DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		NTE SURVEY
		345163	B. WING			C I2/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		2/11/2010
				211 MILTON BROWN HEIRS ROAD		
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		BOONE, NC 28607		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 00	00		
	No deficiencies were complaint investigation	e cited as a result of the on event ID DYNK11.				
F 225 SS=D	483.13(c)(1)(ii)-(iii), (i INVESTIGATE/REPC ALLEGATIONS/INDI	DRT	F 22	25		1/14/16
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have l into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a an employee, which would service as a nurse aide or he State nurse aide registry es.				
	involving mistreatment including injuries of us misappropriation of re- immediately to the ac- to other officials in ac-	nknown source and esident property are reported Iministrator of the facility and cordance with State law procedures (including to the				
	to the administrator of representative and to with State law (includ	estigations must be reported or his designated o other officials in accordance ling to the State survey and within 5 working days of the				
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
	cally Signed					01/14/2016

**Electronically Signed** 

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/21/201 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED C	
		345163	B. WING		12/17/2015	
NAME OF PI	ROVIDER OR SUPPLIER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE	12,11,2010	
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER		11 MILTON BROWN HEIRS ROAD SOONE, NC 28607		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 225		e 1 eged violation is verified e action must be taken.	F 225			
	by: Based on record revi interviews the facility administrator and fail a 24 hour report to th Care Personnel Regis resident's complaint t during incontinence of	is not met as evidenced iews and resident and staff failed to notify the ed to investigate and submit e North Carolina Health stry (state agency) of a hat a staff pinched her arm are and caused a bruise for oled for abuse (Resident		This Plan of Correction constitutes ou written allegation of compliance for the deficiencies cited. However, submissi of this Plan of Correction is not an admission that a deficiency exists or th one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	e on nat	
	02/17/15 with diagnost weakness, dementia, walking, and kidney of recent quarterly Minir 10/25/15 revealed Re- impaired in cognition The MDS also reveal extensive assistance always incontinent of A review of facility ab there were no 24 hou submitted to the North Personnel Registry for A review of the week	mitted to the facility on ses which included muscle heart failure, difficulty in lisease. A review of the most num Data Set (MDS) dated esident #82 was mildly for daily decision making. ed Resident #82 required with toileting and was bowel and bladder. use investigations revealed ir or 5 working day reports h Carolina Health Care or Resident #82. y skin assessments for ed there had been no skin		<ul> <li>F225 Investigate Allegations</li> <li>A 24 hour and a 5 day report for reside</li> <li>#82 were completed and faxed to the state on 12/17/15 and 12/22/15</li> <li>respectively.</li> <li>All residents could potentially be affect by the cited deficiency.</li> <li>The facility's policies and procedures related to abuse prohibition and allegative reporting were reviewed and revised.</li> <li>reporting section of the "Reporting Allegations of Abuse" policy was revise to indicate:</li> <li>1) If the Administrator is in the build he/she must be notified immediately or abuse allegations.</li> <li>2) In the absence of the Administrator the Director of Social Services or the administrative nurse on call must be notified immediately regardless of time day/night.</li> </ul>	ted tion The ed ing, f	

Event ID: DYNK11

Facility ID: 923186

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	, ,		· · ·	IPLETED	
						С	
		345163	B. WING		12	2/17/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		211 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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 225	Continued From page	2	F 22	25			
	A review of the nurse through 12/17/15 indi Resident #82's medic Further review of the documentation in reg abuse and/or the brui forearm. During an interview o Resident #82 she sta pinched her right arm incontinence care the recall the NA's name. while the NA was cha became mad at her b turn herself from side pinched her arm. Res the NA that pinched h had long fingernails. Resident #82's right f inches above the wris she reported it to a m nurse's name becaus the facility. She stated had provided care to happened. She further staff had listened to h one had followed up any questions about the During an interview o Nurse #1 she stated that a nurse aide had couldn't remember th	's notes from 11/28/15 cated no nurse entries in cal record since 11/28/15. nurse's notes revealed no ards to the allegation of ise on Resident #82's right n 12/15/15 at 8:32 AM with ted a nurse aide (NA) and made a bruise during enight before but could not . Resident #82 explained inging her brief the NA secause she was unable to to side quickly and the NA sident #82 further explained her right arm was black and A bruise was observed on orearm approximately 4 st area. Resident #82 stated urse but did not know the se she was a newer nurse at d she had also told NAs who her about what had er stated she did not feel her concerns because no with her or had asked her what had happened. n 12/15/15 at 2:50 PM with Resident #82 had told her pinched her right arm but e NAs name. She stated		<ol> <li>The Director of Social Servic administrative nurse on call must immediately notify the Administrat allegation.</li> <li>The Social Services Director/Desi trained all staff on the Abuse Prof and reporting policies, including th revisions on 1/12 and 1/13/16.</li> <li>The Administrator trained the DOI ADON's/Administrative Nurses, department heads and key staff o revised reporting policy concernin allegations of abuse, neglect, misappropriation, mistreatment of residents on 1/13/16.</li> <li>In-services for Resident Rights ar Prohibition will be held quarterly.</li> <li>Audits will be completed by the Administrator on the next 10 alleg ensure compliance with policy an regulations.</li> <li>Citation will be placed in the QAP program for monthly monitoring/e until resolved but no less than 6 m Completion Date: 1/14/16</li> </ol>	tor of gnee hibition he N, n the g ad Abuse ations to d		
	couldn't remember th she reported it to the (ADON) and to the D Nurse #1 indicated sh	e NAs name. She stated Assistant Director of Nursing irector of Nursing (DON). ne had not filled out an ort and had not documented					

