PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		C 02/24/2018	
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	1 02/2-1/2010	
(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)		
F 000	oxygen tank was obsiback cargo area of a Immediate Jeopardy when the facility provided the potential for more not Immediate Jeopardy systems put into place 2. 483.25 (F695) at J Immediate Jeopardy oxygen tank was obsiwas unsecured in the used for resident tran Jeopardy was remove facility provided and in Allegation of Compliance at a D (Isolated no actual more than minimal had Jeopardy) to ensure replace are effective.	pegan on 02/22/18 when an erved unsecured inside the facility transportation van. was removed on 02/24/18 ded and implemented a Compliance. The facility ance at a scope and plated no actual harm with than minimal harm that is redy) to ensure monitoring are effective. Degan on 02/22/18 when an erved stored on its side and back of a transportation van sports. Immediate and on 02/24/18 when the mplemented a Credible nce. The facility remains a scope and severity level of tharm with the potential for rim that is not Immediate monitoring systems put into was conducted in ecertification and complaint	F 00	· ·		
F 641 SS=D	No deficiencies were	cited as a result of the vestigation. Event ID#	F 64	1	3/19/18	
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> F	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.

Electronically Signed

03/19/2018

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345163	B. WING		C 02/24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	02/24/2010
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 641	Continued From page §483.20(g) Accuracy		F 64	1	
	The assessment must resident's status. This REQUIREMENT by: Based on record rev facility failed to accur	st accurately reflect the Γ is not met as evidenced riew and staff interviews the rately code the Minimum		Glenbridge Nursing and Rehabilitation	
	(PASRR) determinati (Resident #13) identi	offlect the Level II ning and Resident Review on for 1 of 1 resident fied as a PASRR Level II and wed for Hospice (Resident		statement of Deficiencies and proposithis Plan of Correction to the ectent to the summay of findings is factually contained and in order to maintain compliance applicable rules and provisions of que of care of residents. The plan of correction is submitted as a written	hat prrect with
	Findings included: 1. Resident #13 was 11/20/13.	admitted to the facility on		allegation of compliance. Glenbridge Nursing and Rehabilitatio Center□s response to this Statement	of
	Notification indicated determined as PASR results of this screen formulating a determ determination of an a formulating a set of results.	R Level II on 01/29/14. The ing and review are used for ination of need, appropriate care setting, and		Deficiencies does not denote agreem with the Statement of Deficiencies not does it constitute an admission that a deficiency is accurate. Further, Glenbridge Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or leg proceeding.	or iny n
	Set (MDS) assessme the resident was not Level II Preadmission Review (PASRR) pro	#13's annual Minimum Data ent dated 09/25/17 indicated considered by the state a Screening and Resident acess to have a serious intellectual disability.		F641 What measures did the facility put in for the resident affected:	place
	conducted with the M	B AM an interview was IDS Coordinator who stated or coding Section A of		Resident #13 was due to have MDS assessment dated for 09/25/18 that assessment was not coded correctly	to

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUC			(X3) DATE SURVEY COMPLETED			
		345163	B. WING				C / 24/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	02	124/2010
TO THE OT THE	TO VIDER OIL OUT FEILING				11 MILTON BROWN HEIRS ROAD		
GLENBRII	DGE HEALTH AND RE	HABILTATION CENTER			OONE, NC 28607		
240.15	CLIMMADV	STATEMENT OF DEFICIENCIES		_	PROVIDER'S PLAN OF CORRECTION		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From pa	age 2	F	641			
F 641	Resident #13's ann 09/25/17. The MDS unaware that Reside PASRR Level II. The usually received reinformation from the stated the SW had Resident #13 was and was missed for Coordinator stated modification to the dated 09/25/17 to reason to the dated on the dated with the was determined as verified Resident #15 was determined on the Coordinator had not the dated with the dated accurately coded to determined as PAS Supervisor stated in the the the stated on the the dated on the	anual MDS assessment dated S Coordinator stated he was dent #13 was determined as the MDS Coordinator stated he sident PASRR Level II e Social Worker (SW). He not informed him that determined as PASRR Level II	F	641	reflect Level II Passar. on 2/22/18 the MDS coordinator completed modification and resubmitted assessment. Resident # 59 was due to have a MDS assessment dated for 01/15/18 and that assessment was not coded to reflect hospice services. On 02/22/18 MDS Coordinator completed modification and resubmitted assessment. What measures were put in place for residents having the potential to be affected: 02/26/18 100% audit was completed on residents who are on hospice services and level II Passar to ensure accuracy information on MDSs. Administrator in-serviced MDS Nurses and Social Worker on accuracy of MDS section for hospice services and passar. What systems were put in place to prevent the deficient practice from reoccurring: On 2/26/18 the MDS coordinator, MDS nurse, DON, and Social Worker were in-serviced by the facility Administrator related to the Accuracy of information of MDS. How the facility will monitor systems puplace:	at d n all of r	
	assessment. The Nexpectation was the MDS assessment of	MDS Supervisor stated her at a modification to the annual dated 09/25/17 would be t Resident #13 was determined			Beginning 03/05/18 the DON, SDC, an Social Worker will audit MDS assessments to ensure accuracy using MDS proper coding audit tool, audit too will ensure hospice and passar is code	l ol	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	\ , ,	(X3) DATE SURVEY COMPLETED	
		345163	B. WING			C 2/24/2018	
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		2/24/2010	
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From page On 02/21/18 at 11:50 conducted with the E who stated her expe MDS assessment date been accurately cod was PASRR Level II expectation was that submit a modification assessment dated 0 #13 was determined On 02/21/18 at 12:00 conducted with the A expectation was that assessment dated 0 accurately coded to PASRR Level II. The expectation was that submit a modification assessment dated 0 #13 was determined 2. Resident #59 was 10/21/05 with diagnot fibrillation, hypertens disease.	Je 3 Je AM an interview was Director of Nursing (DON) ctation was that the annual ated 09/25/17 would have ed to reflect Resident #13 The DON stated her the MDS Coordinator would not the annual MDS 19/25/17 to indicate Resident as PASRR Level II. Je PM an interview was administrator who stated her the annual MDS 19/25/17 would have been reflect Resident #13 was a Administrator stated her the MDS Coordinator would not the annual MDS 19/25/17 to indicate Resident as PASRR Level II.	F 64	DEFICIENC	completed monthly x 3 mmittee will cy Audit Tool entification of o determine cy of nake		
	A review of the Hosp 01/15/18 indicated R hospice care on 01/2 chronic congestive h A review of the signi Set (MDS) assessmi	pice Care Face Sheet dated Resident #59 was admitted to 15/18 for diagnoses of					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345163	B. WING				C 24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER	1	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	he coded Resident # assessment dated 01 Coordinator stated he change MDS assessivas placed on hospid MDS Coordinator stated he significant change MI stated he would have the significant change 01/15/18 to reflect R	PM an interview was IDS Coordinator who stated 59's significant change MDS I/15/18. The MDS e completed the significant ment because Resident #59 be care on 01/15/18. The sted he missed coding section O on Resident #59's DS. The MDS Coordinator e to submit a modification to the MDS assessment dated esident #59 was receiving PM an interview was dministrator who stated her the significant change MDS I/15/18 would have been effect Resident #59 was re. The Administrator stated that the MDS Coordinator fication to the significant ment to reflect Resident #59 e care.	F	641			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345163	B. WING		C 02/24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	1 02/24/2010
(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 APPROPRI DEFICIENCY)	BE COMPLÉTION
F 641	the significant chang 01/15/18 to reflect R hospice care. On 02/22/18 at 03:04 conducted with the E who stated her expe significant change M 01/15/18 would have reflect Resident #59 The DON stated her MDS Coordinator wo the significant chang 01/15/18 to reflect R hospice care. Free of Accident Haz CFR(s): 483.25(d)(1 S483.25(d) Accident The facility must ens \$483.25(d)(1) The reas free of accident h \$483.25(d)(2)Each in supervision and assi accidents. This REQUIREMENT by: Based on observation resident and staff interprovide a safe environ hazards during transfacility van when an unsecured in the bac which created the posampled residents tr	and submit a modification to the MDS assessment dated esident #59 was receiving 4 PM an interview was Director of Nursing (DON) estation was that the DS assessment dated to been accurately coded to was receiving hospice care. expectation was that the bould submit a modification to the MDS assessment dated esident #59 was receiving the was received the was r	F 68		ave its nce

