CENTERS FO	OR MEDICARE & MEDICAID SERVICES			"A" FORM				
STATEMENT OF	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:				
FOR SNFs AND	NFs	345163	B. WING	2/27/2015				
NAME OF PROV	VIDER OR SUPPLIER	STREET ADDRESS, CITY	STREET ADDRESS, CITY, STATE, ZIP CODE					
GLENBRID	GE HEALTH AND REHABILTATION CENTER	211 MILTON BROV BOONE, NC	VN HEIRS ROAD					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	•						
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE O	OF RIGHTS, RULES,	SERVICES, CHARGES					
	The facility must inform the resident both orahis or her rights and all rules and regulations in the facility. The facility must also provide under §1919(e)(6) of the Act. Such notificative resident's stay. Receipt of such information,  The facility must inform each resident who is admission to the nursing facility or, when the services that are included in nursing facility second be charged; those other items and services that and the amount of charges for those services; and services specified in paragraphs (5)(i)(A)	governing resident co e the resident with the ion must be made pric and any amendments s entitled to Medicaid e resident becomes eli- services under the Star at the facility offers an ; and inform each resident	onduct and responsibilities during the star notice (if any) of the State developed or to or upon admission and during the to it, must be acknowledged in writing. benefits, in writing, at the time of gible for Medicaid of the items and the plan and for which the resident may no and for which the resident may be charged dent when changes are made to the items	y ot i,				
	The facility must inform each resident before resident's stay, of services available in the facilities services not covered under Medicare or by the	cility and of charges for	or those services, including any charges	for				
	The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;							
	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.							
	A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.							
	The facility must inform each resident of the for his or her care.	name, specialty, and	way of contacting the physician responsi	ble				
	The facility must prominently display in the applicants for admission oral and written info benefits, and how to receive refunds for prev	ormation about how to	apply for and use Medicare and Medica	nid				

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

	OR MEDICARE & MEDICAID SERVICES	The course of		A FORM		
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
NO HARM WI	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:		
FOR SNFs ANI	D NFs	345163	B. WING	2/27/2015		
	OVIDER OR SUPPLIER  DGE HEALTH AND REHABILTATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES					
F 156	Continued From Page 1					
	This REQUIREMENT is not met as evident Based on record review and staff interviews resident/responsible party 2 days prior to Met #197).  The findings included: Resident #197 was admitted to the facility of disease and non-Alzheimer's dementia. Review of the SW #1 notes dated 07/09/14 reservices would end on 07/09/14. The note reinform her of therapy services ending but she Resident #197's responsible party a written in An interview conducted on 02/26/15 at 12:00 notice when she sent them to the resident/ressee if they received the notice. She stated she Benefits had to be sent 2 days prior to service management company had sent in a consultat not aware she needed to follow up with the recopy of the signed letter.  An interview was conducted on 02/27/25 at expectation residents/responsible party received and that notice be signed and kept in the median.	the facility failed to edicare benefits end in 09/09/13 with dia- revealed she was ma- evealed SW #1 phone e was not available, notice on 07/09/14, 5 PM with SW #1 r sponsible party nor e was not aware writes ending when she and to train her on lia- resident/responsible 12:15 PM with the ved a written or ver	gnoses of chronic obstructive pulmonary ande aware that Resident #197's therapy and Resident #197's responsible party to a The note further revealed SW #1 mailed the day therapy services were ending, evealed she did not keep a copy of the writted did she follow up with the responsible party atten or verbal notices of ending Medicare of first started as the SW. She further stated the ability when she started the job but she was party that they received the letter or have a Administrator. She stated it was her	the		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PAR'  The resident has the right, unless adjudged in	ncompetent or other	rwise found to be incapacitated under the la	ws		
	A comprehensive care plan must be develop assessment; prepared by an interdisciplinary with responsibility for the resident, and othe needs, and, to the extent practicable, the part legal representative; and periodically review assessment.  This REQUIREMENT is not met as evidence as evidence as a contract of the part legal representative.	ed within 7 days aff team, that includes or appropriate staff it ticipation of the resi red and revised by a	ter the completion of the comprehensive the attending physician, a registered nurse n disciplines as determined by the resident's ident, the resident's family or the resident's	S		
	Based on resident and staff interviews and re	-	acility failed to include 2 of 2 residents			

CENTERS F	OR MEDICARE & MEDICAID SERVICES			"A" FORM					
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FOR SNFs ANI	) NFs	345163	B. WING	2/27/2015					
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, C	CITY, STATE, ZIP CODE						
GLENBRII	OGE HEALTH AND REHABILTATION CENTER	211 MILTON BROBONE, NC	OWN HEIRS ROAD						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES								
F 280	Continued From Page 2								
		sampled for care plan participation (Residents #50 and #64) in their care plan development and failed to revise the care plan to include a change in skin condition and treatment orders for 1 of 3 residents sampled for							
	The findings included:								
	1. Resident #50 was admitted to the facility of hypothyroidism, diabetes, cerebral vascular a		•						
	The care plan sign in sheet for review of the care plan noted that the responsible party and resident did not attend on $06/12/14$ . The sheet noted that the meeting held on $10/01/14$ was attended by the responsible party but not the resident.								
	Her most recent Minimum Data Set (MDS), a significant change dated 12/10/14, coded her as having no cognitive impairments, having other behaviors, requiring extensive assistance with dressing, toileting and hygiene. The MDS coded her with little interest in doing things, having sleep issues, being nonambulatory, having impairment of range of motion on each side, receiving a therapeutic diet and receiving an antidepressant, hypnotic and anticoagulant.								
	There was no sign in sheet reflecting that a care plan meeting review was held following the significant change assessment.								
	On 02/17/15 at 10:49 AM, Resident #50 stated during interview that she was not invited to her care plan meetings and would like to know more about her disability.								
	On 02/24/15 at 9:57 AM, Resident #50 again stated during interview that she wanted to be included with her responsible party in care plan meetings. She further stated she could not recall ever attending a care plan meeting.								
	On 02/24/15 at 3:36 PM, Social Worker (SW based on the schedule that the Minimum Data to responsible parties alerting them of the dat set up care plan meetings extra if a need arose mailed to the responsible party unless a resideresponsible party, SW #2 stated she asked the in the care plan meeting. She stated there was meeting with the resident if the resident was SW #2 stated during the last care plan meeting thought the responsible party invited the resident.	a Set Coordinator de and time of the case or was requested. ent was their own representation of the case of the case of the case of the case of the responsible party as no separate meeting the responsible party as the case of the responsible party.	developed. She stated that a letter was mailed are plan. In addition, SW #2 stated that she are plan. She further stated that the letters were responsible party. If a resident had a if they wished to have the resident involveding to review the care plan or the results of are plan meeting. In regards to Resident # party attended but not the resident. She	ed e d the 50,					
		On 02/24/15 at 3:55 PM MDS coordinator stated that she provided the schedule for care plan conferences to staff to mail to the residents' responsible parties. She stated she hoped that someone, such as she, the social							

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FOR SNFs ANI	) NFs	345163	B. WING	2/27/2015			
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD					
GLENBRII	OGE HEALTH AND REHABILTATION CENTER	BOONE, NC	OWN HEIRS ROAD				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	3					
	worker or family would invite the resident be coordinator could not explain how the resident 2. Resident #64 was admitted to the facility Parkinson's Disease, Panic disorder, bipolar, dated 01/01/15 coded her as being cognitive the Brief Interview for Mental Status).  There was no evidence in the medical record responsible party.  On 02/17/15 at 11:55 AM, Resident #64 stat not been invited to care plan meetings.  On 02/24/15 at 3:36 PM, Social Worker (SW based on the schedule that the Minimum Date to responsible parties alerting them of the daset up care plan meetings if the need arose of the responsible party unless a resident was the SW #2 stated she asked the responsible party meeting. She stated there was no separate meeting. She stated there was not present at	on 09/09/08 with di on 09/09/08 with di depression, and chr ly intact but having and as to who attended ted she was not invo- ted she was not invo- ted and time of the care or was requested. She heir own responsible by if they wished to heeting to review the tothe care plan meeting	the care plan development.  agnosis including altered mental status, conic pain. Her annual Minimum Data Set some impairment (scoring a 9 out of 15 or care plan meeting in the past year. She had lived in daily decisions about her care and explans were scheduled for every Tuesday eveloped. She stated that a letter was mail are plan. In addition, SW #2 stated that she further stated that the letters were mailed a party. If a resident had a responsible parave the resident involved in the care plan care plan or the results of the meeting wing.	n da a had and ed hee d to ty, th			
	On 02/24/15 at 3:55 PM MDS coordinator st staff to mail to the residents' responsible part worker or family would invite the resident be stated that she had gone personally to talk w brought up in care plan meetings. Also MDS the care plan development.  3. Resident #99 was admitted on 10/16/14 w history of deep vein thrombosis of the left lo revealed Resident #99 was at risk for a press assessment.  Review of a care plan dated 11/06/14 revealed.	ties. She stated she but was not sure who with Resident #64 about S coordinator could with diagnoses include ower extremity. An according to the sure ulcer but did not sure ulcer but	took on that responsibility. She further but concerns that her responsible party had not explain how the resident was involved ding chronic congestive heart failure and admission Minimum Data Set dated 10/24 thave a pressure ulcer at the time of the	al i i in			
	due to immobility. The goal was for Resider discoloration through the next review on 01/document any changes in skin status.	nt #99 to have intact	skin, free of redness, blisters, or				

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY					
NO HARM WITH	NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
FOR SNFs AND N	Fs	345163	B. WING	2/27/2015					
NAME OF PROV	DER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE							
GLENBRIDG	E HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC							
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TAG	SUMMARY STATEMENT OF DEFICIENCIES								
F 280	Continued From Page 4								
	Review of a skin integrity report dated 01/08/01/08/15 with an unstageable pressure ulcer of		nt #99 was readmitted to the facility on						
	Review of physician's orders revealed an order pressure ulcer on Resident #99's left heel with	-	eatment Nurse on 01/08/15 to paint the						
	During an interview on 02/24/15 at 11:20 AM the MDS (Minimum Data Set) Coordinator confirmed there was a care plan meeting for Resident #55 on 01/19/15 which she attended in addition to the resident and a family member. The MDS Coordinator could not recall if the potential for pressure ulcer development care plan was reviewed during the meeting but stated the treatment nurse was expected to update care plans to include changes in skin condition and treatment orders.								
	when there were changes in a resident's skin of Treatment Nurse confirmed she should have n	acted with the Treatment Nurse on 02/24/15 at 1:55 PM. The Treatment Nurse stated as in a resident's skin condition or treatment plan she updated the care plan. The med she should have revised Resident #99's care plan on 01/08/15 to include the cer on her left heel and daily treatment order. The Treatment Nurse could not explain not been revised.							
	1								

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345163	B. WING _		02/	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 159 SS=B	staff lowered Resident transfer. Immediate je 02/27/15 at 11:35 AM and implemented an a allegation of compliant of compliance at a low (an isolated deficience potential for more that immediate jeopardy) is systems put into place 483.25 (F323) at J Immediate Jeopardy 1 staff lowered Resident transfer. Immediate je 02/27/15 at 11:35 AM and implemented an allegation of compliant of compliance at a low (an isolated deficience potential for more that immediate jeopardy) is systems put into place is at a scope and sevent 483.10(c)(2)-(5) FACI PERSONAL FUNDS	began on 11/15/14 when a teopardy was removed on when the facility provided acceptable credible acce. The facility remains out wer scope and severity of D y, with no actual harm with a minimal harm that is not to ensure monitoring of a are effective.  began on 11/15/14 when at #24 to the floor during a eopardy was removed on when the facility provided acceptable credible acceptable a	F 01	00		
ABORATORY	funds in excess of \$5	of this section.  Distit any resident's personal  O in an interest bearing  SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			02/	27/2015		
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER		·	211 N	EET ADDRESS, CITY, STATE, ZIP CODE MILTON BROWN HEIRS ROAD DNE, NC 28607					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 159	the facility's operatinall interest earned or account. (In pooled separate accounting)  The facility must main funds that do not except bearing account, interpetty cash fund.  The facility must est that assures a full arraccounting, accordinaccounting principles funds entrusted to the behalf.  The system must preresident funds with for any person other of the individual finance through quarterly state the resident or his or the facility must not Medicaid benefits where it is account resident's account resident's account resident's account resident's other reaches the SSI resources.	e 1 s) that is separate from any of g accounts, and that credits in resident's funds to that accounts, there must be a for each resident's share.)  Intain a resident's personal eeed \$50 in a non-interest erest-bearing account, or  ablish and maintain a system and complete and separate ag to generally accepted as, of each resident's personal e facility on the resident's  eclude any commingling of accility funds or with the funds than another resident.  ital record must be available attements and on request to ther legal representative.  fy each resident that receives then the amount in the eaches \$200 less than the rone person, specified in of the Act; and that, if the int, in addition to the value of nonexempt resources, ource limit for one person, the gibility for Medicaid or SSI.	F	159					
	This REQUIREMEN by:	T is not met as evidenced							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02/27/2015	
	ROVIDER OR SUPPLIER	ABILTATION CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 159	and staff interviews, quarterly statements residents sampled for funds. (Residents #7  The findings included 1. Resident #50 was 10/31/13. Her diagnoweakness, hypothyrovascular accident, coanxiety disorder.  Her Minimum Data Schange dated 12/10/cognitive impairment the Brief Interview for On 02/17/15 at 11:04 a personal fund accobut she never receive of the balance.  On 02/19/15 at 3:24 stated resident funds responsible parties or resident was their own	therviews, record reviews, the facility failed to send to 5 of 5 alert and oriented refacility management of 7, #50, #68, #71, and #157).  It:  admitted to the facility on oses included muscle oldism, diabetes, cerebral pronary artery disease and et (MDS), a significant 14, coded her as having no s, scoring 15 out of 15 on	F 159			
	were sent to the residence quarterly statement was party. She confirmed receive a quarterly at Follow up interview was 02/24/15 at 9:57 AM	dent. Resident #50's were sent to her responsible d Resident #50 did not ccount statement.				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER: A. BUILDING			NSTRUCTION (X3) DATE SURVE COMPLETED		
		345163	B. WING	<del> </del>		02/27/2015
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		·				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 159	that they were going cognition assessment receive a copy of the 2. Resident #7 was 08/04/14. Her diagon heart failure, diabet Her quarterly Minimoded her as cognition of 15 on the Brief Into On 02/17/15 at 10:5 facility managed her on 02/19/15 at 3:24 stated resident functoresponsible parties resident was their on thave a responsivere sent to the restatements were seen to the restatements were seen office Staff #1 confireceive quarterly and Upon follow up interesident #7 statement informity and the statement informity and dition to her family On 02/27/15 at 9:50 that they were going cognition assessment receive a copy of the 3. Resident #68 ware 07/09/10. His diagriful was only of the copy of	AM the Administrator stated g to review each residents' ent and determine who should eir own quarterly statements.  readmitted to the facility on noses included congestive es and macular degeneration. It was a state of the facility on the facility on noses included congestive es and macular degeneration. It was a state of the facility of the facili	F 15	59		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY MPLETED	
		345163	B. WING			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
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F 159	quarterly Minimum Decoded him as being out of 15 on the Brief During interview on stated the facility material account for him but the regarding the balance on 02/19/15 at 3:24 stated resident fund responsible parties or resident was their ownot have a responsil were sent to the resident funding the statements of the resident was their ownot have a responsible were sent to the resident was office Staff did not receive quarterly statements. Business Office Staff did not receive quarterly account.  On 02/24/15 at 10:08 Al receive a quarterly baccount.  On 02/27/15 at 9:50 that they were going cognition assessment receive a copy of the 4. Resident #71 was 06/20/07. Her diagriperipheral vascular of depression. Her quadated 01/28/15 code intact scoring a 15 of for Mental Status.	Data Set dated 12/16/14 cognitively intact scoring a 15 of Interview for Mental Status.  D2/16/15 at 2:19 PM he anaged a personal fund that he received no statement ce.  PM Business Office Staff #1 statements were sent to on a quarterly basis. If a wn responsible party or did cole party then the statements dent. Resident #68's were sent to his family. If #1 confirmed Resident #68 terly account statements.  With Resident #68 on M revealed he wanted to collaince of his personal fund  AM the Administrator stated a to review each residents' ont and determine who should ceir quarterly statements.  Stadmitted to the facility on coses included hypertension,	F 15	59			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345163	B. WING	· · · · · · · · · · · · · · · · · · ·		2/27/2015		
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 0 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		•				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 159	stated resident funceresponsible parties resident was their on thave a responsion were sent to the resquarterly statement Business Office Stadid not receive qual Upon follow up inter AM, Resident #71 sthat her family receistatements.  On 02/27/15 at 9:50 that they were going cognition assessmereceive a copy of the 5 Resident #157 was 04/08/14. Her diagridiabetes, anxiety dimost recent Minimulassessment dated in cognitive impairron the Brief Intervier on 02/16/15 at 2:22 the facility managed did not receive a staher of her balance.  On 02/19/15 at 3:24	I PM Business Office Staff #1 I statements were sent to on a quarterly basis. If a wn responsible party or did ble party then the statements sident. Resident #71's s were sent to her family. If #1 confirmed Resident #71 terly statements.  Project on 02/24/15 at 10:08 stated it was alright with her red her personal fund  O AM the Administrator stated g to review each residents' ent and determine who should eir quarterly statements.  As admitted to the facility on moses included anemia, sorder and depression. Her m Data Set, an annual 02/02/15 coded her as having ments, scoring a 15 out of 15 w for Mental Status.  P PM, Resident #157 stated of her personal funds and she atement quarterly informing	F 15	9				
	responsible parties resident was their o	I statements were sent to on a quarterly basis. If a wn responsible party or did ble party then the statements						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER		21	REET ADDRESS, CITY, STATE, ZIP CODE  1 MILTON BROWN HEIRS ROAD  DONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	#157 did not receive of statements.  On 02/24/15 at 11:23 interviewed again and her family received her family received her family received her they were going to cognition assessment receive a copy of their 483.15(a) DIGNITY A	lent. Resident #157's ras sent to her family. #1 confirmed Resident quarterly account  AM, Resident #157 was d stated that it was alright if er statements.  AM the Administrator stated to look at each residents' t and determine who should r quarterly statements.		159			
SS=D	manner and in an envenhances each reside full recognition of his	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.					
	Based on observation interviews, the facility of residents during transidents sampled for on doors before enter their meal tray (Residents tood over residents to (Residents #29, #56, The findings included 1. Resident #56 was	and #106).					
	Ther diagno						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 241	as having long and s impairment and sever making skills. She wassistance with eatin On 02/16/15 at 11:25 #3 was observed fees stood while Resident wheelchair and NA # each bite as she fed continued feeding Residents and the resident's bed.  On 02/24/15 at 9:34. She stated she had the she fed residents and the resident's bed.  On 02/19/15 at 5:24 observed sitting in best floor. NA #9 was obsthe bed, the tray in frespoon up a bite of for and feed the resident the cup to Resident # cup independently.  NA #9 was interviewed She related that this fed Resident #56 but feeding residents at I did not think to raise food so she could se have positioned the resident was not seen to see the seen the seen that the seen	et dated 01/09/15 coded her hort term memory rely impaired decision ras coded as requiring total g.  6 AM, Nursing Assistant (NA) ding Resident #56. NA #3 #56 was seated in her 3 bent over the resident with Resident #56. She esident #56 while standing at AM, NA #3 was interviewed. Deen instructed to stand as do not to sit in a chair or on PM Resident #56 was ed which was lowered to the served sitting in a chair by ont of the NA. NA #9 would bod, reach over, lean down to each bite. She would hand #56 and she drank from the red on 02/19/15 at 5:41 PM. Was the first time she had that she often assisted with unch time. She stated she the bed and position the etit. She stated she should	F2	241			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		345163	B. WING	<del> </del>		2/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	interviewed and star position themselves when they were feed 2. Resident #106 v 12/30/11 with diagn Alzheimer's Diseas Her quarterly Minim dated 01/12/15 code never understood a memory impairment having severely impand needing total at On 02/19/15 at 5:29 observed feeding Rede. NA #7 was obleaning over Reside bite. NA #7's waist	ge 8 irrector of Nursing #2 were ited that they expected staff to s at eye level with the resident iding a resident during meals.  Ivas admitted to the facility on oses including Diabetes, e, and esophageal reflux.  Inum Data Set, a quarterly ed that she was rarely or ind could not be assessed for its, but that she was coded for oaired decision making skills essistance with feeding.  In PM, Nurse Aide (NA) #7 was desident #106 while she was in served standing at bedside ent #106 while he fed her each was at the same height as the its #7 finished feeding Resident	F 24	41		
	#106 via standing at On 02/19/15 at 5:52. He stated that he h facility approximate always stood when stated he was trains sometimes could no put the bed as high standing up.  Interview with the E Assistant Director of expected staff to fe	<u> </u>				