If continuation sheet Page 3 of 34

					FORI	M APPROVED D. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
	345163	B. WING				C / <b>17/2015</b>
ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				211 MILTON BROWN HEIRS ROAD		
DGE HEALTH AND REHA	ABILTATION CENTER		E	BOONE, NC 28607		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From page	23	F	225	5		
During an interview o NA #1 he stated Resi him that an NA had p incontinence care. He the exact date it happ happened the previou Resident #82 had talk and he thought Resid nurse. During an interview o NA #5 she stated Res an NA on night shift w pinched her arm. NA observed a bruise on had reported it to Nur During an interview o Nurse #2 she confirm charge nurse and any of abuse she was res on-call administrator f what needed to be do Resident #82 reporter NA had pinched her a care. Nurse #2 furthe on-call administrator I that Resident #82 had had pinched the resid was noted to the resid was noted to the resid man of documented her in the resident's n	n 12/16/15 at 4:30 PM with dent #82 had complained to inched her arm during explained he did not know bened but thought it is weekend because and about it several times ent #82 had reported it to a n 12/16/15 at 5:25 PM with sident #82 had told her that vas changing her and #5 further stated she had the resident's arm and she se #1. n 12/17/15 at 6:55 AM with ed she was the 3rd shift vtime there was an allegation ponsible for calling the for instructions/directions on one. Nurse #2 indicated d the incident to her that an arm during incontinence r stated she called the by telephone and reported d informed her that an NA lent's arm and that a bruise dent's right forearm. Nurse all administrator, which was ed her to complete an ort and to slide it underneath for. Nurse #2 confirmed she what Resident #82 had told hedical record because she					
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DGE HEALTH AND REHA SUMMARY ST. (EACH DEFICIENC) REGULATORY OR I Continued From page During an interview o NA #1 he stated Resi him that an NA had pi incontinence care. He the exact date it happ happened the previou Resident #82 had talk and he thought Resid nurse. During an interview o NA #5 she stated Resi an NA on night shift w pinched her arm. NA observed a bruise on had reported it to Nur During an interview o Nurse #2 she confirm charge nurse and any of abuse she was resion- on call administrator fi what needed to be do Resident #82 reported NA had pinched her ar care. Nurse #2 furthe on-call administrator fi what needed to be do Resident #82 reported NA had pinched her ar care. Nurse #2 furthe on-call administrator fi what needed to the resid was noted to the resid #2 indicated the on-ca the ADON, had advised incident/accident reported had not documented her in the resident's ni was not advised to do	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345163         ROVIDER OR SUPPLIER         DGE HEALTH AND REHABILTATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 3         During an interview on 12/16/15 at 4:30 PM with NA #1 he stated Resident #82 had complained to him that an NA had pinched her arm during incontinence care. He explained he did not know the exact date it happened but thought it happened the previous weekend because Resident #82 had talked about it several times and he thought Resident #82 had reported it to a	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         345163       B. WING         ROVIDER OR SUPPLIER       B. WING         CORRECTION       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREF TAG         Continued From page 3       F         During an interview on 12/16/15 at 4:30 PM with NA #1 he stated Resident #82 had complained to him that an NA had pinched her arm during incontinence care. He explained he did not know the exact date it happened but thought it happened the previous weekend because Resident #82 had talked about it several times and he thought Resident #82 had reported it to a nurse.         During an interview on 12/16/15 at 5:25 PM with NA #5 she stated Resident #82 had reported it to a nurse.         During an interview on 12/16/15 at 5:25 PM with NA #5 she stated Resident #82 had reported it to a nurse.         During an interview on 12/16/15 at 5:55 AM with Nurse #2 she confirmed she was the 3rd shift charge nurse and anytime there was an allegation of abuse she was responsible for calling the on-call administrator for instructions/directions on what needed to be done. Nurse #2 indicated Resident #82 reported the incident to her that an NA had pinched her arm during incontinence care. Nurse #2 (truther stated she called the on-call administrator by telephone and reported that Resident #82 reported the incident to her that an NA had pinched her resident's arm and that a bruise was noted to the resident's arm and that a bruise was noted to the resident's arm and that a bruise was noted	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIEVICUA IDENTIFICATION NUMBER:       (X2) MULTIPL A BUILDING.         345163       B. WING         ROVIDER OR SUPPLIER       345163       B. WING         DGE HEALTH AND REHABILTATION CENTER       ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX PREFIX       ID PREFIX         Continued From page 3       F 225         During an interview on 12/16/15 at 4:30 PM with NA #1 he stated Resident #82 had complained to him that an NA had pinched her arm during incontinence care. He explained he did not know the exact date it happened but thought it happened the previous weekend because Resident #82 had reported it to a nurse.       F 225         During an interview on 12/16/15 at 5:25 PM with NA #5 she stated Resident #82 had reported it to a nurse.       During an interview on 12/16/15 at 5:25 PM with NA #5 she stated Resident #82 had told her that an NA on night shift was changing her and pinched her arm. NA #5 further stated she had observed a bruise on the resident's arm and she had reported it to Nurse #1.         During an interview on 12/17/15 at 6:55 AM with Nurse #2 she confirmed she was the 3rd shift charge nurse and anytime there was an allegation of abuse she was responsible for calling the on-call administrator for instructions/directions on what needed to be done. Nurse #2 indicated Resident #82 reported the incident to her that an NA had pinched her resident's arm and that a bruise was noted to the resident's right forearm. Nurse #2 indicated the on-call administrator, which was the ADON, had advised her to complete an incident/accident repo	S FOR MEDICARE & MEDICAID SERVICES         9: DEFICIENCIES       (11) PROVIDERSUPPLICEULA IDENTIFICATION NUMBER:       (P2) MULTIPLE CONSTRUCTION A BUILDING         345183       BUILDING         ROMDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         211 MILTON RROWN HEIRS ROAD BOOKE NOT SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         211 MILTON RROWN HEIRS ROAD BOOKE, NC 28607       PROVIDERS PLAN OF CORRECTION (EACH ODRICET VELATION WIST BE PRECEDED BY FULL REGULATORY OR LIS DENTIFING INFORMATION)         Continued From page 3       F 225         During an interview on 12/16/15 at 4:30 PM with NA #1 he stated Resident #22 had complained to him that an NA had pinched her arm during incontinence care. He explained the did not know the exact date it happened but thought it happened the previous weekend because Resident #82 had topoted her that an NA on night Mit was changing her and pinched her arm. NA #5 further stated she had observed a bruise on the resident #82 had topoted it to a nurse.         During an interview on 12/17/15 at 6:55 AM with Nurse #2 she confirmed she was the 3/d shift ohad reported it to Nurse #1.         During an interview on 12/17/15 at 6:55 AM with Nurse #2 she confirmed she was the 3/d shift ohad reported the incident to her that an NA had pinched her arm and she had reported the resident's arm and she had resident #82 had topone and reported that Resident #82 here complete an incident/sacrident resord here was an allegation of abuse she was resonshible for calling the on-call administrator by telephone and reported that Resident #82 had informed her that an NA had pinched the resident's arm and that a bruise was not advised to to comp	S FOR MEDICARE & MEDICAID SERVICES     OMB NC       S FOR MEDICARE & MEDICAID SERVICES     (v2) MULTIPLE CONSTRUCTION     (v2) MULTIPLE CONS

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345163	B. WING				C 17/2015
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER			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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 225	underneath the ADON been instructed. During an interview o NA #6 she stated Res 12/14/15 that an NA h had left a bruise. NA is observed the bruise of forearm. NA #6 further the resident had told supervisor, Nurse #2. During a telephone in AM with NA #7 she co incontinent care to Re 12/13/15. NA #7 state resident's arm and wa information would be confirmed she had wo 12/13/15. NA #7 indic administration had as and/or advised her of further indicated she DON until the morning During a telephone in AM with the ADON sh with investigations of neglect. She stated if member had been pir with them staff was e2 immediately and the I ADON confirmed that her on 12/14/15 via a	ompleted an ort and she did slide it N's office door as she had n 12/17/15 at 8:07 AM with sident #82 had told her on had pinched her arm and #6 indicated she had on Resident #82's right er stated she reported what her immediately to her terview on 12/17/15 at 8:52 onfirmed she had provided esident #82 on Sunday night as unaware of where that coming from. NA #7 further orked her entire shift on sated that no one from sked her any questions an allegation of abuse. She had not spoken with the g of 12/17/15.	F	225			
	pinched her during in	continence care. She further livised Nurse #2 to complete					

Facility ID: 923186

If continuation sheet Page 5 of 34

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/21/2016 MAPPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION		(X3) DATE COMP	LETED
		345163	B. WING		_		C 17/2015
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
GLENBRI	DGE HEALTH AND REHA	BILTATION CENTER		11 MILTON BROWN HEIR BOONE, NC 28607	RS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	an incident/accident m underneath her office and the DON had talk Tuesday morning 12/ indicated a 24 hour re- completed because th allegation as abuse a origin. During an interview of the Director of Social assisted with investiga and neglect. She state staff member had pine expected to report it in and the Administrator explained it was her e #82 complained staff should have reported investigation could has stated she was inform the DON had obtained handling the investiga revealed she was una not been completed. During an interview of the DON she confirmed or neglect investigation and there was no 24 I North Carolina Health She stated she was m #82's complaint on Tu She further stated a 2 been submitted but sh complaint of being pin-	eport and to slide it door. She indicated she ted with Resident #82 on 15/15. The ADON further eport had not been ney did not see the nd/or an injury of unknown in 12/17/15 at 12:35 PM with Work she confirmed she ations of grievances, abuse, ed if a resident reported a ched them the staff was mmediately and the DON were to be notified. She expectation when Resident had pinched her the staff it immediately so that an ive been done. She further ned of the incident and that d the information and was ation of the allegation. She aware the 24 hour report had in 12/17/15 at 12:57 PM with ed there had been no abuse ons related to Resident #82 hour report submitted to the in Care Personnel Registry. nade aware of Resident uesday morning 12/15/15. A hour report should have ne did not see the resident's inched by staff as abuse or	F 225				

