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 _____	03/07/2019

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
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have an Emergency Preparedness (EP). The EP plan did not include procedures that addressed the patient population, subsistence needs for staff and patients, procedures for tracking of staff and patients, procedures for sheltering in place, procedures for medical documentation, provisions for volunteers, a communication plan, contact information, primary/alternate means of communication, methods of sharing information, EP training or	E 001	Glenbridge Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the extent that the summary 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.	3/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/29/2019

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E 001	Continued From page 1 testing requirements. The findings included: 1. A. Review of the EP manual revealed the manual did not include information about the patient population. B. Review of the EP manual revealed the manual did not include information about the subsistence needs for staff and patients. C. Review of the EP manual revealed the manual did not include procedures for tracking of staff and patients. D. Review of the EP manual revealed the manual did not include procedures for sheltering in place . E. Review of the EP manual revealed the manual did not include procedures for medical documentation. F. Review of the EP manual revealed the manual did not include provision for volunteers during an emergency. G. Review of the EP manual revealed the manual did not include a communication plan. H. Review of the EP manual revealed the manual did not include contact information for staff, resident physicians, and volunteers. I. Review of the EP manual revealed the manual did not include primary or alternate means of communication. J. Review of the EP manual revealed the manual	E 001	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. E001 What measures did the facility put in place for the resident affected: On 03/28/19 Administrator initiated in-services on the new requirements for emergency Preparedness. 03/19/19 Administrator attended a meeting with DSS concerning community involvement in EP 03/20/19 Maintenance Director attended a meeting with the county. The Emergency Preparedness manager of Watauga County, Boone PD, Boone FD, and EMS was in attendance. What measures were put in place for residents having the potential to be affected: 03/19/19 Administrator attended a meeting with DSS concerning community involvement in EP 03/20/19 Maintenance Director attended a meeting with the county. The Emergency	

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E 001	Continued From page 2 did not include methods of sharing information. K. Review of the EP manual revealed the manual did not include the required training or testing requirements. An interview was conducted with the Administrator on 03/07/19 at 9:34 AM. The Administrator stated that she was not as familiar with the EP requirements as she should be. She added that after the recent training she attended she knew she "needed to step it up" in regard to the EP program and the missing components.	E 001	Preparedness manager of Watauga County, Boone PD, Boone FD, and EMS was in attendance. What systems were put in place to prevent the deficient practice from reoccurring: 03/28/19 100% Education to all staff regarding facility Emergency Preparedness Plan was Initiated and will be on going due to it being required yearly. All New Hire Staff will be Trained upon Hire of Emergency Preparedness Plan On 03/28/19 met with Taylor Marsh Director of Emergency Management Preparedness of Watauga County he stated that he will keep me updated on any scheduled community drills, at this this time they do not have one scheduled. Maintenance Director and/or SW has contacted a local transport company in the case of evacuation. Maintenance Director has contacted a local school if we must evacuate having them be one of our location. a local church being the second location if needed. A Review of the EP manual revealed the manual did not include information about the patient population. 03/28/19 Glenbridge Manual was updated the patient population. B. Review of the EP manual revealed the manual did not include information about	

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E 001	Continued From page 3	E 001		

the subsistence needs for staff and patients. 03/28/19 Glenbridge Manual was updated for the needs for staff and residents.

C. Review of the EP manual revealed the manual did not include procedures for tracking of staff and patients. 03/28/19 Glenbridge Manual was updated for Tracking Staff and Patients.

D. Review of the EP manual revealed the manual did not include procedures for sheltering in place. 03/28/19 Glenbridge Manual was updated for sheltering in place.

E. Review of the EP manual revealed the manual did not include procedures for medical documentation. 03/28/19 Glenbridge Manual was updated for medical Documentation.

F. Review of the EP manual revealed the manual did not include provision for volunteers during an emergency. 03/28/19 Glenbridge Manual was updated for provision during emergency.

G. Review of the EP manual revealed the manual did not include a communication plan.
03/28/19 Glenbridge Manual updated a communication plan.

H. Review of the EP manual revealed the manual did not include contact information for staff, resident physicians, and volunteers. 03/28/19 Glenbridge Manual

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E 001	Continued From page 4	E 001	was updated to include contact information for staff, resident physicians, and volunteers I. Review of the EP manual revealed the manual did not include primary or alternate means of communication. 03/28/19 Glenbridge Manual was updated to include primary and alternate means of communication. J. Review of the EP manual revealed the manual did not include methods of sharing information. 03/28/19 Glenbridge Manual was updated to include methods of sharing information. K. Review of the EP manual revealed the manual did not include the required training or testing requirements. 03/28/19 Glenbridge Manual was updated for Tracking Staff and Patient. How the facility will monitor systems put in place: The monthly QI committee will review the results of the EP audits 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. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further	

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E 001	Continued From page 5	E 001	recommendations and oversight. Facility Administrator is responsible for implementing plan of correction	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		3/30/19