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345163	B. WING		,	C 2/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/24/2010	
	10 113 211 011 001 1 21211			211 MILTON BROWN HEIRS ROAD	-		
GLENBRII	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 6	F 68	39			
	failed to provide a co	mprehensive training					
		tation drivers which included		What measures were put in pla	ace for		
	safe transportation of			residents having the potential affected:	to be		
		began on 02/22/18 when an					
	, 0	served unsecured inside the		02/23/18 100% audit was com	•		
		facility transportation van.		Maintenance Director on both	vans with		
		was removed on 02/24/18		no negative findings.	. In conject		
		rided and implemented a f Compliance. The facility		02/23/18 Facility Administrator maintenance Director on o2 ta			
	remains out of compl			secure at all times during trans	-		
		olated no actual harm with		Maintenance Director in service	•		
		than minimal harm that is		who transports residents in tra			
	-	ardy) to ensure monitoring		vans to ensure that o2 is alway	•		
	systems put into place	- · · · · · · · · · · · · · · · · ·		appropriately secured.			
	Findings included:			What systems were put in place prevent the deficient practice f			
	The facility Administra	ator provided a copy of a		reoccurring:	10111		
	document titled Main	· · · · · · · · · · · · · · · · · · ·		recearing.			
		tion labeled Procedures		02/23/2018 Transportation Aid	was in		
		gen must be transported in		serviced on how to do a walk t			
	an oxygen cart, secu	red on the back of a		van prior to going on a transpo	ort and		
	wheelchair or in the o	cylinder holder.		reporting any issues to Admini or maintenance Director Imme			
		ent titled Safety Data Sheet					
		oxygen cylinders (tanks)		How the facility will monitor sy	stems put in		
	_	pressure and in a fire or if		place:			
		crease would occur and the					
	•	or explode. A section		The Maintenance Director or D	-		
	_	storage indicated cylinders		will audit using the Daily Van A			
		ght with valve protection cap ecured to prevent falling or		The audit will be completed 5x			
	being knocked over.	cured to prevent failing of		4 weeks then weekly x 4 week monthly thereafter. The month			
	being knocked over.			committee will review the resu			
	a Resident #38 was	admitted to the facility on		Van audit tool monthly for 3 m			
		ses which included chronic		identification of trends. The ad			
	_	isease, type 2 diabetes,		and/or DON will present the fir			
	anxiety, depression a			recommendations of the mont			

Facility ID: 923186

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			1	24/2018	
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE	021	24/2010	
	to the Little of the Little				MILTON BROWN HEIRS ROAD			
GLENBRII	DGE HEALTH AND REHA	ABILTATION CENTER			ONE, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	÷ 7	F 6	89				
	disease. A review of Minimum Data Set da Resident #38 was coo	the most recent quarterly ited 01/06/18 revealed gnitively intact for daily required limited assistance			committee to the quarterly executive Q committee for further recommendations and oversight. Facility Administrator is responsible for Plan of Care.			
	Resident #38 stated if week and was transp appointments in the state 2 vans the facility residents. He explair secured the straps in and he did not have a he was concerned abseen in the past in the He stated he saw the between the wall of the could not recall how le had seen it. He further tank unsecured within and he had told a var but could not recall he had been transported earlier today to his did did not see the oxyge He stated Resident # dialysis on the same of been transported to a today in the smaller face.	maller transportation van of used for transportation of used the driver always the van to his wheelchair any concerns about that but out an oxygen tank he had a van that was not secured. oxygen tank inside the van the van and a seat but he ong it had been since he are stated he had seen the are the last several months and driver about his concerns are name. He explained he in the smaller facility van alysis appointments but he in tank during the transport. 9 was also transported to days and they had both and from dialysis earlier acility van. Idmitted to the facility on sees which included heart the sand kidney disease. A cent annual MDS indicated intively intact for daily required extensive						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	' '	ATE SURVEY OMPLETED
		345163	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		02/24/2018
(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 APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	Resident #9 confirm facility van 3 days a appointments and R van on the same da wheelchair was sect transport but he was tank that was stored explained he was no was secured and cohim about the tank or when he had last it today because he seat of the van. He former van driver ab was done about it an name of the driver. During an observation area. During an interview Transportation Aide been transportation Aide been transported resident had 2 transportation multi-passenger var and a smaller mini-tused to transport reappointments and to confirmed she trans to dialysis 3 days a susually transported transportation van. time she was the on	ed he rode in the smaller week to his dialysis esident #38 also rode in the ys with him. He stated his ured in the van during concerned about an oxygen in the back of the van. He of sure how the oxygen tank uld not recall who had told or how long it had been there seen it but he did not observe could not see over the back further stated he had asked a out it but was not sure what he he could not recall the on on 02/21/18 at 4:20 PM a ter van was located under a centrance of the facility but the on van was not in the parking on 02/22/18 at 10:14 AM, (TA) #1 explained she had sidents since July 2017 and so daily. She stated the facility vans and one was a large used mostly for activities ype van that she routinely sidents to physician's of dialysis appointments. She ported Resident #38 and #9 week at the same time and	F 6	39		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OMPLETED
		345163	B. WING _			C 02/24/2018
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	'	V212 1120 10
(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 SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	transported resident in-service training withe van and took at transport of oxygen had to transport Reappointment today in van. c. Resident #294 was 02/04/18 with diagn walking, weakness, weakness and abnormatical eview of the admiss 02/20/18 indicated Fintact for daily decise extensive assistance. During an observation TA #1 secured Resist the safety straps in Resident #294 was not speak as she was Observations inside of the van revealed between the wall of then opened the baran oxygen tank was cover behind the baran	AD) or a Nurse Supervisor ts. She stated she had then she was hired to drive test but the test did not include tanks. She further stated she sident #294 to a doctor's in the smaller transportation as admitted to the facility on oses which included difficulty lack of coordination, muscle ormal gait and mobility. A sion (5 day) MDS dated Resident #294 was cognitively ion making but and required	F 6	89		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		02/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From page	ge 10 he van or who had placed it	F	689		
	there or how long it stated she had never back of the van becausually transported in resident's wheelchait been trained to drive Maintenance Director worked at the facility Director was in character of the tank of the tank was lying on its covered inside a bluate metal handle at the of the tank was lying cushions. Observative revealed the end of with all purpose clear miscellaneous packet to the oxygen tank. Picked up the oxyge secured to any type of the van. He also had a needle position square inch (psi) who contained oxygen. Stated the oxygen tastored in the back of was not sure who had been there but it facility to storage.	had been there. She further in used the oxygen tank in the ause oxygen tanks were in a rack on the back of the ir. She explained she had at the facility vans by the or and TA #2 who no longer and the Maintenance ge of training van drivers. On and interview on 02/22/18 intenance Director opened the he small transportation van en tank was lying in the cargo back of the van behind the ther inspection, the oxygen side and was partially e cover and had a gauge with the top of the tank and the top on top of several small black ions at the bottom of the tank the tank was next to a bucket uning supplies inside and ages of briefs were lying next. The Maintenance Director in tank and verified it was not of rack or holder in the back verified the gauge on the tank and at 1,000 pounds per ich indicated the tank. The Maintenance Director in the way in the would take it inside the lefurther stated when				
	facility to storage. He residents were trans					

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F 689	He confirmed he wa to van drivers but als materials did not contanks. He stated he mechanical problem securement straps be inspections to see where compartments of the did not know who pure or why it was there also seen an oxygen tank transportation van in van and he had remutime TA #2 had left the had transported a result to the did not document any in-service training. During a follow up in PM, the Maintenance in-service materials he explained the dopresentation for train contained informatic service of the vans as	e back of their wheelchair. Is assigned to provide training to confirmed the training ter transportation of oxygen checked the van for so and he checked the van the did not do periodic that was stored in the storage to vans. He further stated he at the oxygen tank in the van the but a month or so ago he had to inside the small the passenger area of the oved it. He explained at that the tank in the van after she sident and he had reminded by could not transport oxygen the facility vans. He confirmed the incident or document the growth of the drivers at that time. Interview on 02/22/18 at 5:53 the Director provided copies of the used to train van drivers. Couments were copies from a sing van drivers and and for loading and unloading the confirmed and the folloading and unloading the confirmed and for loading and unloading the same training van drivers and the confirmed and for loading and unloading the confirmed the confirmed the confirmed the confirmed and for loading and unloading the confirmed the	F	BEFICIENCY)			
	covered responsibilivan was involved in expected to call 911 stated he was not redrivers but when a condition of the training did not to they reviewed the management of the training did not to they reviewed the management of the training did not to they reviewed the management of the training did not to they reviewed the management of the training did not to the t	ted the materials also ties of the van driver and if a an accident the driver was for assistance. He further sponsible for hiring van river was hired the ector of Nursing (DON) called aining to them. He explained ake long and on the first day aterials and he gave them a aterials he had provided to					