If continuation sheet Page 6 of 34

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED 0. 0938-0391
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		PLETED
		345163	B. WING			C / <b>17/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBRII	DGE HEALTH AND REHA	BILTATION CENTER		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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 225 F 226 SS=D	Administrator stated r that staff had pinched incontinent care. She made aware of the ind 12/17/15. She indicate reported to her so an been done and it was report immediately wh pinched and/or was ro investigate it. The Add she considered the in Resident #82 being p allegation of abuse. 483.13(c) DEVELOP/ ABUSE/NEGLECT, E The facility must develop policies and procedur	no one had reported to her Resident #82 during further stated she was cident the morning of ed it should have been investigation could have her expectation for staff to nen a resident reported staff ough with them so she could ministrator further indicated cident in regards to inched by staff as an IMPLMENT TC POLICIES elop and implement written es that prohibit , and abuse of residents	F 2			1/14/16
	by: Based on record revi interviews the facility policy and procedure complaint that a staff incontinent care and o residents sampled for The findings included A review of an undate Administrative Policy Neglect, Misappropria	is not met as evidenced ews, resident, and staff failed to follow their abuse to investigate a resident's had pinched her arm during caused a bruise for 1 of 2 abuse (Resident #82). d policy and procedure titled and Procedure: Abuse, ation, Mistreatment Policy ed in part it was the policy		F 226 Develop/Implement Abuse/Ner Policies A 24 hour and a 5 day report for resid #82 were completed and faxed to the state on 12/17/15 and 12/22/15 respectively. All residents could potentially be affect by the cited deficiency. The facility's policies and procedures related to abuse prohibition and alleg reporting were reviewed and revised. reporting section of the "Reporting	ent sted	

Event ID: DYNK11

Facility ID: 923186

If continuation sheet Page 7 of 34

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМЕ	
		345163	B. WING		1	C 2/17/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE		
				211 MILTON BROWN HEIRS ROAD		
GLENBRI	DGE HEALTH AND REH	ABILIATION CENTER		BOONE, NC 28607		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	free and protected fro labeled policy indicate the facility would not anyone, including but section labeled physi physical abuse includ pinching. A section la part it was the policy investigate any suspe- has occurred in the n grounds, and events source, unusual occu- present a reasonable appropriate staff. The Administrator would p appropriate staff. The Administrator would p appropriate staff and Resident #82 was ad 02/17/15 with diagnor weakness, dementia, walking, and kidney or recent quarterly Minin 10/25/15 revealed Re- impaired in cognition The MDS also reveal extensive assistance always incontinent of	residents have the right to be om physical abuse. A section ed in part the residents of be subjected to abuse by t not limited to, facility staff. A cal abuse read in part that ded hitting, slapping, and abeled reporting revealed in of the facility to report and ected or alleged violation that ursing facility, and on the such as bruising of unknown irrences, patterns/trends that e suspicion by the e policy indicated in part the provide notice to all a regulatory agencies. mitted to the facility on ses which included muscle heart failure, difficulty in disease. A review of the most mum Data Set (MDS) dated esident #82 was mildly for daily decision making. ed Resident #82 required with toileting and was	F 226	<ul> <li>Allegations of Abuse" policy we to indicate:</li> <li>4) If the Administrator is in the/she must be notified immedia abuse allegations.</li> <li>5) In the absence of the Administrative nurse on call ministrative nurses on 1/12 and 1/13/16. The Social Services Director/E trained all staff on the Abuse F and reporting policies, including revisions on 1/12 and 1/13/16. The Administrator trained the I ADON's/Administrative Nurses department heads and key starevised reporting policy concereallegations of abuse, neglect, misappropriation, mistreatment residents on 1/13/16. In-services for Resident Rights Prohibition will be held quarter Audits will be completed by the Administrator on the next 10 a ensure compliance with policy</li> </ul>	he building, diately of hinistrator, or the ust be s of time of rvices or the ust strator of Designee Prohibition og the DON, S, iff on the rning it of s and Abuse e llegations to	
	submitted to the Nort Personnel Registry fo	ir or 5 working day reports h Carolina Health Care or Resident #82. ly skin assessments for		regulations. Citation will be placed in the C program for monthly monitorin until resolved but no less than Completion Date: 1/14/16	g/evaluation	
	Resident #82 indicate assessments comple	ed there had been no skin ted since 11/27/15.				

Facility ID: 923186

If continuation sheet Page 8 of 34

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED
		345163	B. WING			С
	ROVIDER OR SUPPLIER	545165		STREET ADDRESS, CITY, STATE, ZIP CC		2/17/2015
	NOVIDER OR OUT FIER			211 MILTON BROWN HEIRS ROAD		
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		BOONE, NC 28607		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 226	Continued From page	e 8	F 2	26		
		icated no nurse entries in	1 2			
		cal record since 11/28/15.				
		nurse's notes revealed no				
		ards to the allegation of ise on Resident #82's right				
	forearm.	ise of Resident #02 5 fight				
		n 12/15/15 at 8:32 AM with				
		ited a nurse aide (NA) and made a bruise during				
		hight before but could not				
		. Resident #82 explained				
		anging her brief the NA because she was unable to				
		to side quickly and the NA				
	pinched her arm. Res	sident #82 further explained				
		ner right arm was black and				
		A bruise was observed on orearm approximately 4				
		st area. Resident #82 stated				
	· ·	urse but did not know the				
		se she was a newer nurse at				
	had provided care to	d she had also told NAs who her about what had				
	-	er stated she did not feel				
		ner concerns because no				
	· ·	with her or had asked her				
	any questions about	what най нарреней.				
	During an interview o	on 12/15/15 at 2:50 PM with				
		Resident #82 had told her				
		l pinched her right arm but e NAs name. She stated				
		Assistant Director of Nursing				
	(ADON) and to the D	irector of Nursing (DON).				
		he had not filled out an				
	incident/accident report the incident in the nu	ort and had not documented				

If continuation sheet Page 9 of 34

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/21/2016 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345163	B. WING				17/2015
NAME OF P	ROVIDER OR SUPPLIER	I	<b>I</b>	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	DGE HEALTH AND REHA			2	211 MILTON BROWN HEIRS ROAD		
GLENDKI	DOE MEALIN AND REMP			1	BOONE, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 226	During an interview o NA #1 he stated Resi him that an NA had p incontinent care. He e the exact date it happ happened the previou Resident #82 had talk and he thought Resid nurse. During an interview o NA #5 she stated Res an NA on night shift w pinched her arm. NA observed a bruise on had reported it to Nur During an interview o Nurse #2 she confirm charge nurse and any of abuse she was res on-call administrator t what needed to be do Resident #82 reporte NA had pinched her a care. Nurse #2 furthe on-call administrator t that Resident #82 had had pinched the resio was observed to the n Nurse #2 indicated th which was the ADON complete an incident/ it underneath the ADO Resident #82 had tolo medical record becau do so by the ADON d	n 12/16/15 at 4:30 PM with dent #82 had complained to inched her arm during explained he did not know bened but thought it us weekend because ked about it several times lent #82 had reported it to a n 12/16/15 at 5:25 PM with sident #82 had told her that vas changing her and #5 further stated she had the resident's arm and she res #1. n 12/17/15 at 6:55 AM with hed she was the 3rd shift ytime there was an allegation ponsible for calling the for instructions/directions on one. Nurse #2 indicated d the incident to her that an arm during incontinence r stated she called the by telephone and reported d informed her that an NA lent's arm and that a bruise resident's right forearm. e on-call administrator, , had advised her to 'accident report and to slide DN's office door. Nurse #2 of documented what d her in the resident's use she was not advised to	F	226			

