STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graham Healthcare and Rehabilitation Center	811 Snowbird Road Robbinsville, NC 28771

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51140 Based on record reviews and staff interviews, the facility failed to submit a request for an evaluation of updated Pre-Admission Screening and Resident Review (PASARR) determination for 1 of 3 residents reviewed (Resident #11). The findings included: Resident #11 was originally admitted to the facility on [DATE] with fibromyalgia, osteoarthritis, and Post Traumatic Stress Disorder (PTSD). On 04/10/2024, resident was diagnosed with Major Depressive Disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had moderate cognitive impairment. The MDS further revealed diagnoses on 04/10/2024 of major depressive disorder. Behaviors during the look back period included feeling down, depressed or sleepy. Care plan dated 04/28/2024 revealed Resident #11 had feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/activities. A review of the Psychiatric Periodic Evaluation revealed that Resident #11 was assessed for depression. Nurse Practitioner (NP) on 04/08/2024 included major depressive disorder. NP documented to continue duloxetine (for depression and anxiety) and Wellbutrin XL (for depression), and to utilize non-pharmacological interventions. Review of medical record revealed a new application for Level II PASARR had not been completed after the diagnosis of Major Depressive Disorder. Interview with Social Worker on 12/18/2024 at 10:59 AM revealed she was responsible for notifying State Mental Health Authority of resident's new mental health condition to establish a new PASARR level and a Level II PASARR had not been completed. Social Worker explained that she must be notified by nursing of any new mental health diagnoses to submit the evaluation for screening. On 12/18/2024 at 11:20 AM, the MDS Coordinator interview revealed the NP had not notified nursing of the additional diagnoses of major depressive disorder for Resident #11. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with Unit Manager on 12/19/204 at 8:05 AM, it was revealed that NP no longer came to the facility and the replacement Physician Assistant (PAs) first day was today. On 12/19/2024 upon interview with the PA at 10:50 AM, it was revealed this was his first day at the facility, and he was unfamiliar with the resident's case. Interview with Interim Administrator on 12/19/2024 at 2:50 PM disclosed that she expected a Level II PASARR to be completed for residents that were diagnosed with additional mental health diagnoses.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41069 Based on observations and staff and Consultant Pharmacist interviews, the facility failed to discard expired medications from 2 of 2 medication rooms (North and South medication rooms), and 1 of 2 medication carts (South medication cart). The facility also failed to date an eye drop after opening in 1 of 2 medication carts (South medication cart). The findings included: 1.a. An observation of the North medication room refrigerator on 12/18/24 at 11:08 AM with Nurse #1 revealed five full bags of Normal Saline 250 milliliters labeled as containing Gentamicin Injection with Resident #4's name. Each bag had a sticker that indicated do not use after with the following dates: 12/9/24, 12/11/24, 12/13/24, 12/15/24, and 12/17/24. There was also another bag labeled the same way which was half full and the sticker date was to discard after 12/5/24. An interview with Nurse #1 on 12/18/24 at 11:10 AM revealed she was not sure why the bags of Normal Saline with Gentamicin were still available in the medication room refrigerator. Nurse #1 stated they were supposed to have been used to irrigate Resident #4's urinary catheter and this procedure had been scheduled for the evening shift. A phone interview with the Consultant Pharmacist on 12/18/24 at 4:14 PM revealed they had sent pre-mixed Gentamicin solution for Resident #4's urinary catheter irrigation, and the Normal Saline bags were only good for 48 hours because they had already been punctured by the pharmacy adding the Gentamicin medication into the bags of saline. She stated that any unused solution should have been discarded after two days. b. Further observation of the North medication room on 12/18/24 at 11:15 AM with Nurse #1 revealed two boxes of Bisacodyl suppositories marked with a manufacturer's expiration date of 8/31/24. One box contained 24 suppositories, and the other box contained 15 suppositories. There was also a 473 milliliter (ml) bottle of Guaifenesin marked with an expiration date of August 2024. Both medications were available for use in the North medication room. An interview with Nurse #1 on 12/18/24 at 11:18 AM revealed the nurses were responsible for checking the medication room for expired medications. Nurse #1 stated she thought they had one of the medication aides go through the medication rooms this week. An interview with the Nurse Supervisor on 12/19/24 at 11:24 AM revealed she usually checked the medication rooms at the beginning of each month, but she did not notice any of the expired medications that were observed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 12/19/24 at 3:27 PM revealed she did not know why there were expired medications available for use in both medication rooms and the South medication cart. The DON stated she would have thought that the supervisors would have caught them sooner and addressed them. The DON further stated that she called pharmacy and verified that the Normal Saline bags expired in two days only if they were punctured, and she did not think any of them were punctured. The DON also said that the supervisors should check the stock medications in the medication rooms, while the nurses were responsible for checking the medication carts. 