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	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	'	0212-4/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	(TA #2) went out wit transports for approvan drivers were exannually. He further that drivers were nounsecured oxygen texplained no one hat tank was in the back but he would have eremove the cylinder get to the bottom of there. During a telephone PM, TA #2 confirme more than 3 weeks facility as a van drive she had in-service thired as a van drive annually and demorresident's wheelchaexplained she was a supposed to be transwheelchair in a tank supposed to be transback of the van how	ge 12 The or the previous van driver the new driver during simately a week. He stated dected to re-take the test of stated it was his expectation at supposed to transport an early in a facility van. He are reported to him the oxygen of the small transport van expected van drivers to and report it so they could how the oxygen tank got a facility a little eago but had worked at the early for 2 years. She explained raining when she was first or and she had to take a test estrate how to secure a facility and she further expected on the back of a holder and were not sported unsecured in the ever, she confirmed she had of oxygen on long transports	F6	689			
	of oxygen before the She stated when sh usually stored in the transportation van. laid the oxygen tank packages of supplie gloves and wipes ar was also a bucket o oxygen tank in case	want the resident to run out ey got to their appointment. e took an extra tank it was back cargo area of the small She explained she usually down on its side and placed s such as briefs, boxes of ound it. She confirmed there f cleaning supplies next to the a resident had an accident in inside the van and there					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			C 02/24/2018	
	ROVIDER OR SUPPLIER DGE HEALTH AND RE	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	ATE, ZIP CODE		
(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 CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	they used to put in they were uncomfor remember if anyone oxygen tank that was resident might run of transport and she woxygen tank just in further stated she cosaw an oxygen tank transportation van been told by the Manot supposed to cat that was unsecured to put the tank up in came back with the when the Maintenance Direct mechanical issue working an interview Maintenance Direct mechanical issue working an interview drivers to report it to past oxygen issues Administrator and hocheck the safety see wheelchairs but not During a follow up in AM the Maintenance tank he removed frow you on 02/22/18 was with capacity for 30	shions around the oxygen tank resident's wheelchairs when retable. She stated she did not e told her to transport the ay but she was afraid a out of oxygen on a long vanted to have an extra case she needed it. She ould not say when she last in the back of the small out recalled the drivers had aintenance Director they were rry an oxygen tank in the van and they were told they had not side the facility when they wan but she did not recall noce Director talked to them. 102/23/18 at 10:17 AM, the or stated if there was a with the van he expected the or him. He further stated in the was reported to the DON or its concerns were for drivers to curement straps to the anything related to oxygen. 11 Interview on 02/23/18 at 10:38 are Director verified the oxygen om the small transportation as a large Type E oxygen tank on PSI pressure. He repeated sible for oxygen or transport of	F	889			
	AM, TA #1 confirme as part of van traini	nterview on 02/23/18 at 11:55 ed she did not watch a video ng. She explained she was in mately 2 weeks and the first					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			C 02/24/2018	
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	'	32.220	
(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 689	after the first day shof the week and the explained Resident ago about an oxyge the small transporta uncomfortable with She stated she reportation of the stated she further remember a specific Director told them in that were unsecured During an interview Administrator stated was responsible for residents in facility who no longer work expected to also trated the state of the s	the Maintenance Director and e rode with TA #2 for the rest following week. She further #38 told her several months in tank that was unsecured in tion van and he was it and TA #2 was present. Orted it to the Maintenance of the extra the	F	889			
	was aware the Mair responsible for trans drivers. She stated was an oxygen tank small transportation	DON. She explained she atenance Director was sportation and training of van she had no knowledge there a unsecured in the back of the van. She further stated it in for oxygen tanks to be					

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 _			C 02/24/2018
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	02/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	for harm. She explatransported in a met wheelchair or they cover that was strap of the wheelchair. expected for van dri were in the van and transport of oxygen During an interview Activity Director stat back-up van drivers approximately 15 ye first started driving t with her and she ha further explained sh passenger van for a resident if the smalle She stated she was supposed to be sec resident's wheelcha unsecured oxygen to multi-passenger van During an interview Administrator stated oxygen tanks should transported in a faci training needed to boxygen tanks should vans. During a follow up in PM the Administrator residents currently a routinely transported residents who usual	ported to prevent the potential sined oxygen tanks should be all rack on the back of a sould be in a cloth transport uped and secured to the back. She further stated she wers to check supplies that training should include in a van. On 02/24/18 at 9:18 AM, the ed she was one of the and had been a van driver for ears. She explained when she he Maintenance Director rode d to take a test annually. She e usually drove the large multi ctivities or to pick up a er van was out on a transport. aware oxygen tanks were ured on the back of a ir and had not seen an	F	889		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			C 02/24/2018	
	ROVIDER OR SUPPLIER	EHABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	•	12/24/2010	
(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 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Nursing Supervisor up van driver but of was out of the factoresident. She expendition was trained to the smaller transposed was usually used physician appoint she was trained to by a former Maintopaper test after he she had not had a training and had of time when she was She explained if a had a cloth bag on their wheelchair a supposed to be stone was the eard before that unsecured in the lovan before now. The Administrator informed of Immediate 1:52 PM. The facility providallegation for immediate 2/24/18 at 04:57. Credible Allegation Removal F689 Free of accil Supervision/Device she was out of the provided and the second	w on 02/24/18 at 11:34 AM, a or confirmed she was a back-only drove a facility van if TA #1 ility transporting another plained she drove the larger an because that was the one of drive. She further explained ortation van was the one that to transport residents to ments or to dialysis. She stated of drive the multi-passenger van enance Director and she took a er initial training. She confirmed any retraining since her initial only taken the paper test one as first trained as a van driver. The resident required oxygen they a metal rack on the back of and that was where the tank was ored. She stated she had not an oxygen tank was stored back of the small transportation. and Director of Nursing were diate Jeopardy on 02/23/28 at led an acceptable credible ediate jeopardy removal on PM. In of Immediate Jeopardy	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			C 02/2 4	4/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	CODE	VZIZ	20.10
(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 AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 689	oxygen tank in the faduring a recent trans, 22, 2018 at approxim requested to speak to wanted to see her se upon request to look Aide (TA) #1 opened van and surveyor obsa blue cover laying of On February 22, 201 Aide #1 returned to that she transported in Observations of the trevealed the tank of side in bag noted in the transport van the transport van the transport van the transport van attention. He then plaroom in oxygen holder revealed facility transport adequately trained or oxygen, in the facility for the facility transport van the transport van the transport van the facility	of observing an unsecured cility's transport van #1 port in this van. On February ately 10:00 am Surveyor of transport aid stated she cure a resident in the van, in the van Transportation the back-hatch door of the served an oxygen tank inside in its side. 8 at 4:34 PM Transportation are facility with the resident in transport Van #1. It ransport van at this time oxygen was still laying on its the van's rear interior storage area. The oxygen tank was cured and improperly stored The facility's Maintenance removed the oxygen tank in when it was brought to his aced it in the dirty supply er. Additionally, it was port staff were not in how to properly transport transport van. The training orters includes a packet of power point handout that orientation, and a final in facility transport staff and actor revealed staff were not it the facility's transport van's gensure the van was safe	F	589			
		only staff who transport					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			C 02/24/2018	
	ROVIDER OR SUPPLIER	HABILTATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		02/24/2010	
(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	As of 02/23/18 the fresidents who were facility's two transport facility's two transport facility Staff interviet there were no harmifindings. On February 23, 20 Manager put a systenew check off sheet assess the van's intrissues before and a sheet directs staff to including; observing On 02/23/18 the Add the maintenance dicheck off sheet and prior to resident transport to resident transport of the Administrator trained by Facility Nadministrator trained how to implement the list, to assess the faprior to transporting should be properly serviced by the Maintenance Directed on 02/23/18 Transporticed by the Maintenance Directed on 02/23	facility transport vans. acility has a total of 5 regularly transported in the ort vans on a weekly basis. ewed these 5 residents and ful effects or negative 18 the facility's Clinical Risk em in place that included a for transportation aids to erior and exterior for safety fter each use. This check off o observe for hazards for improper oxygen storage. ministrator provided training to irector on how to fill out the assess the van for safety hisports. This training included fuct the van assessment and hey are to report these issues administrator and/or the or. Illity's Administrator was Nurse Consultant then d maintenance director on he new audit titled Skill Check cility's vans for safety issues residents, on how oxygen secured in the van and how to	F6	89			
	resident transport, o	en in van if needed for a on the new check off sheet to eafety prior to transporting a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			C 02/24/2018	
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	1	3272-772313	
(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 689	identified must be readministrator and/o training included co "Transport" which is be secured in a hole wheelchair or secure wheelchair in an ox secure it to wheelch in a secure it in a did not a secure it in a did not a secure it in a secure it in a did not a secure it in a did not a secure it in a secure it in a did not a secure it in a did not a secure it in a secu	pectation that any issue eported immediately to the reported immediately to the reported immediately to the reported immediately to the reported immediately to the pecifies all oxygen tanks must dereither in the back of a led in a van on the back of the lygen holder that is made to hair. 18 all other applicable staff the Activity Director, LPN, were included on the insport" and the Skills Check List of vans for safety issues intenance Director. This lat when staff conduct the van dany concerns they are to	F 6	89			

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			C 02/24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	DDE	02/2-4/2010
(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 ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	to the Facility Orienta hired nursing staff, tr. maintenance staff. The to use the check off stransport safety issue concerns immediatel maintenance director. Beginning on 02/24/1 Van checks off list, at by the maintenance of a month, then weekly concerns will be immediality's administration monthly audit. All find recommendations with committee during monthly audit. The facility's administration monthly audit. All find recommendations with committee during monthly audit. All find recommendations with the facility's administration and the facility's administration and the facility of the fac	ansportation aides and his training will include how sheet to identify possible van es and the need to report by to the administrator and/or and Safety will be completed director five times a week for a for four weeks. Any ediately reported to the r. Then will continue as a dings, concerns, and ll be reported to the QI	F	689		
F 690 SS=D	in-service training on tanks in facility owne interviews with Maint had also received intransportation of oxygvans. Bowel/Bladder Incon CFR(s): 483.25(e)(1) §483.25(e) Incontine §483.25(e)(1) The faresident who is contin	. ,	F	590		3/19/18