Facility ID: 923186

If continuation sheet Page 10 of 34

		MEDICAID SERVICES		E CONSTRUCTION		10. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>		· · ·	MPLETED	
						С	
		345163	B. WING		1	2/17/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		211 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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 226	Continued From page	e 10	F 220	6			
	-	t/accident report and she did e ADON's office door as she					
	NA #6 she stated Res 12/14/15 that an NA I had left a bruise. NA observed the bruise of forearm. NA #6 further	on Resident #82's right er stated she reported what her immediately to her					
	AM with NA #7 she c incontinent care to Re 12/13/15. NA #7 state resident's arm and we information would be confirmed she had we 12/13/15. NA #7 indic administration had as and/or advised her of	nterview on 12/17/15 at 8:52 onfirmed she had provided esident #82 on Sunday night ed she had not pinched a as unaware of where that coming from. NA #7 further orked her entire shift on cated that no one from sked her any questions an allegation of abuse. She had not spoken with the g of 12/17/15.					
	AM with the Assistant she confirmed she as grievances, abuse, a resident reported a st pinched or had been expected to report it i was to be notified. Th Nurse #2 had reported telephone conversation	aterview on 12/17/15 at 9:45 t Director of Nursing (ADON) ssisted with investigations of nd neglect. She stated if a taff member had been rough with them staff was mmediately and the DON he ADON confirmed that ed to her on 12/14/15 via a on that Resident #82 had IA had pinched her during					

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	MENT OF HEALTH AN					FORM	2: 01/21/2016 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345163	B. WING		_	( 12/ <sup>-</sup>	; 17/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
GLENBR	DGE HEALTH AND REHA	BILTATION CENTER		211 MILTON BROWN HEIRS BOONE, NC 28607	S ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	incident/accident report her office door. She in had talked with Resid morning 12/15/15. Th 24 hour report had not they did not see the a injury of unknown orig During an interview of the Director of Social assisted with investig and neglect. She state staff member had pin- expected to report it in and the Administrator explained it was her e #82 complained staff should have reported investigation could has stated she was inform the DON had obtained handling the investigat revealed she was una not been completed. During an interview of the DON she confirmed or neglect investigation and there was no 24 I North Carolina Health She stated she was m #82's complaint on Tu She further stated a 2 been submitted but si complaint as abuse o origin. During an interview of	ort and to slide it underneath ndicated she and the DON ent #82 on Tuesday e ADON further indicated a t been completed because llegation as abuse and/or an	F 22	6			

Facility ID: 923186

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/21/20 FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		C 12/17/2015	
NAME OF PF	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETIO	
F 226	Continued From page	e 12	F 226			
		Resident #82 during				
		further stated she was				
		cident the morning of ed it should have been				
		investigation could have				
		s her expectation for staff to				
		hen a resident reported staff				
		ough with them so she could ministrator further indicated				
	she considered the ir	cident in regards to				
	Resident #82 being p	pinched by staff as an				
F 242	allegation of abuse. 483 15(b) SELE-DET	ERMINATION - RIGHT TO	F 242		1/14/16	
SS=E				-		
	The resident has the	right to choose activities,				
	schedules, and healt	h care consistent with his or				
		ments, and plans of care;				
		s of the community both e facility; and make choices				
	about aspects of his	or her life in the facility that				
	are significant to the	resident.				
		is not met as evidenced				
	by: Based on record rev	iews, resident, and staff		F242 Right to Make Choices		
		failed to assess residents		The Social Services Director/Designed	e	
	0 0	r of showers preferred per		has interviewed all resident's, including	g	
	week for 3 of 3 reside (Resident #35, #123,	ents reviewed for choices #3)		resident #'s 35, 123 and 3, for their preference in number of showers each		
	$\left  \left( 1 \times 3 \times$	ποj.		week.		
	The findings included	:		The chower echodule has have a lite		
	1. Resident #35 was	admitted on 11/04/15 with		The shower schedule has been update with resident's preferences for the num		
		dementia, history of hip		of showers per week and timing of		
	fracture, and chronic	obstructive pulmonary		showers. When a resident could not		
	disease.			answer for themselves, the		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/21/2010 FORM APPROVED OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345163	B. WING		C 12/17/2015
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-
GLENBRII	DGE HEALTH AND REH	ABILTATION CENTER		211 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 242	Continued From page	e 13	F 242		
	(MDS) dated 11/11/14 severely impaired cog dependent on staff wi An interview was con family member on 12 the interview the fami #35 received 2 showed like for him to have 3 interview further reve not been asked how of Resident #35 preferred During an interview of Nurse Aide (NA) #1 s scheduled 2 to 3 show checked the daily ass beginning of the shift were scheduled for st further stated if a resi showers he tried to a An interview with NA revealed residents we showers a week and showers the NAs tried request. An interview with the on 12/17/15 at 10:32 Worker (SW) had recor	ducted with Resident #35's /15/15 at 2:32 PM. During ily member stated Resident ers a week and she would showers a week. The aled the family member had many showers a week ed. n 12/17/15 at 8:13 AM tated residents were wers a week and he signment sheet at the to see which of his residents howers that day. NA #1 dent requested additional ccommodate the request. #2 on 12/17/15 at 8:20 AM ere scheduled 2 to 3 if they requested additional d to accommodate the Director of Nursing (DON) AM revealed the Social ently interviewed residents ning shower preference and		family/responsible party was asked Shower preferences has been adde the admission packets. New reside be asked about their preferences, frequency and time of day, upon admission. If the resident is unable answer a family member/responsibl party will be asked. Admissions Dir will be responsible for relaying the information to the Staffing Coordinat showers can be scheduled accordin preference. The Staffing Coordinat responsible for updating the master schedule and the schedule on each Audits will be completed by the DON/Designee at a rate of 25% of residents every week for four weeks every two weeks for one month, the monthly for two months at a minimu Citation will be placed in the QAPI program for monthly monitoring/eva until resolved but no less than six m Completion Date 1/14/16	ed to ents will to le rector ator so ng to cor is nunit. s, then en um.
	were not assessed for				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	e survey Ipleted
		345163	B. WING			1:	C 2/17/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 242	able to verbalize a pro 2 showers a week. During an interview of SW stated she and he interviewed all current if they preferred a sho lunch, or after supper the Staff Scheduler for The residents were not they preferred every were not contacted for able to voice a prefer a resident requested week she notified the could be placed on the interview further reve- being asked if they pr breakfast, after lunch An interview with the at 12:32 PM revealed interviewed all current if they preferred a sho lunch, or after supper her to be added to the residents were not as preferred every week she was typically noti resident requested mission week and she change accordingly. An interview conducted with the Administrator expectation for reside showers a week as the residents or their fam	eference were scheduled for In 12/17/15 at 11:16 AM the er assistant had recently t residents and asked them ower after breakfast, after and gave this information to or the master shower list. ot asked how many showers week and family members or residents that were not ence. The SW noted when more than 2 showers a Staff Scheduler so this e master shower list. The aled new admissions were referred a shower after or after supper. Staff Scheduler on 12/17/15 the SW had recently t residents and asked them ower after breakfast, after and gave this information to e master shower list. The ked how many showers they . The Staff Scheduler stated fied by the SW when a ore than two showers a ed the master shower list ed on 12/17/15 at 4:45 PM	F	242			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345163	B. WING				C / <b>17/2015</b>
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 242	when they were admi 2. Resident #123 was 01/14/14 with diagnos chronic kidney diseas His most recent Minin dated 09/29/15, code cognition, having no t assistance with bathin assistance with other skills. During an interview o Resident #123 stated choose the number o week. He stated he w wee, on Wednesday2 admitted to the facility recently on 07/16/14. would prefer 3 showe Interview with Nurse / PM revealed the show nurse aides by nursin During follow up inter PM, Resident #123 sta asked how many sho He further stated he r showers a week. If g #123 stated he would week. Nurse Aide (NA) #4 s 12/17/15 at 10:47 AM per the printed showe Resident #123 will oc	tted to the facility. a admitted to the facility on ses including diabetes, se, ad hypertension. num Data Set, a quarterly d Resident #123 with intact behaviors, and requiring total ng but only set up to limited activities of daily living n 12/15/15 at 8:51 AM, that he was not able to f showers he preferred each vas given showers twice a 2. Resident #123 was y on 01/14/14 and most His and Saturday but rs each week. Aide #3 on 12/16/15 at 2:37 wers were assigned to the g supervisors. view on 12/16/15 at 4:18 tated that he was never wers he would like a week.	F	242			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345163	B. WING				C / <b>17/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	_ <u>.</u>	
				2	211 MILTON BROWN HEIRS ROAD		
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER		E	BOONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	shower he is happy. additional shower, NA accommodate the red staff on duty. Social Worker (SW) v at 12:50 PM. SW sta assistant went to each and asked them what preferred to receive th options included befo further stated neither residents how many s per week, only what t receive a shower. SW	If a resident requests an A #4 stated staff try to quest if there are enough was interviewed on 12/17/15 ted that she and her h alert and oriented resident t time of day the resident ne shower. SW stated the re or after meal times. She she nor her assistant asked showers they wanted to take ime of day they preferred to V also stated that residents or more than two showers	F	242			
	11/06/14 with diagnost hypertension and oste Minimum Data Set (M revealed Resident #3 required extensive as An interview conducte with Resident #3 reve showers a week and least 3 to 4 showers a she had been asked of showers to be but had many showers a wee She further stated she nurse aides (NAs) she showers.	eoporosis. The annual IDS) dated 10/15/15 was cognitively intact and sistance with bathing. ed on 12/16/15 at 8:32 AM					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 01/21/2016 MAPPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345163	B. WING		12	2/17/2015	
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		11 MILTON BROWN HEIRS ROAD SOONE, NC 28607			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	Nurse Aide #1 stated to 3 showers a week assignment sheet at see which of his resid showers that day. No resident requested ad accommodate the red An interview with NA revealed residents we showers a week and showers a week and showers the NAs triev request. An interview with the on 12/17/15 at 10:32 Worker (SW) had red regarding day or ever gave the list to the St information could be shower list. The DON were not assessed for preferred every week able to verbalize a pr 2 showers a week. During an interview of SW stated she and h interviewed all current if they preferred a she lunch, or after supper the Staff Scheduler for The residents were not they preferred every were not contacted for able to voice a prefer a resident requested week she notified the	residents were scheduled 2 and he checked the daily the beginning of the shift to dents were scheduled for A #1 further stated if a dditional showers he tried to quest. #2 on 12/17/15 at 8:20 AM ere scheduled 2 to 3 if they requested additional d to accommodate the Director of Nursing (DON) AM revealed the Social cently interviewed residents ning shower preference and aff Scheduler so the	F 242				