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345163	B. WING		02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REI	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 241	weakness, hypothyl vascular accident, canxiety disorder.  Her Minimum Data change dated 12/10 cognitive impairment the Brief Interview for the Brief I	noses included muscle roidism, diabetes, cerebral coronary artery disease and Set (MDS), a significant 1/14, coded her as having no ats, scoring a 15 out of 15 on for Mental Status.  9 PM Nurse Aide (NA) #7 did ent #50's door before entering dent #50's door before entering dent #50's door before entering.  15 PM NA #7 was interviewed resident doors, he stated that Resident #50's door because or stated he had been here 3 are was supposed to knock on afore entering.  16 PM Na #7 was interviewed resident #50's door because or stated he had been here 3 are was supposed to knock on afore entering.  17 PM Na #7 was interviewed resident #50's door because or stated he had been here 3 are was supposed to knock on afore entering.  18 PM Na #7 was interviewed resident #50's door because or stated he had been here 3 are was supposed to knock on afore entering.  18 PM Na #7 was interviewed resident #50's door because or stated he had been here 3 are was supposed to knock on afore entering.	F 24		
	and a stroke.  A review of the mos Data Set (MDS) dat				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER	,	STREET ADDRESS, CITY, STATE, ZII 211 MILTON BROWN HEIRS ROAI BOONE, NC 28607	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 241	Continued From pag	e 10	F 2	241			
	The MDS also indical independent with ear only.  During an observation Resident #29 was sirroom with a meal trace overbed table. Resideft hand and was ferfood. At 5:47 PM Resident hand stopped PM Nurse Aide (NA) #29's room and asket then NA #10 picked feeding Resident #29 and over her. NA #1	ion for daily decision making. ated Resident #29 was ting and required set up help on on 02/19/15 at 5:35 PM tting in a wheelchair in her y in front of her on an dent #29 had a spoon in her eding herself small bites of esident #29 laid the spoon on of feeding herself. At 5:52 #10 walked into Resident ed if she was still eating and up the spoon and started 9 while standing next to her 10 continued to feed Resident intil 6:05 PM when Resident her head and stated					
	NA #10 she stated sherself and ate well is She explained she tr #29 to eat and offere stopped eating. She routine to stand next could see her while stated she had not his sitting or standing withere was no policy to During an interview of Director of Nursing a Nursing #2 stated the	on 02/19/15 at 6:20 PM with ometimes Resident #29 fed but sometimes she didn't. ried to encourage Resident ed her food to eat when she estated it was her usual to Resident #29 where she she fed her. She further ad any in-services regarding nile feeding residents and that she was aware of.  On 02/24/15 at 2:22 PM the and Assistant Director of ey expected staff to position evel with the resident when in meals.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 11 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 241	Continued From pa	ge 11	F 241			
	11/06/14 with diagn	admitted to the facility on oses of congestive heart kness, high blood pressure eath.				
	Data Set (MDS) dat Resident #4 had sh memory problems a in cognition for daily also indicated Resid	st recent quarterly Minimum ted 01/27/15 indicated ort term and long term and was moderately impaired y decision making. The MDS dent #4 required extensive for activities of daily living.				
	Nurse Aide (NA) #1	ion on 02/19/15 at 6:09 PM 0 entered Resident #4's room d did not knock before she t's room.				
	NA #10 she confirm room with a meal tr not wait for permiss stated she knew sh introduce herself ar stated she tried to k before she entered	on 02/19/15 at 6:20 PM with led she entered Resident #4's lay without knocking and did lion to enter the room. She le was supposed to knock, and then go in. She further knock on resident's doors the room but when it got busy the room without knocking.				
	the Director of Nurs Nursing #2 they sta	on 02/24/15 at 2:26 PM with ing and Assistant Director of ted it was their expectation for me they entered a resident's				
	Resident #4 she sta knock on her door t because she wante	on 02/26/14 at 12:04 PM with ated she preferred for staff to before they entered the room d to know who was coming further stated she did not like				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:		IG	TRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING_			02/	27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 241	Continued From page	e 12 ed on in her room without	F 2	41				
F 253 SS=E	letting her know they	were coming in first. KEEPING &	F 2	53				
		ide housekeeping and secessary to maintain a comfortable interior.						
	by: Based on observation facility failed to maintain broken vinyl panels or resident closet doors 202, 212, 211, 303, 4 maintain wooden han scraped and missing 100, 200, 300, and 40 maintain wheelchairs (Halls 200, 300, and 40 The findings included 1. On 2/16/15 at 11:00 the facility and again revealed the following closet doors in reside Room 202- exterior poloset door was loosed corners.  Room 212- exterior popen with sharp corner moving by the door.  Room 211- exterior popen with sharp corner popen with sharp corner moving by the door.  Room 303-exterior pand cracked at the collection of the company of the corner and cracked at the collection of the	c) AM during the initial tour of on 02/25/15 at 11:00 AM gobservations were made of int rooms: anel on the front of the experience and frayed at the experience and on closet door was split ers exposed to anyone anel on closet door loose, anel on closet door loose						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 253	Continued From pag	ne 13	F 2	53		
	easily separated from Room 414- exterior the middle and sharp side of the split. Room 416- exterior the corners and loos	panel on closet door split in o edges protruding on each				
	days revealed no recrepair of closet doors. Interview with the Ma 02/25/15 at 10:30 Al doors in the resident indicated the outside moisture under them completely. The mai the maintenance depairs of close to the complete of	quests were identified for				
	of the facility, and age the following observed handrails: 100 Hall- wooden had observed with areas gave the wood a grad Other areas of the hitted and scraped. 200 Hall- wooden had observed with areas gave the wood a grad Other areas of the hipitted and scraped. It walking in the hallware wheelchairs by using 300 Hall- wooden had	ation AM during the initial tour gain on 02/25/15 at 11:00 AM ations were made of facility andrails in the hallway were that was missing varnish that iny, rough feel to touch. andrails were observed to be andrails in the hallway were that was missing varnish that iny, rough feel to touch. andrails were observed to be Residents were observed to be Residents were observed ay and ambulating with go the handrails for assistance. Andrails in the hallway were that was missing varnish that				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			2/27/2015	
	ROVIDER OR SUPPLIER	EHABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	2.2172010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACT)  CROSS-REFERENCED TO T  DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 253	Other areas of the pitted and scrape walking in the hall wheelchairs by us 400 Hall- wooden observed with are gave the wood a gother areas of the pitted and scrape. A review of the midays for Halls 200 requests were ide Interview with the 02/25/15 at 10:30 wooden handrails they were easily of wheelchairs causi the handrails. He could sand the haget hit by a wheel damaged before to occurred frequent department could.  3. During the su were made of res a. 200 Hall- On 02 was observed sitt. The right padded missing exposing metal bar to rest in the wheelchair was also was observed sitt.	grainy, rough feel to touch.  chandrails were observed to be and. Residents were observed way and ambulating with sing the handrails for assistance. In handrails in the hallway were was that was missing varnish that grainy, rough feel to touch.  It handrails were observed to be additionable to the handrails one down and there were throughout the building and damaged when hit by the splintering and damage to revealed the maintenance staff indrails one day and they would chair or cart and splinter, or be the next day. The MD stated this the latest day and the maintenance not stay ahead of the issue.  Invey the following observations ident wheel chairs:  2/17/15 11:30 AM Resident #193 ing in his room in a wheelchair. armrest on the chair was only a round stainless colored ight arm. The left armrest on as observed to be tattered and	F 2		τ)		
	resident's arm. Fu #193 on 02/18/15 AM, 02/23/15 at 1 AM revealed he w	cracked vinyl material to the arther observations of Resident at 10:30 AM, 02/19/15 at 10:50 0:30 AM and 02/25/15 at 11:00 vas seated in his wheelchair and light armrest was missing and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			2/27/2015	
	ROVIDER OR SUPPLIER	EHABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 253	b. 200 Hall- On 02 #37 was observed hallway. Wheelch armrest that expo to resident's arm. Resident #37 on 0 02/23/15 at 10:30 his wheelchair and was cracked and c. 300 Hall- On 02 #84 was observed room. The wheelch frayed, and cracked armrests exposing ragged vinyl surfa observation of Re AM and 02/25/15 sitting in his wheel and right armrest d. 400 Hall- On 02 Resident #55 was a wheelchair. When o armrest on left metal bar to rest in frayed exposing the arm. Further observation. The wharmrest and the ricracked.  On 02/24/15 at 10 conducted with Numaintenance issu attention she would maintenance. Nur	as cracked and frayed. 2/17/15 at 11:30 AM Resident d sitting in a wheelchair in air had a cracked and frayed left sed the cracked vinyl material Further observations of 02/19/15 at 10:50 AM, and AM revealed he was sitting in d the wheelchair's left armrest	F 2	53			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING	<del></del>		02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	Continued From pag		F 2	53		
	the nurse aides to le or maintenance issu she was not aware on on the 200 Hall at the A review of the main days for Halls 200, 3 requests for wheelch	stenance logs for the past 30 s00, and 400 indicated no hair repairs for the identified				
	On 02/25/15 at 10:3 conducted with the I He stated he had we years. The MD indiction a weekly and mo also revealed facility when issues were returned to the maintenance discount were logs on each he maintenance needs maintenance depart each day. He stated	ment checked those logs staff could also call or tenance issues that needed				
	Director again stated particular issues with believed therapy and	5 AM the Maintenance d he was not aware of these n wheelchairs. He stated he d nursing staff would have e of the issues with the				
	conducted with the A	ted it was her expectation that es with the maintenance				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING		_	02/:	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER		STREET ADDRESS, CITY, STA 211 MILTON BROWN HEIRS BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	her. She stated she e	e issues also be reported to expected any facility obe reported immediately.		253 272			
30 =	a comprehensive, acc	duct initially and periodically curate, standardized nent of each resident's					
	resident assessment by the State. The ass least the following: Identification and den Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-bei Physical functioning a Continence; Disease diagnosis an Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments ar Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and	dent's needs, using the instrument (RAI) specified sessment must include at mographic information;  atterns; ing; and structural problems; at health conditions; status;					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02/27/2015		
	ROVIDER OR SUPPLIER	EHABILTATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		, 022		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 272	Continued From pa	age 18	F 27	2			
	by: Based on record recility failed to corresidents sampled residents' strength area impacted function the information decare plan. (Reside #55, #158, #107, #The findings include 1. Resident #50 w 10/31/13. Her diag weakness, hypothy	ras admitted to the facility on gnoses included muscle yroidism, diabetes, cerebral					
	anxiety disorder.  Her Minimum Data change dated 12/1 cognitive impairme requiring extensive toileting and hygie little interest in doin nonambulatory, ha motion on each sid and receiving an a anticoagulant.  Review of the Care dated 12/15/14 revianalysis of the cheeping and the control of the care dated 12/15/14 revianalysis of the cheeping and the control of the care dated 12/15/14 revianalysis of the cheeping and the care dated 12/15/14 revian	a Set (MDS), a significant 0/14, coded her as having no ents, having other behaviors, a assistance with dressing, ne. The MDS coded her with ng things, having sleep issues, aving impairment of range of de, receiving a therapeutic diet intidepressant, hypnotic and exercise Area Assessments (CAA) wealed a checklist but no ecked items or any analysis of tems affected the resident's					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1 ' '	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		<del> </del>	02	/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER	•	211 MI	TADDRESS, CITY, STATE, ZIP CODE LTON BROWN HEIRS ROAD NE, NC 28607	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 272	take. Examples as a. Cognition/Deliriur decreased ability to had confusion, disor and the only comme checking items on the disruptive sounds or stated she yelled out considerations was Socially Disruptive Ereduce the number of other disciplines state encourage and support of the disciplines state of the problem, and only communication in problem, and only communication in problems, received and hypnotic medical but failed to analyze how this affected he understood. This was calculated to analyze how this affected he understood. This was made. This was d. Psychosocial Well and the additional in problem with psychothe diagnoses of an only other analysis of continue to utilize Distribution will continue to encountered by residen Worker #2.  e. Behavioral Symptosis of Behavioral Symptosis and the additional Symptosis worker #2.	ection the care plan would	F	272				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			2/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REI	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From page	ge 20	F 2	72			
	according to the Flo checklist, notes indi utilize Socially Inapp in hopes of reducing continue to encoura by resident. This wa #2.	vior as indicated by yelling out ow sheets. In addition to the cated that the facility will propriate Behavior Care Plan on number of outbursts and will age and support as tolerated as written by Social Worker					
	interviewed. Due to forming words clear clearly. Throughout expressed concern to understand her a	her stroke, she had trouble ly and expressing herself the interview, Resident #50 that staff did not take the time nd figure out that she was					
	On 2/23/15 at 10:14 conducted with the and Social Worker interview it was reversible completing MDSs in started the end of July that he just received on how to complete information within the hired quality assuras stated that if he kneed care plan he just us checklist and was us analysis on the CAA never been trained generally just put in interview for mental that the new QA nurcoming in the future stated she always he CAAs and has been	AM, an interview was MDS coordinator, MDS nurse (SW) #2. During the ealed that MDS nurse started a September 2014 and SW #2 culy 2014. MDS nurse stated a quick overview this month a CAA analyze the ne last week from the newly nce (QA) nurse. MDS nurse w he was going to develop a led the information from the naware he had to explain his A. SW #2 stated she had on how to complete CAA and the information from the brief status. She further stated rese told her that training was at the noverwhelmed with the new has taken on since becoming					

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		02/2	27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER	21	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 272	the coordinator.  On 02/27/15 at 9:50 that she had identific completed correctly nurse to assist with the second process of the cardiovasc and history of cardia.  The admission Minimals of the cardiovasc and history of cardia.  The admission Minimals of the cardiovasc and history of cardia.  The admission Minimals of the cardiovasc and history of cardia.  The admission Minimals of the cardiovasc and history of cardia.  The admission Minimals of the cardiovasc and history of cardia.  The admission Minimals of the cardiovasc and history of cardiovasc and histo	AM, the Administrator stated ed that CAAs were not being so she brought in the QA training the MDS staff.  admitted to the facility on osis included severe acute ular accident, hypertension	F 272				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/	27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 11 MILTON BROWN HEIRS ROAD COONE, NC 28607	, , ,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 272	interview it was revice completing MDSs in started the end of J that he just received on how to complete information within the hired quality assurated that if he knew care plan he just us checklist and was used analysis on the CAA never been trained generally just put in interview for mental that the new QA nucoming in the future stated she used to area but when the ficare system she quefurther stated she and understanding the coverwhelmed with the hast aken on since.  On 02/27/15 at 9:50 that she had identific completed correctly nurse to assist with  3. Resident #77 was 06/16/12 with diagram hypertension, must thrombosis and fraction.	(SW) #2. During the ealed that MDS nurse started in September 2014 and SW #2 uly 2014. MDS nurse stated id a quick overview this month is a CAA analyze the ine last week from the newly ince (QA) nurse. MDS nurse is whe was going to develop a seed the information from the inaware he had to explain his information from the inaware he had to explain his information from the brief it status. She further stated in the information from the brief it status. She further stated in it doing the summaries. She in it doing the coordinator.  O AM, the Administrator stated it in the CAAs were not being if so she brought in the QA training the MDS staff.  The MDS staff.	F	272				
	term memory proble	ed her with long and short ems and having severely						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	Continued From pag	e 23	F 2	72			
	total assistance with skills, rejected care of days and received a 120 pounds.  Review of the Care of nutrition dated 06/27 no analysis of the chord function or what directake. In addition to the Resident #77 had ar nutrition, and requirect hypertension and a publication of the rationale for care pla weight +/- 5% Blood normal range. Resid w/o (without) chewin signs of aspiration." completed by the Die Interview with the DN	all activities of daily living 1-3 days in the previous 7 mechanical diet and weighed Area Assessment (CAA) for 7/14 revealed a checklist but ecked items or any analysis items affected the resident's ction the care plan would he checklist, the CAA noted hactual problem with ed a no added salt diet due to corred diet due to chewing impact of this problem and anning, the CAA noted "stable pressure will be within ent will tolerate diet texture g or swallowing difficulty or This was signed as being etary Manager (DM).  M on 02/24/14 at 9:25 AM					
	type of diet the resid were getting that typ tried to know what w as how much feeding	completed a CAA she put the ent was on and why they e of diet. She stated she as going on with them such g assistance they needed. at she was just learning how as.					
	that she had identified completed correctly	AM, the Administrator stated at that CAAs were not being so she brought in the QA raining the MDS staff.					
		admitted to the facility on uses of pneumonia, urinary					

