STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

(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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		5/18/18

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

Electronically Signed | 05/18/2018

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F 842	Continued From page 1 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to accurately document a resident's diagnosis in the medical record for 1 of 3 residents sampled for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 03/30/18 with diagnoses which included acute delirium, atrial fibrillation and Parkinson's	F 842	Glenbridge Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the ectent that the summay of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.	

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F 842	Continued From page 2 disease. A review of Resident #1's admission Minimum Data Set (MDS) dated 04/11/18 revealed he was cognitively intact for daily decision making and required limited assistance of one for transfers and ambulation. A review of Resident #1's Care Area Assessment (CAA) for activities of daily living (ADLs) dated 04/11/18 revealed in part he went to the emergency room on 03/22/18 with altered mental status, in a delirious state, had a low pulse and had encephalopathy (any disorder or disease of the brain usually chronic in nature). While in the hospital, Resident #1 was placed on an antipsychotic medication for delusions and hallucinations. The CAA further explained he could verbalize his needs and had made a large improvement in his cognition since admission to the facility. A review of Resident #1's Care Plan dated 04/18/18 revealed the use of an antipsychotic medication due to behavior and the goal was for Resident #1 to remain free of complications from the psychotropic drug use. The interventions indicated in part to monitor for side effects every shift. A review of Residents #1's medical record revealed an additional diagnosis of dementia on the cumulative diagnosis list which was a list of the resident's diagnosis in chronological order. On 05/03/18 at 7:20 PM an interview with the MDS Coordinator (MDSC) revealed he had added a diagnosis of dementia to Resident #1's cumulative diagnosis list when he read the	F 842	Glenbridge Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Glenbridge Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F842 What measures did the facility put in place for the resident affected: MDS Coordinator was interviewed on 05/03/18 revealed he had added a diagnosis of dementia to Residents # 1 Diagnosis list when he read the phrase “Dementia like symptoms” in the records. He corrected the diagnosis list for Resident 1. What measures were put in place for residents having the potential to be affected: 05/4/18 100% audit was completed on all residents all new admissions for the past 30 days to see if they have correct diagnosis. Administrator in-serviced MDS Nurses on accuracy of MDS What systems were put in place to prevent the deficient practice from	

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F 842	Continued From page 3 phrase "dementia like symptoms" in the resident's hospital records but could not recall the specific document where he had read the information. An interview with the Administrator on 05/03/18 at 7:30 PM revealed she would have expected the MDSC to have accurately documented the appropriate diagnosis on Resident #1's medical record.	F 842	reoccurring: On 5/04/18 the MDS coordinator were in-serviced by the facility Administrator related to the Accuracy of information on an MDS. How the facility will monitor systems put in place: Beginning 05/03/18 the Administrator, and DON will audit MDS assessments to ensure accuracy using MDS accuracy audit tool. This audit will be completed weekly x 5 weeks and then monthly x 3 months. The monthly QI committee will review the results of accuracy Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance.	