Facility ID: 923186

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/21/2016 MAPPROVEE D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING			C 12/17/2015		
	ROVIDER OR SUPPLIER	ABILTATION CENTER		211	REET ADDRESS, CITY, STATE, ZIP CODE MILTON BROWN HEIRS ROAD ONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 242 F 272 SS=D	being asked if they publicated being asked if they publicated asked if they publicated be asked and the at 12:32 PM revealed interviewed all current if they preferred a shellunch, or after supper her to be added to the residents were not as preferred every week she was typically not ir resident requested m week and she change accordingly. An interview conduct with the Administrator expectation for Reside showers a week as the Resident's or their Reasked how many show when they were admit 483.20(b)(1) COMPR ASSESSMENTS The facility must conda comprehensive, accordingle assessment of a resider the state. The assignment by the State. The assignment by the State. The assignment by the following:	aled new admissions were referred a shower after , or after supper. Staff Scheduler on 12/17/15 The SW had recently it residents and asked them ower after breakfast, after and gave this information to e master shower list. The sked how many showers they the Staff Scheduler stated fied by the SW when a ore than two showers a ed the master shower list ed on 12/17/15 at 4:45 PM r revealed it was her ent's to receive as many hey wanted. She stated esponsible Party should be wers they wanted a week itted to the facility. REHENSIVE duct initially and periodically curate, standardized nent of each resident's		242			1/14/16	

Facility ID: 923186

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/21/2016 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345163	B. WING		C 12/17/2015
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 211 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 PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 272	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-be Physical functioning a Continence; Disease diagnosis ar 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	Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding he additional assessment performed on the care areas triggered by the completion of the Minimum		72	
	by: Based on record rev facility failed to comp triggered area related	is not met as evidenced iew and staff interview, the rehensively assess the to falls for 1 of 3 sampled r falls. (Resident #86).		272 Comprehensive Asset The IDT reviewed/analyzed last 5 months for resident # The care plan was reviewe as indicated.	d falls for the ≇ 86 on 1/14/16.
	03/28/11. Her diagno	mitted to the facility on oses included Alzheimer's n, major depressive disorder,		Residents who fall have the affected by the cited deficient	-