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		345163	B. WING _			)2/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	12/03/14 revealed R cognitively impaired assistance with bed limited assistance w personal hygiene and Review of the Care added 12/03/14 reveanalysis of the check how the checked ite function or what directake. Examples as for Cognitive Loss/Demidecreased ability to to understand others comments other that were she had cognitive recent medical conditional communication, professional Worker #1. Communication checommunication, professional worker was known, has some confectious process. To Coordinator. Urinary incontinence additional comment occupational therapy functioning, incontinence additional comment occupational therapy functioning incontinence additional comment occupational therapy functioning incontinence additional comment occupational to increase. This was a checklis information of history occupational to increase.	yroid disorder. The Data Set (MDS) dated esident #92 was severely She required extensive mobility and dressing and ith transfers, toileting, d bathing.  Area Assessments (CAA) aled a checklist but no ked items or any analysis of ms affected Resident #92 's ction the care plan would bllows: entia checked that she had make herself understood or s, and the only other n checking items on the form ive loss potentially due to itions and did not have a tia. This was written by  cked that she had expressive blems describing objects and e communication. The only she was able to make needs onfusion, possibly due to This was written by the MDS e was a checklist with the only of working with physical and y to increase physical ence episodes should	F 2	72			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 272	additional informatic impaired mobility, or infectious process a clostridium difficle,  An interview was concerned and with the MDS of Social Worker (SW was revealed the M the MDS office in 0 work at the facility is stated he received a 2/2015, on how to on the newly hired Quanthe MDS Nurse stated to develop a care prometime the checklist and explain his analysis she had never been CAA and generally brief interview for mostated she had been she would be trained. The MDS Coordinationally analysis and summer for the CAA but she the amount of work the MDS Coordination on 02/27/15 at 9:50 she had identified to completed correctly Nurse to assist with	s a checklist with the only on of being at risk due to occasional incontinence, and development of a bacterial infection.  Inducted on 02/23/15 at 10:14 coordinator, MDS Nurse and 0) #2. During the interview it IDS Nurse began working in 9/2014 and SW #2 began in 07/2014. The MDS Nurse a quick overview this month, complete a CAA analysis from ality Assurance Nurse (QA). ated if he knew he was going lan he used the information and was unaware he had to a for the CAA. SW #2 stated in trained on how to complete a put in the information from the inental status. She further in informed by the QA Nurse and on how to complete a CAA, tor stated she was aware an ary needed to be completed a had been overwhelmed by she had to do when she took or position in 09/2014.	F 27	2	
	5. Resident #99 wa	as admitted on 10/16/14 with			

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	l \ /	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 272	diagnoses including failure and history of left lower extremity.  Review of an admis (MDS) dated 10/24 was at risk for a prepressure ulcer at the The Admission MDC cognitively intact.  Review of the Care pressure ulcers datitems but no analyst analysis of how the function or what direction or what d	chronic congestive heart of deep vein thrombosis of the assessment. So noted Resident #99 was deep vein thrombosis of the checked items or any of the checked items or any of the care plan would deep vein thrombosis of the checked items on the CAA summary noted pressure ulcers were a vein to immobility, cognitive the deep vein thrombosis of the checked under any of the cate the reason the item(s) of cate the reason the item(s) of cate the reason the item(s) of cate the reason thrombosis of the checked of the plan with no further	F 2'				
	Nurse. During the i MDS Nurse began 09/2014 and he red month, 2/2015, on I analysis from the na Nurse (QA). The M was going to develo	coordinator and the MDS Interview it was revealed the working in the MDS office in eived a quick overview this how to complete a CAA ewly hired Quality Assurance DS Nurse stated if he knew he op a care plan he used the e checklist and was unaware					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	MDS Coordinator sta analysis and summa for the CAA but she the amount of work s the MDS Coordinato On 02/27/15 at 9:50 she had identified Completed correctly Nurse to assist with 6. Resident #55 was diagnoses including cerebrovascular acc anxiety, and depress A significant change dated 09/10/14 reveal	s analysis on the CAA. The ated she was aware an ary needed to be completed had been overwhelmed by she had to do when she took or position in 09/2014.  AM the Administrator stated AAs were not being and she brought in the QA training the MDS staff.  It is admitted on 02/25/11 with dementia, history of falls,	F 2	72		
	The significant changes #55 required extension had unclear speech, understood. In addit disorganized thinking and she was short to 2 to 6 days during the The significant changes #55 received an antiday assessment per re-entry to the facility.  Review of the Care of dated 09/15/14 reveal analysis of the check how they affected the	g were continuously present empered and easily annoyed e 7 day assessment period. ge MDS revealed Resident depressant daily during the 7 iod and had no falls since her				

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	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	and long-term men noted dementia, de understood, decline poor nutrition, and The only comments heading of "Natur which stated Resid Alzheimer's disea dementia unspecifi disturbances. The to indicate that cog addressed in the cadocumentation note b. Mood State trigg score. The checke underlying health p problems, psychiat neurological disease the form were under Problem/Condition had a diagnosis of behavioral disturbat depressive disorde psychotic condition	Dementia triggered due to short nory loss. The checked items acreased ability to make herself in activities of daily living, psychiatric or mood disorder. So on the form were under the e of Problem/Condition "ent #55 had a diagnoses of se, senile dementia, and ed with behavioral CAA summary was checked nitive loss/dementia would be are plan with no further ed.  Dered due to mood severity and items noted a relapse of problem, communication ric disorder, dementia, se, and pain. Comments on er the heading of "Nature of "which stated Resident #55 dementia with unspecified ince, unspecified psychosis, r, anxiety state, unspecified	F 27	2			
	state would be add the analysis was to attend activities even support and encouresident.  c. Falls triggered di transition and antidi checked items note	resed in the care plan and encourage the resident to en if to observe and provide ragement as tolerated by the ue to balance problems during lepressant medications. The ed difficulty maintaining sitting palance during transitions.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _	<del> </del>		02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REI	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 272	or leg movement, in cognitive impairment depression, and pai were under the heat Problem/Condition had a history of falls psychiatric diagnost narcotics, and impassummary was check be addressed in the analysis block was occupational therapand treat.  d. Psychotropic Druuse of antidepressatitems noted antidepressatitems. An interview was checkly care plan and it was Resident #55 was to before discharge arrecently. Resident medication daily anneeded.  An interview was considered with the MDS office in Oscial Worker (SW) was revealed the M the MDS office in Oscial Worker	chritis, hip fracture, loss of arm acontinence, dementia, at, anxiety disorder, n. Comments on the form ding of "Nature of "which stated Resident #55 s, poor safety awareness, es, dementia, medications, ired mobility. The CAA ked to indicate that falls would a care plan and listed in the for physical therapy, y, speech therapy to evaluate g Use triggered due to the nt medications. The checked ressant use with adverse sked as anxiety, depression, abilities, and disturbances of ositioning ability. Comments ander the heading of "Nature on " and listed Resident #55" issant medication. The CAA	F 2	72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		345163	B. WING _		0	2/27/2015	
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZI 211 MILTON BROWN HEIRS ROA BOONE, NC 28607	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 272	2/2015, on how to the newly hired Qu The MDS Nurse st to develop a care prometry from the checklist a explain his analysis she had never bee CAA and generally brief interview for ristated she had bees she would be train. The MDS Coordinated analysis and summ for the CAA but she the amount of work the MDS Coordinated Completed correctly Nurse to assist with the amount of work the MDS Coordinated Completed Correctly Nurse to assist with the amount of work the MDS Coordinated Completed Correctly Nurse to assist with the ADS Coordinated Completed Correctly Nurse to assist with the ADS Coordinated Completed Correctly Nurse to assist with the ADS Coordinated Completed Correctly Nurse to assist with the ADS Coordinated Coor	a quick overview this month, complete a CAA analysis from ality Assurance Nurse (QA). ated if he knew he was going plan he used the information and was unaware he had to son the CAA. SW #2 stated in trained on how to complete a put in the information from the mental status. She further an informed by the QA Nurse and on how to complete a CAA, ator stated she was aware an mary needed to be completed a had been overwhelmed by a she had to do when she took for position in 09/2014.  O AM the Administrator stated CAAs were not being and she brought in the QA in training the MDS staff.  It was admitted to the facility on moses that included but was not on, anxiety, dementia, it and post-hip replacement. Stated to always be and bladder. Resident #158 are antidepressant, antianxiety, cations 7 days a week.	F	272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	dated 11/07/14 reversionallysis of the checked the checked items at function, or what directly follow. Examples are supported and checked that limitations such as we complications of immincontinence, and do checked with no add other than the checked MDS Coordinator.  Psychosocial well-be #158 had health statistical involvement the sucial involvement the Activities Director Activities checked the issues that result in activity participation anxiety, cognitive demedications, numero health problems amount further analysis was the Activities Director Falls checked that Remaintaining balance transitions, psychotrological involvement, and incontinued the checked. Resident #MDS to be incontinued.	Area Assessments (CAA) aled a checklist, but no ked items or analysis of how ffected Resident #158 's ection the care plan should as as follows:  Resident #158 had physical reakness, and was at risk for hobility such as contractures, repression. These areas were litional information provided list. This was written by the  sing checked that Resident us factors that could inhibit hat included decline in ADL ' problems, health problems, hissues. No further analysis of byided. This was written by r.  at Resident #158 had health decreased participation in to include depression or ficits, use of psychoactive bus treatments, and chronic long other checked issues. No provided. This was written by	F 2	72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345163	B. WING			)2/27/2015	
	NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EA		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 272	mental status, incon medications, and fur motion among other Resident #158 's ris was written by the M An interview was co AM with the MDS Co Social Worker (SW) was revealed the MI the MDS office in 09 work at the facility in stated he received a 02/2015, on how to from the newly hired (QA). The MDS Nurgoing to develop a conformation from the he had to explain his stated she had never complete a CAA and information from the status. She further she was aware an at to be completed for overwhelmed by the do when she took the in 9/2014.  On 02/27/15 at 9:50 she had identified Completed correctly	cked risk factors as altered tinence, antipsychotic nctional limitation of range of s. No further analysis of k factors were provided. This IDS Coordinator.  Inducted on 02/23/15 at 10:14 coordinator, MDS Nurse and #2. During the interview it DS Nurse began working in 1/2014 and SW #2 began 07/2014. The MDS Nurse quick overview this month, complete a CAA analysis Quality Assurance Nurse se stated if he knew he was are plan he used the checklist and was unaware as analysis on the CAA. SW #2 or been trained on how to be generally put in the brief interview for mental tated she had been informed to expect the coordinator stated analysis and summary needed the CAA but she had been amount of work she had to the MDS Coordinator position  AM the Administrator stated	F 27	2			

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(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 272	Continued From page	ge 33	F 2	72	
	07/31/14 with diagn	as admitted to the facility on oses including hypertension, eimer's), anxiety disorder, and			
	(MDS) dated 01/13/ cognitively impaired one or more unheal stage IV pressure u extensive assistance dressing, toileting, a	ment Minimum Data Set 15 coded Resident #107 as . The MDS indicated she had ed pressure ulcers and one lcer. Resident #107 required e for bed mobility, transfers, and personal hygiene. She ys incontinent of bowel and			
	dated 01/13/15 revenot analyzed with the determine the reside and how her condition follows:  a. Nutritional CAA: a problem/condition we regular diet; under of that can affect appearessure ulcer was to nutritional needs. nutritional status in pressure ulcer inclustrators was not ana b. Pressure Ulcer Coproblem/condition we complications and reinformation was listed consider were care no analysis of the interest of the state of the	vas ideal body weight and other diseases and conditions tite or nutritional needs, not mentioned in relationship. The decision not to care plan relationship to stage IV ding complications and risk lyzed.  AA: under nature of vas stage IV; under			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From pag	ge 34	F 2	72			
	at 10:17 AM revealed on the CAA. She state came from the MDS she had been doing her head around what the CAAs. The MDS should be a summal further shared that rule in the case of the case	DS Coordinator on 02/23/15 Ind she did not write a narrative atted the checks on the CAA I. She shared that as long as MDS, she had not wrapped at was expected related to a Coordinated stated there are if there is a CAA and atted a lot of work with this.  DS nurse on 02/23/15 at the learned how to analyze a largo from the new quality are MDS nurse shared he is just a worksheet to get to admitted to the facility on coses including anemia, pression, manic depression and schizophrenia.  ge Minimum Data Set dated dident #5 as cognitively intact desident #5 required limited					
	assistance for transf dressing, toileting, a	ers, walking in room, nd personal hygiene.					
	dated 01/19/15 reve not analyzed with th determine the reside and how her condition follows:	Area Assessment (CAA) aled the following area was e MDS information to ent's strengths, weaknesses on affected this area as					
	problem/condition w schizophrenia, antid	g Use CAA: under nature of as written antipsychotics for epressant sertraline for lproex for anxiety; under					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345163	<b>345163</b> B. WING			)2/27/2015	
	NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272		sk factors was the potential	F 27	2			
	psychotropic medica consider were the ca was no analysis to it use of psychotropic	ects related to the use of ations; and under factors to are plan interventions. There dentify nature of condition for medications and the effects on Resident #5's quality of					
	at 10:17 AM reveale on the CAA. She sta came from the MDS she had been doing her head around wh the CAAs. The MDS should be a summa	DS Coordinator on 02/23/15 and she did not write a narrative sted the checks on the CAA be shared that as long as MDS, she had not wrapped at was expected related to a Coordinated stated there by if there is a CAA and deeded a lot of work with this.					
	10:17 AM revealed I CAA about a month assurance nurse. The	DS nurse on 02/23/15 at the learned how to analyze a ago from the new quality the MDS nurse shared he s just a worksheet to get to					
	12/26/12 with diagnoral blood pressure, diffination swallowing, anxiety,	as admitted to the facility on oses which included high culty speaking, difficulty generalized muscle ease, right sided paralysis					
	dated 10/23/14 indic term memory proble cognition for daily de also indicated Resid	ual Minimum Data Set (MDS) cated short term and long cms and severe impairment in ecision making. The MDS lent #29 required extensive or activities of daily living.					