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F 580	Continued From page 6 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify the medical provider when a resident experienced fever, lethargy, and vomiting for 1 of 1 residents sampled for change in condition (Resident #89). The findings included: Resident #89 was admitted to the facility on 11/16/17 and readmitted on 12/03/18 with diagnoses that included: sepsis, metabolic encephalopathy, weakness, depression, and Parkinson's disease. Review of a health status note dated 11/30/18 at 6:30 PM read, Resident #89 "with complaints of nausea this morning, emesis (vomiting) x 1 prior to breakfast. Resident #89 lethargic throughout the shift, poor appetite, and slightly confused and harder to understand due to speech being more garbled than usual. Temperature 101.6, Tylenol 650 milligrams (mg) administered with	F 580	What measures did the facility put in place for the resident affected: On 12/01/19 Resident #89 was transferred to ER for evaluation What measures were put in place for residents having the potential to be affected: During Clinical team meeting Tuesday -Friday we review the 24hour report on all residents and on Monday we review the 72 hour for the weekend to identify any acute changes Admin Staff will follow up to ensure correct action is taken. What systems were put in place to prevent the deficient practice from reoccurring: On 3/11/19 Staff Development Nurse initiated in services to all licensed staff on notifying physicians of acute changes of	

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F 580	Continued From page 7 temperature of 101.6 at this time." Signed by Nurse #3. Review of a health status note dated 11/30/18 at 6:33 PM read, Resident #89 "complained of nausea this morning, emesis x 1 before breakfast then resident denied nausea the rest of the shift. Lethargic and weak he remained in bed throughout the day, appetite very poor however he did take fluids well when offered and reminded. Temperature of 101.6, Tylenol 650 mg given with temperature of 101.1 after Tylenol. Will continue to monitor." Signed by Nurse #3. Review of the comprehensive Minimum Data Set (MDS) dated 12/15/18 revealed that Resident #89 was moderately impaired for daily decision making and required extensive assistance with activities of daily living. Review of Resident #89's medical record revealed no physician orders that were written on 11/30/18 or note indicating that the medical provider was notified of the change in condition. Further review of the medical record revealed there was no medical provider progress note on 11/30/18. Multiple attempts were made to speak to Nurse #3 on 03/06/19 and 03/07/19 with no success. An interview was conducted with the Nurse Practitioner (NP) on 03/06/19 at 2:21 PM with the Director of Nursing (DON) present. The NP stated that she had been visiting the facility for a year and was at the facility 2 times a week. The NP stated she was familiar with Resident #89 who had been very sick in the last couple of months. The NP stated that Resident #89 had	F 580	Residents. New Staff will be in serviced upon hire. Director of Nursing or designee will audit 24-hour report 5 days a week for 5 weeks weekly for 5 weeks and monthly for 3 months, using change in condition audit. How the facility will monitor systems put in place: On 03/11/19 the DON and Admin Nurse began auditing 24 Reports will be completed 5x a week for 5 weeks then weekly x 5 weeks then monthly x 3 months. The monthly QI committee will review the results of the 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. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. Facility Administrator is responsible for implementing plan of correction.	

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F 580	Continued From page 8	F 580		

been diagnosed with septic pneumonia at the hospital and the presenting sign of that was lethargy and altered mental status. She added that the fever could have been indicative of a few other things, but laboratory values would have been needed to determine that. The NP stated that generally when Resident #89 became sick he would have a high temperature and be lethargic. The NP stated that she could not recall being made aware of the incident on 11/30/18 with Resident #89 but added that if she had been she would have ordered laboratory test to determine what was going on and to her knowledge that did not occur. The NP stated that she would have expected Nurse #3 to contact the medical provider on call when Resident #89 experienced a fever, lethargy, and vomiting on 11/30/18.

An interview was conducted with the Medical Director (MD) on 03/07/19 at 8:37 AM. The MD stated that he had only been at the facility for a month but was familiar with Resident #89. The MD stated that if Resident #89 had an isolated fever then giving the Tylenol and monitoring the resident would have been appropriate but when Resident #89 had lethargy and vomiting the nurse should have completed a head to toe assessment that included a full set of vital signs and contacted the on call medical provider so that laboratory test could have been completed to determine the treatment for Resident #89.

An interview was conducted with the DON on 03/07/19 at 12:06 PM. The DON confirmed that to her knowledge and review of Resident # 89's medical record the on call medical provider was not notified on 11/30/18 when Resident #89 experienced a fever, lethargy, and vomiting. She added that the telehealth service that took acute

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F 580	Continued From page 9 calls on the evenings and weekends denied having any incoming calls in regards to Resident #89 on 11/30/18. The DON stated that she expected Nurse #3 to contact the on call medical provider so that appropriate diagnoses and treatment could have been initiated.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 - (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	F 656		3/30/19

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F 656	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement fall care plan interventions for transfers with 2-person assistance (Resident #77), failed to develop a care plan for a resident who experienced weight loss (Resident #89), and failed to develop a care plan for colostomy care for a resident that had a colostomy (Resident #49) for 3 of 3 residents sampled. The findings included: 1. Resident #77 was admitted to the facility on 08/09/17 with diagnoses that included repeated falls, weakness, abnormal gait, cognitive communication deficit, depression, and others. Review of the quarterly Minimum Data Set (MDS) dated 02/19/19 revealed that Resident #77 was cognitively intact and required extensive assistance of 2 staff members with transfers. Review of a care plan that was updated on 01/03/19 read in part, Resident #77 required assistance with activities of daily living due to impaired mobility. The goal of the care plan read,	F 656	What measures did the facility put in place for the resident affected: Resident 77 was Assessed by a licensed Nurse after Fall and Skin Tear was Treated per orders. On 03/06/19 Resident # 89 care plan was updated to include resident to have Weight Loss. On 03/07/19 Resident # 49 Care Plan was updated to include Colostomy Care. What measures were put in place for residents having the potential to be affected: On 3/11/19 the Facility MDS Nurse completed a 100% audit of resident's that transfer with Hoyer Lift. All care plans were updated as necessary. 03/11/19 Dietary Manager completed a 100% audit of all Residents with Weight Loss to ensure that they were care plan. ON 03/11/19 The Facility MDS Nurse completed a 100% audit of all residents with ostomy's to ensure they were Care	