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 _			C 02/24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	I	02/24/2010
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 690	condition is or becon	unless his or her clinical nes such that continence is	F 6	90		
	ensure that- (i) A resident who en indwelling catheter is resident's clinical concatheterization was in (ii) A resident who er indwelling catheter or is assessed for remorance is assessed for remorance is assessed for remorance to the cand (iii) A resident who is receives appropriate prevent urinary tract continence to the extensive asset of	esident with urinary on the resident's ssment, the facility must ters the facility without an a not catheterized unless the indition demonstrates that necessary; ners the facility with an a subsequently receives one aval of the catheter as soon ne resident's clinical condition atheterization is necessary; incontinent of bladder treatment and services to infections and to restore tent possible. Tesident with fecal on the resident's ssment, the facility must not who is incontinent of bowel treatment and services to mal bowel function as T is not met as evidenced T is not met as evidenced		FTAG 690 What measures did the facility properties for the resident affected: Resident # 51 was noted to have bag position on the crossbars of wheelchair and not on the frame chair which allowed it to move of	ve catheter of his e of the	

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 _				C 24/2018
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
OL ENDOU	NOT LIE ALTIL AND DELLA	ADULTATION CENTED		21	1 MILTON BROWN HEIRS ROAD		
GLENBRII	OGE HEALTH AND REHA	ABILIATION CENTER		В	DONE, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From page Resident #51 was ad	e 22 mitted to the facility on	F 6	90	Resident #51 was observed sitting in h	is	
	retention of urine, neu bladder and parapleg	ses that included: sepsis, uromuscular dysfunction of ia among others. Review of recent assessment (MDS) oded as a quarterly			Wheelchair with his catheter bag touch the floor, DON assessed placement of resident □s catheter bag with no negati findings.	-	
	assessment revealed cognitively intact. Re coded as requiring lin personal hygiene and	Resident #51 to be sident #51 was further nited assistance with locomotion on/off unit and			What measures were put in place for residents having the potential to be affected:	1-	
	personal hygiene and	sistance with toilet use, I transfer. Further review of esident #51 was coded as catheter.			02/26/18 Don initiated 100% in-service all nursing staff on Catheter Bags. Catheter Bags at no time can be touch the floor. In-service will be completed b 03/16/18	ing	
	A review of Resident #51's care plan revealed a care plan area for: "[Resident #51] has an indwelling urinary catheter secondary to a neurogenic bladder from his paraplegia".				02/26/18 100 % audit was completed all residents with Catheters to ensure n bags where touching the floor.		
	tubing below the leve				What systems were put in place to prevent the deficient practice from reoccurring:		
	3:25 PM revealed the conversing with visito in his wheelchair with room. At this time, R was observed to be to hung on the crossbar	rvation of Resident #51 at resident to be in his room rs. Resident #51 was sitting his back to the door of his esident #51's catheter bag buching the floor as it was of his wheelchair			02/26/18 Don initiated 100% in-service all nursing staff on Catheter Bags. Catheter Bags at no time can be touch the floor. In-service will be completed b 03/16/18.	ing yy	
	underneath the seat. An observation made	on 02/22/18 at 3:56 PM			How the facility will monitor systems puplace:	ıt in	
	revealed resident to be outside of the facility area. At the time of the	oe sitting in his wheelchair in the designated smoking his observation, it was noted atheter bag was touching			On 02/26/18 The Don, MDS Nurse, Treatment Nurse or Floor Nurse will au Catheters to ensure they are not touch the floor 5x a week for 3 weeks then weekly x 3 weeks then monthly x 3 months. The monthly QI committee will review the results of the audit tool mon	ing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ '	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			C 02/24/2018	
NAME OF PR	ROVIDER OR SUPPLIER	2.0.00		STREET ADDRESS, CITY, STATE	ZIP CODE	02/24/2016	
				211 MILTON BROWN HEIRS R	OAD		
GLENBRII	OGE HEALTH AND REHA	ABILTATION CENTER		BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 690 F 695 SS=J	catheter bag drag the not know whether or staff hang his bag on stated he mainly hear would cross door three go out on the patio to was worried if his bag might get "hung up so "wear a hole" in the bound prefer his catheter bakeep it from dragging. During an interview woon 02/23/18 at 6:57 At that catheter bags we it was her expectation touch the floor. During an interview woo2/23/18 at 4:48 PM sexpectation that cathete and reported she would have the problem fixed Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and tracheal succare, consistent with practice, the comprehence and 483.65 of this sulface.	ne reported hearing his floor "constantly" and did not it was due to where the his wheelchair. He further d the bag drag when he sholds and when he would smoke. He reported he continued to drag that it omewhere" or that he may ag. He stated he would g to be elevated more to the ground. The Director of Nursing M she reported knowing are not to be on the floor and a that catheter bags do not The Administrator on she reported it was her eter bags not touch the floor and sith the Administrator on she reported it was her eter bags not touch the floor and simmediately. Tomy Care and Suctioning The y care, including and tracheal suctioning. The y care including that a resident who the, including tracheostomy thoning, is provided such professional standards of the professional standards of	F 6	for 3 months for identiactions taken, and to a for and/or frequency of monitoring and make for monitoring for confit The administrator and the findings and recommentally QI committee executive QA committer recommendations and Administrator is respondere.	determine the need of continued recommendations tinued compliance. Wor DON will present need to the quarterly tee for further d oversight. Facility	3/19/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345163	B. WING			02/	/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CI ENDDI	OCE HEALTH AND DE	HADII TATION CENTED		2	11 MILTON BROWN HEIRS ROAD			
GLENDKII	DGE REALIR AND RE	HABILTATION CENTER		В	OONE, 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 695	Continued From pa	ge 24	F	695				
	· ·	-	' '	555				
		ions, record reviews and			F695 final	000		
		terviews the facility failed to			What measures did the facility put in pl	ace		
		g of an oxygen tank in a n van used for resident			for the resident affected:			
	transports when an	oxygen tank was observed			on 02/22/18 small van was noted to ha	-		
	stored on its side ar	nd unsecured in the back of a			o2 tank in cargo area of van laying on	its		
		vith the potential for injury for			side in a carrier. On 2/22/18 Maintenar	ıce		
		dents transported in the van			Director removed o2 tank, with no			
	(Resident #38, #9 a	and #294).			negative findings.			
	Immediate Jeopard	y began on 02/22/18 when an			What measures were put in place for			
	oxygen tank was ob	oserved stored on its side and			residents having the potential to be			
	was unsecured in the	ne back of a transportation van			affected:			
	used for resident tra	ansports. Immediate						
	Jeopardy was remo	oved on 02/24/18 when the			02/23/18 100% audit was completed by	y		
	facility provided and	d implemented a Credible			Maintenance Director on both vans wit	h		
	Allegation of Compl	liance. The facility remains			no negative findings.			
	out of compliance a	t a scope and severity level of			Facility Administrator In-serviced			
	D (Isolated no actua	al harm with the potential for			Maintenance Director to make sure tha	ıt		
	more than minimal	harm that is not Immediate			o2 is always appropriately secured whe	en		
		e monitoring systems put into			transported. Maintenance Director in			
	place are effective.				serviced all Drivers of the transportatio	n		
					vans to make sure that o2 is always			
	Findings included:				appropriately secured when transporte	d.		
		trator provided a copy of a			What systems were put in place to			
		intenance of Oxygen			prevent the deficient practice from			
		ection labeled Procedures			reoccurring:			
		ygen must be transported in						
		cured on the back of a			02/23/2018 Facility Administrator			
	wheelchair or in the	cylinder holder.			In-serviced Maintenance Director on w	alk		
					thru on van. Maintenance Director in			
		nent titled Safety Data Sheet			serviced Transportation Aid on how to			
		d oxygen cylinders (tanks)			a walk thru on the van prior to going or	ıa		
	_	er pressure and in a fire or if			transport and reporting any issues to			
		increase would occur and the			Administrator and or maintenance			
		t or explode. A section			Director.			
		d storage indicated cylinders						
	should be stored up	oright with valve protection cap			How the facility will monitor systems pu	ıt in		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G			(X3) DATE SURVEY COMPLETED	
		345163	B. WING _		_	C 02/24/2018		
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, ST	ATE. ZIP CODE	1 02/2	14/2010	
				211 MILTON BROWN HEIRS	•			
GLENBRII	DGE HEALTH AND REHA	ABILTATION CENTER		BOONE, NC 28607	o none			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From page	e 25	F 6	95				
	being knocked over. a. Resident #38 was	cured to prevent falling or admitted to the facility on ses which included chronic			sportation Aid, and tor, or Designee will sure no o2 on the v			
	lung disease, heart di anxiety, depression a disease. A review of Minimum Data Set da Resident #38 was co	sease, type 2 diabetes,		is unsecure. The M Designee will audit Audit tool. The auda week for 4 weeks weeks then monthly monthly QI committ results of the Van a	laintenance Director using the Daily Van dit will be completed then weekly x 4 y there after The tee will review the audit tool for	r or 1 I 5x		
	Resident #38 stated if week and was transp appointments in the sidents. He explair concerns about how if in the van but he was tank he had seen in the not secured. He state inside the van betweek seat but he could not since he had seen it be last several months. Told a van driver about recall her name. He is transported in the sm to his dialysis appoint oxygen tank during the Resident # 9 was also the same days and the transported to and from the smaller facility van	smaller of 2 transportation for transportation of hed he did not have any his wheelchair was secured concerned about an oxygen he past in the van that was hed he saw the oxygen tank en the wall of the van and a recall how long it had been but thought it was within the He further stated he had at his concerns but could not explained he had been aller facility van earlier today the transport. He stated to transported to dialysis on the had both been out dialysis earlier today in h.		and/or DON will pre recommendations of committee to the que committee for further	uarterly executive Q er recommendation ility Administrator is	nd A s		
		dmitted to the facility on sees which included heart						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345163	B. WING _			C 02/24/2018	
	ROVIDER OR SUPPLIER DGE HEALTH AND REF	IABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	'	0212-712010	
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	Continued From pag	ge 26	F 6	595			
	review of the most re Resident #9 was cog decision making and assistance with trans	•					
	van on the same day wheelchair was secutransport but he was tank that was stored explained he was no was secured and co	week to his dialysis esident #38 also rode in the ys with him. He stated his ured in the van during concerned about an oxygen in the back of the van. He ot sure how the oxygen tank uld not recall who had told or how long it had been there					
	or when he had last it today because he seat of the van. He former van driver ab	seen it but he did not observe could not see over the back further stated he had asked a out it but was not sure what he could not recall the					
	Transportation Aide been transporting re transported resident usually transported mini-type van provid physician's appointmappointments and a						
	to use for resident tr she transported Res days a week at the s transported them in	ansports. She confirmed ident #38 and #9 to dialysis 3 same time and usually the small transportation van sport Resident #294 to a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345163	B. WING		0,	C 2/24/2018	
	ROVIDER OR SUPPLIER DGE HEALTH AND REI			STREET ADDRESS, CITY, STATE, ZIP COD 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		1/24/2018	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	transportation van. c. Resident #294 wa 02/04/18 with diagn walking, weakness, weakness and abnoreview of the admis 02/20/18 indicated intact for daily decise extensive assistance. During an observati TA #1 secured Resithe passenger compartansportation van abetween the wall of then opened the baan oxygen tank was cover behind the banot move the oxyge from the back of the door of the van. During an observati 02/22/18 at 4:27 PM transporting Reside the small transportatentrance of the facilishe did not know whoak cargo area of there or how long it stated she had never back of the van becusually transported resident's wheelchaask anyone about it training to drive and	as admitted to the facility on oses which included difficulty lack of coordination, muscle ormal gait and mobility. A sion (5 day) MDS dated Resident #294 was cognitively ion making but required e with transfers. On on 02/22/18 at 10:29 AM, dent #294's wheelchair inside partment of the small and there was no oxygen tank the van and a seat. TA #1 ck hatch door of the van and a lying on its side inside a blue ck seat of the van. TA #1 did in tank or attempt to remove it it van and closed the back On and follow up interview on 1, TA #1 was observed in #294 in a wheelchair from tion van parked at the front ity to her room. TA #1 stated by the oxygen tank was in the he van or who had placed it had been there. She further er used the oxygen tanks were in a rack on the back of the iir but she had not thought to she explained she received	F 69	95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345163	B. WING				C 24/2018
	ROVIDER OR SUPPLIER	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	vans. During an observation at 4:34 PM, the Main back hatch door of the and verified an oxyge compartment in the back seat. Upon furt tank was lying on its covered inside a blue a metal handle at the of the tank was lying cushions. Observation revealed the end of the with all purpose clear miscellaneous packate to the oxygen tank. To picked up the oxygen secured to any type of the van. He also whad a needle position square inch (psi) which contained oxygen. To stated the oxygen tanks to the oxygen tank to the oxygen tank of the van. To picked up the oxygen secured to any type of the van. He also whad a needle position square inch (psi) which contained oxygen. To stated the oxygen tank the oxygen tank the oxygen tank the to storage. He residents were transported in the wasto van drivers but als materials he provided transportation of oxygen tanks.	n and interview on 02/22/18 tenance Director opened the le small transportation van en tank was lying in the cargo lack of the van behind the her inspection, the oxygen side and was partially e cover and had a gauge with top of the tank and the top on top of several small black ons at the bottom of the tank he tank was next to a bucket ning supplies inside and ges of briefs were lying next the Maintenance Director of tank and verified it was not of rack or holder in the back terified the gauge on the tank hed at 1,000 pounds per ch indicated the tank the Maintenance Director of the was not supposed to be the van unsecured and he d left it there or how long it e would take it inside the	F	695			