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		345163	B. WING	<del> </del>		02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 36	F 2	72		
	dated 02/01/15 reversionallysis of the check how the checked its function or what direct take. Examples as a. Activities indicated but the section labed problem/condition we checked which indict functional/mobility deficits and chronic was no analysis of a how activities were care plan consideral maintain current lever completed by Activities. Falls indicated the only checked items sitting balance, imperansitions, use of a antianxiety medicate of any of the areas plan consideration with minimized decline, in functioning and min completed by MDS c. Communication in problem and only cland mental health pand antidepressant communication, or a mood problems but of the areas to describe ability to communication ability to communicate documented. This was a supplementation of the areas to describe a supplementation.	d this was an actual problem led nature of the vas left blank. Items were cated depression or anxiety, or balance problems, cognitive health conditions but there any of the areas to describe planned or provided. Under tion was the comment to rel of functioning. This was ties Director. is was an actual problem and such as difficulty maintaining aired balance during ntidepressants and ions but there was no analysis to prevent falls. Under care was the comment to slow or maintain current level of imize risks. This was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	the problem/condition checked such as de mood, health proble communication but of the areas to descripsychosocial well-beconsideration was the current level of function by Activities Director.  During an interview MDS coordinator, M (SW) #2 revealed the completing MDSs in started the end of Justian the just received on how to complete further stated if he kad a care plan he just to checklist and was unanalysis on the CAA never been trained and generally just probability brief interview for mostated the new qual her that training was MDS Coordinator strunderstanding the Coverwhelmed with the communication of the communication of the coverwhelmed with the communication of the communication of the communication of the coverwhelmed with the communication of the communi	a section labeled nature of on was left blank. Items were lirium, aphasia, depression, ms and change in there was no analysis of any ribe how this affected hereing. Under care plan ne comment to maintain tioning. This was completed for on 02/23/15 at 10:14 AM the IDS nurse and Social Worker of MDS nurse started a September 2014 and SW #2 July 2014. MDS nurse stated a quick overview this month a CAA. The MDS nurse new he was going to develop used the information from the naware he had to explain his a. SW #2 stated she had on how to complete the CAA jut in the information from the ental status. She further ity assurance (QA) nurse told is coming in the future. The lated she always had trouble	F 2				
	Activity Director exp and Director of nurs with her. She stated was unaware that si	on 02/23/15 at 11:01 AM the lained a former MDS nurse ing had gone over the CAA d she had not been told and ne was supposed to do notes e activities or psychosocial					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _	B. WING		02/:	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	;ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 272	2 Continued From page 38		F:	272			
F 309 SS=J	she had identified that completed correctly s nurse to assist with to	AM, the Administrator stated at CAAs were not being so she brought in the QA raining the MDS staff.  ARE/SERVICES FOR	F:	309			
	Each resident must r provide the necessar or maintain the highe mental, and psychos	eceive and the facility must ry care and services to attain est practicable physical,					
	by: Based on record rev physician interviews assessment for 1 res to the floor by staff w failed to assess the r from the floor into a s sampled residents fo  Immediate Jeopardy staff failed to assess lowered to the floor b Immediate jeopardy v 11:35 AM when the fi implemented an acce compliance. The fac compliance at a lowe (an isolated deficience potential for more that	eptable credible allegation of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345163	B. WING		02/27/2015		
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER			211 MILTON BROWN HEIRS ROAD	·		
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION		
A review of a facility that was not dated, procedure is to be f sustains a fall: a ful conducted to deterr and monitored for 2 Resident #24 was a 02/17/14 with diagn high blood pressure swallowing, arthritis paralysis and stroke A review of a Nursir sheet dated 02/17/14 alert and aware, no understand others a questions. The not dependent for trans A review of Resider on 02/17/14 reveale indicated a total soci	ace are effective.  A document titled "Falls Policy" indicated in part, the following collowed for any resident that I body assessment will be mine if any injury has occurred A hours after the fall.  Admitted to the facility on coses which included diabetes, a, difficulty speaking and a, depression, right sided as.  In Admission Information		,			
A review of a physic dated 02/18/14, ind transferred by a me  A review of the adm (MDS) dated 03/03, severe impairment	icated she was to be schanical lift.  hission Minimum Data Set //14 revealed Resident #24 had in cognition for daily decision					
	ROVIDER OR SUPPLIER  SUMMARY: (EACH DEFICIEN REGULATORY O  Continued From pa systems put into pla  The findings include A review of a facility that was not dated, procedure is to be f sustains a fall: a ful conducted to deterr and monitored for 2  Resident #24 was a 02/17/14 with diagn high blood pressure swallowing, arthritis paralysis and stroke A review of a Nursir sheet dated 02/17/ alert and aware, no understand others a questions. The not dependent for trans  A review of Resider on 02/17/14 reveale indicated a total soc high risk for falls.  A review of a physic dated 02/18/14, ind transferred by a me  A review of the adm (MDS) dated 03/03, severe impairment making. The MDS	A review of a facility document titled "Falls Policy" that was not dated, indicated in part, the following procedure is to be followed for any resident that sustains a fall: a full body assessment will be conducted to determine if any injury has occurred and monitored for 24 hours after the fall.  Resident #24 was admitted to the facility on 02/17/14 with diagnoses which included diabetes, high blood pressure, difficulty speaking and swallowing, arthritis, depression, right sided paralysis and stroke.  A review of a Nursing Admission Information sheet dated 02/17/14 indicated Resident #24 was alert and aware, non-verbal but was able to understand others and answered yes and no to questions. The notes also indicated she was dependent for transfers and bed mobility.  A review of Resident #24's Fall Risk Assessment on 02/17/14 revealed a score of 14 which indicated a total score of 10 or above represented	ROVIDER OR SUPPLIER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    Continued From page 39	ROVIDER OR SUPPLIER  DGE HEALTH AND REHABILTATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 39  systems put into place are effective.  The findings included:  A review of a facility document titled "Falls Policy" that was not dated, indicated in part, the following procedure is to be followed for any resident that sustains a fall: a full body assessment will be conducted to determine if any injury has occurred and monitored for 24 hours after the fall.  Resident #24 was admitted to the facility on 02/17/14 with diagnoses which included diabetes, high blood pressure, difficulty speaking and swallowing, arthritis, depression, right sided paralysis and stroke.  A review of a Nursing Admission Information sheet dated 02/17/14 indicated Resident #24 was alert and aware, non-verbal but was able to understand others and answered yes and no to questions. The notes also indicated she was dependent for transfers and bed mobility.  A review of Resident #24's Fall Risk Assessment on 02/17/14 revealed a score of 14 which indicated a total score of 10 or above represented high risk for falls.  A review of a mechanical lift.  A review of the admission Minimum Data Set (MDS) dated 03/03/14 revealed a Resident #24, dads severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 had severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 had severe impairment in cognition for deily decision making. The MDS also indicated Resident #24 had severe impairment in cognition for deily decision making. The MDS also indicated Resident #24 had severe impairment in cognition for deily decision making. The MDS also indicated Resident #24 had severe impairment in cognition for deily decision making. The MDS also indicated Resident #24 had severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 had severe impairment in cognition		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pag	ge 40	F3	09			
		The MDS indicated Resident y with a fall in the last month					
		sk Assessment on 05/24/14 icated she was high risk for					
	for accidents/fall risk 10/25/14 indicated a	an with a problem statement with an updated date of approaches to determine terns associated with falls or transfers.					
	for total dependence	lan with a problem statement with an updated date of loyer lift to chair every day.					
	for activities of daily	lan with a problem statement living with updated date of ft for transfers and out of bed					
		thly physician's orders for cated activity level of a					
		on Administration Records er 2014 indicated activity al lift.					
		notes dated 11/15/14 revealed 's notes during the 7:00 AM -					
	PM indicated Reside	s note dated 11/15/14 at 8:30 ent #24 was lying in bed e #2 went to resident's room					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		345163	B. WING			02/27/2015	
	ROVIDER OR SUPPLIER	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	further indicated wh raised Resident #24 revealed Resident # history of a stroke b appropriately by not The notes further reshe was hurting Resleg. The notes indicated in ovisual injuries or was made to roll Rescreaming loudly an party was notified at transport to the emeral transport to the emeral A review of a nurse PM revealed emerg was in the facility to hospital emergency  A review of an EMS indicated EMS was 9:03 PM. A section Resident #24 initially not fall however upostaff it was found out fall earlier today.  A review of a nurse PM indicated Nurse Nurse Aides (NAs) a #24 during the 7:00 there were no reporprevious shift to Nur A review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and was informed Resident #24 and review of a nurse 12:30 AM indicated and revi	the medications. The notes are the head of the bed was began yelling out. The notes 24 was nonverbal due to ut could answer questions adding her head for yes and no. Wealed when asked where sident #24 pointed to her right thated an assessment showed redness but when an attempt sident #24 over she began down the resident #24 responsible and hospital was notified for the regency room.  Is note dated 11/15/14 at 9:02 the room for evaluation.  The report dated 11/15/14 at 9:02 the room for evaluation.  The report dated 11/15/14 at 9:02 the room for evaluation.  The report dated 11/15/14 at 9:05 the room for evaluation.  The report dated 11/15/14 at 9:05 the room for evaluation.  The report dated 11/15/14 at 9:05 the room for evaluation.  The report dated 11/15/14 at 9:05 the room for evaluation.  The room for evaluation the room for evaluation at labeled narrative indicated at labeled narra	F 3	09			

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			02/27/2015		
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607				
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F 309	nurse (Assistant Dire on call and contacted give an update.  A review of a nurse's 12:42 AM indicated sthe facility and report questioned she indiconto the floor earlier indicated Administratinotified.  A review of a Physicidated 11/16/14 indicated 11/16/14 indicated 11/16/14 indicated 11/16/14 indicated 11/16/14 indicated 11/16/14 indicated Resident #2 staff lying in bed comapparently had a hist day where she may hotes further indicated to the hospital emergrevealed a displaced intertrochanteric/subthe thigh bone) fracture A review of an Operatindicated intertrochanteric/subthe thigh bone) fracture of the right hindicated surgery wareduction (to realign position) and internal keep bone fracture sinfection) with a short	se #2 notified Administrative actor of Nursing (ADON)) #1 d Resident #24's family to a note dated 11/16/14 at staff from the hospital called ated when Resident #24 was ated she had been dropped in the day. The notes further sive nurse (ADON #1) was an's Report of Consultation ated a consulting diagnosis of per part of the thigh bone) or Resident #24 who had a right hemiparesis (paralysis) by speaking). The notes 24 was found by the nursing applaining of hip pain and tory of falling earlier in the mave injured that hip. The ad Resident #24 was brought gency room and x-rays atrochanteric (upper quarter of the right hip.  Attive report dated 11/17/14 anteric/subtrochanteric ip. The notes further s completed with open bone fracture into normal a fixation (hardware used to table to heal and prevent	F3	509				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/	27/2015	
	ROVIDER OR SUPPLIER	EHABILTATION CENTER		211	REET ADDRESS, CITY, STATE, ZIP CODE 1 MILTON BROWN HEIRS ROAD DONE, NC 28607	, <u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	but signed by the I indicated the follow morning of 11/15/1 up and ready for si assist with transfer chair. The 2 NAs a #24 with an arm ar resident without distarted to pivot resident the resident continue to assist attempted to place but due to her weigh into the chair. Both slowly lowered resimmediately to ale get NA #3 to assist in the shower chair not confirm or deny of the incident. NA in transferring Resident. NAs report of pain or show sight this transfer. After transferred Reside The resident particular to complain of pain of pain. At approx #4 was changing Figelling out and granamed) asked the she nodded her her nodded her her lands her groin area and her groin area and	racture which was not dated Director of Nursing (DON) wing summary in part: On the 4 NA #1 went in to get resident hower. NA #1 asked NA #2 to ring Resident #24 from bed to attempted to transfer Resident and arm method. They stood fficulty but when the NAs ident to place her in a shower went limp" and was unable to the NAs with the transfer. NAs Resident #24 in shower chair ght was unable to get her safely in NAs report they together ident to the floor. NA #2 went to the nurse of the incident and it them in putting Resident #24 in Nurse #1 reported she could by she was immediately notified in the was in pain during lunch NA #1 and NA #2 ident #24 from floor to shower Resident #24 did not complain ans or symptoms of pain during lunch NA #1 and NA #3 int #24 from wheelchair to bed. In in a show signs or symptoms imately 2:00 PM NA #1 and NA Resident #24 and she started being at her leg. NA (not resident if she was in pain and and yes. NA #4 went to get went to check the resident and legs looked symmetrical and withing out of the ordinary." Resident #24 was scratching at she had just recently duled Tylenol to Resident #24.	F	309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILTATION CENTER	·	STREET ADDRESS, CITY, STATE, 211 MILTON BROWN HEIRS RO BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page		F 3	309			
	apply protective ointh asked Resident #24 if the resident shook her came in Resident #24 pain and Nurse #2 see her diagnosis was intright hip.  During an interview of Resident #24 she smup and down as a restrepetitive sounds but when spoken to. She down yes when questlast November. Whe facial expression chattearful and attempted unable to form the work head vigorously up at questioned if her hip head from side to sid moved her left hand the rubbing motion.  During an interview of Reside 11/15/14 she did not 11/15/14 when the rehospital but if the number then they probable.	the NAs to clean resident and ment. At 4:00 PM Nurse #1 If her leg was still hurting and er head no. When night shift appeared to be in severe ent resident to the ER and ertrochanteric fracture of  In 02/19/15 at 11:08 AM with illed and nodded her head sponse for yes and made was unable to form words ee nodded her head up and tioned if she had a hip injury in asked if she had a fall her inged and she became it o say something but was ords and then nodded her head down yes. When was better she shook her ee as a response for no and oward her right hip in a  In 02/23/15 at 11:48 AM the Nursing (ADON) #1 stated ent #24's nurse's notes for remember being called on sident was sent to the reses documented they called by did. She further stated in going to the facility on					
	11/15/14 or 11/16/14. thing she remembere morning meeting the had complained of se	She explained the only of was she heard during following week Resident #24 evere pain in her hip and was and she had a hip fracture.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	· /	DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	Director of Nursing (Inurses notes for Resconfirmed there were assessment during the During a telephone in PM NA #1 explained to get Resident #24 con 11/15/14. She staworking with Resider her with 2 staff assist previously stood Restransfer her and their that was the way she She explained during she had her arm und armpits and NA #2 harmpit and they stood when they turned her NA #1 stated when Rote to the floor they tried because she was too when they realized the lowered her to the floget a nurse. NA #1 fonto Resident #24's sthe floor and thought her. NA #1 stated NA and they picked Resishe took her to the sl shower. She stated so obvious redness or b Resident her shower assisted her to stand shower chair and into	e 45 In 02/23/15 at 12:14 PM the DON) upon review of the ident #24 on 11/15/14 In on urse's notes or nursing the 7:00 AM to 7:00 PM shift.  Interview on 02/23/15 at 6:44 Ishe and NA #2 were trying that of bed into a shower chair atted therapy staff had been at #24 to stand and transfer and NA #1 stated she had ident #24 next to her bed to resident had done fine and usually transferred her.  If the transfer on 11/15/14 are one of Resident #24's ad her arm under the other of her up at the bedside but to pivot her she went limp.  Resident #24 started to slide to lift her up but they couldn't to heavy. She explained they could not lift her up they or and she told NA #2 to go curther explained she held shoulders while she sat in her legs were out in front of A#2 came back with NA #3 dent #24 up off the floor and nower room and gave her a she did not notice any ruising when she gave and after the shower NA #2 Resident #24 up from the or a wheelchair. NA #1 inch she got NA #2 and NA	F3	009		
	I .	Resident #24 and they stood				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pag	ge 46	F3	309		
	hours after Resident she was moaning ar was rubbing it and s	ad. She explained about 3 #24 was lowered to the floor and holding her right leg and the reported it to Nurse #1.				
	received from NA #1 remembered when s #1 the nurse did not	she stated she had she sent NA #2 to get Nurse come to the resident's room as not assessed while she				
	was in the floor or w shower chair or whe	hen she was lifted into the n she was transferred back She further stated when NA				
	said to put Resident	room and stated Nurse #1 #24 in the shower chair they loor and into the chair.				
	PM with NA #2 she stransfer Resident #2 She explained they side of the bed for a up and turned her to started to buckle. S	nterview on 02/23/15 at 7:04 stated she went to help NA #1 4 on 11/15/14 for a shower. sat Resident #24 up on the few seconds, then stood her wards the left and she he stated Resident #24's right er upper body turned and she				
	slid down to the floo Resident #24 was in straight out but her r under her left leg an	r. She further stated when the floor her left leg was ight leg was crisscrossed d was bent at a 90 degree NA #2 stated she went to get				
	fallen or slid to the fl nurse the resident h said ok and to go ah in the shower chair a	orse asked if the resident had oor and when she told the ad slid to the floor the nurse ead and get Resident #24 up and give her a shower. NA #2 k to Resident #24's room and				
	she and NA #1 place Resident #24's armp	ed their arms under each of object and lifted her from the object chair. She stated				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER	•	STREET ADDRESS, CITY, STATE, Z 211 MILTON BROWN HEIRS ROA BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	a little bit when she we chair but she thought on her legs from the she did not assist NA shower and also veri to Resident #24's root the floor or after they chair.  During an interview of NA #3 she stated NA her to assist with get floor on 11/15/14 bed floor. She stated wh #24's room the reside and she remembered not straight out in fro couldn't straighten he previous stroke with She explained she pin Resident #24's armpunder Resident #24's her up off the floor we chair. She confirmed the room while she wand after they placed chair she left the room on a different hall.	e 47  ained of her right leg hurting was placed in the shower to it was caused by pressure shower chair. She stated with a 1 during Resident #24's fied Nurse #1 did not come on while the resident was in got her into the shower  on 02/24/15 at 1:54 PM with with a #1 or NA #2 came and got ting Resident #24 off the cause she had slid to the en she went into Resident ent was sitting on the floor of Resident #24's legs were not of her because she er legs out fully due to a paralysis on her right side. Laced her arm under one of its and NA #1 placed her arm of sother armpit and they lifted hile NA #2 held the shower Nurse #1 did not come in was in Resident #24's room of the Resident #24 in the shower of the resume her assignment on 02/23/14 at 8:13 PM with	F3	BOS DEFICI	ENCY)		
	when NA #2 reported floor. She stated she that day and she tool doing what she was confirmed the only as	ned she did not go to to assess her on 11/15/14 If the resident had slid to the was having a very bad day k full responsibility for not supposed to do. She ssessment she did was later ident #24 was crying out in					