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F 656	Continued From page 11 Resident #77 would receive services and assistance to achieve and/or maintain highest possible level of functioning by the review date. The interventions of the care plan included: Resident #77 required extensive assistance of 2 staff members with the mechanical lift for transfers. Review of an incident report dated 02/10/19 read, called to Resident #77's room by Nursing Assistant (NA) #2 who stated that while transferring Resident #77 from the bed to the wheelchair, the sling pad came unhooked from the mechanical lift and Resident #77 fell to the floor from the mechanical lift. The investigation read, NA #2 transferred Resident #77 with the mechanical lift and 1 person and she slipped out of the lift to the floor. The form was signed by Nurse #2. An interview was conducted with NA #2 on 03/06/19 at 8:57 AM. NA #2 confirmed that she was caring for Resident #77 on 02/10/19 when she fell from the mechanical lift. She stated that she had provided care to Resident #77 and was going to get her up for breakfast. NA #2 stated that she put the lift pad under Resident #77 and then hooked the straps to the mechanical lift and lifted her into the air from the bed. NA #2 stated that as she was guiding Resident #77 to the wheelchair she did not realize that the strap had come unhooked from the mechanical lift and as she began to lower Resident #77 to the wheelchair she slipped out of the lift to the floor. NA #2 stated that she was aware that she should not have transferred Resident #77 that day alone, but the other staff were busy getting other residents up and she just decided to do it by herself.	F 656	planed What systems were put in place to prevent the deficient practice from reoccurring: On 02/25/19 ADON intentioned Inservice on Transfers with Hoyer Lifts, Admin staff completed a 100% audit on all Residents who required transfer with a Hoyer Lift. All New Hires will be educated on proper Transfers with Hoyer lifts. On 3/11/19 the Administrator in-serviced the MDS Coordinator, MDS nurse, ADON and DON related to Care Plans and Transfers, Weight Loss, and Ostomy's being included in resident's plan of care. How the facility will monitor systems put in place: Resident's with Weight Loss, Ostomys, and that are transferred with a Hoyer will be audited by the DON/ADON/SDC/UNIT Mangers using the Care Plan Audit Tool for OSTOMYS, WEIGHT LOSS, AND TRANSFERS. The audit will be completed weekly for 5 weeks then monthly for 3 months. The monthly QI committee will review the results of the audits 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. The administrator	

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	345163	A. BUILDING _____ B. WING _____	03/07/2019

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GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 656	Continued From page 12 An interview was conducted with Nurse #2 on 03/07/19 at 11:12 AM. Nurse #2 stated that on 02/10/19 she was summoned to Resident #77's room by NA #2. She stated that NA #2 reported that while transferring Resident #77 from the bed to the wheelchair the strap of the sling pad came unhooked from the mechanical lift and Resident #77 slipped from the sling pad to the floor. Nurse #2 added that NA #2 should not have transferred Resident #77 alone on 02/10/19 she should have requested assistance and followed the plan of care for Resident #77 who required 2-person assistance with transfers via the mechanical lift. An interview was conducted with the Director of Nursing (DON) on 03/07/19 at 12:02 PM. The DON stated NA #2 should have had 2 people assisting with the transfer of Resident #77 via the mechanical lift as directed by her plan of care. 2. Resident #89 was admitted to the facility on 11/16/17 and readmitted on 02/14/19 with diagnoses that included: metabolic encephalopathy, weakness, dysphagia, depression, and Parkinson's disease. Review of a nutrition note dated 02/20/19 read in part, Resident #89's weight prior to admission was 185 pounds and on readmission his weight was 165 pounds. Weight loss occurred in the hospital and will start health shakes with meals and continue weekly weights until stable. Signed the Dietary Manager (DM). Review of the comprehensive Minimum Data Set (MDS) dated 02/26/19 revealed that Resident #89 was severely cognitively impaired for daily decision making and required extensive	F 656	and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 656	Continued From page 13	F 656		

assistance of one staff member with eating. The MDS further revealed that Resident #89 weight 165 pounds and had experienced a significant weight loss.

Review of Resident #89's medical record revealed no care plan to address the significant weight loss or the interventions implemented to treat the weight loss.

An interview with the DM was conducted on 03/06/19 at 8:04 AM. The DM stated that Resident #89 was doing well until he got sick and went to the hospital and when he returned they identified a significant weight loss. She stated that she had added health shakes with his meals, and speech therapy (ST) was working with him and he was added to the weekly weight list. The DM stated that shortly after he readmitted and with the addition of the health shakes and working with ST he was able to feed himself again and his weights picked back up. The DM stated that she would be responsible for implementing the weight loss care plan and adding the interventions that had been implemented and then revising the care plan as instructed by the care plan schedule. The DM indicated that she had not implemented a weight loss care plan but would do so immediately.

An interview was conducted with the Director of Nursing (DON) on 03/06/19 at 5:17 PM. The DON stated that she would expect weight loss and interventions to be care planned.

3. Resident #49 was admitted to the facility on 01/11/19 with diagnoses that included encounter for surgical aftercare following surgery.