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/:	24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	'E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	PM, the Maintenance expectation that van transport an unsecure van. He explained not the oxygen tank was transport van but he varieties to remove the they could get to the tank got there. During a telephone in PM, TA #2 confirmed more than 3 weeks a facility as a van drive she was aware oxyge be transported uprigh wheelchair in a tank is supposed to be trans back of the van howe taken an extra tank of the van howe taken an extra tank of the oxygen before they She stated when she usually stored in the litransportation van. Staid the oxygen tank of packages of supplies gloves and wipes aro was also a bucket of oxygen tank in case and they had to clear were also small cush they used to put in rethey were uncomfortation.	Director stated it was his drivers were not supposed to ed oxygen tank in a facility of one had reported to him in the back of the small would have expected van cylinder and report it so bottom of how the oxygen she left the facility a little go but had worked at the refor 2 years. She explained en tanks were supposed to it on the back of a holder and were not ported unsecured in the ver, she confirmed she had foxygen on long transports want the resident to run out of got to their appointment. Took an extra tank it was back cargo area of the small she explained she usually down on its side and placed such as briefs, boxes of und it. She confirmed there cleaning supplies next to the a resident had an accident inside the van and there ions around the oxygen tank sident's wheelchairs when able. She stated she did not old her to transport the	F	95			
	resident might run ou transport and she wa	t of oxygen on a long					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			1	C 24/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	2-7/2010	
GI ENBRII	DGE HEALTH AND REHA	ARII TATION CENTER		21	1 MILTON BROWN HEIRS ROAD			
GLLIADIKII	JOE HEALIN AND KEN	ADICIATION 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From page	e 30	F 6	395				
	further stated she cousaw an oxygen tank is transportation van but been told by the Mair not supposed to carry that was unsecured at to put the tank up inscame back with the when the Maintenance them. During an interview of Maintenance Director removed from the sm 02/22/18 was a large	ase she needed it. She ald not say when she last in the back of the small it recalled the drivers had intenance Director they were in an oxygen tank in the van and they were told they had ide the facility when they an but she did not recall be Director had talked with in 02/23/18 at 10:38 AM the recruited the oxygen tank he hall transportation van on Type E oxygen tank with						
		I pressure. He repeated he for oxygen or transport of ans.						
	DON stated she had almost 2 years but ha weeks as the acting I was aware the Mainteresponsible for transporters. She stated swas an oxygen tank is small transportation was her expectation is secured when transported in a meta wheelchair or they cover that was strappof the wheelchair.	on 02/23/18 at 3:45 PM, the worked at the facility for ad been assigned less than 3 DON. She explained she enance Director was portation and training of van the had no knowledge there can be further stated it for oxygen tanks to be corted to prevent the potential and oxygen tanks should be all rack on the back of a build be in a cloth transport and secured to the back on 02/24/18 at 9:18 AM, the						
	Activity Director state							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345163	B. WING			C)2/24/2018		
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		212-412010		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 695	approximately 15 ye aware oxygen tanks secured on the back but she had not see in the large multi-particle drove when she transported in a facility for activities. During an interview Administrator stated oxygen tanks should transported in a fact the training needed oxygen tanks in facility transported oxygen tanks in facility transported in a fact the training needed oxygen tanks in facility transport up van driver but or multi-passenger fact the facility transport explained if a reside usually had a cloth back of their wheeld tank was supposed The Administrator a informed of Immediation for imme	and had been a van driver for ears. She explained she was a were supposed to be a of a resident's wheelchair on an unsecured oxygen tank assenger van she occasionally asported residents out of the on 02/23/18 at 8:52 AM, the at the was her expectation that do be secured if they were allity van. She further stated to include how to transport allity vans. On 02/24/18 at 11:34 AM, a confirmed she was a backally drove the larger allity van if TA #1 was out of ing another resident. She eat required oxygen they bag or a metal rack on the chair and that was where the to be stored. Ind Director of Nursing were ate Jeopardy on 02/23/28 at an acceptable credible diate jeopardy removal on	F 69	95				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			C 02/24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	ODE	02/24/2010
(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	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 695	oxygen tank in the faduring a recent trans 22, 2018 at approxim requested to speak to wanted to see her see upon request to look Aide (TA) #1 opened van and surveyor obta a blue cover laying of the facility of the facility transported to be unseein the transport vantention. He then play room in oxygen holder revealed facility transported facil	cility's transport van #1 port in this van. On February lately 10:00 am Surveyor of transport aid stated she cure a resident in the van, in the van Transportation the back-hatch door of the served an oxygen tank inside in its side. 8 at 4:34 PM Transportation the facility with the resident in transport Van #1. ransport van at this time oxygen was still laying on its the van's rear interior storage area. The oxygen tank was cured and improperly stored The facility's Maintenance removed the oxygen tank in when it was brought to his aced it in the dirty supply er. Additionally, it was sport staff were not in how to properly transport transport van. The training orters includes a packet of cower point handout that orientation, and a final in facility transport staff and ector revealed staff were not if the facility's transport van's ensure the van was safe	F	595		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345163	B. WING			C 02/24/2018	
	ROVIDER OR SUPPLIER	HABILTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	'	0212-42010	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	hazards including; storage. On 02/23/2 provided training to how to fill out the cl van for safety prior training included the assessment and fin report these issues Administrator and to On 02/23/18 the fact maintenance direct new audit titled Skil facility's vans for satransporting resider	ot directs staff to observe for observing for improper oxygen 18 the Clinical Risk Manager the maintenance director on neck off sheet and assess the to resident transports. This at when staff conduct the van and any concerns they are to immediately to the he Maintenance Director. Cility's Administrator trained the or on how to implement the I Check list, to assess the affety issues prior to nots, on how oxygen should be the van and how to report any	F 69	95			
	On 02/23/18 Transport on 02/23/18 Transport of transport	portation aide #1 was in intenance Director on how to gen in van if needed for a Any identified issues must be sly to the administrator and/or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345163	B. WING			1	C 24/2018
	OVIDER OR SUPPLIER	ABILTATION CENTER	1	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 .SC 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 700 SS=D	nursing staff, transpomaintenance staff. The to use the check off stransport safety issue concerns immediately maintenance director. The facility's administimplementing the facility when interviews with and nursing staff valid in-service training on tanks in facility owned interviews with Maintenance director. Immediate Jeopardy when interviews with and nursing staff valid in-service training on tanks in facility owned interviews with Maintenance directors with Maintenance directors. Bedrails CFR(s): 483.25(n)(1)- §483.25(n) Bed Rails The facility must atternatives prior to in a bed or side rail is us correct installation, us rails, including but no elements. §483.25(n)(1) Assessentrapment from bed §483.25(n)(2) Review bed rails with the resi	n program for all newly hired relation aides and his training will include how heet to identify possible van is and the need to report in the administrator and/or it trator is responsible for lity's Credible Allegation of was removed on 02/24/18 van transportation drivers dated they had received transportation of oxygen dot transportation vans. An enance Director revealed he service training regarding gen tanks in facility owned for the facility must ensure see, and maintenance of bed to the resident for risk of the resident for risk of trails prior to installation.		700			3/19/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING _		02/2	4/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/2-	772010
GLENBRII	DGE HEALTH AND REHA	ABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 700	F 700 Continued From page 35		F 7	00		
	to installation.					
		e that the bed's dimensions e resident's size and weight.				
	and maintaining bed	d specifications for installing				
	by: Based on observations, resident and staff interviews and record review, the facility failed to			F700		
		a side rails for a resident who		What measures did the facility put	t in place	
		ils to both sides of his bed. n 1 of 1 residents (Resident		for the resident affected: Resident #92 was admitted on 01	/17/18	
		ed for side rail usage.		no side rail assessment was com		
	,	3		on admission. on 02/22/18 Reside		
	Findings Included:			observed in bed with half side rail upright position, Resident #92 did	-	
		mitted to the facility on		have a side rail assessment comp		
		es that included: muscle communication deficit,		point click care. On 02/27/18 side assessment was completed for re		
		/ walking, hemiplegia and		#92.	sident	
		others. Review of Resident		#32.		
		mum Data Set (MDS) dated		What measures were put in place	for	
		dent to be mildly cognitively		residents having the potential to b		
	impaired. Resident #	92 was also coded as not		affected:		
	utilizing side rails at t	he time of MDS completion.		03/13/18 Admin Nurses complete audit on all residents to ensure the		
		#92's care plan on 2/22/18		a side rail assessment.		
	revealed no care plar	n area for side rail use.				
	<u> </u>	#00L P L L		What systems were put in place to		
		#92's medical chart revealed		prevent the deficient practice from	ו	
	no current side rall as	ssessment for the resident.		reoccurring: On 03/01/18 Don initiated an in-se	erviced	
	An observation of res	sident on 2/22/18 at 1:37 PM		for all licensed Nurses on complete		
	revealed him to be in	his room, in bed and		Rail Assessments on all new adm	-	
	_	hile visiting with his spouse. is time that Resident #94		in-service completed by 03/16/18.	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345163	B. WING			C 02/24/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		12/24/2010	
GLENBRIDGE HEALTH AND REHABILTATION CENTER			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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 700	Continued From page	e 36	F 7	00			
	had half side rails on Further observations 2/21/18 at 9:47 AM recontinue to be in the Resident #94 was in During an interview v 2/22/18 at 2:53 PM, sknowledge, Resident rails on his bed while During an interview v at 3:19 PM, she reporecent admission to the She further stated that responsible to do sid residents upon admissionable to do sid residents upon admissionable facility. When asked #92's assessment up she stated "I don't see During an interview v on 2/23/18 at 12:03 Fiside rail assessment admission. During a side rail assessment admitted or readmitted reported it was her exassessments were to resident's entry into the second of t	both sides of his bed. on 2/20/18 at 3:41 PM and evealed the half side rails to upright position while bed. with Nurse Aide #3 on she reported to her #92 had always had side a resident at the facility. with Hall Nurse #1 on 2/23/18 rted Resident #92's most he facility was on 1/17/18. at hall nurses were e rail assessments on asion or readmission into the if she could locate Resident ion his reentry into the facility e it it's not in here". with the Director of Nursing PM she verified there was no for Resident #92. 1/17/18 follow up interview with the n 2/23/28 at 3:41 PM she assessment should have Resident #92. She verified responsible for completing s on residents when they are ed to the facility. She further ed to the facility. She further ed to the facility. She further ed to the facility.		How the facility will monitor syplace: Beginning 02/26/18 the DON, will audit side rail assessment accuracy using side rail audit audit will be completed weekly on all new admissions and the 3 months on all new admission. The DON and/or ADON will prindings to the monthly QI commonthly QI commonthly QI committee will reversults of accuracy Audit Tool 3 months for identification of the administrator and/or DON will findings and recommendation monthly QI committee to the executive QA committee for furecommendations and oversign Administrator is responsible for Care.	or designee ts to ensure tool. This y x 5 weeks en monthly x ons. resent mmittee. The iew the monthly for rrends. The present the so of the quarterly urther ght. Facility		
	3:52 PM revealed sh	Administrator on 2/23/18 at e expected the hall nurses to of residents upon their cility but that the					