` '			(X3) DATE SURVEY COMPLETED			
	345163	B. WING _			02/27	7/2015
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTAT	TION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	CODE	-	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST I TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 309 Continued From page 48 pain and was reaching towa the area was red. She state remember exactly what she she gave Resident #24 som pain but did not report it or d she did not think anything ha anything needed to be report  During a telephone interview PM with Nurse #2 she stated 7:00 PM to 7:00 AM shift on evening the NAs came and shad taken Resident #24 her she was screaming in pain. couldn't assess her or touch was in such pain. She furthe #24 had an incontinent episc clean her or turn her becaus verified she had not received #1 during shift change that F to the floor earlier that day. the resident to the hospital e evaluation and treatment be did not usually complain of p figure out why she was havi She explained she called the on call and verified that was further explained ADON #1 of facility that night and told he document everything so she her nurses notes. She state nurse from the hospital calle fall that Resident #24 had ea further stated that was the fi told Resident #24 had a fall.  During an interview on 02/24 Licensed Physical Therapist therapy staff had been work	and she couldn't saw but remembered be routine Tylenol for cocument it because and happened or that ted or documented.  If on 02/23/15 at 7:56 at she worked on the 11/15/14 and that got her because they bedtime snack and She explained she her because she her because she her explained Resident ode but they couldn't he of the pain. She at a report from Nurse Resident #24 had slid She stated she sent her she she sent her because Resident #24 had slid She stated she sent her gency room for cause Resident #24 had slid she stated she sent her she she she couldn't had such severe pain. Her and she couldn't had such severe pain. Her and her wrote all she knew in the diater that night a had and asked about a harlier that day. She rest time she had been 14/15 at 3:01 PM with #1 he explained	F3				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	
F 309	to her fall on 11/15/1 participation varied a stand but then she w He stated it was his staff had been trans mechanical lift and t been to use a mech Resident #24 was of with a maximum ass  During a phone intet the physician who w Director stated he w #24's fall after she h stated the informatic sliding to the floor di happened but he wo incident or somethin put her at higher risk was his expectation evaluate residents in when they were low stated he expected to physician to report w resident's level of co and their level of co and their level of co residents should be and there and all fal high risk and staff sh prevent falls.  During an interview the Rehabilitation Di therapy's intent for r they were doing with sessions and did no something different	Asserts with 2 staff assist prior 4. He stated Resident #24's and some days she would would spontaneously sit down. understanding that nursing ferring Resident #24 with a he plan of care would have anical lift for transfers until eared by therapy to transfer	F 3/	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345163	B. WING			)2/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From pag	e 50	F 30	09			
	transfer a resident sl the nurse for clarifica nursing staff should required for transfers	questions about how to the instructed them to go to stion. She further stated know what each resident stated the state of					
	AM the DON stated the nurse should ass were witnessed or un follow up to make su	it was her expectations that sess for falls whether they n-witnessed and should re the resident was ok. She lent was injured the nurse					
	hospital. She explair guide staff with care should match the ca	should provide first aid or send the resident to the hospital. She explained the care plan should guide staff with care and the transfer technique should match the care plan. She further					
	provided by NAs tha closet should match the closet care plan	care plan which guided care t was located in the resident's the care plan. She stated that was in place prior to as discarded when she went					
	Hoyer lift for transfer documented on the ostated they would no	ne would expect it indicated s since that was what was care plans. She further it change the care plan					
	the resident 100 per technique. She state Resident #24's fractu	Inless therapy had released cent for a change in transfer d when staff was notified of ure she should have also urther stated she was not					
	aware and was shoo nurse's notes for Re- the 7:00 AM to 7:00	ked to see there were no sident #24 on 11/15/14 for PM shift until she was					
	indicated she docum Resident #24's fracti on Monday 11/17/14 realize Nurse #1 had	during the survey. She also sented the Investigation of sure after she talked to staff and at that time she did not I not gone to Resident 24's to the floor and did not assess					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345163	B. WING	<del> </del>	02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 309	Nursing were notifice 02/24/15 at 3:31 PM facility provided a compliance on 02/2 following interventic facility to remove the Credible Allegation Resident #24 was a room on November resulting in surgical.  Two nurse aides into on 11/15/14 were vertheir next schedule moving a resident assessed the reside involved received vertilization of gait be assessment required licensed nurse prior a fall.  Nurse #1 received and completing resulting resulting resident is moved. The regarding fall investigation of the identifice fall prior to the identifice of the complete fall prior to the identification of the complete fall prior to the complete fall prior to the complete fall prior to the complet	istrator and Director of ed of Immediate Jeopardy on of for Resident #24. The redible allegation of 127/15 at 11:35 AM. The ons were put into place by the le Immediate Jeopardy.  of Compliance: sent to the hospital emergency 15, 2014 with right hip pain repair.  volved with resident #24's care erbally instructed on 11/16/14, d work day, regarding not after a fall before a nurse ent. On 11/17/14 all 3 CNAs erbal education regarding lt for transfers and ed to be completed by a reto moving any resident after a written coaching on no completing incident reports ident assessments, including that after a fall before the She was also educated tigation and assessment after deficient practice were	F 30	0.9	
	practice on 11/14/1	ompliance with standards of 4 -11/16/14 and was utilized to vere other falls that occurred			

	DF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED			
		345163	B. WING			02/	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE I1 MILTON BROWN HEIRS ROAD OONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	meeting daily Monday 11/18/14. This is a st looks at falls. Fall au ensure timely assess documentation, and u On February 24, 2019 aides present was in New falls and fall risk implemented on Febr Assessment and first Record vital signs and injuries to the head, r If evidence of signification provide first aid Once an assessment nursing staff will help sitting, lying, or stand not be moved until nu completed. Initial documentation notification of physicia Defining details of fall Identifying causes of All off the above items Fall: Initial Document Notes-5 day This new form implent 2015 will be placed in nurse's notes after co documentation. Performing a post-fall Within 24 hours after should watch the resi	and/or problems with There were no other Implemented fall clinical y through Friday on ubcommittee that specifically dit tool initiated 11/18/14 to ment, appropriate updated care plan.  5 at 11 pm nurses and nurse serviced on: policy and procedure uary 24, 2015. aid devaluate for possible leck, spine, and extremities ant injury, nursing staff will rules out significant injury, resident to a comfortable ing position. Resident will ursing assessment is regarding fall and an and family fall or fall risk s will be documented on tation Note/Progress mented on February 22, the MAR and placed in the impletion of 5 day post fall I evaluation a first fall, the nurse on duty dent rise from the chair, os if able, and return to	F	309			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE S	
		345163	B. WING		02/2	7/2015
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	Į VZIZ	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	needed. If the resid referral is initiated. on Fall: Initial Documon Fall: Initial Programment of the condition of the resident's clinical received the condition the resident's clinical received Fall: Interventions, first a Notification of physical All of the above to be Documentation Note within Completion of fall risk Appropriate interventials Signature and title of Report fall to DON, An in service on falls procedure and trans be completed for all pm on February 25, department employed above in service or procedure of the proced	r evaluation may not be ent has difficulty therapy This should be documented mentation Note/Progress  sess the resident and e any changes or esult of a fall every shift for 5 on Fall: Initial press Note-5 day cions of falls  ediate assessment of fallen and documentation in cord ident was found cluding vital signs, and any id, or treatment administered cian and family e documented on Fall: Initial ex/Progress Notes-5 day  k assessment tions taken to prevent further of person recording data ADON, or RN Supervisor and fall risk policy & fers and mechanical lift will nursing department staff by 8	F 30	09		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE COMP	SURVEY LETED
		345163	B. WING _			02/	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, C 211 MILTON BROWN BOONE, NC 2860			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E EFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	service will be given monitor the daily sch that has not had the scheduled to work ur completed. All new remployees will be in Immediate jeopardy 11:35 AM with intervilicensed nursing staff received in-service trisk policy and procellifts prior to reporting. A review of in-service documentation of stain-services. The DO had not attended in-swere cross reference there were no staff will listed on the schedul. Interviews with NAs in-service training an notify a nurse immediately and interviews with nurse attended in-service training an included lowering a relatended in-service training and included lowering a relatended in-service training and included lowering a relatended in-service training and included lowering a relatended in-service to the floor. They described in the floor in the floor. They described in the school in the floor in th	to treceive the above in to the DON. The DON will edule to ensure that anyone above training will not be not the in service is nursing department serviced during orientation.  Was removed on 02/27/15 at lews of direct care and f who confirmed they raining on new falls and fall dure and use of mechanical for duty.  Le sign in sheets contained off who had attended the N had a list of all staff who services and these names and with staff schedules and who had not been trained es for work.  Le veeled they had attended the work of th	F3	609	DETIGENOT)		
	administrative nursin	an, responsible party and g staff and completion of the post fall evaluation and aled the Fall: Initial					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING	<del></del>	02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	HABILTATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 309		e/Progress Notes-5 day form	F 30	09		
	policy and procedure 02/24/15.	n 02/22/15 and a new fall risk e was implemented on				
F 311 SS=D	IMPROVE/MAINTAI		F 3 <sup>2</sup>	11		
	services to maintain	ne appropriate treatment and or improve his or her abilities ph (a)(1) of this section.				
	by: Based on observati interviews, the facilit sampled residents to #56 was fed two me	ons, record review and staff ty failed to allow 1 of 7 to feed themselves. Resident als and not given the nerself using cues for ed.				
	10/01/14. Her diagr ischemic cardiovasc	s admitted to the facility on noses included severe acute cular accident. Upon				
		ician orders revealed she was tric tube (NG) and took				
		nerapy notes revealed I speech therapy on 10/02/14 Iow techniques.				
		tube was removed on ician ordered a puree diet on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02	/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		211 N	ET ADDRESS, CITY, STATE, ZIP CODE IILTON BROWN HEIRS ROAD NE, NC 28607	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 311	for the problem of in adequately consume swallow dysfunction chew/swallow without she alternate liquids and sips with minima care plan also noted follow safe swallow. Her quarterly Minima coded her as having impairment and sever making skills. She wassistance with eatin On 02/16/15 at 11:2 #3 was observed fee continued feeding R 02/24/15 at 9:34 AM She stated that Residing for some measurement when she was in her she gave Resident herself. NA #3 state on allowing Residen On 02/18/15 at 11:2 aide (NA) #11 stated restorative dining for there was no restorative dining for there was no restorative dining for the same properties of the same problem.	an was created on 10/15/14 Inpaired ability to safely and a current diet related to . Goals included to . Goals included to . The last assistance of one. The . Ishe needed verbal cues to techniques.  In Data set dated 01/09/15 . Ilong and short term memory erely impaired decision vas coded as requiring total ng.  In AM, Nursing Assistant (NA) eding Resident #56. She esident #56 at 12:26 PM. On . NA #3 was interviewed. Indent #56 went to restorative alls but she always just fed her er room. She further stated and she was never instructed at #56 to feed herself.  In AM, the restorative nurse at that Resident #56 ate in a breakfast and lunch, as ative dining in the evening.  In AM Resident #56 was erself in restorative dining. NA positioning the food in front	F	311			
		PM Resident #56 was ed which was lowered to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345163	B. WING _			02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 311	the bed, the tray in encourage or assist during the meal. No and allowed the restrom the cup.  NA #9 was interview. She related that this fed Resident #56. Card stated the type resident needed but gave no indication on needed and the oth Resident #56 needed fed Resident #56.  On 02/23/15 at 11:5 interviewed again, was doing exception stated that staff needed make sure she ate liquids, and staff president was doing staff president.	front of the NA. NA #9 did not to the Resident #56 to feed herself A #9 would hand her a cupsident to drink independently wed on 02/19/15 at 5:41 PM. It was the first time she had She further stated the tray to e of feeding assistance at the tray e of feeding assistance at the tray e of the type of assistance she wer nurse aides told NA #9 and help feeding so NA #9 just as NA #11 stated Resident #56 anally well feeding herself. She eded to thicken the liquids, slowly, alternated bites and essented one bowl at a time so out get overwhelmed with the	F3	,		
	She stated Resider stroke and was tube restorative had bee and watched her so bites. ST stated the trained on supervis meals. Follow up in Manager/ST on 02/that her self feeding staff needed to most	herapist (ST) was interviewed.  It #56 had a devastating  It fee fed originally. ST stated  In working with Resident #56  It she does not take too big of  It is family and staff had been  It is family and staff had been  It is family and staff desident #56 during				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE  11 MILTON BROWN HEIRS ROAD  BOONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 311 F 323 SS=J	moved to her current months. Rehab Manaunsure if the staff on currently resided had supervision required to 00 02/24/15 at 2:22 Fand Assistant Directo during interview that the providing cuing so Reherself safely. They fit the process of inservito include the type of each resident.  483.25(h) FREE OF AHAZARDS/SUPERVITTHE facility must ensuenvironment remains as is possible; and each and the staff of the s	rehabilitation unit and room after the first few ager/ST stated she was the hall where the resident been instructed on the for Resident #56.  PM, the Director of Nursing r of Nursing #2 revealed they expected staff to be esident #56 could feed urther stated they were in icing and updating tray cards supervision required for ACCIDENT SION/DEVICES  are that the resident as free of accident hazards		311			