A review of Resident #49's most recent

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 _____	03/07/2019

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F 656	Continued From page 14	F 656		

comprehensive Minimum Data Set (MDS) Assessment dated 01/23/19 and coded as an admission assessment revealed Resident #49 to be cognitively intact. Further review of the MDS Assessment revealed Resident #49 had a colostomy.

A review of Resident #49's physician orders from admission on 01/11/19 revealed orders that included to document stool amount and consistency from ostomy every day and night shift and to change colostomy wafer and bag three times per week and as needed.

A review of Resident #49's care plan dated 01/14/19 revealed there was no care plan for ostomy care.

During an interview with Wound Nurse #1 on 03/07/19 at 10:58 AM, she reported she was responsible for providing and completing colostomy care. She stated she received her direction from physician orders that were on the Treatment Administration Record. She continued, stating that hall nurse aides were responsible for checking and emptying Resident #49's colostomy bag and reported the nurse aide's Kardex should provide information on how often to check and empty the colostomy bag.

During an interview with Nurse Aide #1 on 03/07/19 at 11:09 AM revealed she was responsible for checking the level of and emptying Resident #49's colostomy bag. She reported she was unsure if directions for colostomy care was indicated on her Kardex (a form detailing individual care needs and instructions for direct care floor staff). She also reported she knew what to do for Resident #49's

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F 656	Continued From page 15 colostomy based on information she had been taught during her Certified Nursing Assistant classes. She stated she had not received any specific direction from the facility on how often or how to provide Resident #49 with colostomy care. An interview with MDS Nurse #1 on 03/07/19 at 12:09 PM revealed she was responsible for developing care plans for residents in the facility. She reported she had been completing care plans for a little over a year. MDS Nurse #1 noted residents who had a colostomy bag should have individualized care plans directing care for the colostomy bag. She stated Resident #49 should have had a colostomy care plan and stated she could "not believe" she missed it. She reported she would immediately add in colostomy care into Resident #49's care plan. During an interview with the Director of Nursing on 03/07/19 at 12:35 PM she stated colostomy care should be care planned for residents that have a colostomy bag. She indicated that Resident #49 did have a colostomy bag and that colostomy care should have been care planned.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		3/30/19

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F 684	Continued From page 16 by: Based on observations, record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to assess or obtain a full set of vital signs on a resident who was experiencing a fever, vomiting, and lethargy for 1 of 1 resident sampled for change in condition (Resident #89). The findings included: Resident #89 was admitted to the facility on 11/16/17 and readmitted on 12/03/18 with diagnoses that included: sepsis, metabolic encephalopathy, weakness, depression, and Parkinson's disease. Review of a health status note dated 11/30/18 at 6:30 PM read, Resident #89 "with complaints of nausea this morning, emesis (vomiting) x 1 prior to breakfast. Resident #89 lethargic throughout the shift, poor appetite, and slightly confused and harder to understand due to speech being more garbled than usual. Temperature 101.6, Tylenol 650 milligrams (mg) administered with temperature of 101.6 at this time." Signed by Nurse #3. Review of a health status note dated 11/30/18 at 6:33 PM read, Resident #89 "complained of nausea this morning, emesis x 1 before breakfast then resident denied nausea the rest of the shift. Lethargic and weak he remained in bed throughout the day, appetite very poor however he did take fluids well when offered and reminded. Temperature of 101.6, Tylenol 650 mg given with temperature of 101.1 after Tylenol. Will continue to monitor." Signed by Nurse #3.	F 684	What measures did the facility put in place for the resident affected: On 12/01/19 Resident #89 was transferred to ER for evaluation What measures were put in place for residents having the potential to be affected: During Clinical team meeting Tuesday -Friday we review the 24hour report on all residents and on Monday we review the 72 hour for the weekend to identify any acute changes Admin Staff will follow up to ensure correct action is taken. What systems were put in place to prevent the deficient practice from reoccurring: On 3/11/19 Staff Development Nurse initiated in services to all licensed staff on notifying physicians of acute changes of Residents. New Staff will be in serviced upon hire. Director of Nursing or designee will audit 24-hour report 5 days a week for 5 weeks weekly for 5 weeks and monthly for 3 months, using change in condition audit. How the facility will monitor systems put in place: On 03/11/19 the DON and Admin Nurse began auditing 24 Reports will be completed 5x a week for 5 weeks then weekly x 5 weeks then monthly x 3 months.	

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F 684	Continued From page 17 Review of the comprehensive Minimum Data Set (MDS) dated 12/15/18 revealed that Resident #89 was moderately impaired for daily decision making and required extensive assistance with activities of daily living. Review of Resident #89's medical record revealed no physician orders that were written on 11/30/18 or note indicating that the medical provider was notified of the change in condition. Further review of the medical record revealed there was no medical provider progress note on 11/30/18. An observation of Resident #89 was made on 03/06/19 at 8:32 AM. Resident #89 was up in his wheelchair eating breakfast. He was alert and verbal and stated that the breakfast tasted good. Multiple attempts were made to speak to Nurse #3 on 03/06/19 and 03/07/19 with no success. An interview was conducted with the Nurse Practitioner (NP) on 03/06/19 at 2:21 with the Director of Nursing (DON) present. The NP stated that she had been visiting the facility for a year and was at the facility 2 times a week. The NP stated she was familiar with Resident #89 who has been very sick in the last couple of months. The NP stated that Resident #89 had been diagnosed with septic pneumonia at the hospital and the presenting sign of that was lethargy and altered mental status. She added that the fever could have been indicative of a few other things, but laboratory values would have been needed to determine that. The NP stated that generally when Resident #89 became sick he would have a high temperature and be lethargic. The NP stated that she would expect the nursing	F 684	The monthly QI committee will review the results of the 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. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. Facility Administrator is responsible for implementing plan of correction.	

