 at 9:30 AM. He revealed he expected food allergies would be addressed by nurses. He went on to say the admitting hall nurse should address allergies on admission prior to the first meal service.	F 806	to ensure all concerns are addressed. The Administrator will forward the results of allergy Audit Tool to the Quality Performance Improvement Committee monthly x 2 months for review and to determine trend and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		5/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7	F 880		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement their policy for enhanced barrier precautions (EPB) when Nurse Aide #1 and Nurse Aide #2 failed to wear a gown when providing incontinence care for Resident #14. This was for 2 of 9 staff members observed for infection control practices. Findings included: A review of the facility's policy titled "Enhanced Barrier Precautions" dated last revised on 4/1/24 revealed in part the following: "Enhanced Barrier Precautions (EBP) are used in conjunction with Standard Precautions to reduce the risk of MDRO [Multidrug-resistant bacteria] transmission during high-contact resident care activities. [It includes] the use of both gowns and gloves. ...Enhanced Barrier Precautions apply to residents with any of the following: ...Wounds with or without the presence of an MDRO infection. ...Example[s] of chronic wounds requiring EBP include but are not	F 880	On 5/5/25, the Quality Assurance Nurse (QI) updated residents #14 door with Enhanced Barrier Precaution (EBP) signage per facility protocol. The resident care plan and care guide were updated to reflect EBP utilization. On 5/5/25, the Director of Nursing (DON) initiated an audit of all residents to identify residents meeting the Enhanced Barrier Precautions criteria during high-contact areas. Any identified residents room was verified to ensure the correct isolation signation placed on the resident door and all necessary personal protective equipment (PPE) was available near the residents room for use. The Unit Manager and the QI Nurse will address all concerns identified during the audit to include placing or removing isolation signage, stocking PPE supplies near resident rooms, and the education of staff. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 limited to the following types of wounds: Pressure ulcers ...Resident care activities that are considered high contact include but are not limited to: ...changing briefs or assisting with toileting." During observation on 5/5/25 at 1:36 PM Nurse Aide #1 and Nurse Aide #2 were observed providing incontinent care for Resident #14. Nurse Aide #2 was observed to shut the resident's door, close the window blinds, and then both nurse aides performed hand hygiene. Both nurse aides introduced themselves to Resident #14 and explained what they were about to do. Nurse Aide #1 raised the bed and then lowered the head of bed and both nurse aides used hand sanitizer and then put on gloves. As Nurse Aide #1 pulled the covers back on Resident #14 and the nurse aides were about to start incontinent care, both nurse aides were asked to stop and step outside of the hearing of the resident. During an interview on 5/5/25 at 1:43 PM both Nurse Aide #1 and Nurse Aide #2 stated Resident #14 did have a wound at one point, but due to there being no EBP signage or Personal Protective Equipment (PPE) on the door, the wound must now be closed, and the dressing was a preventative dressing. Due to this, there was no need for them to wear a gown for EBP. Both nurse aides stated they could not remember Resident #14 having Enhanced Barrier Precautions so the wound must have been closed for a long time. The nurse aides then continued to complete incontinent care on Resident #14. While completing the observation of incontinent care on Resident #14 on 5/5/25 at 1:43 PM, a clean and dry border foam wound dressing	F 880	audit was completed on 5/5/25. On 5/5/25, the DON completed an in-service with the Infection Preventionist regarding Enhanced Barrier Precaution (EBP) guidelines with emphasis placed on residents with wounds requiring EBP including chronic wounds such as skin breaks, or skin tears covered with an adhesive bandage or similar dressing. On 5/5/25, the DON initiated an in-service for all staff to include nursing assistant (NA) #1 and NA #2 regarding the Enhanced Barrier Precaution guidelines with emphasis placed on criteria requiring EBP to include but limited to residents with wounds such as skin breaks, or skin tears covered with an adhesive bandage or similar dressing. The in-service will be completed by 5/16/25. After 5/16/25, any staff who have not worked and received the education will receive upon their next scheduled shift. All newly hired staff will be educated during the orientation regarding EBP. The QI Nurse will review all residents orders, progress notes, and new admission records 5 x per week x 4 weeks, and monthly x 1 month to identify residents who meet the criteria for EBP. The QI Nurse will ensure the implementation of required action items per the guidelines (EBP signage), facilitate discussions in morning interdisciplinary team meetings (IDT), and document actions taken on the infection control precaution audit tool for all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 approximately 2 inches by 2 inches was observed on Resident #14's sacrum. During an interview on 5/5/25 at 1:48 PM the Infection Preventionist stated Resident #14 did have a chronic sacral pressure ulcer with a small opening that on 4/29/25 was measured to be 2.5 centimeters by 2.5 centimeters by 0.1 centimeters depth with no drainage. She stated Resident #14 had the pressure ulcer for over a year and it would not close but was very small and had no drainage. The Infection Preventionist stated that because there was no drainage and the wound was small and could be covered with boarder foam dressing, she did not believe Resident #14 needed enhanced barrier precautions. If residents were on EBP then staff should wear a gown and gloves for incontinence care. She stated she was trained on EBP 3/4/25 and had a refresher course on 3/31/25. During an interview on 5/5/25 at 3:49 PM the Director of Nursing stated Resident #14 should have been on enhanced barrier precautions due to his chronic wound and signage and PPE should have been placed on his door to alert the staff of this. A gown and gloves should have been worn by the nurse aides while providing incontinence care to Resident #14. During an interview 5/6/25 at 12:04 PM the Administrator stated the Enhanced Barrier Precautions policy and procedures should be followed by staff.	F 880	identified residents. The Administrator and/or DON will attend the IDT meetings and ensure all areas of concern are addressed. The QI Nurse will complete return demonstrations with 5 staff weekly x 4 weeks then monthly x 1 month to ensure staff demonstrates knowledge and understanding of the EBP procedures. During the return demonstrations, staff will be immediately retrained for any identified areas needing improvement. The Administrator or DON will present the findings of the infection control precaution audit tools and return demonstrations to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months, to determine trends and/or issues that may need further interventions and/or additional monitoring.	