Event ID: DYNK11

Facility ID: 923186

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		ATE SURVEY
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C
		345163	B. WING			12/17/2015
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
GLENBRII	OGE HEALTH AND REHA	ABILTATION CENTER		211 MILTON BROWN HEIRS RO BOONE, NC 28607	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 272	Continued From page	e 20	F 272	2		
	spinal stenosis and a			The QAPI Director in-se	erviced/trained the	
				Interdisciplinary Team of		
		Data Set (MDS) dated dent #86 with intact cognitive		process on 1/13/16. Tr 1) Rationale for comp		
		limited assistance with bed		CAA's	setting/working	
	mobility, transfers, to	ileting and bathing, and		2) The CAA process		
	-	falls since the previous		3) Linking risk factors	with carry-over to	
	MDS (which was a qu	uarterly dated 09/29/15).		the care plan 4) Using appendix C	of the RAI manual	
	The Fall Care Area A	ssessment (CAA) was dated		5) Analyzing data of t		
		sis of Findings stated "The		6) Care plan decision	making and writing	
	resident has had a fa			the CAA Summary narr	ative.	
		was no injury at the time of ical performance limitations,		The QAPI Director will	roviow fall CAA's	
		sident had difficulty with		prior to the closing of th		
		cluded conditions that can		evaluate/audit the proc		
	contribute to her fall r	0		This will be done week		
		, and pain from arthritis. The		then monthly for one m	onth at a	
	falling to adequate as	ze the circumstances of her		minimum.		
	individual strengths, v			Citation will be placed i	n the QAPI	
	-	the falling and effects the		program for monthly me		
	fall has had on Resid	ent #86.		until resolved but no les		
	Interview with MDS N	lurse #1 on 12/17/15 at 3:19		Completion Date 1/14/	10	
		been doing MDSs since				
		d that the MDS staff has				
	-	e MDS consultant who has				
	working on being more	She stated she had been				
		the CAA and stated that				
	Resident #86's fall C/					
		ine the cause and effect of				
		he MDS. The QA nurse				
		conversation explaining cussed in morning meeting				
		tances of the fall and the				
	intervention to follow.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/21/2016 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345163	B. WING				17/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GLENBRI	DGE HEALTH AND REHA	BILTATION CENTER			1 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	21	F:	278			
F 278 SS=D	483.20(g) - (j) ASSES ACCURACY/COORD		F	278			1/14/16
	The assessment mus resident's status.	t accurately reflect the					
	A registered nurse mu each assessment with participation of health						
	A registered nurse mu assessment is comple	ust sign and certify that the eted.					
		completes a portion of the n and certify the accuracy of essment.					
	willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material an	ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money					
	Clinical disagreement material and false sta						
	by:	is not met as evidenced			E278 Assessment Accuracy		
	facility failed to accura Data Set (MDS) and I	ew and staff interviews, the ately complete the Minimum have accurate information in ment for 1 of 3 residents esident #86).			F278 Assessment Accuracy A modification was made to resident # 86's MDS of 9/29/15 to correct the cod error for number of falls. This was dor	ling	

Facility ID: 923186

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/21/2016 1 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING			C 12/17/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	DGE HEALTH AND REHA			21	11 MILTON BROWN HEIRS ROAD		
GLENDRI	JGE HEALTH AND REHA	BILIATION CENTER		в	OONE, NC 28607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	22	F 2	278	on 1/11/16.		
	The findings included				611 1/11/18.		
	Resident #86 was adı 03/28/11. Her diagno	nitted to the facility on ses included Alzheimer's , major depressive disorder,			On 1/14/16, the Administrator complete an MDS accuracy audit of 30% of residents who fell in October, Novembe and December 2015. The QAPI Director trained/educated the	er	
	dated 0731/15 for Res A Falls Investigation V Resident #86 had fall				Interdisciplinary Team on 1/12/16 and 1/13/16 on the CAA process and care planning. The team was also educated on MDS accuracy by the QAPI Coordinator.	ł	
	revealed a restorative on the floor in front of A Falls Investigation V Resident #86 had fall The nursing note date revealed the resident to her bed and she sta transfer herself to the bathroom. A quarterly MDS date	aide found Resident #86 the commode. Vorksheet revealed en on 08/26/15 at 8:15 AM. ed 08/26/15 at 8:33 AM was found on the floor next			New MDS's will be audited by the Administrator if the resident had a fall since the previously completed assessment. Audit will be completed once a week for four weeks then twice month for 1 month then once a month for one month to assess coding accuracy related to falls. Citation will be placed in the QAPI program for monthly monitoring/evalua until resolved but no less than six mont Completion Date 1/14/16	ör tion	
	<ul> <li>wandering behaviors, requiring limited assis transfers and toileting Resident #86 had had assessment.</li> <li>B. Review of addition Worksheets and nursi #86 had the following *on 10/02/15 at 7:30 F on the floor and stated</li> </ul>	being nonambulatory and tance with bed mobility, . The MDS indicated I no falls since the prior al Falls Investigation ing notes revealed Resident					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE			
		345163	B. WING				C /17/2015		
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE				
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER		211 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			3E	(X5) COMPLETION DATE		
F 278	No injuries were docu *on 10/10/16/15 at 2: found on the floor by herself. She sustained leg and left arm. *on 10/26/15 at at 5:5 found on the floor new back. She stated she on. No injuries were *on 11/14/15 at 10:30 on the floor beside he trying to transfer hers wheelchair. There we *on 11/15/15 at 9:30 F on her back, on the fluc sustained an abrasion her lower leg, and a b The annual Minimum 11/20/15 coded Resid impairment, requiring mobility, transfers, toi having had 2 or more previous MDS (which 09/29/15). The Fall Care Area As 11/26/15. The Analys resident has had a fall assessment. There w the fall." The fall CAA circumstances of her Resident #86's individ and any associated co effects the fall has ha Interview with the MD 3:19 PM revealed she	<ul> <li>amented.</li> <li>55 AM the resident was the bed, attempting to toilet ed a bruise on her lower left</li> <li>60 PM the resident was at to her bed, lying on her e was trying to put her shoes documented.</li> <li>9 PM the resident was found er bed. She stated she was elf from the bed to her ere no injuries documented.</li> <li>PM the resident was found oor in front of the toilet. She n to her hip, 2 skin tears to bruise to her leg.</li> <li>Data Set (MDS) dated dent #86 with intact cognitive limited assistance with bed leting and bathing, and falls with no injury since the was a quarterly dated</li> <li>essessment (CAA) was dated sis of Findings stated "The II since the last MDS vas no injury at the time of A did not analyze the falling to adequate assess dual strengths, weaknesses auses of the falling and</li> </ul>	F	278					

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		ND HUMAN SERVICES			FOF	ED: 01/21/20 RM APPROVE O. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · /	CONSTRUCTION		E SURVEY	
		345163	B. WING		C 12/17/2	
NAME OF PI	ROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	DGE HEALTH AND REH	ABILITATION CENTER	21	11 MILTON BROWN HEIRS ROAD		
JELINDIA			B	OONE, NC 28607		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 278	Continued From page	e 24	F 278			
F 279 SS=D	the chart, the point cl by the nurse aides, th gathered during inter- residents and/or fami falls were discussed meetings and a noted office referencing eac to when completing eac this book, the fall on the fall book, however, the recorded in the fall book stated she did not know Resident #86's falls a MDS. MDS Nurse #' 11/20/15 inaccurately had 2 or more with no stated the CAA dated reflect Resident #86 I no-major injuries. She she made this error. 483.20(d), 483.20(k)(COMPREHENSIVE CON A facility must use the to develop, review and comprehensive plan The facility must develop plan for each residen objectives and timetal medical, nursing, and needs that are identiff assessment. The care plan must do	ly. She further stated that at the morning clinical book was kept in the MDS ch fall which she could refer each MDS. In referring to 08/13/15 was noted in the ne fall for 08/26/15 was not book. MDS Nurse #1 further ow how she missed coding accurately on the 09/29/15 1 stated the MDS dated r identified that Resident #86 o major injury. She further 11/26/15 did not accurately had multiple falls with ne was unable to explain how (1) DEVELOP CARE PLANS e results of the assessment ad revise the resident's of care. elop a comprehensive care t that includes measurable ibles to meet a resident's d mental and psychosocial ied in the comprehensive	F 279			1/14/16