	by: Based on record revi physician interviews t mechanical (full body 12 sampled residents The facility also failed for 1 Resident on 1 of	is not met as evidenced iews and staff, resident and the facility failed to utilize a ) lift during transfers for 1 of for falls (Resident #24). It to secure a loose side rail f 4 hallways (Resident #33). began on 11/15/14 when dent #24 three times without					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345163	B. WING _		02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 323	removed on 02/27/15 facility provided and credible allegation of remains out of comp severity of D (an isol actual harm with potharm that is not imm monitoring of system Example 2 is at a soft The findings included A review of a facility Checklist" that was recomplete the falls in statements; Notify D Administrator if injury to emergency room; to make sure date at what the resident sar observed, what assemental, range of more consciousness and princidents from occur and it should include information.  1. Resident #24 was 02/17/14 with diagnor high blood pressure, swallowing, arthritis, paralysis and stroke.  A review of a Nursing sheet dated 02/17/14 alert and aware, non understand others at	iff. Immediate jeopardy was 5 at 11:35 AM when the implemented an acceptable of compliance. The facility liance at a lower scope and ated deficiency, with no ential for more than minimal ediate jeopardy) to ensure as put into place are effective. ope and severity of D. d:  d:  document titled "Falls not dated, indicated in part, to estigation and witness irector of Nursing (DON) and y sustained and resident sent complete falls investigation and time are correct, include id, include what you essments and results for skin, tion, vital signs and level of colan to prevent further ring; complete progress note in detail all of the above as admitted to the facility on oneses which included diabetes, difficulty speaking and depression, right sided	F 3.	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 323	A review of a Fall R #24 on 02/17/14 review of a physic indicated Resident a mechanical lift.  A review of the adm (MDS) dated 03/03/severe impairment imaking. The MDS was totally dependent and transfers and R was sometimes uncunderstood others.  A review of a Fall R #24 on 05/24/14 review of a care p for accidents/fall ris 10/25/14 indicated a possible causes/paraccidents and lift for A review of a care p for total dependence	fers and bed mobility.  isk Assessment for Resident realed a score of 14 which ore of 10 or above represented from the first order dated 02/18/14 from Minimum Data Set 14 revealed Resident #24 had in cognition for daily decision for daily decision for daily decision for daily decision for bed mobility from the first on staff for bed mobility from the first odd and usually from the first odd and usually from falls.  It isk Assessment for Resident realed a score of 11 which for falls.  It isk Assessment for Resident realed a score of 11 which for falls.	F 323			
	for activities of daily	lan with a problem statement living with updated date of ift for transfers and out of bed				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION  A. BUILDING		' '	(X3) DATE SURVEY COMPLETED		
		345163	B. WING	<del> </del>		02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	HABILTATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	ge 61	F 32	23		
		thly physician's orders for icated activity level for a				
		ion Administration Records er 2014 indicated activity al lift.				
		notes dated 11/15/14 revealed 's notes during the 7:00 AM -				
	PM indicated Reside grunting when Nurse to administer bedtim further indicated whe raised Resident #24 revealed Resident # history of a stroke be appropriately by noo The notes further reshe was hurting Resident Resident History of a stroke be appropriately by noo The notes further reshe was hurting Resident Resident History of the notes further reshe was hurting Resident Reside	s note dated 11/15/14 at 8:30 ent #24 was lying in bed e #2 went to resident's room ne medications. The notes en the head of the bed was began yelling out. The notes e24 was nonverbal due to ut could answer questions adding her head for yes and no. Exercise when asked where sident #24 pointed to her right eated an assessment showed				
	was made to roll Re screaming loudly an	redness but when an attempt sident #24 over she began d Resident #24's responsible nd hospital was notified for ergency room.				
	PM revealed emerge was in the facility to	s note dated 11/15/14 at 9:02 ency medical services (EMS) transport Resident #24 to the room for evaluation.				
	indicated EMS was	report dated 11/15/14 at Resident #24's bedside at labeled narrative indicated				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 323	not fall however upon staff it was found our fall earlier today.  A review of a nurse's PM indicated Nurse Nurse Aides (NA's) a #24 on the 7:00 PM were no reports of in previous shift to Nur A review of a nurse's 12:30 AM indicated and was informed R the hospital with a rifurther indicated Nurnurse (Assistant Direon call and contacted give an update.  A review of a nurse's 12:42 AM indicated the facility with quest Resident #24 was questioned have a pursue (ADON #1) was A review of a Physic dated 11/16/14 indicintertrochanteric (up fracture of right hip finistory of stroke with and aphasia (difficul revealed Resident # staff lying in bed cor apparently had a his	y stated on scene that she did in talking to emergency room it that she did indeed have a  s note dated 11/15/14 at 9:25 #2 had a conference with assigned to care for Resident to 7:00 AM shift and there ujury received from the se #2 or to NAs.  s note dated 11/16/14 at Nurse #2 called the hospital esident #24 was admitted to ght hip fracture. The notes rise #2 notified Administrative ector of Nursing (ADON)) #1 Id Resident #24's family to  s note dated 11/16/14 at estaff from the hospital called tions and reported when uestioned she indicated she into the floor earlier in the iner indicated Administrative	F 3.	23	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SU			(X3) DATE SURVEY COMPLETED		
		345163	B. WING			02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	notes further indicated to the hospital emer revealed a displace intertrochanteric/sult the thigh bone) fraction the thigh bone) fraction are indicated intertrochaft indicated intertrochaft indicated surgery was reduction (to realign position) and internate keep bone fracture infection) with a should be a should be a sist with transferrich and ready for should be a sist with transferrich are indicated the following morning of 11/15/14 up and ready for should be assist with transferrich are indicated to pivot resident. The 2 NAs at #24 with an arm and resident without difficult in the resident "voontinue to assist the attempted to place in but due to her weigh into the chair. Both slowly lowered residing the shower chair. not confirm or deny of the incident. NA	red Resident #24 was brought gency room and x-rays do brochanteric (upper quarter of ture of the right hip.  rative report dated 11/17/14 canteric/subtrochanteric hip. The notes further as completed with open a bone fracture into normal all fixation (hardware used to stable to heal and prevent	F 32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED			
		345163	B. WING _			02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER	·	STREET ADDRESS, CITY, STATI 211 MILTON BROWN HEIRS F BOONE, NC 28607		
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F 323	this transfer. After lutransferred Resident The resident participa not complain of pain of pain. At approxim #4 was changing Resyelling out and grabb named) asked the re she nodded her head Nurse #1 and she we reported that both leg she "didn't see anyth Nurse #1 noticed Resher groin area and sh administered schedu Nurse #1 instructed to apply protective ointrasked Resident #24 the resident shook he came in Resident #24 the resident shook he came in Resident #24 pain and Nurse #2 se her diagnosis was intright hip.  During an interview of Resident #24 she sm up and down as a restrepetitive sounds but when spoken to. Sh down yes when quest last November. Whe facial expression chat tearful and attempted unable to form the we head vigorously up a questioned if her hip head from side to sid	s or symptoms of pain during inch NA #1 and NA #3 #24 from wheelchair to bed. ated with the transfer and did or show signs or symptoms ately 2:00 PM NA #1 and NA sident #24 and she started sing at her leg. NA (not sident if she was in pain and did yes. NA #4 went to get ent to check the resident and ing out of the ordinary." sident #24 was scratching at the had just recently led Tylenol to Resident #24. The NAs to clean resident and ment. At 4:00 PM Nurse #1 if her leg was still hurting and the head no. When night shift 4 appeared to be in severe ent resident to the ER and tertrochanteric fracture of the total pain and the head is sponse for yes and made a was unable to form words are nodded her head up and stioned if she had a hip injury an asked if she had a fall her langed and she became if to say something but was bords and then nodded her	F3	323		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02/27/2015
	ROVIDER OR SUPPLIER	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	, 32.2.12013
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F 323	Assistant Director of after review of Resid 11/15/14 she did not 11/15/14 when the resident hospital but if the mer then they probal she did not rememb 11/15/14 or 11/16/14 she remembered was meeting the followin complained of sever sent to the hospital as She further stated si involved in an investigate.  During an interview Director of Nursing (nurses notes for Reconfirmed there were assessment during to During a follow up in PM the DON explair supposed to call the when a resident had on call should go to call the DON and shinvestigate. She cound did not go to the 11/16/14 to investigate During a telephone PM NA #1 explained to get Resident #24	on 02/23/15 at 11:48 AM the Nursing (ADON) #1 stated dent #24's nurse's notes for the remember being called on esident was sent to the curses documented they called only did. She further stated er going to the facility on the stated the only thing as she heard during morning and week Resident #24 had be pain in her hip and was and she had a hip fracture. The did not remember being tigation regarding Resident when the pool of the sident #24 on 11/15/14 are no nurse's notes or nursing the 7:00 AM to 7:00 PM shift. The facility to investigate or the would go to the facility to investigate or the would go to the facility to investigate or the would go to the facility to investigate or the would go to the facility to interview on 02/23/15 at 6:44 as he and NA #2 were trying out of bed into a shower chair that the therapy staff had been in the facility to a shower chair that there is the facility and the and the pool of the facility and the nurse the facility on 11/15/14 or the Resident #24's fall.	F 3:	23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345163	B. WING			02/27/2015
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F 323	her with 2 staff as previously stood F transfer her and the that was the way she explained durshe had her arm use armpits and NA ## armpit and they she when they turned NA #1 stated when to the floor they trobecause she was when they realized lowered her to the get a nurse. NA #Resident #24's she floor and thought NA #1 further state and they picked F she took her to the shower. She exploited between the shower chair and after lunch she got transfer Resident #24 up from her whole. She explained #24 was lowered and holding her right she reported it to the shower Resident #24 up from her whole. She explained #24 was lowered and holding her right she reported it to the shower Resident She explained the she was lowered and holding her right she reported it to the she was lowered and holding her right she was lowered an	dent #24 to stand and transfer sist and NA #1 stated she had Resident #24 next to her bed to he resident had done fine and she usually transferred her. ring the transfer on 11/15/14 under one of Resident #24's 2 had her arm under the other tood her up at the bedside but her to pivot her she went limp. In Resident #24 started to slide ited to lift her up but they couldn't too heavy. She explained do they could not lift her up they a floor and she told NA #2 to go at 1 stated she held on to coulders while she sat in the her legs were out in front of her. Ited NA #2 came back with NA #3 tesident #24 up off the floor and the shower room and gave her a lained she did not notice any for bruising when she gave wer and after the shower NA #2 and Resident #24 up from the into a wheelchair. NA #1 stated at NA #2 and NA #3 again to #24 and they stood Resident wheelchair and transferred her to ged about 3 hours after Resident to the floor she was moaning ght leg and was rubbing it and	F	323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/	27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		211	REET ADDRESS, CITY, STATE, ZIP CODE  1 MILTON BROWN HEIRS ROAD  DONE, NC 28607			
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F 323	started to buckle. Sileg did not turn as its slid down to the floor Resident #24 was its straight out but her under her left leg at angle at her knee. Nurse #1 and the nurse the resident it said ok and to go at in the shower chair stated she went based and NA #1 place Resident #24's arm floor and into the slike Resident #24's arm floor and into the slike did not assist its hower and also verto Resident #24's rother floor or after the chair. She explained Monday 11/17/14 to during the transfer and sometime after about use of gait be to everybody but the During an interview NA #3 she stated in her to assist with ge floor. She stated we #24's room the resident resident.	owards the left and she she stated Resident #24's right her upper body turned and she or. She further stated when in the floor her left leg was right leg was crisscrossed and was bent at a 90 degree NA #2 stated she went to get urse asked if the resident had floor and when she told the had slid to the floor the nurse head and get Resident #24 up and give her a shower. NA #2 ok to Resident #24's room and bed their arms under each of upits and lifted her from the hower chair. She stated blained of her right leg hurting was placed in the shower the it was caused by pressure the shower chair. She stated was placed in the shower had under the property of the property	F	323				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
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F 323	straight out in front is straighten her legs of stroke with paralysis demonstrated she president #24's army under Resident #24 her up off the floor with chair. She confirmed the room while she and after they place chair she left the room a different hall. So remember anyone a happened or what so Resident #24's room when NA #2 reporter floor. She stated she and took full respons was supposed to do assessment she did Resident #24 was coreaching toward her red. She stated she what she saw but red. She she she what she she was	because she couldn't but fully due to a previous on her right side. She laced her arm under one of bits and NA #1 placed her arm its other armpit and they lifted while NA #2 held the shower of Nurse #1 did not come in was in Resident #24's room of Resident #24 in the shower of the stated she did not isked her about what had he saw when she went to he saw when she went to he was having a very bad day sibility for not doing what she was later in the day when rying out in pain and was a peri area and the area was a couldn't remember exactly membered she gave routine Tylenol for pain but occument it because she did ad happened or that anything	F 3:	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/	27/2015	
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F 323	was in such pain. #24 had an inconticlean her or turn haverified she had not #1 during shift chat to the floor earlier the resident to the evaluation and treadid not usually configure out why she She explained late hospital called her Resident #24 had a fall. She #1 who was the first time #24 had a fall. She #1 who was the nuthe hospital had retold her to make such that day because in the day because in the day because in the day because in the floor during shift reconsident had a fall she thought there is investigation to detain hip fracture since floor during transfer During an interview Licensed Physical therapy staff had be on standing and trate to her fall on 11/15 participation varied stand but then she He stated it was him to the floor turn to her she he stated it was him to the floor turn to her she he stated it was him to her fall on the she he stated it was him to her fall on the floor turn to her she he stated it was him to her fall on the floor turn to her she he stated it was him to her fall on the floor turn to her fall on the floor turn the	r or touch her because she She further explained Resident nent episode but they couldn't er because of the pain. She of received a report from Nurse nge that Resident #24 had slid that day. She stated she sent hospital emergency room for atment because Resident #24 nplain of pain and she couldn't was having such severe pain. If that night a nurse from the and asked about a fall that earlier that day. She stated me she had been told Resident the explained she called ADON tree on call and told her what ported. She stated ADON #1 ture she had everything the stated nobody on her shift tut Resident #24's fall earlier thothing had been reported to the port. She explained she turning documentation when a tor was lowered to the floor and should have been some termine why Resident #24 had the she had been lowered to the	F	323				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, ( 211 MILTON BROWN BOONE, NC 2860			
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F 323	been to use a mechal Resident #24 was clewith a maximum assing During a follow up in PM the DON verified titled Investigation of she talked to staff who for Resident #24 on a summarization of vistated she could not related to Resident #incident recorded on Resident on 11/15/14. During a phone intensite physician who was Director stated he was #24's fall after she has stated the information sliding to the floor did happened but he woo incident or something her at higher risk for his expectation for no residents immediated were lowered to the expected the nurses what had happened, comfort was, their less consciousness. He sassessed right away should be considered should do what they	the plan of care would have sinical lift for transfers until geared by therapy to transfer st of 2 staff.  Atterview on 02/24/15 at 3:24 she wrote the summary Resident #24's fracture after no had been assigned to care Monday 11/17/14 and it was what staff had told her. She find an incident report 24's fall and there was no the incident logs for	F	323			
	the Rehabilitation Dir	rector she stated it was not ursing staff to mirror what					