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 _			l	C 24/2018
	ROVIDER OR SUPPLIER	ABILTATION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 11 MILTON BROWN HEIRS ROAD OONE, NC 28607	, <u>v=</u> ,	- 112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	ensure the completion further stated it was had "assessments were to manner".	should have followed up to n of all assessments. She her expectation that to be completed in a timely		700			
F 761 SS=D	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the capplicable. §483.45(h) Storage of §483.45(h)(1) In accordance Federal laws, the faci biologicals in locked of temperature controls, personnel to have accessor instructions with the faci biologicals in locked of temperature controls, personnel to have accessor instructions with the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in locked of temperature controls, personnel to have accessor in the faci biologicals in th	of Drugs and Biologicals aused in the facility must be with currently accepted as, and include the yand cautionary expiration date when If Drugs and Biologicals ardance with State and lity must store all drugs and compartments under proper and permit only authorized	F	761			3/19/18
		n, record review, and staff failed to discard 1of 1 vaccine vial that was			F761 What measures did the facility put in pla	ace	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345163	B. WING			C 02/24/2018
NAME OF PROVIDER OR SUPPLIER GLENBRIDGE HEALTH AND REHABILTATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		02/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIA	DATE
F 761	Continued From page opened and undated 1 of 2 medication reference in Findings included: A review of the man for multi-dose tuberd once opened the proafter 30 days. A review of the facility Medications (revised facility shall not use drugs or biologicals, returned to the dispedestroyed. On 02/21/18 at 9:08 tuberculin purified processed facility shall not use drugs or biologicals, returned to the dispedestroyed. On 02/21/18 at 9:08 tuberculin purified processed facility purified the tuberculin undated and remain refrigerator ready for stated the facility povial when opened. Note the facility povial when opened. Note the facility povial when opened then it could tuberculin vaccine with the facility povial when opened then it could tuberculin vaccine with the facility povial when opened then it could tuberculin vaccine with the facility povial when opened then it could tuberculin vaccine with the facility povial when opened then it could tuberculin vaccine with the facility povial when opened then it could tuberculin vaccine with the facility povial when opened then it could tuberculin vaccine with the facility povial when opened then it could tuberculin vaccine with the facility povial was observed to the facility povial when opened then it could tuberculin vaccine with the facility povial was observed to the facility povial when opened then it could tuberculin vaccine with the facility povial was observed to	ge 38 If and was available for use in frigerators. Dufacturer's recommendation culin vaccine indicated that oduct was to be discarded Ity policy entitled Storage of the outdated or deteriorated the outdated or deteriorated All such drugs were to be ensing pharmacy or AM 1of 1 multi-dose vial of rotein derivative with lot # nufacturer's expiration date of erved opened and undated in dication refrigerator. Nurse #2 in vaccine was opened and	F 7	DEFICI	: room refrigerat tuberculin that ad no open date e vial was ith no negative ut in place for tential to be ed 100% audit of e all medication 2/21/18 100% i DON on propervice will be in place to actice from ced on 02/26/18 on proper labelin leted by 03/16/2 itor systems pund Admin Nursems and med cast will be r 3 weeks then	tor e 8 ng 18. ut in e arts
	On 02/21/18 at 9:18 conducted with the I who verified that the multi-dose vial was use in the 300-400 h	AM an interview was Director of Nursing (DON) tuberculin vaccine opened and ready for resident nall medication refrigerator. tuberculin vaccine should		months. The monthly QI committ results of the audit tool r months for identification taken, and to determine and/or frequency of con and make recommendal monitoring for continued	tee will review the monthly for 3 of trends, action the need for tinued monitoring tions for	ons ng