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STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
	345163		B. WING	_		С		
	ROVIDER OR SUPPLIER	545105	5		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	/17/2015	
	NOVIDER ON SUIT LIER							
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 279	Continued From page 25 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under		F	279				
	under §483.10(b)(4).	e right to refuse treatment						
	Based on record rev facility failed to devel for 2 of 6 sampled res assistance with activi #91 and #3).	ties of daily living (Residents			F279 Comprehensive Care Plans Resident #'s 91 and 3 have care plans addressing their ADL needs. All residents have the potential to be	i		
	The findings included				affected by cited deficiency.			
		readmitted on 07/05/15 with			The QAPI Coordinator educated the N			
	•	Alzheimer's disease, muscle			Coordinators and Interdisciplinary Teal	m		
	weakness, chronic re				on 1/13/16 on developing care plans			
	congestive heart failu	ire.			based on CAA information, specific			
					resident risks, strengths, weaknesses,			
		ant change Minimum Data			etc. and to ensure if CAA says "will			
		21/15 revealed Resident #91			proceed to care plan" that a care plan			
		d cognition and required			actually is developed or the current ca plan is reviewed and revised if needed			
		with bed mobility, transfer, and personal hygiene. The						
	significant change MI				Once comprehensive assessments are	2		
	extremity had impaire				completed, the MDS Coordinators will			
					print the CAA Summary and compare			
	Review of the Care A	rea Assessment (CAA)			care plan decision against the actual c			
		s of Daily Living (ADL)			plans to ensure none are missed. The			
		tion Potential dated 10/21/15			will then sign and date it and turn it in t	•		
		had the risk of functional			the QAPI Director for review/verificatio			
	decline secondary to				This will be done for three months.			
	-	loss, and depression. The						
	-	Resident #91 required			The MDS Coordinator will complete ar	ı		
	-	with most ADL and was			initial audit of 100% of care plans to ve			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/21/2016 MAPPROVED O. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345163	B. WING			12	C 2/17/2015	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				21	11 MILTON BROWN HEIRS ROAD			
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		в	OONE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	prevent decline in abi the highest level of pr bathing. The CAA Su Functional/Rehabilita and would be address Review of Resident # revealed no care plan An interview was con #1on 12/17/15 at 11:2 stated if the ADL Fun should be addressed #1 reviewed Residen MDS during the interv completed the assess not locate a care plan for Resident #91 and when she completed plans. 2. Resident #31 was a 11/06/14 with diagnos hypertension and ost Minimum Data Set (M revealed Resident #3 required extensive as of daily living (ADL). Review of the Care A 10/12/15 revealed AE plan for Resident #3. Review of the care pl 01/2016 revealed the Resident #3. An interview conductor with the MDS Coordin have been an ADL car stated he was behind	lance. The goal was to lility to bathe and to achieve ractical self-sufficient ummary further stated ADL tion Potential had triggered sed in a care plan. 191's medical record in that addressed ADL. ducted with MDS Nurse 22 AM. MDS Nurse #1 ctional care area triggered it in a care plan. MDS Nurse 22 AM. MDS Nurse #1 ctional care area triggered it in a care plan. MDS Nurse t #91's significant change view and confirmed she had sment. MDS Nurse #1 could in plan that addressed ADL stated she had missed it Resident #91's other care dmitted to the facility on ses of heart failure eoporosis. The annual	F	279	all residents have a care plan address their ADL needs. The MDS coordina will also verify care plans are present/developed according to the or plan decisions on the CAA summary. The DON/Designee will audit the care plans for four weeks then twice a mo for one month then monthly for one n to monitor continued compliance. Citation will be placed in the QAPI program for monthly monitoring until resolved but no less than three month Completion Date 1/14/16	tor are e nth nonth		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/21/207 FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345163		345163	B. WING		C 12/17/2015		
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE				
GLENBRI	DGE HEALTH AND REH	ABILTATION CENTER		11 MILTON BROWN HEIRS ROAD SOONE, NC 28607			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
F 279 F 371 SS=D	with the Director of N was her expectation f date. She stated Res have been updated in review. 483.35(i) FOOD PRC STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	ed on 12/17/15 at 4:30 PM ursing (DON) revealed it for all care plans to be up to ident #3's care plan should n 10/2015 after the last OCURE, ERVE - SANITARY n sources approved or rry by Federal, State or local stribute and serve food	F 279		1/14/16		
	by: Based on observatio procedures, and staff to keep track of peris and dating food items room refrigerators. The findings included Initial observations of nourishment room on revealed the following large capital letters of - "Please do not put h refrigerator!! Bring the	t interviews the facility failed hable food by not labeling from 1 of 2 nourishment the 100/200 hall's 12/14/15 at 10:33 AM g notices were posted in n the front of the refrigerator:		F371 Food Storage The Dietary Manager in-serviced the dietary staff on the food storage policy 12/14/15, including disposing of out of date foods, not leaving health shakes the refrigerators and cleaning of refrigerators. Health shakes will be labeled with a "discard by" date when taken out of the freezer. Discard date to be 14 days. nourishment room refrigerators will be checked twice a day by the dietary aid The aide will dispose of out of date food	in e The e.		

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345163	B. WING		C 12/17/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBRIDGE HEALTH AND REHABILTATION CENTER			211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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 COMPLETIC	
F 371	our residents please I in this refrigerator. Co placed in this refrigera or 3 days. Use by da and then disposed of, resident food only!!" the DM. Observations of the co nourishment room ref 10:33 AM revealed the Eleven (11) 4 ounce of supplement shakes we date to discard noted One paper bag of par with a resident name room number or date placed in the refrigeration indicated the food wa One plastic grocery s partially consumed bu majority of the grapes color. There was not noted on plastic bag i placed in the refrigeration on the outside with a number but had no da placed in the refrigeration sliced sandwich meat grocery store label or items were purchased colored mold was not One plastic grocery s on partially consume pumpkin pie. The store	ted in part: "For the safety of label and date foods placed ooked/prepared foods ator can remain for 72 hours tes will be honored until date . This refrigerator is for The notice was signed by contents of the 100/200 hall's frigerator on 12/14/15 at le following: cartons of nutritional <i>vith</i> no resident name or on any of the cartons. tially consumed fast food written on the bag but no indicating when it was ator. The receipt in the bag is purchased on 11/19/15. tore bag which contained a unch of green grapes. The s were yellow, brown in name, room number or date indicating when they were ator. tore bag which was labeled resident name and room ate indicating when it was ator. The bag contained deli	F 37	<ul> <li>take any health shakes left in refrige back to the kitchen and will clean the refrigerator per policy. After the refrigerators are checked, the dieta is to initial on the date of a dedicate calendar.</li> <li>The Dietary Manager in-serviced restaff on the food storage policy on and 1/13/16.</li> <li>To ensure compliance, the Dietary Manager will check the nourishme refrigerators twice daily, Monday the Friday for four weeks then twice a for two weeks then once a month the months. The Dietary Manager will the calendar behind the dietary aid Citation will be placed in the QAPI program for monthly monitoring ur resolved but no less than six mont Completion Date 1/14/16</li> </ul>	he ary aide ed nursing 1/12 nt room hrough week for two i initial de.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	M APPROVED D. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE			
		345163	B. WING			C 12/17/2015			
NAME OF P	NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
	_			2	211 MILTON BROWN HEIRS ROAD				
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER		E	BOONE, NC 28607				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	box indicating when t refrigerator. A subsequent observ nourishment pantry o revealed Dietary Aide contents of the refrige items. Dietary Aide # nutritional supplement containing the fast foo meat/cheese but did A n interview was con during the observatio discarding any snack the previous evening. resident's personal foo Dietary Aide #1 states something had been An interview with the on 12/14/15 at 3:29 F the kitchen staff to me nourishment room ref date food items and b The DON stated resid should be labeled wit placed in the refrigera contents of the 100/2 the interview and con grapes, pies, and slic have been discarded During an interview o DM stated daily moni room refrigerators wa dietary staff twice a d	I on the plastic bag or either he pies were placed in the ation in the 100/200 hall's n 12/14/15 at 11:24 AM e #1 checking over the erator and discarding a few 1 handled several of the t shakes, and the bags bd, grapes, pies, and sliced not discard any of the items. ducted with Dietary Aide #1 n and he stated he was s with a resident label from . When asked about od stored in the refrigerator d when he noticed there awhile he threw it out. Director of Nursing (DON) PM revealed she expected ponitor the contents of the frigerators and discard out of peverages as needed daily. dent's personal food items h their name and date it was ator. The DON observed the 00 halls refrigerator during firmed the fast food bag, ed meat/cheese should per the posted procedure. n 12/14/15 at 3:37 PM the toring of the nourishment is an assigned task for ay and she expected them snacks from the previous	F	371					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>	PLE CONSTRUCTION	(X3) DATE	
			A. BUILDIN	G	C	
		345163	B. WING		12/	17/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBRI	DGE HEALTH AND REHA	ABILTATION CENTER		211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 371	labeled with a name a the refrigerator and w staff after 7 days. The the nutritional suppler supposed to be stored refrigerator because to days after they were to way to know what day when it was placed in refrigerator. The DM supplement shakes, f and sliced meat/chee discarded per the pos staff including Dietary explain why these iter and noted all dietary s regarding the nutrition discarding out of date During a follow up inte AM the DM stated res could actually store of the nourishment room she needed to change the refrigerator. An interview with the a 3:32 PM revealed she to remove any unlabe supplement shakes, a from the nourishment	in the refrigerator should be and the date it was placed in ould be discarded by dietary e interview further revealed ment shakes were not d in the nourishment room hey were only good for 14 thawed and there was no y the shake was thawed a nourishment room confirmed the nutritional ast food bag, grapes, pies, se should have been ted procedure by dietary Aide #1. The DM could not ms had not been discarded staff had been inserviced hal supplement shakes and foods. erview on 12/15/15 at 8:10 sidents' and family members poked or prepared foods in a refrigerators for 7 days and e the notice on the front of Administrator on 12/17/15 at e expected the dietary staff eled food, nutritional and out of date food items room refrigerators when ing and evening rounds. ERS/MEET	F 3			1/14/16