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F 684	Continued From page 18 staff to complete a nursing assessment that included a full set of vital signs when Resident #89 had devloped a fever, lethargy, and vomitting. An interview was conducted with the Medical Director (MD) on 03/07/19 at 8:37 AM. The MD stated that he had only been at the facility for a month but was familiar with Resident #89. The MD stated that if Resident #89 had an isolated fever then giving the Tylenol and monitoring the resident would have been appropriate but when Resident #89 had lethargy and vomiting the nurse should have completed a head to toe assessment that included a full set of vital signs. An interview was conducted with the DON on 03/07/19 at 12:06 PM. The DON confirmed that to her knowledge and review of Resident # 89s medical record no full assessment or vital signs were obtained when Resident #89 had the fever, vomiting, and lethargy on 11/30/18. The DON stated that she expected Nurse #3 to complete a full head to toe assessment that included a full set of vital signs and document them in the medical record.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		3/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 19 by: Based on observations, record review, resident and staff interview the facility failed to safely transfer a resident using the mechanical lift with 2 person assist that resulted in a resident falling from the lift and obtaining a skin tear (Resident #77), failed to correctly place a sling pad under a resident before lifting the resident using the mechanical lift (Resident #59) and failed to securely lock up a residents smoking materials (cigarettes and lighter) on the medication cart (Resident #192) for 3 of 3 resident sampled for supervision to prevent accidents. The finding included: Review of the Manufacture Recommendations for the Mechanical Lift read in part, the handle on the back section of the sling should face outward. Position the sling under the patient so the "U" shaped aligns with the base of the spine and the top of the sling close to the neck. 1. Resident #77 was admitted to the facility on 08/09/17 with diagnoses that included repeated falls, weakness, abnormal gait, cognitive communication deficit, depression, and others. Review of the comprehensive minimum data set (MDS) dated 11/19/18 revealed that Resident #77 was cognitively intact and required total assistance of 2 staff members with transfers. Review of a care plan that was updated on 01/03/19 read in part, Resident #77 required assistance with activities of daily living due to impaired mobility. The goal of the care plan read, Resident #77 would receive services and assistance to achieve and/or maintain highest	F 689	F689 What measures was put in place for affected residents: - Resident 77 was assessed by nurse after fall occurred and skin tear was treated per orders. - Resident 59 sling pads was correctly placed under Resident prior to transfer being completed - Resident 192 was reeducated on facility smoking policy and smoking items were removed from room and locked on medication cart What measures were put in place for residents having the potential to be affected: - on 03/11/19 staff development nurse reeducated all smoking residents on facility smoking policy - on 03/13/19 staff development nurse educated staff that all smoking residents smoking items are locked in the medication cart What systems were put in place to prevent the deficient practice from reoccurring: - on 03/05/19 staff development nurse educated staff on proper sizing and positioning of Hoyer sling pads on 02/25/19 staff development nurse educated staff on proper Hoyer lift transfers with return demonstration.	

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F 689	Continued From page 20 possible level of functioning by the review date. The interventions of the care plan included: Resident #77 required extensive assistance of 2 staff members with the mechanical lift for transfers. Review of an incident report dated 02/10/19 read, called to Resident #77's room by Nursing Assistant (NA) #2 who stated that while transferring Resident #77 from the bed to the wheelchair, the sling pad came unhooked from the mechanical lift and Resident #77 fell to the floor from the mechanical lift. NA #2 stated that she held onto Resident #77 to prevent a hard fall however Resident #77 received a skin tear to her right forearm. The investigation read, NA #2 transferred Resident #77 with the mechanical lift and 1 person and she slipped out of the lift to the floor. The form was signed by Nurse #2. An interview was conducted with NA #2 on 03/06/19 at 8:57 AM. NA #2 confirmed that she was caring for Resident #77 on 02/10/19 when she fell from the mechanical lift. She stated that she had provided care to Resident #77 and was going to get her up for breakfast. NA #2 stated that she put the lift pad under Resident #77 and then hooked the straps to the mechanical lift and lifted her into the air from the bed. NA #2 stated that once Resident #77 was in the air she realized that she had the wheelchair too close to the bedside table and the lift would not go between the 2, so she went to the front of the lift to move the wheelchair and she grabbed Resident #77 by the strap on the back of the lift pad to guide her to the wheelchair and as she began to lower Resident #77 to the wheelchair she noticed that the strap at her right foot had come unhooked from the mechanical lift. NA #2 stated that	F 689	New Hires will be educated during orientation on Proper Sizing of Hoyer Slings, and Hoyer Transfers - Administrative nurses or designee will audit staff performing Hoyer lift transfers 5x week for 5 weeks weekly x 5 weeks and monthly x 3 months - Administrative nurses or designee will audit smoking residents smoking items being locked in med carts 5x week for 5 weeks weekly x5 weeks and monthly x3 months. How the facility will monitor systems put into place: The monthly QI committee will review the results of the smoking, Hoyer lift with correct sling, audit tools 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. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. Facility Administrator is responsible for implementing plan of correction.	