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE : COMPI	
		345163	B. WING _			02/3	24/2018
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 02/1	24/2010
(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 ADEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 865 SS=D	policy. The DON state manufacturer's instru once opened. The DO tuberculin vaccine was could not be determine expire. The DON state system in place to chin the medication refrom the medication refrom the medication refrom the medication was that located with the Adexpectation was that located in the 300-40 would have been date manufacturer's recompolicy. The Administrativaccine was good for because it was not dedetermined when the QAPI Prgm/Plan, Dis CFR(s): 483.75(a)(2) §483.75(a) Quality as improvement (QAPI) §483.75(a)(2) Present Survey Agency no late promulgation of this results of the Secretary of the Secretary of the recomposition of the recomposition of the secretary of the recomposition of the secretary of the secretary of the recomposition of the secretary of the secretary of the secretary of the recomposition of the recomposition of the secretary of t	en opened as per facility ed the tuberculin vaccine per ctions was good for 30 days DN stated because the is not dated when opened it ned when the vaccine would ed she did not have a eck for out dated medication igerator. AM an interview was dministrator who stated her the tuberculin vaccine 0 hall medication refrigerator ed when opened per mendation and facility ator stated the tuberculin 30 days once opened but ated it could not be vaccine would expire. closure/Good Faith Attmpt (h)(i) ssurance and performance program. It its QAPI plan to the State er than 1 year after the egulation; e of information. ery may not require ords of such committee ch disclosure is related to ch committee with the section.	F 7	administrator and/or DON will findings and recommendations monthly QI committee to the quexecutive QA committee for fur recommendations and oversig Administrator is responsible for implementing plan of correction	of the uarterly rther ht. Facilit	ty	3/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345163	B. WING		C 02/24/2018	
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/24/2010	
GLENBRIDGE HEALTH AND REHABILTATION CENTER				211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
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F 865	Continued From pag	e 40	F 86	65		
	Good faith attempts I and correct quality do a basis for sanctions. This REQUIREMENT by: Based on record reversal facilities Quality Asset Committee failed to reprocedures and monthe committee put intrecertification survey two recited deficience cited in February 2017 recited on the curren 02/24/18. The repeatareas of accuracy of respiratory care. The facility during two feed a pattern of the facilitie effective Quality Asset Findings included: This tag is cross referenced to accurately continuous and statement of the facilitied to accurately continuous and Residual determination for 1 or identified as a PASR reviewed for Hospice During the recertificat 2017 the facility was	by the committee to identify eficiencies will not be used as an action of the session of the ses		F-865 On 2/27/18 the facility Executive QI Committee held a meeting. Adminis DON, MDS Nurse, Treatment nurse, facilitator, Maintenance Director, and Housekeeping Supervisor will attend Committee Meetings on an ongoing and will assign additional team mem as appropriate. On 2/27/18 the facility consultant in-serviced the facility administrator. Facility administrator in-serviced dire of nursing, MDS nurse, treatment nu maintenance director, dietary manag and housekeeping supervisor related the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing approp plans of action for identified facility concerns. As of 2/27/18, after the facility consu in-service, the facility QI Committee to begin identifying other areas of quali concern through the QI review proce for example: review rounds tools, rev of Point Click Care (Electronic Medic Record), resident council minutes,	Staff I QI basis bers cctor rse, ier, d to criate Itant will ty ss, view	
	assess residents' de	ntal status on the Minimum essment for 3 of 22 residents				

A. BUILDING	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	124/2010	
GLENBRIDGE HEALTH AND REHABILTATION CENTER 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
b. F695 Respiratory Care: Based on observations, record reviews and resident and staff interviews the facility failed to provide and assure safe handling of oxygen in a facility transportation van used for resident transports when an oxygen tank was observed stored on its side and unsecured in the back of a transportation van with the potential for injury for 3 of 3 sampled residents transported in the van (Resident #38, #9 and #294). During the recertification and complaint survey of February 3, 2017 the facility was cited for failure to administer oxygen at the physician ordered liters per minute for 1 of 6 residents reviewed for oxygen therapy (Resident #141). During an interview on 02/24/18 at 5:08 PM, the Administrator explained the facility conducted monthly Quality Assessment and Assurance meetings and the Administrator, Director of Nursing, Medical Director and various department managers attended the meetings. She further explained the Pharmacist attended the meetings quarterly. She stated the Quality Assessment and Assurance Committee had discussed the deficiencies and the plan of correction after the last annual recertification survey. She explained they had also reviewed the past deficiencies in preparation for the current recertification survey. She stated it was her expectation for the facility to not have repeat deficiencies. F 880 Infection Prevention & Control The facility must establish and maintain an	3/19/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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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	02/2	.4/2010
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F 880	infection prevention a designed to provide a comfortable environmed evelopment and transition of the facility must estate and control program. The facility must estate and control program a minimum, the follow \$483.80(a)(1) A system of the facility must estate and communicable distaff, volunteers, visite providing services unarrangement based unconducted according accepted national state \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveit possible communicate infections before they persons in the facility (ii) When and to whom communicable disease reported; (iii) Standard and transit to be followed to prevent of the procedures of the procedures in the facility (iii) When and to whom communicable disease reported; (iiii) Standard and transit to be followed to prevent of the procedures including but (A) The type and durated to the province of the procedures of t	and control program a safe, sanitary and bent and to help prevent the asmission of communicable ans. brevention and control blish an infection prevention (IPCP) that must include, at ving elements: am for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals der a contractual apon the facility assessment to §483.70(e) and following andards; a standards, policies, and bogram, which must include, blance designed to identify ble diseases or a can spread to other a m possible incidents of a e or infections should be assmission-based precautions a tent spread of infections; blation should be used for a t not limited to:	F 88			

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER	343103			TREET ADDRESS, CITY, STATE, ZIP CODE	02/2	24/2018
GLENBRIDGE HEALTH AND REHA	ABILTATION CENTER		21	11 MILTON BROWN HEIRS ROAD OONE, NC 28607		
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least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected sicontact with residents contact will transmit to (vi)The hand hygiened by staff involved in disease of infection disease or infected sicontact will transmit to (vi)The hand hygiened by staff involved in disease of involved involv	at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct or their food, if direct he disease; and a procedures to be followed rect resident contact. The for recording incidents acility's IPCP and the sen by the facility. The store, process, and to prevent the spread of the irregram, as necessary. This not met as evidenced the sen of t	F	380	F880 What measures did the facility put in pl for the resident affected: on 2/21/18 Nurse #1 was observed not following the manufacturers instruction on cleaning glucometer. on 02/21/18 Administrator / DON initiated In-service proper cleaning of glucometer. What measures were put in place for residents having the potential to be	s S	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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HEALTH AND REHA	ABILTATION CENTER					
D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
eview of the manu	facturer's package	F 8	880	affected: 02/21/18 100% in service was initiated	by	
posable Wipe indicated and the surfle wiped and left the wiped and left the wipe (s) if reductional wipe (s) if reduction of wet contacts to remain visibly	cated the wipe was to be ace of the glucometer was noroughly wet. Use needed to assure continuous act time. The treated surface			DON on proper cleaning of glucometer	s.	
PM Nurse #1 was on Resident #6 d supplies in the tated on the medication as shed her hands cometer from the incometer from the	as observed obtaining a 67. Nurse #1 disposed of the rash and sharps container ation cart and laid the the medication cart. Nurse 6 and removed another medication cart and			Nurses on proper cleaning of glucomet it will be completed by 03/16/18. On 2/21/18 Don and Admin Nurses began auditing Glucometer cleaning using autool named Glucometer Audit.	dit	
as on Resident #8 d supplies in the to detend on the medical cometer that was the medication car a used for Resider wes and removed micidal disposable and opened the pes, and back of the Resident #51 for a laid the glucome cometer that was the cometer that was the wiped the front, se cometer for approximate	51. Nurse #1 disposed of the rash and sharps container ation cart. She laid the used on Resident #51 on top to next to the glucometer that at #67. Nurse #1 donned an individual packet of a wipe from the medication backage and wiped the front, as glucometer that was used approximately 30 seconds are on top of the medication liately picked up the used to obtain a FSBS on and the same germicidal wipe sides, and back of the kimately 30 seconds and laid			began auditing glucometer cleaning. Using Audit tool named Glucometer au will be completed 5x a week for 3 week then weekly x 3 weeks then monthly x months. The monthly QI committee will review the results of the audit tool mon for 3 months for identification of trends actions taken, and to determine the new for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further	dit. ks 3 thly ed s e. sent	
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Attinued From page 44 Eview of the manufacturer's package ructions entitled Sani-Cloth Bleach Germicidal posable Wipe indicated the wipe was to be olded and the surface of the glucometer was a wiped and left thoroughly wet. Use itional wipe (s) if needed to assure continuous inute of wet contact time. The treated surface is to remain visibly wet for a full 4 minutes and	RECTION IDENTIFICATION NUMBER: 345163 B. WING REALTH AND REHABILTATION CENTER SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Attinued From page 44 Price wife of the manufacturer's package ructions entitled Sani-Cloth Bleach Germicidal posable Wipe indicated the wipe was to be olded and the surface of the glucometer was e wiped and left thoroughly wet. Use ittional wipe (s) if needed to assure continuous inute of wet contact time. The treated surface is to remain visibly wet for a full 4 minutes and wed to air dry. Ing a continuous observation on 02/21/18 at 9 PM Nurse #1 was observed obtaining a 38 on Resident #67. Nurse #1 disposed of the disupplies in the trash and sharps container sted on the medication cart and laid the exameter from the medication cart and lairered supplies and was observed obtaining a 38 on Resident #51. Nurse #1 disposed of the disupplies in the trash and sharps container sted on the medication cart. She laid the exameter from the medication cart and lairered supplies and was observed obtaining a 38 on Resident #51. Nurse #1 disposed of the disupplies in the trash and sharps container sted on the medication cart. She laid the exameter from the medication cart and lairered supplies and was observed obtaining a 38 on Resident #51. Nurse #1 disposed of the disupplies in the trash and sharps container sted on the medication cart and lairered supplies and was observed obtaining a 38 on Resident #51. Nurse #1 disposed of the disupplies in the trash and sharps container sted on the medication cart and lairered supplies and was observed obtaining a 38 on Resident #51 no representation cart and lairered supplies in the trash and sharps container sted on the medication cart and lairered supplies in the trash and sharps container sted on the medication cart and lairered supplies in the trash and sharps container sted on the medication cart and lairered supplies in the trash and sharps container sted on the medication c	RECTION Satisfa B. WING B. WING	### A BUILDING 345163 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE	A BUILDING 345163 BE ONE SUPPLER HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION WIST BE PRECIDED BY THILL REGULATORY OR LSC IDENTIFYING INFORMATION) Titinued From page 44 Intitude From p