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	CODE	
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F 323	they were doing duri did not instruct nursing different than what wexplained when nursing questions about how instructed them to go She further stated nurse ach resident required. During another follow 11:34 AM the DON states the nurse should they were witnessed follow up to make surexplained if the resides should provide first a hospital. She explained the closet should match the care should match the care should match the closet should match the closet should match the closet should match the closet care plant Resident #24's fall who to the hospital but should have been do stated they would not related to transfers up the resident 100 peropertical to the should have been do have also been notified of Resident stated she was notified of Resident stated she was noted they would be further stated she was noted they would be further stated she was noted.	ng therapy sessions and they ng staff to do something as on the care plan. She ing staff came to her for to transfer a resident she to to the nurse for clarification. Ursing staff should know what ed for transfers.  If you p interview on 02/27/15 at tated it was her expectations assess for falls whether or un-witnessed and should the resident was ok. She ent was injured the nurse id or send the resident to the need the care plan should and the transfer technique	F3	323		

. , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	questioned about it Nurse #1 had told h #24 but she did not had not assessed t lowered to the floor from the floor to the During an interview Administrator expla work in the facility of facility was lacking number of issues wexplained a lot of work processes and lot of work that nee The facility's Admin Nursing were notific 02/24/15 at 3:31 PM facility provided a compliance on 02/2 following intervention facility to remove the Credible Allegation Resident #24 was stroom on November resulting in surgical Upon readmission assessed by ADON to impaired cognition habitus, and recent and it was determine method was mechal	during the survey. She stated her she assessed Resident realize at that time Nurse #1 he resident after she was or before she was moved e shower chair.  I on 02/27/15 at 12:20 PM the ined she had just started to on 11/11/14 and identified the processes to address a which included falls. She ork had begun to implement I changes but there was still a ded to be done.  I istrator and Director of end of Immediate Jeopardy on M for Resident #24. The redible allegation of 17/15 at 11:35 AM. The ons were put into place by the le Immediate Jeopardy.  Of Compliance  Sent to the hospital emergency 115, 2014 with right hip pain	F 32	3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	· /	(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
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F 323	is located in resident refer to for care including the resident at assessed the resident involved received we utilization of gait belt assessment required licensed nurse prior a fall.  Nurse #1 received at 11/17/2014 regarding and completing resident is moved. The regarding fall investing falls on 11/21/2014.  All documented falls prior to the identified audited to assess contaction on 11/14/14 determine that there occurred with other with transfer technique meeting daily Mondation 11/18/14. This is a solooks at falls. Fall a ensure timely assess documentation, and	4. Resident care information t's closets for direct care to uding transfers for residents.  cloved with resident #24's care erbally instructed on 11/16/14, work day, regarding not fiter a fall before a nurse nt. On 11/17/14 all 3 CNAs erbal education regarding t for transfers and d to be completed by a to moving any resident after  written coaching on g completing incident reports dent assessments, including t after a fall before the She was also educated gation and assessment after  that occurred in November d deficient practice were empliance with standards of e-11/16/14 and was utilized to experience with standards of e-11/16/14 and was utilized to experience with standards of e-11/16/14 and was utilized to experience with standards of e-11/16/14 and was utilized to experience with standards of e-11/16/14 and was utilized to experience with standards of e-11/16/14 and was utilized to experience with standards of experience with	F3	23		
		ed with 100% completion on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	1, ,	(X3) DATE SURVEY COMPLETED	
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F 323	February 25, 2015.  On February 24, 20 aides present was in New falls and fall ris implemented on Fel Assessment and firs Record vital signs a injuries to the head, If evidence of signification provide first aid Once an assessment ursing staff will hel sitting, lying, or stannot be moved until recompleted. Initial documentation notification of physication of physi	15 at 11 pm nurses and nurse in serviced on: It policy and procedure or serviced and evaluate for possible neck, spine, and extremities cant injury, nursing staff will ont rules out significant injury, president to a comfortable ding position. Resident will nursing assessment is in regarding fall and can and family all of fall or fall risk in swill be documented on nutation Note/Progress or mented on February 22, in the MAR and placed in the completion of 5 day post fall	F 32	·			
	unsteadiness, further needed. If the residence referral is initiated. on Fall: Initial Documotes-5 day	er evaluation may not be ent has difficulty therapy This should be documented mentation Note/Progress ssess the resident and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	days and document Documentation/Pro Identifying complicate requirement for imma residents who have resident's clinical rethe condition the reassessment data in obvious injuries Interventions, first a Notification of physic Completion of fall ri Appropriate interventialls Signature and title of Report fall to DON, All of the above should be completed by An in service on fall procedure and transpecture and transp	result of a fall every shift for 5 con Fall: Initial gress Note-5 day attions of falls nediate assessment of fallen and documentation in cord sident was found cluding vital signs, and any aid, or treatment administered cian and family sk assessment attions taken to prevent further of person recording data ADON, or RN Supervisor and be documented on the antation/Progress Notes-5 day, the end of shift sand fall risk policy & sfers and mechanical lift will a nursing department staff by 8 2015. Any nursing ee that has not attended participated in phone in 25, 2015 at 8 pm will not be a list of nursing department not receive the above in the DON. The DON will hedule to ensure that anyone above training will not be	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345163	B. WING		0	2/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	DON, ADONs, nurs residents who were assistant with trans on 2.25.15 for screet technique.  Every resident fall withrough Friday each Meeting and will enbeen completed. A been implemented documentation and strategies are implewhen a fall occurs.  Immediate jeopardy 11:35 AM with interlicensed nursing stareceived in-service risk policy and proclifts prior to reportin A review of in-service documentation of staresidents.	issessed for transfers by ie, and therapy. All affected identified as two person fers were referred to therapy en to verify safest transfer  will be reviewed Monday in morning at the Clinical sure initial documentation has revised falls audit tool has on 02/25/2015 and will include confirmation that all fall emented and action taken  was removed on 02/27/15 at views of direct care and aff who confirmed they training on new falls and fall edure and use of mechanical	F 32				
	were cross reference staff that had not be schedules.  Interviews with NAs in-service training a notify a nurse immedincluded lowering a Interviews with nurse attended in-service knowledgeable to reference in the staff of the	-services and these names ced with schedules and no seen trained was listed on the arevealed they had attended and were knowledgeable to ediately after a fall which resident to the floor. Sees revealed they had training and were espond and assess residents fall or if they were lowered to					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02/27/2015		
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	·		
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 323	the floor. They desproviding first aid, on otification of physiadministrative nursifall risk assessmen incident report.  Record reviews rev Documentation Not was implemented opolicy and procedur 02/24/15.  Review of the management of the manageme	cribed the expectations for locumentation of the incident, cian, responsible party and ing staff and completion of the t, post fall evaluation and  ealed the fall: Initial e/Progress Notes-5 day form in 02/22/15 and a new fall risk re was implemented on edical record revealed admitted on 10/05/06 with g Alzheimer's disease, chronic ary disease (COPD), and	F 32	3			
	associated with der of pelvis fracture, a the goals was an er of accident or fall hard interventions included epartment of any obed side rails, hand Review of the most dated 10/24/14 revibed rails for turning cognitive impairment boundaries.  Review of a quarter dated 11/15/14 reve	mentia, COPD, anxiety, history and medications. Included in navironment as free as possible azards for the next 90 days. Led notifying the maintenance defective equipment such as I rails, chairs, and beds.  Trecent side rail assessment realed Resident #33 required and repositioning, had ant, and could identify bed  Ty Minimum Data Set (MDS) realed Resident #33 had required					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		345163	B. WING	<del></del>	ا ا	2/27/2015		
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607				
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F 323	extensive assistand mobility and transfer Review of the log ure of repairs for Resider revealed there were documented from 0 Resident #33's bed the maintenance click Observations of Reside rails were as for On 02/16/15 at 2:2 loose and the top or edge of the mattres. The left side rail was leaned away from the lambda and the top or edge of the mattres. The left side rail was leaned away from the lambda and the top or edge of the mattres. The left side rail was leaned away from the left side rail was loose and leaned amattress approximately 1 incompared to the ledge of the linch.	sed to notify maintenance staff ent #33's side of the facility 7 side rail related problems 1/01/15 through 02/24/15. side rails were not listed on 1/15 board.  sident # 33's bilateral 1/4 bed ollows: 22 PM the right side rail was 1/16 the rail leaned away from the 1/16 approximately 2 inches. Is not loose and fit properly.  On PM the right side rail was 1/16 the rail leaned away from the 1/16 approximately 2 inches. Is loose and the top of the rail the edge of the mattress 1/16.  On PM the right side rail was 1/16 the rail leaned away from the 1/16 approximately 2 inches. Is loose and the top of the rail the edge of the mattress 1/16 the edge of	F 32	23				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED			
		345163	B. WING			02/27/2015	
	ROVIDER OR SUPPLIER	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	loose and leaned av mattress approxima was loose and the to from the edge of the inch.  An interview with Nu at 10:49 AM revealer rails while providing when she noticed a this to the maintenal paged them overheadsisted Resident # also stated Resident turn in bed and where for transferring out or revealed NA #5 was	vay from the edge of the tely 4 inches. The left side rail op of the rail leaned away mattress approximately 1  urse Aide (NA) #5 on 02/24/15 and she checked the bed side care to her residents and loose side rail she reported note department directly or ad. NA #5 confirmed she had 33 out of bed on 02/24/15 and the #33 used the side rails to a she had the side rail	F 32				
	Maintenance Director maintenance issues overhead paging hir or documenting the log. The Maintenan checked the mainten facility daily and he acompleted an audit o2/20/15 and 02/23/ revealed the Mainte 100 and 200 hall be was assigned to audited rails. At 02/25/ Maintenance Director Resident #33's room rails. The Maintenan screws that secured	on 02/25/15 at 10:16 AM the or stated staff notified him of and needed repairs by when he was in the facility issue on the maintenance ce Director stated he nance log on both sides of the and his assistant had just of all bed side rails on 15. The interview further nance Director audited the d side rails and his assistant dit the 300 and 400 hall bed 15 at 10:21 AM the or was accompanied to a nand examined the bed side nice Director stated the two the right side rail were also noted this particular type					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 11 MILTON BROWN HEIRS ROAD COONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329 SS=E	both side rails would make the bed side ra Maintenance Director noted one of the clips right side rail to the b stated it would need to A follow up interview Maintenance Director The Maintenance Director The Maintenance Director The Maintenance Director Side rails had not bee 02/23/15 because his days of the audit. The bed side rails were the Maintenance Director Screws worked their vifresidents leaned on 483.25(I) DRUG REGUNNECESSARY DREACTOR Each resident's drug unnecessary drugs. It drug when used in example adverse consequences and the reduced or combinations of the resident, the facility many have not used an given these drugs un	up quickly. The r confirmed the screws for need to be tightened up to ils fit properly. The r then lifted the mattress and so on the rod that secured the ed frame was missing and to be replaced.  was conducted with the r on 02/25/15 at 3:23 PM. ector stated the 300 hall bed en audited on 02/20/15 or assistant was off one of the e interview further revealed epically audited every two entation was maintained. ector further stated the way out of the bed side rails in the bed side rail.  BIMEN IS FREE FROM UGS  regimen must be free from An unnecessary drug is any accessive dose (including for excessive duration; or nitoring; or without adequate is or in the presence of es which indicate the dose of discontinued; or any		323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			02/27/2015		
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIA	DATE		
F 329	record; and resident drugs receive gradua behavioral interventi	ocumented in the clinical s who use antipsychotic al dose reductions, and	F3	329				
	by: Based on record rev pharmacist and phys failed to stop a disco residents sampled for	T is not met as evidenced views, staff interviews, and sician interviews the facility entinued medication for 1 of 5 or maintaining a drug regimen medications (Resident						
	11/29/12 with diagnoral limited to diabetes, in disease, and kidney recent quarterly Mini 01/02/15 indicated reintact. Further review Resident #135 requibeing totally depend living (ADL's). The M #135 received antibit week.  Review of the medic #135 was admitted the with a diagnosis of a	admitted to the facility on uses that included but was not useart disease, Parkinson's disease. Review of the most mum Data Set (MDS) dated esident #135 was cognitively of the MDS revealed red extensive assistance to ent for most activities of daily IDS also indicated Resident otic medication 7 days a all record revealed Resident to the hospital on 07/28/2014 in acute episode of blood in er issues. After he received						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED			
		345163	B. WING _			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	HABILTATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	Continued From page		F 3	29			
	7/29/14. Physician's discharge summary an antibiotic, Ceftin times daily for 5 day Review of the Medic (MAR's) from July or evealed the order v #135 to be started of (mgs.) two times da review of the MAR is documented to have since 07/29/14 with be stopped.	eleased back to the facility on a orders reviewed on his indicated he was to receive 250 milligrams (mgs.) two as for urinary tract infection.  Cation Administration Records of 2014 to February of 2015 was transcribed for Resident on Ceftin 250 milligrams ily on 07/29/14. Further indicated the medication was be been given two times daily no date for the medication to					
	conducted with the A (ADON #1). She was for the Ceftin, or det was to be stopped. And retrieved Reside summary from the O stated the orders income been stopped or the clarified by someone were conducted. And know why the medic days or the physician her expectation that the medication error medication reviews. make the correction physician.  On 02/18/15 at 12:2 conducted with the I She stated the faciliar the redication that the she stated the faciliar than the I she she stated the faciliar than the I she	O AM an interview was Assistant Director of Nursing as unable to locate the order termine when the medication ADON #1 called the hospital ent #135's discharge 17/29/14 hospitalization. She dicated the Ceftin should have to orders should have been to when monthly MAR reviews DON #1 stated she did not totation was not stopped after 5 an notified. She stated it was to staff would have discovered to during the monthly The ADON stated she would immediately and notify the  TO PM an interview was Director of Nursing (DON). ty had a system in place to orders which included the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZI 211 MILTON BROWN HEIRS ROA BOONE, NC 28607	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 329	orders and checked a dates. The DON furth during monthly review should have been cla a stop date indicated was her expectation followed each month case.  On 02/18/15 at 3:40 I conducted with the D telephone conference Director (MD). She st medication should had days from the start darevealed the MD ordediscontinued and a urobtained for Resident needed a long-term at On 02/19 15 at 12:00 conducted with the faindicated she had be the resident's medicas since August or Septipharmacist stated the reviewing resident meall medications for cumaking sure all medicated she would requiphysician. She stated ordered for Resident discovered during physician date secured from the On 02/25/15 at 2:00 I	the resident, transcribed the fall medication orders for stop are acknowledged that wo f medications, the order wrified with the physician and on the order. She stated it for the process to be and it was not done in this.  PM another interview was ON. She indicated a sewas held with the Medical stated he acknowledged the we been discontinued after 5 ate of 07/29/14. The DON ered for the medication to be rology consult was to be at #135 to determine if he antibiotic.  I Noon an interview was excility pharmacist. She een doing monthly reviews on the ember of 2014. The emonthly process of edications involved checking arrent diagnoses as well as cations had a stop date on one did not include a stop eest a stop date from the lathest top date for the Ceftin #135 should have been armacy reviews and a stop en physician.	F3	329		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345163	B. WING			02/	27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REHA	ABILTATION CENTER		211 N	EET ADDRESS, CITY, STATE, ZIP CODE MILTON BROWN HEIRS ROAD DNE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	stated the error should was missed by a num for medication review should be provided w	e 84 dication error. The MD ld never have occurred and nber of people responsible vs. He stated no antibiotic vithout a stop date, and stop dates should be clarified	F	329			
F 333 SS=E	483.25(m)(2) RESIDI SIGNIFICANT MED I The facility must ensu any significant medic	ERRORS  ure that residents are free of	F	333			
	by: Based on record rev pharmacist and physi failed to prevent a sig						
	11/29/12 with diagnost limited to diabetes, he disease, and kidney or recent quarterly Minir 01/02/15 indicated reintact. Further review Resident #135 requir being totally dependently (ADL's). The M	dmitted to the facility on ses that included but was not eart disease, Parkinson's disease. Review of the most mum Data Set (MDS) dated sident #135 was cognitively					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING			2/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 333	#135 was admitted to with a diagnosis of a his urine among other treatment, he was re 7/29/14. Physician's discharge summary an antibiotic, Ceftin 2 times daily for 5 days. Review of the Medic (MAR's) from July of revealed the order w #135 to be started or (mgs.) two times daily review of the MAR in continued to be give 07/29/14 with no dat stopped.  On 02/18/15 at 11:40 conducted with the A (ADON #1). She was for the Ceftin, or dete was to be stopped. A and retrieved Reside summary from the 0 stated the orders indicated by someone were conducted. AD know why the medic days or the physician her expectation that the medication error the monthly medication to the conducted to the	al record revealed Resident to the hospital on 07/28/2014 in acute episode of blood in er issues. After he received leased back to the facility on orders reviewed on his indicated he was to receive 250 milligrams (mgs.) two is for urinary tract infection.  ation Administration Records 2014 to February of 2015 as transcribed for Resident in Ceftin 250 milligrams y on 07/29/14. Further indicated the medication had in two times daily since in the form the medication to be of AM an interview was assistant Director of Nursing is unable to locate the order ermine when the medication ADON #1 called the hospital	F 3:	33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING	<del></del> -	02/27/2015	
	ROVIDER OR SUPPLIER	HABILTATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 333	conducted with the She stated the facili review medication or nurse who admitted orders and checked dates. The DON fur during monthly revies should have been or a stop date indicate was her expectation followed each mont case.  On 02/18/15 at 3:40 conducted with the telephone conference Director (MD). She medication should have from the start revealed the MD or discontinued and a obtained for Reside needed a long-term.  On 02/19 15 at 12:0 conducted with the indicated she had be the resident's medications for conducted with the indicated she had be the resident's medications for conducted with the indicated she had be the resident's medications for conducted with the indicated she had be the resident's medications for conducted with the since August or Sepharmacist stated the MAR. If medicated the MAR. If medicated the MAR. If medicated for Resident she would requiply sician. She state ordered for Resident resident for Resident	Director of Nursing (DON).  ty had a system in place to orders which included the the resident, transcribed the all medication orders for stop ther acknowledged that ew of medications, the order larified with the physician and d on the order. She stated it for the process to be h, and it was not done in this DON. She indicated a ce was held with the Medical stated he acknowledged the lave been discontinued after 5 date of 07/29/14. The DON dered for the medication to be urology consult was to be int #135 to determine if he	F 33	33		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345163	B. WING _		02/27/2015			
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607				
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F 333	date secured from the The pharmacist also adverse effects of Cediarrhea, nausea, vo bacteria. She stated be provided for long-replace depleted back Resident #135 was renzyme.  On 02/25/15 at 2:00 conducted with the Newas aware of the methe biggest concern taking Ceftin for such be diarrhea and develor drug reaction. The never have occurred number of people where the provided with the physician. 483.35(i) FOOD PROSTORE/PREPARE/STORE/STORE/PREPARE/STORE/PREPARE/STORE/PREPARE/	indicated that long-term eftin use could include miting, and loss of intestinal an intestinal enzyme could term antibiotic usage to steria in the intestine. Not receiving an intestinal enzyme could term antibiotic usage to steria in the intestine. Not receiving an intestinal endergraph of the receiving an intestinal endergraph of the revealed for Resident #135 related to a long period of time would elopment of a drug sensitivity of MD stated the error should and was missed by a so should have reviewed the endergraph of the revealed for Stated in antibiotic without a stop date, and stop dates should be clarified endergraph of the stated in antibiotic without a stop date, and stop dates should be clarified endergraph of the sources approved or only by Federal, State or local distribute and serve food	F3					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	02/2//2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 371	by: Based on observations of the O2/18/15 at 12:39 Fpiece of dried orange madoors, and brown dried orange madoors, and brown of the O2/19/15 at 4:07 Plof dried orange madoors.  Observations of the O2/19/15 at 4:07 Plof dried orange madoors.  Observations of the O2/19/15 at 4:07 Plof dried orange madoors.  Observations of the O2/19/15 at 4:07 Plof dried orange madoors.  An interview was complete dried spills of and brown dried madoors.  An interview was complete dried spills of and brown dried madoors.	NT is not met as evidenced tions and staff interviews the intain the cleanliness of the s of the reach-in refrigerator, nachine, and microwave.	F 37	71		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345163	B. WING		02/27/2015			
	ROVIDER OR SUPPLIER  DGE HEALTH AND REI	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607				
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F 371	Continued From pag	ge 89 to be cleaned were initialed	F 37	71				
		reach-in refrigerator was						
	02/23/15 at 1:08 PM of dried orange mat white dried spills on	reach-in refrigerator on I revealed a dime-sized piece ter on the left exterior door, the exterior of both doors, tter on the top half of both						
	PM the DM observed the reach-in refriger clean. The cleaning 02/16/15 through 02 reach-in refrigerator and also the DM. Tweekly cleaning schassigned areas afte been completed. The not notice the dried the exterior door parefrigerator when ships the reach-in refrigerator when ships the refrigerator when ships the reach-in refrigerator when refrigerator when refrigerator when refrigerator when refrigerator when refri	nterview on 02/23/15 at 1:16 d the exterior door panels of ator and agreed they were not a schedule for the week of 2/22/15 was reviewed and the was initialed by a dietary aide the DM stated she initialed the redule for each of the rashe confirmed the task had the DM further stated she did food matter or dried spills on the completed her observations initialed the cleaning						
	9:48 AM revealed the dried brown spills of top of the rack when inserted had a thick.  Observations of the 12:39 PM revealed dried brown spills of top of the rack when	the knife rack on 02/16/15 at the front of the knife rack had over the entire surface and the enthe knife blades were covering of white dust.  knife rack on 02/18/15 at the front of the knife rack had over the entire surface and the enthe knife blades were covering of white dust.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING	<del></del>	02/27/2015		
	NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 371	4:07 PM revealed to dried brown spills of top of the rack whe inserted had a thick.  An interview was completed to the column next to the top of the dietary aid column next to the top of the complete their clean cleaning schedule was reviewed during the assigned areas as completed. The the weekly cleaning.  Observations of the 1:11 PM revealed to the died brown spills of top of the rack whe inserted had a thick.  During a follow up to the polymorphism of the polymorphism of the thick when inserted had a thick that the polymorphism of the polymorphism of the polymorphism of the thick when inserted had a thick that the polymorphism of the p	e knife rack on 02/19/15 at the front of the knife rack had over the entire surface and the re the knife blades were a covering of white dust.  Inducted with the Dietary 02/19/15 at 4:10 PM. The DM a cleaning schedule weekly a responsible was listed in the list of areas to be cleaned. The staff had until 02/22/15 to ning assignments. The weekly for 02/16/15 through 02/22/15 ag the interview and none of to be cleaned were initialed a knife rack was not listed on	F 371				
	add it.  3. Observations of 02/19/15 at 4:07 PI dust on the entire to dried green particle.  An interview was contact of the desired statement of	the coffee machine on M revealed a thick covering of op surface and dried spills and is on the right side panel.  Onducted with the Dietary 02/19/15 at 4:10 PM. The DM					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING _		02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	1 02/2//2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 371	and the dietary aide column next to the li The DM indicated the complete their clean cleaning schedule for was reviewed during the assigned areas the assigned areas the assigned areas the weekly cleaning.  Observations of the at 1:11 PM revealed the entire top surface green particles on the During a follow up in PM the DM observed agreed it was not clearly aide and also the initialed the weekly cleaning the task had been constated she did not not matter, or dried spills when she completed initialed the cleaning.  4. Observations of the 4:07 PM revealed dried spills on the exhandle was sticky to An interview was considered to the considered the cleaning of the considered the c	cleaning schedule weekly responsible was listed in the st of areas to be cleaned. e staff had until 02/22/15 to ing assignments. The weekly or 02/16/15 through 02/22/15 the interview and none of the interview and none of the coffee machine was listed on schedule.  coffee machine on 02/23/15 at thick covering of dust on the and dried spills and dried the right side panel.  terview on 02/23/15 at 1:16 the coffee machine and the coffee machine and the coffee machine and the coffee machine was initialed by so the DM. The DM stated the completed. The DM further of the dust, dried food the coffee machine and schedule.  The cleaning schedule for the dust, dried food the coffee machine and schedule.  The microwave on 02/19/15 at the coffee machine and the	F 3	71		

NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 371  Continued From page 92 and the dietary aide responsible was listed in the column next to the list of areas to be cleaned. The DM indicated the staff had until 02/22/15 to complete their cleaning assignments. The weekly cleaning schedule for 02/16/15 through 02/22/15 was reviewed during the Interview and none of the assigned areas to be cleaned were initialed as completed. The microwave was not listed on the weekly cleaning schedule.  Observations of the microwave on 02/19/15 at 1:16 PM revealed dried food matter on all the surfaces of the inside of the microwave and white dried spills on the exterior of the door handle was sitely to the touch.  During a follow up interview on 02/23/15 at 1:23 PM the DM observed the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
CALID   SUMMARY STATEMENT OF DEFICIENCIES   PROFITE			345163	B. WING _			02/27/2015	
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 371  Continued From page 92 and the dietary aide responsible was listed in the column next to the list of areas to be cleaned. The DM indicated the staff had until 0/2/2/15 to complete their cleaning assignments. The weekly cleaning schedule for 02/16/15 through 02/22/15 was reviewed during the interview and none of the assigned areas to be cleaned were initialed as completed. The microwave was not listed on the weekly cleaning schedule.  Observations of the microwave on 02/19/15 at 1:16 PM revealed dried food matter on all the surfaces of the inside of the microwave and white dried spills on the exterior of the door. The door handle was sticky to the touch.  During a follow up interview on 02/23/15 at 1:23 PM the DM observed the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave this week but had not noticed the spills on the exterior of the door or the condition of the door handle.  F 441  SS=D  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission			ABILTATION CENTER	211 MILTON BROWN HEIRS ROAD				
and the dietary aide responsible was listed in the column next to the list of areas to be cleaned.  The DM indicated the staff had until 02/22/15 to complete their cleaning assignments. The weekly cleaning schedule for 02/16/15 through 02/22/15 was reviewed during the interview and none of the assigned areas to be cleaned were initialed as completed. The microwave was not listed on the weekly cleaning schedule.  Observations of the microwave on 02/19/15 at 1:16 PM revealed dried food matter on all the surfaces of the inside of the microwave and white dried spills on the exterior of the door. The door handle was sticky to the touch.  During a follow up interview on 02/23/15 at 1:23 PM the DM observed the microwave and agreed it was not clean and stated the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave this week but had not noticed the spills on the exterior of the door or the condition of the door handle.  F 441 483.65 INFECTION CONTROL, PREVENT F 441 SS=D SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	and the dietary aide recolumn next to the list. The DM indicated the complete their cleaning cleaning schedule for was reviewed during the assigned areas to as completed. The method the weekly cleaning second of the method that the weekly cleaning second of the method that the weekly cleaning second of the method that the method that the method that the method that the properties of the inside dried spills on the extended and so the method to the method that	esponsible was listed in the t of areas to be cleaned. e staff had until 02/22/15 to an assignments. The weekly 02/16/15 through 02/22/15 the interview and none of the be cleaned were initialed nicrowave was not listed on achedule.  Inicrowave on 02/19/15 at end food matter on all the end of the microwave and white erior of the door. The door the touch.  In erview on 02/23/15 at 1:23 the microwave and agreed stated the microwave was kely cleaning schedule and led it. The DM further stated browave this week but had on the exterior of the door or oor handle.  CONTROL, PREVENT  Dilish and maintain an agram designed to provide a mifortable environment and evelopment and transmission on.  Program blish an Infection Control of it -					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345163	B. WING	B. WING		02/27/2015	
	ROVIDER OR SUPPLIER	ABILTATION CENTER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 111 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	should be applied to a (3) Maintains a record actions related to infection (b) Preventing Spread (1) When the Infection determines that a respreyent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will transpare (3) The facility must remands after each direct hand washing is indiced professional practice. (c) Linens Personnel must hand	cedures, such as isolation, an individual resident; and d of incidents and corrective actions.  d of Infection In Control Program ident needs isolation to a infection, the facility must be or infected skin lesions the residents or their food, if insmit the disease. It is incepted by accepted is incident in the disease.	F	441			
	by: Based on observatio interviews the facility	ns, record review and staff failed to follow contact resident reviewed for Resident #192).					
	dated November 200 precautions would be	Contact Isolation Policy					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REI	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	transmitted by direct such as hand or skit performing resident the residents dry sk such as touching er resident care items further revealed gloentering the resider and removed before with immediate han washing and glove touch potentially consurfaces or items in transfer to other resident are selected. Review of the physical revealed Resident are contact isolation for staphylococcus aur resistant organism in wound.  An observation was AM of Resident #19 precaution sign on that an over bed table work room.  An observation made revealed hospitality Resident #192's room without hand sanitizer and event washing her without washing her resident are such as a such	ge 94 corganisms that could be to contact with the resident in contact that occurred from care that required touching in and by indirect contact environmental surfaces or in their room. The policy eyes should be worn when it's room on Contact Isolation is leaving the residents room dividents or environmental the resident's room to avoid idents or environments.  In cian orders dated 02/13/15 if 192 was to be placed on methicillin resistant in eus (MRSA), a multiple drug in a stage III sacral pressure  In made on 02/16/15 at 11:00 if 12's room with a contact in the wall beside the door and ith gloves located outside the in without gloves on and ith gloves on and ith gloves on and itable. HA #1 left Resident it washing her hands or using entered Resident #92's room in hands and began to set up it over bed table for Resident	F 44			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _	<del></del>		02/27/2015
	ROVIDER OR SUPPLIER	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From paç	ge 95	F 4	41		
	revealed HA #1 enter without washing her #1 straightened Resclosed his privacy or tray out of his room HA #1 did not wash sanitizer after leavin. An interview was cop PM with HA #1. She hands or wear glove because she did not precautions. She state contact precautions gloves outside his rohave washed her hashe was in his room and washed her harm. An interview was cop AM with the Director stated it was her expression of the weak was and weak hands when entering had any contact with items in the room. Since the straight items in the room.	e on 02/16/15 at 11:52 AM  ared Resident #192's room hands or wearing gloves. HA dident #192's bed linens, artain and brought his lunch and placed it on the tray cart. her hands or use hand g Resident #192's room.  Inducted on 02/16/15 at 1:30 Istated she did not wash her is in Resident #192's room It know he was on contact ated she did not see the dign or notice the table with froom. HA #1 stated she should ands and worn gloves while and discarded the gloves ands before leaving his room.  Inducted on 02/27/15 at 10:50 In of Nursing (DON). She bectation for staff to follow the digns posted on Resident ar gloves and wash their g and leaving the room if they in the resident or resident he stated she was unaware billowing contact precautions				
F 514 SS=E	483.75(I)(1) RES	ETE/ACCURATE/ACCESSIB	F 5	14		
	resident in accordan	intain clinical records on each ice with accepted professional ices that are complete;				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/27/2015	
	ROVIDER OR SUPPLIER	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 514	The clinical record minformation to identification to identificati	ted; readily accessible; and lized.  nust contain sufficient by the resident; a record of the ents; the plan of care and the results of any ning conducted by the State;  T is not met as evidenced views and staff interviews the ment nurse's notes regarding lowered to the floor during a product of the floor	F 5	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	1, ,	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02	/27/2015	
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		1 02/27/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 514	Continued From page	ge 97	F 5	14			
	(MDS) dated 03/03/severe impairment imaking. The MDS adid not speak but we usually understood.  A review of nurse's there were no nurse assessment during review of Resident at there was no documber. During an interview Director of Nursing nurses notes for Reconfirmed there was notes or nurse's confirmed there was nurse's notes or nurse's nurse's notes or nurse's notes or nurse's notes or nurse's nurse's notes or nurse's nurse's notes or nurse's nurs	notes dated 11/15/14 revealed					
	PM indicated Resid grunting when Nurs room to administer notes further indicat was raised Residen notes revealed Res to history of a stroke appropriately by noo The notes further reshe was hurting Resleg. The notes indic no visual injuries or was made to roll Res	es note dated 11/15/14 at 8:30 ent #24 was lying in bed e #2 went to the resident's bedtime medications. The ted when the head of the bed at #24 began yelling out. The ident #24 was nonverbal due be but could answer questions dding her head for yes and no. evealed when asked where sident #24 pointed to her right cated an assessment showed redness but when an attempt esident #24 over she began and Resident #24's responsible					

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015	
	ROVIDER OR SUPPLIER  DGE HEALTH AND REH	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  211 MILTON BROWN HEIRS ROAD  BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514	A review of a hospital Consultation dated 1 consultation dated 1 consulting diagnosis part of the thigh bone Resident #24. The right was found by the nurcomplaining of hip particularly have injured that hip During a telephone in PM NA #1 explained to get Resident #24 on 11/15/14. She explained to get Resident #24's armpunder the other armpunder the side to the but they couldn't become the state of the state o	d hospital was notified for gency room.  Il Physician's Report of 1/16/14 indicated a of intertrochanteric (upper e) fracture of right hip for notes revealed Resident #24 rsing staff lying in bed ain and apparently had a er in the day where she may	F 5	14			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345163	B. WING			02/27/2015	
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 514	transferred her to be hours after Residen she was moaning at was rubbing it and s Nurse #1.  During a phone intereceived from NA # remembered she set the nurse did not co. She further stated F assessed while she was lifted into the stransferred back to explained NA #3 cathe nurse said to puchair so the NAs lifted her in the chair.  During an interview Nurse #1 (who was Resident #24 on the 11/15/14) she confir	ge 99 m her wheelchair and ed. She explained about 3 t #24 was lowered to the floor and holding her right leg and she (NA #1) reported it to  rview on 02/26/15 at 5:48 PM 1 she stated she had ent NA #2 to get a nurse but ame to the resident's room. Resident #24 was not was in the floor or when she abover chair or when she was bed after lunch. She ame back to the room and said t Resident #24 in the shower ed her up off the floor and put  on 02/23/14 at 8:13 PM with responsible for the care of e 7:00 AM-7:00 PM shift on amed she did not go to in to assess her on 11/15/14	F 5′	14			
	floor. She confirmedid was later in the crying out in pain arperi area and the arcouldn't remember of remembered she garoutine Tylenol for produment it becaus had happened or threported or document.	and the resident had slid to the digital the only assessment she day when Resident # 24 was and was reaching toward her ea was red. She stated she exactly what she saw but ave Resident #24 some ain but did not report it or e she did not think anything at anything needed to be need.  Interview on 02/23/15 at 7:56 the stated she worked on the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		02	2/27/2015
	ROVIDER OR SUPPLIER  DGE HEALTH AND REF	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	evening the NAs ca had taken Resident she was screaming couldn't assess her was in such pain. Sereceived a report from change that Resider earlier that day. She to the hospital emerand treatment becausually complain of out why she was ha explained she expediocumentation whe lowered to the floor.  During an interview Nurse #1 who was a Resident #24 on the 11/15/14 she confirm Resident #24's room when NA #2 reporte floor. She stated shand took full respon was supposed to do assessment she did Resident #24 was coreaching toward her red. She stated she what she saw but re Resident #24 some did not report it or donot think anything he needed to be report further confirmed shassessment immedit to the floor because	shift on 11/15/14 and that me and got her because they #24 her bedtime snack and in pain. She explained she or touch her because she she verified she had not om Nurse #1 during shift int #24 had slid to the floor e stated she sent the resident gency room for evaluation use Resident #24 did not pain and she couldn't figure ving such severe pain. She cted to see nursing in a resident had a fall or was	F 5	14		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345163	B. WING		02/27/2015	
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABIL	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 514 Continued From page 10 NAs told her Resident #2 pain in her right leg.  During a follow up intervi AM the DON stated she is no nurse's notes for Resi the 7:00 AM to 7:00 PM is questioned about it durin Nurse #1 had told her sh #24 but she did not realiz assessed the resident aff the floor or before she wa to the shower chair. 2. Resident #198 was ac 06/13/14 with diagnoses myeloma, uncontrolled hy weakness.  Review of nursing notes 06/14/14 at 1:10 AM, Res ambulate to the bathroon assistance and fell onto t position. The nursing not a 1 centimeter (cm) supe head and was sent to the evaluation. Nursing note #198 returned from the h 4:00 AM. In addition to th head, Resident #198 also half cm skin tear on her le dressing in place.  The medical record lacke follows:  a. Review of the medica documentation that nurse neurochecks upon her re-	ew on 02/27/15 at 11:34 was unaware there were ident #24 on 11/15/14 for shift until she was g the survey. She stated e assessed Resident te that Nurse #1 had not ter she was lowered to as moved from the floor dmitted to the facility on including multiple ypertension, and muscle  revealed that on sident #198 attempted to n without calling for the floor from a standing te indicated she received erficial laceration to her the emergency room for an teres revealed that Resident toospital on 06/14/14 at the laceration on her to returned with a small eft elbow that had a  I record revealed no tes completed	F 51	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		02/27/2015	
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	, 02.2.7.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 514	nursing notes on 06/ was conducted on 0 #5 stated he barely is sending Resident #1 upon her return he is neurochecks per the have lasted at least this would have been sheet for neurochecks started documentation or not.  The Treatment Nursing PM, neurochecks is Resident #198 and is documentation in the On 02/23/15 at 4:17 of Nursing #1 and #2 and stated neurochecks following any fall with sheet or in the nursing 4, then every 30 mind 4 and then very shiff the hospital then nur pick up neurochecks the building.  b. Review of the mewas documented abor any treatments are from the hospital.  Interview with the Triat 10:18 AM revealed documentation and fincluding skin tears.	ith Nurse #5 who wrote the 114/14 at 1:10 AM and 4 AM 2/19/15 at 6:02 PM. Nurse recalled the incident and 98 to the hospital. He stated hould have started facility policy which would 72 hours. He further stated in documented on a specific ks. He could not recall if he on on the neurocheck sheet e stated on 01/19/15 at 4:24 ould have been started for she could not find any	F 5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345163	B. WING			2/27/2015	
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
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F 514	she would then follow begin documentation  Follow up interview of 02/19/15 at 4:50 PM documentation about other than the nursing returned from the hostated that she recall concern about the slinfected and when so not infected but scale there should have be treatment record about treatments administed.  Interview with the Diale Assistant Director of at the time of this result of 12/24/14 at 1:58 PM provide any documentear on her elbow with hospital.  3. Resident #56 was 10/01/14. Her diagnosischemic cardiovasco admission, the physical only by nasogas nothing by mouth.  Physician Orders da #56 was to received NG tube until Osmol The Perative was to	with the Treatment Nurse on revealed she could locate no to the skin tear or treatments ag note on 06/14/14 when she spital with a dressing. She led family expressing kin tear possibly being the looked the skin tear was obed. She confirmed that the endocumentation on the bout the skin tear and any ered.  Trector of Nursing and Nursing #1 (both employed sident's stay) was held on . Neither could recall or intation relative to the skin hich was treated at the sadmitted to the facility on oses included severe acute ular accident. Upon cian orders revealed she was tric tube (NG) and took  ted 10/01/14 noted Resident Perative (tube feeding) via ite 1.5 became available. be increased on 10/01/14 to 0 PM and then increased to	F 5	14			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	ULTIPLE CONSTRUCTION  LDING		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			02/27/2015	
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•		
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F 514	(MAR) for October feedings were disc Osmolite was never started. Per the M nutrition from 10/03 was started on 10/13/14.  On 02/25/15 at 2:0 Nursing (ADON) #3 stated that the Osm was not put on the She further stated record.  4. Review of an urin part: "The follow for any resident that (neurological) checappropriate."  Review of an undain part: "Initiate neuror staff witness train Resident #55 was diagnoses includin cerebrovascular actions.  A significant chang dated 09/10/14 revand long-term menimpaired cognitive The significant chang #55 required extensions.	ication Administration Record 2014 revealed that all tube ontinued on 10/02/14. In entered on the MAR as being AR, Resident #56 received no 8/14 until an intravenous (IV) 10/14 at 4:00 AM. A diet for ordered by the physician until 0 PM Assistant Director of 2 was interviewed. ADON #2 nolite must have come in and MAR in place of the Perative. This was an inaccurate medical adated facility falls policy stated ing procedure is to be followed at sustains a fall. #2. Neuro eks will be done as	F 5	14			

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NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	, 32.2.2.2	
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F 514	Continued From pa	ge 105	F 5	14		
	reviewed on 01/16/falls due to impaired dementia, and agitatoilet frequently, chatagainst the wall, fall and non-skid footward.  Review of nurse's most of 6:00 AM the nurse was room by a nurse aid Resident #55 sitting side of her face. A was noted over her minimal bleeding. It state what happener Resident #55 was owheelchair in her room to make the state what happener was sident #55 was owheelchair in her room to impair to the state what happener resident #55 was owheelchair in her room to impair to the state what happener room to impair to the state what happener room to impair to the state what happener room to impair to the state was noted to the state what happener room to impair to the state was noted to the state what happener room to the state was noted to the sta	#55's care plan for falls last 15 stated she was at risk for d mobility, cognition, ation. Interventions included: air and bed alarms, bed mats when in bed, low bed, ear.  otes revealed on 06/24/14 at was called to Resident #55's le (NA) and observed on the floor holding the right less than one inch laceration right eye with bruising and Resident #55 was unable to d. The nurse also noted observed sitting in her om a few minutes before the were not mentioned in the				
	AM revealed the nu personal alarm sour #55 fall from her whon the floor. The nu attempting to pick at the time of the fall.	note dated 12/04/14 at 11:40 rse heard Resident #55's nd and observed Resident heelchair hitting her forehead urse noted Resident #55 was piece of tissue off the floor at				
	12/04/14 revealed F fall from her wheel of attached written state nurse stated she he alarm sound on 12/ observed Resident wheelchair touching	vestigation worksheet dated Resident #55 had a witnessed chair at 11:40 AM. In an tement dated 12/08/14 the eard Resident #55's personal 04/14 at 11:40 AM and #55 leaning over in her of the floor. The nurse further able reach Resident #55 in				

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NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		1 022772010	
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F 514	forward out of her wild documented Reside stable, she moved a pupils were equal at There was no further of a neuro check.  Review of Resident revealed no docume unwitnessed fall on with head trauma or An interview was concept of Nursing 4:17 PM. During the nursing staff were echecks for any unwing witnessed a resident A follow up interview #1 on 02/24/15 at 3 #55's fall were review interview neuro cheon 12/04/14 and 06/ADON #1 stated she current and thinned checks.  During an interview ADON #2 stated she #55's medical record documented neuro of occurred on 12/04/11	fall and Resident #55 fell wheelchair. The nurse and #55's vital signs were all four extremities, and her and reactive to light (PERLA). ar documentation of any part  #55's medical record anted neuro checks for the 06/24/14 or the observed fall an 12/04/14.  Anducted with Assistant (ADON) #1 on 02/23/15 at the interview ADON #1 stated expected to complete neuro attenssed fall or if staff at hitting their head.  A was conducted with ADON and the sident and the would review Resident and the would review Resident #55's a medical record for the neuro  on 02/26/15 at 12:05 PM the had reviewed Resident de and did not locate any checks for the falls that	F 5			

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F 514	not limited to diabetheart failure, and heart failure, and he the latest quarterly dated 01/01/15 indintact, and was on Review of Residen revealed he had a his dialysis fistulated and bruit at the site dated 04/28/14, and Also ordered on 04 to receive weekly of Thursday to including respirations, temporal levels. Documentations, temporal levels. Documentation Administrather review of the findly of the fistulation for December of 2014 initiated. The review multiple days where on the MAR or in the Included in the missof the fistula site entrill and bruit at the documentation also missed vital signs included document of December 2014 month left omitted. On 02/19/15 at 3:50 conducted with Nunurse. She stated Resident #132 after included fistula check included fistula check.	noses that included but were stes, end stage renal disease, high blood pressure. Review of Minimum Data Set (MDS) icated he was cognitively dialysis. It #132's medical record physician order for checking site and listening for the thrill every shift. The order was ad no stop date was ordered. If No8/14 was for Resident #132 checks of vital signs every every blood pressure, pulse, erature, and blood oxygen tion of Resident 132's fistula was to be indicated on the stration Record (MAR). In the medical record, which of Resident #132's dialysis the months of November and the number of the number of the number of the weeks of and blood oxygen levels, which that on shown only the first week with the remainder of the	F	514			

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F 514	fistula and vital signs the MAR. She acknown why there were areas on the MAR. Nurse # expect nurses' to doctime dialysis checks a completed. Nurse #4 another place in the ridocumentation of the located.  On 02/19/15 at 4:15 conducted with the DShe acknowledged it nurses document in the an assessment was prevealed spot checks MAR's to check for cobut these issues were indicated the facility of documenting in the On 02/24/15 at 9:45 conducted with Nurse nurse's responsibility each time he returner revealed she knew an recorded on the MAR but acknowledged she when she completed On 02/27/15 at 9:40 conducted with the A was her expectation in the A wa	should be documented on wledged she did not know so of documentation omitted 4 indicated she would sument their findings each and vital signs were stated she was not aware of medical record where dialysis checks were  PM an interview was irector of Nursing (DON). was her expectation that the he appropriate places when performed. The DON were being done on the completed documentation, and addressed. She was trying to do a better job e medical record.  AM an interview was e #3. She stated it was the to assess Resident #132 d from dialysis. Nurse #3 in assessment should be a each time it is performed, ie did not always document the assessment checks.	F 51	4		