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	01/21/2016 APPROVED 0.0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		(X3) DATE	
		345163	B. WING		C 12/17/2015		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	DGE HEALTH AND REHA			211 MILTON BROWN HEIRS ROAD			
GLENDKI	DOE NEALTH AND KENA	BILIATION CENTER		BOONE, NC 28607			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 520	assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activiti develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as suc compliance of such correquirements of this s Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observation resident and staff inte Assessment and Assis maintain implemented these interventions th place in February of 2 recited deficiencies w February 2015 on the on the current recertif deficiencies were in th abuse allegation, corr and food procuremen	in a quality assessment and consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of ified quality deficiencies. ary may not require rds of such committee h disclosure is related to the committee with the ection. y the committee to identify ficiencies will not be used as is not met as evidenced ns, record reviews and rviews the facilities Quality urance Committee failed to d procedures and monitor at the committee put into 2015. This was for three hich were originally cited in recertification survey and ication survey. The ne areas of reporting an nprehensive assessments t/storage. The continued	F	520 520 520 F520 QAA Committee Quality Assurance Performance Improvement Committee memb key staff were in-serviced on wi is, why it is important and the ba principles of the five elements co program on 1/13/16 by the QAF The five elements are as follow 1) Design and Scope 2) Governance and Leadersh 3) Feedback, Data Systems a	bers and hat QAP asic of a QAP PI Directo s: ip	1	
	these interventions the place in February of 2 recited deficiencies w February 2015 on the on the current recertif deficiencies were in the abuse allegation, corr and food procurement	at the committee put into 2015. This was for three hich were originally cited in recertification survey and ication survey. The ne areas of reporting an aprehensive assessments		<ul> <li>key staff were in-serviced on while is, why it is important and the barrinciples of the five elements of program on 1/13/16 by the QAF The five elements are as follow</li> <li>1) Design and Scope</li> <li>2) Governance and Leadersh</li> </ul>	hat QAP asic of a QAP PI Directo s: ip	1	

Facility ID: 923186

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION UMBER:		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CC	MPLETED
						С
		345163	B. WING			12/17/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GLENBRIDGE HEALTH AND REHABILTATION CENTER			211 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 PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 520	Continued From page	e 32	F 52	0		
		n of the facilities inability to		4) Performance Improvem	ent Projects	
	•	Quality Assurance Program.		5) Systematic Analysis and Action		
	The findings included	1:				
	-			The QAPI Director/Designee		
	This tag is cross refe	rred to:		additional training sessions		
	1 EDDE Departing of	was ellegations. Deced on		committee members/key sta	•	
		ouse allegations. Based on esident and staff interviews		more in-depth training of the elements. Training will be c		
		otify the administrator and		the next five weeks.		
	-	ind submit a 24 hour report				
		Health Care Personnel		The five elements will be inc	•	
		cy) of a resident's complaint		the QAA program so as to tr	ansition to a	
		er arm during incontinence ruise for 1 of 2 residents		QAPI program.		
		Resident #82). F225 was		The QAA/QAPI program will	meet monthly	
	originally cited during			to evaluate compliance for c		
	recertification survey	for failure to investigate an gin and file a 24 hour and 5		deficiencies for no less than		
		the North Carolina Health		The facility Administrator will	ensure	
	Care Personnel Regi	stry (NCHCPR).		training and meetings occur		
		conducted on 12/17/15 at		Administrator and Risk Mana		
		trator stated the Quality		monitor compliance of the co		
		urance (QAA) Committee ork on areas of concern from		regarding implemented proc interventions for no less that		
	-	vey conducted in February			i six montris.	
		y had a large staff turnover				
	and were continuing	to educate staff on a daily				
		ated the QAA Committee was				
	working very hard to					
		sive assessments. Based on aff interview, the facility failed				
		assess the triggered area				
		f 3 sampled residents				
		lesident #86). F272 was				
	originally cited during					
	recertification survey					
	comprehensively ass sampled for assessm	ess 10 of 33 residents				

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	MENT OF HEALTH AN						FORM	D: 01/21/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVE COMPLETED	
		345163	B. WING		_	C 12/17/2015		
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBR	DGE HEALTH AND REHA	ABILTATION CENTER			11 MILTON BROWN HEIRS OONE, NC 28607	S ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 520	strengths and weakne impacted functionality information determining plan. During an interview of 5:15 PM the Administ Assessment and Asse were continuing to we the recertification surve 2015. She stated they and were continuing to basis. She further sta working very hard to r 3. F371 Food storage posted facility proced the facility failed to ke by not labeling and da nourishment room ref originally cited during recertification survey cleanliness of the exter reach-in refrigerator, I and microwave. During an interview of 5:15 PM the Administ Assessment and Asse were continuing to wo the recertification surve 2015. She stated they and were continuing to	esses, how the area and the analysis of the ng the direction of the care onducted on 12/17/15 at rator stated the Quality urance (QAA) Committee ork on areas of concern from vey conducted in February v had a large staff turnover o educate staff on a daily ted the QAA Committee was make improvements. b Based on observations, ures, and staff interviews ep track of perishable food ating food items from 1 of 2 rigerators. F371 was the February 2015 for failure to maintain the erior door panels of the knife rack, coffee machine, onducted on 12/17/15 at rator stated the Quality urance (QAA) Committee ork on areas of concern from vey conducted in February v had a large staff turnover o educate staff on a daily ted the QAA Committee was	F	520				

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