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
	345163	B. WING		0.2	C 2/ 24/2018		
NAME OF PROVIDER OR SUPPLIER GLENBRIDGE HEALTH AND REHABILTATION CENTER			211 MILTON BROWN HEIRS ROAD		02/24/2018		
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restroom that was I and used the paper observed wetness I Nurse #1 discarded towels, and gloves medication cart and obtain a FSBS on F gathered supplies a glucometers form the and carried the glucometer #30 that is FSBS. Nurse #1 was prior to obtaining a On 02/21/18 at 4:38 conducted with Nurunsure of the exact glucometer. Nurse germicidal wipe the medication cart to of #1 obtained a germ medication cart and instructions for use wipe was required to continuous wet con and allowed to air of anot provided continuint time to each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surfaces of each glucometer to had briefly wiped easame germicidal will surface will be a surface will be	ocated by the medication cart towels to wipe off the located on each glucometer. If the germicidal wipe, paper in the trash receptacle on the Id indicated she was ready to Resident #30. Nurse #1 and picked up one of the line top of the medication cart cometer and supplies into line. Nurse #1 informed lishe was ready to obtain a las stopped by the observer FSBS on Resident #30 In PM an interview was lishe was ready to obtain a las stopped by the observer FSBS on Resident #30 In PM an interview was lishe was located on the lishinfect the glucometer. Nurse lishinfect the glucometer. Nurse lishinfect the glucometer. Nurse lishinfect the germicidal lish have 4 minutes of wet contact lish have 4 minutes of wet c	F 880					
instructions for use wipe was required to continuous wet contant and allowed to air of not provided continuime to each glucomeach glucometer to had briefly wiped essame germicidal wis surfaces of each glucometer and obtain individual germicidal glucometer and obtains wipe was required to the same germicidal wis surfaces of each glucometer and obtains with the same germicidal glucometer and obtains with the same germicidal glucometer and obtains with the same same germicidal glucometer and obtains with the same same germicidal glucometer and obtains with the same same same same same same same sam	and verified the germicidal to have 4 minutes of tact time with the glucometer dry. Nurse #1 stated she had uous 4 minutes of wet contact meter and had not allowed air dry. Nurse #1 stated she ach glucometer using the pe and then wiped the ucometer with a paper towel. e should have used an all wipe to disinfect one rained another germicidal wipe						
	OVIDER OR SUPPLIER SUMMARY (EACH DEFICIET REGULATORY OF The Supplies of The Paper observed wetness in Nurse #1 discarded towels, and gloves medication cart and obtain a FSBS on Figathered supplies a glucometers form the and carried the glucometers form the and carried the glucometers form the supplies and carried the glucometers form the supplies and carried the glucometer #30 that is FSBS. Nurse #1 was prior to obtaining a On 02/21/18 at 4:38 conducted with Nurunsure of the exact glucometer. Nurse germicidal wipe that medication cart to of #1 obtained a germ medication cart and instructions for use wipe was required to continuous wet continu	OVIDER OR SUPPLIER	OVIDER OR SUPPLIER GE HEALTH AND REHABILTATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 restroom that was located by the medication cart and used the paper towels to wipe off the observed wetness located on each glucometer. Nurse #1 discarded the germicidal wipe, paper towels, and gloves in the trash receptacle on the medication cart and indicated she was ready to obtain a FSBS on Resident #30. Nurse #1 gathered supplies and picked up one of the glucometers form the top of the medication cart and carried the glucometer and supplies into Resident #30's room. Nurse #1 informed Resident #30's room. Nurse #1 informed Resident #30's room. Nurse #1 informed Resident #30's room state the glucometer and supplies into Resident #30 that she was ready to obtain a FSBS. Nurse #1 who stated she was unsure of the exact process to disinfect the glucometer. Nurse #1 stated she used the germicidal wipe that was located on the medication cart and read the manufacturer's instructions for use and verified the germicidal wipe that was located on the medication cart and read the manufacturer's instructions for use and verified the germicidal wipe was required to have 4 minutes of continuous wet contact time with the glucometer and allowed to air dy. Nurse #1 stated she had not provided continuous 4 minutes of wet contact time to each glucometer and had not allowed each glucometer and had not allowed each glucometer and had not allowed each glucometer to air dry. Nurse #1 stated she had not provided continuous 4 minutes of wet contact time to each glucometer with a paper towel. Nurse #1 stated she should have used an individual germicidal wipe to disinfect one glucometer and obtained another germicidal wipe	OVIDER OR SUPPLIER 345163 STREET ADDRESS, CITY, STATE, ZIP COD 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 45 restroom that was located by the medication cart and used the paper towels to wipe off the observed wethers located on each glucometer. Nurse #1 discarded the germicidal wipe, paper towels, and gloves in the trash receptacle on the medication cart and raried the glucometer and supplies and picked up one of the glucometers from the top of the medication cart and carried the glucometer and supplies into Resident #30. Nurse #1 informed Resident #305 room. Nurse #1 who stated she was ready to obtain a FSBS. Nurse #1 who stated she was renormed Resident #305 room. Nurse #1 who stated she was conducted with Nurse #1 who stated she was conducted with Nurse #1 stated she used the germicidal wipe that was located on the medication cart and read the manufacturer's instructions for use and verified the germicidal wipe was required to have 4 minutes of the medication cart and read the manufacturer's instructions for use and verified the germicidal wipe was required to have 4 minutes of ocntinuous wet contact time to each glucometer and had not allowed each glucometer to air dry. Nurse #1 stated she had not provided continuous 4 minutes of wet contact time to each glucometer with a paper towel. Nurse #1 stated she had not provided continuous 4 minutes of wet contact time to each glucometer with a paper towel. Nurse #1 stated she had not provided continuous 4 minutes of wet contact time to each glucometer with a paper towel. Nurse #1 stated she had not allowed each glucometer with a paper towel. Nurse #1 stated she should have used an individual germicidal wipe to disinfect one glucometer and obtained another germicidal wipe	OWIDER OR SUPPLIER GE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCES REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 F 880 F 880		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345163	B. WING		C		
NAME OF PROVIDER OR SUPPLIER GLENBRIDGE HEALTH AND REHABILTATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	02/24/2018		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 880	have wiped each glucor wet for 4 minutes. Nu have read the manufidisinfecting the glucor. On 02/21/2018 at 4:30 conducted with the Ustated Nurse #1 had disinfect the glucome her expectation that I followed the facility precommendations lost to disinfect the glucor. On 02/21/18 at 4:50 conducted with the A expectation was that disinfected the glucor manufacturer's recon Administrator stated on cleaning and disinfected with the D who stated it was her would have disinfected the policy and manufactured the DON stated it was her Nurse #1 obtained the	cometer with a paper towel neter was required to remain arse #1 stated she should acturer's instructions prior to meters. 19 PM an interview was nit Manager (UM) who been in-serviced on how to ster. The UM stated it was Nurse #1 would have olicy and the manufacture's cated on the germicidal wipe meter. PM an interview was dministrator who stated her Nurse #1 would have meter per facility policy and mendations. The Nurse #1 had been trained affecting the glucometer. PM an interview was irrector of Nursing (DON) are expectation that Nurse #1 and the glucometer per facility arer's recommendations. The expectation that after the FSBS on Resident #67 are immediately disinfected the	F 880				