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F 689	Continued From page 21	F 689		

Resident #77 slipped from the lift pad and she grabbed at her but of course she hit the floor. She added that she tired to break her fall, but she still hit the floor and she had a skin tear to her right forearm. NA #2 stated that after the fall she went and summoned Nurse #2 to the room. NA #2 stated that Nurse #2 come to the room and made sure Resident #77 was ok and then they manually lifted Resident #77 from the floor to the wheelchair. NA #2 stated that she was aware that she should not have transferred Resident #77 that day alone, but the other staff were busy getting other residents up and she just decided to do it by herself. NA #2 stated that after the fall the facility management had reeducated her about never transferring anyone with 1 person using the mechanical lift again.

An observation and interview were conducted with Resident #77 on 03/06/19 at 9:15 AM. Resident #77 was up in wheelchair next to her bed. She was observed to have a sling pad under her. Resident #77 stated that the staff had transferred her with the mechanical lift and had no problems. Resident #77 was able to recall the fall that she had on 02/10/19 from the mechanical lift and stated that it hurt when she hit the floor, but the skin tear she had received had healed and she was ok.

A follow up interview was conducted with NA #2 on 03/06/19 at 11:22 AM. NA #2 confirmed that straps were securely attached to the mechanical lift when she lifted Resident #77 from the bed on 02/10/19. She stated that she believed that when she pulled Resident #77 by the strap on the back of the sling pad to guide her to the wheel chair that was what caused the strap to come unattached from the mechanical lift and caused

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F 689	Continued From page 22	F 689		

Resident #77 to fall from the lift to the floor. NA #2 confirmed that the strap was not broken it had just came unhooked from the mechanical lift.

An interview was conducted with Nurse #2 on 03/07/19 at 11:12 AM. Nurse #2 stated that on 02/10/19 she was summoned to Resident #77's room by NA #2. She stated that NA #2 reported that while transferring Resident #77 from the bed to the wheelchair the strap of the sling pad came unhooked from the mechanical lift and Resident #77 slipped from the sling pad to the floor. Nurse #2 stated that she went down to the room and assessed Resident #77 who had sustained a skin tear to her right forearm. Nurse #2 stated that she cleaned the skin tear and applied and dressing to the area. She added that Resident #77 had full range of motion to her extremities and denied hitting her head. Nurse #2 stated that after determining that Resident #77 had no other injuries they used the mechanical lift to transfer her from the floor to the wheelchair and then she notified Resident #77's family and the physician. She added that the lift pad was not torn or broken that day it has just came unhooked from the mechanical lift which is what caused Resident #77 to fall from the mechanical lift. Nurse #2 added that NA #2 should not have transferred Resident #77 alone on 02/10/19 she should have requested assistance.

An interview was conducted with the Director of Nursing (DON) on 03/07/19 at 12:02 PM. The DON stated when they investigated Resident #77's fall on 02/10/19 they determined that the it was a user error and not a mechanical issue. She stated that NA #2 should have had 2 people assisting with the transfer via the mechanical lift and the action of pulling Resident #77 up by the

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F 689	Continued From page 23	F 689		

strap on the back cause the strap to unhook from the mechanical lift.

2. Resident #59 was admitted to the facility on 09/20/16 with diagnoses that included: weakness, history of falls, dysphagia, and others.

Review of a care plan revised on 08/28/18 read in part, Resident #59 required assistance with activities of daily living due to impaired mobility. The goal of the care plan read, Resident #59 would receive services and assistance to achieve and/or maintain the highest possible level of functioning by the review date. The interventions included: Resident #59 required extensive assistance of 2 person with transfers via the mechanical lift.

Review of a comprehensive minimum data set (MDS) dated 01/30/19 revealed that Resident #59 was cognitively intact and required extensive assistance of 2 staff members with transfers.

An observation of Resident #59 was made on 03/05/18 at 9:28 AM. Nursing Assistant (NA #3) and the Administrative Nurse (AN) bathed and dressed Resident #59 in the bed. Once Resident #59 was dressed NA #3 and the AN proceeded to place a sling pad under him. The sling pad was placed with the neck portion at Resident #59's feet and the handle on the back section of the sling was facing inward against Resident #59. NA #3 and the AN attach the straps of the sling to the mechanical lift. NA #4 entered the room to assist with the lift and transfer. As NA #4 was pressing the button on the lift remote to raise Resident #59 off the bed the lift was stopped, and the staff asked if the sling pad was positioned correctly. The AN stated that she did not catch that the sling

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 _____	03/07/2019

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F 689	Continued From page 24	F 689		

pad was inside out. Resident #59 was positioned back on the bed and as he was turned to the side to fix the sling pad, NA #4 stated that the sling pad was also upside down. The sling pad was placed correctly under Resident #59 and again hooked up to the mechanical lift. He was safety transferred to his recliner at bedside.

An interview was conducted with NA #3 on 03/05/18 at 10:14 AM. NA #3 stated that she was still very new to the facility and that was the reason the AN had come in the room to assist her with the care of Resident #59. She stated that she had been taught how to correctly use the mechanical lift during orientation and did not catch that the sling pad was placed incorrectly under Resident #59. NA #3 stated that she was nervous and just did not see that it had been placed under Resident #59 the incorrect way.

An interview was conducted with the AN on 03/05/19 at 10:25 AM. The AN stated that she had come into Resident #59's room to assist NA #3 with care as she was very new to the facility. The AN stated that she had not caught the fact that the lift pad that she had placed under Resident #59 was incorrect and with all the commotion did not realize it until the lift was stopped and she was asked about the sling pad. The AN stated that when they turned Resident #59 over to turn the sling pad the correct way she realized that it was also upside down. She stated that NA #3 and NA #4 correctly placed the sling under Resident #59 and he was safely transferred to his recliner.