2. An observation of the South medication room with Nurse #2 on 12/18/24 at 12:03 PM revealed a 236 ml unopened bottle of Multi-Vite marked with an expiration date of November 2024. An interview with Nurse #2 on 12/18/24 at 12:05 PM revealed the night shift nurses were responsible for checking the medication room for expired medications and also which ever nurse put the stock medications into the cabinets. She did not know why the expired bottle of Multi-Vite was left available for use in the South medication room. An interview with the Nurse Supervisor on 12/19/24 at 11:24 AM revealed she usually checked the medication rooms at the beginning of each month, but she did not notice any of the expired medications that were observed. An interview with the Director of Nursing (DON) on 12/19/24 at 3:27 PM revealed she did not know why there were expired medications available for use in both medication rooms and the South medication cart. The DON stated she would have thought that the supervisors would have caught them sooner and addressed them. The DON also said that the supervisors should check the stock medications in the medication rooms, while the nurses were responsible for checking the medication carts. 3. An observation of the South medication cart with Nurse #2 on 12/18/24 at 12:13 PM revealed a box of twelve Hemorrhoidal suppositories marked with an expiration date of September 2024 available for use. There was also an opened bottle of Latanoprost eye drops with no open date. It was marked as sent by the pharmacy on 11/7/24. The bottle had a sticker that indicated it expired six weeks after opening. An interview with Nurse #2 on 12/18/24 at 12:15 PM revealed the nurses on the cart were responsible for going through it to check for expired medications. Nurse #2 stated she did not notice both medications because the Hemorrhoidal suppositories were no longer needed by the resident for whom it was ordered and the Latanoprost eye drops were only given at bedtime. Nurse #2 stated that whoever opened the Latanoprost eye drop bottle should have put a date on it due to the expiration date being six weeks after opening. An interview with the Director of Nursing (DON) on 12/19/24 at 3:27 PM revealed she did not know why there were expired medications available for use in both medication rooms and the South medication cart. The DON stated she would have thought that the supervisors would have caught them sooner and addressed them. The DON also said that the supervisors should check the stock medications in the medication rooms, while the nurses were responsible for checking the medication carts.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45272 Based on record reviews, observations, and staff interviews, the facility failed to implement their infection control policy when 3 staff members (Nurse Aides #1, #2, and #3) failed to sanitize their hands in between resident contacts and contact with surfaces in the dining room during meal service. In addition, Nurse #1 failed to don Personal Protective Equipment (PPE) including a gown when providing urinary catheter care and failed to perform hand hygiene before applying gloves and after removing gloves during catheter care for Resident #4. This involved 4 of 5 staff members observed for infection control practices (Nurse Aides #1, #2, #3 and Nurse #1). The findings included: Review of the facility's policy for Handwashing dated 4/2023 indicated that the facility ensures that all employees wash hands using soap, running water, and friction in the following situations: immediately or as soon as feasible after removal of gloves or other personal protective equipment. 1.a. Nurse Aide (NA) #2 was observed on 12/16/24 at 11:51 AM touching the hands and hair of a resident in the dining room. NA #2 then walked to another resident in the dining room without washing or sanitizing her hands and then touched the resident on the hands. On 12/16/24 at 12:05 PM NA #2 was observed assisting a resident with meal set up while wearing gloves, then immediately assisted another resident with meal set up without removing the gloves. NA #2 then helped cut the resident's food and touched the resident's bread while wearing the same gloves. NA #2 was interviewed on 12/16/24 at 12:50 PM. She stated she would wash and sanitize her hands after delivering meals to each resident and after assisting a resident with eating before assisting another resident with a meal. NA #2 said her usual procedure was to wash her hands after removing gloves or replacing them and after touching hair or other areas of the body. NA #2 said she did not wash or sanitize her hands for every occasion needed when she assisted residents in the dining room. b. On 12/16/24 at 11:59 AM NA #1 was observed adjusting a residents clothing protector with his hands, then immediately serve another resident a meal tray without sanitizing or washing his hands. On 12/16/24 at 12:20 PM NA #1 was observed touching and readjusting a resident's clothing protector and then immediately assisted another resident with their meal. NA #1 did not wash or sanitize his hands before assisting the resident with their meal. NA #1 was interviewed on 12/26/24 at 12:56 PM. He stated he usually would wash or sanitize his hands after he helped set a resident up for a meal and after touching a resident. NA #1 stated he overlooked washing and sanitizing his hands between assisting residents with meals and after touching clothing protectors. c. On 12/16/24 at 12:10 PM NA #3 was observed placing gloves in her coat pocket and washing her hands. NA #3 then removed the gloves from her coat pocket, placed them on her hands and touched a resident's sandwich. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NA #3 was interviewed 12/16/24 at 12:39 PM. NA #3 stated she would wash or sanitize her hands before and after she passed meals to each resident, after she touched clothing, and after she removed gloves. NA #3 said she did forget to sanitize and wash when she used gloves and after touching residents clothing before assisting another resident. The Director of Nursing (DON) stated on 12/19/24 at 3:39 PM the NAs and Nurses should have washed or sanitized their hands in-between assisting residents with meals. The DON stated hands should be washed or sanitized after touching their own clothing, residents clothing, hair, face, and after removing gloves. The Administrator was interviewed on 12/19/24 at 4:08 PM and stated Nurses and NAs should have sanitized hands in-between assisting residents with meals. She stated hands should have been sanitized after touching hair, clothing and before they assisted a resident with eating. 41069 2. Review of the facility's policy for Enhanced Barrier Precautions (EBP) revised on 6/13/24 indicated Enhanced Barrier Precautions will be utilized by staff for all residents with a known CDC (Centers for Disease Control and Prevention) targeted MDRO (multidrug-resistant organism) infection or colonization (when contact precautions are not indicated) and/or residents without known MDRO who have wounds and/or implanted medical devices. An observation on 12/18/24 at 10:29 AM revealed Resident #4 had signage for EBP posted on his door. The signage indicated all healthcare personnel must wear gloves and gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use to include urinary catheter, and wound care. Nurse #1 entered Resident #4's room to provide urinary catheter care without wearing a gown for the procedure. Nurse #1 put gloves on both hands without performing hand hygiene and obtained soapy water in a kidney basin from Resident #4's bathroom sink faucet. Nurse #1 placed the kidney basin on Resident #4's bedside table, uncovered Resident #4, and pulled open his brief. Nurse #1 wiped Resident #4's urinary catheter insertion site with a washcloth soaked in the soapy water from the kidney basin. She removed both gloves and without performing hand hygiene, she proceeded to put on a new set of gloves to both hands. She reached inside her shirt pocket and obtained a tube of antibiotic ointment. Nurse #1 squeezed the contents of the tube into a medicine cup and placed the cup on Resident #4's bedside table. Nurse #1 changed her gloves without doing hand hygiene. She applied the ointment onto Resident #4's urethral meatus (passage or opening leading to the interior of the body). Nurse #1 removed her gloves and put on a new pair of gloves to both hands. She wiped the rest of Resident #4's urinary catheter, discarded any unused supplies, removed her gloves and washed her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Nurse #1 on 12/18/24 at 10:36 AM revealed that she did not notice the sign for EBP on Resident #4's door and stated that the sign must have just been put up. Nurse #1 indicated she was supposed to have put on a gown when she provided catheter care to Resident #4. Nurse #1 stated that she had washed her hands prior to entering Resident #4's room, and she would normally wash her hands prior to putting gloves on but Resident #4 was agitated and wanted to get up, so she was trying to hurry. Nurse #1 further stated that she had not heard that she was supposed to sanitize her hands after removing gloves and before applying new ones. Nurse #1 stated that she had received education on hand hygiene and EPB, and that she knew what she was supposed to do, but she could not explain why she hadn't donned a gown or perform hand hygiene after removing her gloves. Nurse #1 stated that there was no excuse. An interview with Director of Nursing (DON) who also served as the facility's Infection Preventionist on 12/19/24 at 3:27 PM revealed staff was supposed to wash their hands and apply PPE when going into rooms on EBP. The DON stated Nurse #1 should have worn a gown and gloves while providing catheter care to Resident #4. The DON also stated that Nurse #1 should have done hand hygiene after removing her gloves. She shared that Nurse #1 had been educated on the facility's infection control policies and should have known what to do.