An interview was conducted with Resident #59 on 03/06/19 at 1:57 PM. Resident #59 confirmed that the staff used the mechanical lift each day to

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F 689	Continued From page 25	F 689		

transfer him to/from the bed. He stated that to his knowledge they have never had any problems using the lift until 03/05/19 when they put the pad under him incorrectly. Resident #59 also confirmed that he had never fallen or been dropped from a mechanical lift.

An interview was conducted with the Director of Nursing (DON) on 03/07/19 at 12:04 PM. The DON stated that she expected the staff to place the sling pad correctly under Resident #59 or identify that it was placed incorrectly prior to lifting Resident #59.

3. A review of the facility's smoking policy titled "Smoking Policy and Procedure" dated 01/2019 stated in part "it was the policy of Glenbridge to allow residents the ability to smoke ... . Cigarettes and other smoking items will be kept locked up for the health and safety of all Facility residents. Any infraction of this policy will result in the resident becoming a supervised smoker for the safety of all staff and residents." The policy continue to state "Cigarettes and other smoking items will be kept in a locked medication cart."

Resident #192 was admitted to the facility on 11/11/18 with diagnoses which included heart failure, peripheral vascular disease and diabetes mellitus. The most recent comprehensive Minimum Data Set (MDS) assessment dated 12/09/18 indicated he had intact cognition, was independent with his activities of daily living and he was a tobacco user.

A review of Resident #192's Care Plan dated 12/26/18 revealed he was a safe smoker and had an established goal that he would not sustain injuries related to unsafe smoking habits with the

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	345163	A. BUILDING _____ B. WING _____	03/07/2019

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F 689	Continued From page 26	F 689		

interventions which included he could smoke unsupervised, to instruct him on the facility's smoking policies and to notify the charge nurse immediately if it was suspected that he violated the facility's smoking policy.

A review of Resident #192's Smoking assessment dated 01/11/19 revealed he had been in the facility several times and always exhibited safe smoking habits. The assessment also indicated he was able to light his cigarette and open doors (to the designated smoke area).

An observation of Resident #192 on 03/04/19 at 3:06 PM revealed he ambulated to the designated smoke area, removed his cigarette and lighter from his jacket and proceeded to light the cigarette and smoke it in a safe manner.

A review of a Smoking assessment dated 03/06/19 for Resident #192 indicated he was able to light his own cigarette and had no burns in his clothing. The assessment also noted that he was able to keep his cigarettes in his room.

During an interview with Resident #192 on 03/07/19 at 8:38 AM he stated he was able to smoke anytime he chose to do so and was allowed to keep his smoking materials (cigarettes and lighter) in his room. After which Resident #192 opened the top drawer to his bedside table and revealed a carton of cigarettes and a lighter.

An interview with Nurse #1 on 03/07/19 at 8:48 AM, revealed Resident #192 was deemed a safe smoker and was allowed to keep his cigarettes and lighter with him all of the time.

An interview with the Director of Nursing (DON)

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	345163	A. BUILDING _____ B. WING _____	03/07/2019

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F 689	Continued From page 27 on 03/07/19 at 10:46 AM revealed she was not sure what the smoking policy stated but that Resident #192 was one of two residents who were assessed as safe smokers that were allowed to keep their cigarettes and lighter with them and all of the other smokers had to keep their smoking items locked on the medication carts. After divulging the facility's Smoking policy and the previous observation to the DON she stated her expectation was that Resident #192 abide by the smoking policy and his cigarettes and lighter be kept on the medication cart. During an interview with the Administrator on 03/07/19 at 11:10 AM she stated her expectation was for all smoking paraphernalia be locked on the medication carts as the policy stated.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		3/30/19

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F 761	Continued From page 28 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to discard an opened and outdated multi dose vial of Tuberculin Purified Protein (TB) vaccine that was in the refrigerator and available for use for 1 of 2 medication rooms reviewed. The findings included: The Manufacture recommendation for the TB vaccine read, discard opened products after 30 days. An observation of the medication room refrigerator at the 100/200 hall was made on 03/06/19 at 4:43 PM. The refrigerator was noted to have an opened multi dose vial of TB vaccine that had been opened on 01/31/19. The multi dose vial of TB vaccine was given to the Unit Manager (UM). An interview was conducted with the Unit Manager on 03/06/19 at 4:46 PM. The UM confirmed that the opened multi dose vial of TB vaccine that was in the refrigerator and available for use was past its 30 days and should have been discarded. An interview was conducted with the Director of Nursing (DON) on 03/07/19 at 12:25 PM. The	F 761	What measures did the facility put in place for the resident affected: 03/06/19 out dated vial of tuberculin was discarded no negative findings. What measures were put in place for residents having the potential to be affected: 03/06/19 ADON completed 100% audit of all med rooms to ensure all medication was properly labeled. 03/06/19 100% in service was initiated by DON on proper labeling of drugs. In-service will be completed by 03/29/19. What systems were put in place to prevent the deficient practice from reoccurring: Don/Adon initiated an in-serviced on 03/06/19 for all licensed Nurses on proper labeling of drugs, it will be completed by 03/29/19. All new Nurses will be inserviced upon hire on proper labeling. How the facility will monitor systems put in	

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	345163	A. BUILDING _____ B. WING _____	03/07/2019

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F 761	Continued From page 29 DON stated she expected the opened multi dose vial of TB vaccine that was in the refrigerator and available for use to have been discarded 30 days after it was opened per the manufacture recommendations.	F 761	place: On 03/11/19 the DON and Admin Nurse began auditing med rooms and med carts for proper labeling. Audit will be completed 5x a week for 5 weeks then weekly x 5 weeks then monthly x 3 months. The monthly QI committee will review the results of the 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. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. Facility Administrator is responsible for implementing plan of correction.	
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	F 842		3/30/19

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F 842	Continued From page 30 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 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.	F 842		

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F 842	Continued From page 31 §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 review, staff and Registered Dietician interviews the facility failed to maintain complete and accurate nutritional assessments for 1 of 1 resident reviewed for dialysis (Resident #48). The finding included: Resident #48 was admitted to the facility on 12/20/16 with diagnoses that included end stage renal disease. Review of Resident #48's recent significant change Minimum Data Set (MDS) assessment dated 01/12/19 revealed he had intact cognition and required limited assistance with most of his activities of daily living. The MDS also indicated he received dialysis. Review of Resident #48's Care Plan dated 02/19/18 revealed he was at risk for dehydration related to his noncompliance to fluid restrictions. The goal was for him to be compliant with his fluid restrictions by utilizing interventions which included, dietary consults prn, offering allowed	F 842	F842 What measures did the facility put in place for the resident affected: On 3/19/19 Administrator Inservice RD on what is expected on documentation of residents. On 03/19/19 Registered Dietician documented her assessment on Resident #48 What measures were put in place for residents having the potential to be affected: On 03/11/19 100% audit was completed by RD to ensure all residents had a quarterly assessment. On 03/19/19 RD was in serviced by Administrator on ensuring residents have quarterly assessments. What systems were put in place to prevent the deficient practice from reoccurring: Administrator in serviced RD on 03/19/19 on completing Admission and quarterly	

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F 842	Continued From page 32 amount of fluids and observing for signs and symptoms of dehydration. Review of Resident #48's medical record for a Nutritional assessment revealed the last Nutritional progress note was dated 03/26/18 written by the Dietary Manager (DM). The record also indicated that the last Nutritional assessment by a Registered Dietician (RD) was dated 10/30/17. An interview was conducted with the DM on 03/06/19 at 8:18 AM who indicated she had conversations with Resident #48 several times a week because of his noncompliance to his dietary restrictions. The DM stated Resident #48 often requested foods that were not on a renal diet and drank in excess of the 1500 milliliter fluid restriction he was allowed per day because there were days when he had to be scheduled an extra day a week in addition to his three day a week for dialysis. The DM reported that the RD was in the facility twice a month for consultations. On 03/07/19 at 10:10 AM during a telephone interview with the RD she confirmed she had been employed by the facility since October, 2018 and she was in the facility twice a month for Nutritional assessments on the residents. The RD stated she had completely dropped the ball on documenting her assessments on Resident #48 and because of his significant issues with his noncompliance with his diet, she should have made at least monthly assessments on him. An interview was conducted with the Administrator on 03/07/19 at 11:09 AM who stated her expectation was for the RD to have made at least quarterly progress notes on	F 842	assessments. How the facility will monitor systems put in place: On 03/11/19 the Administrator, Dietary Manager, and Registered dietician began auditing RD Assessments twice a month x 3 months. The monthly QI committee will review the results of the RD 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. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. Facility Administrator is responsible for implementing plan of correction	

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F 842	Continued From page 33 Resident #48.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place February 2018 following a recertification and complaint survey and subsequently recited in March 2019 on the current recertification survey. The repeat deficiency is in the area of medication storage and labeling (F 761). This deficiency was recited during the facility's current recertification survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F 761: Based on observations, record review, and staff interviews the facility failed to discard an opened and outdated multi dose vial of Tuberculin Purified Protein (TB) vaccine that was in the refrigerator and available for use for 1 of 2 medication rooms reviews.	F 867	F-867 QAPI Committee On 03/15/19 the facility Executive QI Committee held a meeting. Administrator, DON, MDS Nurse, Treatment nurse, Staff facilitator, Maintenance Director, and Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. During this meeting one of the areas that was talked about was F761 us receiving this tag last year and again this year. On 03/15/19 the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility	3/30/19

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 _____	03/07/2019

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F 867	Continued From page 34 During the recertification and complaint survey of 02/24/18, this regulation was cited for failing to discard 1 of 1 multi-dose tuberculin vaccine vial that was opened and undated and was available for use in 1 of 2 medication refrigerators. An interview was conducted with the Administrator on 03/07/19 at 1:13 PM. The Administrator stated that the Quality Assurance (QA) committee met monthly and consisted of the Director of Nursing (DON), the Administrator in Training (AIT), and all the department heads. She added that quarterly the pharmacist and registered dietitian would attend. The Administrator stated that currently they were continuing their work on survey preparedness and reducing the use of antibiotics in the facility along with reducing hospital readmissions. The Administrator stated that all the audits from the recertification survey in 2018 were resolved and she felt like they remained back in compliance. She stated that with the findings discovered during the current recertification survey that they would have to reeducate the staff again and very closely monitor the medication rooms and refrigerators to make sure all the dates were there and appropriate.	F 867	concerns. As of 03/15/19, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and Medication Room Audit. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. The Committee will continue to meet at a minimum of monthly. The Executive QI Committee, including the Medical Director will meet on a quarterly basis, the committee will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next	

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F 867	Continued From page 35	F 867	scheduled meeting.	