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51140 Based on record reviews and resident and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 3 of 6 residents reviewed for infection control (Resident #2, Resident #11, and Resident #18). The findings included: 1. Resident #2 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #2's cognition was severely impaired. The electronic immunization record revealed that Resident #2 received the COVID-19 immunization on 10/16/2024. A review of Resident #2's medical record revealed there was no information documented in Resident #2's medical record that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 vaccine. During an interview with the Interim Assistant Director of Nursing (ADON) on 12/18/2024 at 7:54 AM, she stated that she had been at this facility since the second week of November 2024. The ADON stated that she served as Staff Development Coordinator (SDC) and Quality Improvement (QI) nurse. She stated that she was responsible for resident and staff immunizations with consents and was catching up with the administration of the vaccines. At 1:00 PM on 12/19/2024, The Director of Nursing (DON) and the Regional Director were asked for documentation of the education provided for Resident #2 regarding the benefits and potential side effects of the COVID-19 immunization. The information was not received. The Director of Nursing (DON) who was interviewed on 12/19/2024 at 3:40 PM revealed that she was responsible for resident immunizations and acknowledged that she did not have documentation about providing education about benefits and potential side effects of COVID-19 immunization. The Interim Administrator was interviewed on 12/19/2024 at 4:25 PM and stated that she expected staff to educate and document education provided regarding benefits and potential side effects of COVID-19 immunizations. 2. Resident #11 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had moderate cognitive impairment. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the electronic immunization record revealed that Resident #11 refused the COVID-19 immunization in 2024 without a documented date. On 09/25/2024, a note was authored by the Assistant Director of Nursing (ADON) who was no longer employed at the facility and stated that Resident and legal representative refused the COVID vaccine. During an interview with the Interim ADON on 12/18/2024 at 7:54 AM, she stated that she had been at this facility since the second week of November 2024. The ADON also that she served as Staff Development Coordinator (SDC) and Quality Improvement (QI) nurse. She stated was responsible for resident and staff immunizations with consents and was catching up with the administration of the vaccines. At 11:05 AM on 12/18/2024, Resident #11 was interviewed. She remembered refusing the COVID-19 vaccine this fall and stated that she did not recall being educated about the benefits and potential side effects of the vaccine. At 1:00 PM on 12/19/2024, The Director of Nursing (DON) and the Regional Director were asked for documentation of the education provided for Resident #11 regarding the benefits and potential side effects of the COVID-19 immunization. The information was not received. The DON who was interviewed on 12/19/2024 at 3:40 PM revealed that she was ultimately responsible for resident immunizations and acknowledged that she did not have documentation about providing education about benefits and potential side effects of COVID-19 immunization. The Interim Administrator was interviewed on 12/19/2024 at 4:25 PM and stated that she expected staff to educate and document education provided regarding benefits and potential side effects of COVID-19 immunizations. 3. Resident #18 was admitted to the facility on [DATE]. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had moderate cognitive impairment. A review of the electronic immunization record revealed that Resident #18 refused the COVID-19 immunization for 2024 without a documented date. On 09/25/2024, a note was authored by the former Assistant Director of Nursing (ADON) who was no longer employed at the facility and stated that Resident and legal representative refused the COVID vaccine. During an interview with the Interim ADON on 12/18/2024 at 7:54 AM, she declared that she had been at this facility since the second week of November 2024. The ADON also that she served as Staff Development Coordinator (SDC) and Quality Improvement (QI) nurse. She sated was responsible for resident and staff immunizations with consents and was catching up with the administration of the vaccines. At 11:05 AM on 12/18/2024, Resident #18 was interviewed. She remembered refusing the COVID-19 vaccine this fall and stated that she did not recall being taught about the benefits and potential side effects of the vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:00 PM on 12/19/2024, The Director of Nursing (DON) and the Regional Director were asked for documentation of the education provided for Resident #18 regarding the benefits and potential side effects of the COVID-19 immunization. The information was not received. The Director of Nursing (DON) was interviewed on 12/19/2024 at 3:40 PM, revealed that she was responsible for vaccine and acknowledged that she did not have documentation about providing education about benefits and potential side effects of COVID-19 immunization. The Interim Administrator was interviewed on 12/19/2024 at 4:25 PM and stated thatshe expected staff to educate and document education provided regarding benefits and potential side effects of COVID-19 immunizations.