STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted on 04/01/25 through 04/02/25. Additional information was obtained offsite on 04/03/25, 04/04/25, and 04/16/25. Therefore, the exit date was changed to 04/16/25. Event ID #YOG211. The following intake was investigated NC00228025. 3 of 3 allegations did not result in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		5/2/25

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

Electronically Signed | 04/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner and staff interviews, the facility failed to notify the provider when five daily doses of Metoprolol Succinate ER (medication to treat heart failure) and Quetiapine Fumarate (an antipsychotic medication that helps regulate mood behaviors and thoughts) was not administered for 1 of 1 resident reviewed for notification (Resident #36). The findings included: Review of the hospital discharge summary dated 3/20/2025 revealed orders for Metoprolol Succinate 25 milligrams 24 hr tablet. Take 0.5 tablets (12.5 milligram total) by mouth nightly, and Quetiapine 25 milligram tablet. Take 1 tablet	F 580	Glenbridge Health and Rehabilitation Center acknowledges the receipt of the statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Glenbridge Health and Rehabilitation Centers response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 (25mg total) by mouth nightly. Resident #36 was admitted to the facility on 3/21/2025 with diagnoses that included chronic systolic (congestive) heart failure, type 2 diabetes mellitus with diabetic peripheral angiopathy (the presence of diabetes which involves damage to the blood vessels particularly to the extremities), hypertensive heart disease with heart failure, unspecified dementia with agitation. A physician order dated 3/25/2025 read Metoprolol Succinate ER tablet Extended Release 24 hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime HOLD if heart rate less than 60 beats per minute. Review of Resident #36's medication administration record (MAR) dated March 2025 revealed the following: a. Documented by Nurse #1 that on 3/21/2025 Resident #36 did not receive the metoprolol due to the medication not being available. b. Documented by Nurse #2 that on 3/22/2025, 3/23/2025, 3/24/2025, Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available. Nurse #2 documented on 3/27/2025 Resident #36 did not receive Quetiapine Fumarate due to medication not being available. c. Documented by Nurse #3 that on 3/25/2025 Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available. There were no nursing progress notes that indicated the provider had been notified that Resident #36 had not received the doses of	F 580	Glenbridge Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Address how corrective action will be accomplished for those residents found to have been affected: The facility failed to notify a provider timely when a resident missed five doses of metoprolol succinate ER and Quetiapine Fumarate from when resident was admitted on 3/21/25 to when the medication arrived 5 days later. NP was notified the morning of 3/24/2025. Resident was assessed by NP 3/24/2025 with no noted concerns. Medication was reordered and delivered to the facility on 3/26/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility DON completed an audit on 4/7/2025 of all admissions for the past two weeks, to ensure all residents received medications and all orders are confirmed. No other residents were identified as missing their medication, and all orders were current and confirmed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Facility Staff Development Nurse initiated education with all nurses and medication aids on 4/7/25 on the facility guidelines on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 Metoprolol Succinate ER on 3/21/2025, 3/22/2025, 3/23/2025, 3/24/2025 and 3/25/2025, or the doses of Quetiapine Fumarate on 3/22,2025, 3/23/2025, 3/24/2025, 3/25/2025 and 3/27/2025. Nurse #1 was interviewed by phone on 4/2/2025 at 4:27pm. Nurse #1 stated when he worked on 3/21/2025 it was his first and only shift that he worked at the facility. Nurse #1 stated Resident #36 was admitted late in the evening of 3/21/2025 and some of the medications had not arrived from pharmacy in time for the 9:00pm med pass, but arrived in the midnight delivery. Nurse #1 stated he reported to the oncoming shift that not all of Resident #36's medications had arrived from pharmacy. Nurse #1 stated he did not notify a provider regarding the missing medication because the resident had just been admitted. Nurse #3 was interviewed on 4/2/2025 at 6:00pm. Nurse # 3, an agency nurse, stated she was not normally assigned to Resident #36's hall. Nurse #3 stated if a resident did not have a medication that was ordered she would verify the medication had been reordered, indicate on the MAR the medication was not available, add a note in the MAR, and notify the unit manager. Nurse #3 stated that was the only night she had worked with Resident #36 and was unaware the night she worked was the fifth night Resident #36 had not received metoprolol succinate and fourth night Resident #36 did not receive quetiapine fumarate. Nurse #3 stated she normally notified the provider after the first missed dose of medication. Nurse #3 stated if she did not document she had notified the provider, she probably did not notify the provider. Nurse #3 stated she should have notified the provider about the missed	F 580	missing medications and notification of a provider. All new nurses and medication aides will be educated upon hire during the orientation process. No nurses or medication aides will be allowed to work after 5/1/2025, until they have been educated by the Staff Development Coor or designee on the facility guidelines on missing medications and notification of a provider On 4/25/25 the Asst Director of Nursing was educated by the Director of Nursing on daily monitoring (Monday through Friday) of the 24/72-hour report to ensure all medications that are labeled as unavailable have a documented progress note ensuring a provider was aware and that pharmacy was called with date of arrival. These findings will also be included in the QA process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: All new admissions are being audited by the Director of Nursing or designee, to ensure that all orders are signed and confirmed, and medication has arrived two times a week for 4 weeks then monthly for 2 months.. The Director of Nursing or designee will present to QA committee the results of Audit Tools, identification of trends, actions taken, and determine the need for and/or frequency of continued monitoring for continued compliance for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 medications. Nurse #2 was interviewed by phone on 4/2/2025 at 7:53pm. Nurse #2 verified she had worked with Resident #36 on 3/22/2025, 3/23/2025, and 3/24/2025, and 3/27/2025. Nurse #2 stated she did not notify the provider of the missed doses of metoprolol succinate and quetiapine fumarate because it was the weekend and the on-call providers would say it was a pharmacy issue regarding delivery, not an issue that required a new order or monitoring. During a telephone interview on 4/3/2025 at 10:06am, the Nurse Practitioner (NP) stated he had been notified on the morning of 3/24/2025 through a text chain application on his phone, that Resident #36 had missed doses of two medications over the weekend. The NP stated he was not notified of further missed doses of metoprolol succinate on 3/24/2025 and 3/25/2025, and quetiapine fumarate on 3/24/2025, 3/25/2025, and 3/27/2025. The NP stated the on-call providers on the weekend could have been notified that Resident #36 missed doses of scheduled medications. During an interview on 4/2/2025 at 5:30pm the Director of Nursing (DON) stated she would expect nurses to notify the provider of missed doses of metoprolol succinate and quetiapine fumarate. During an interview on 4/4/2025 at 12:40pm the Administrator stated she would expect the provider to be notified when a nurse became aware a dose of medication was missed.	F 580		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		5/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 5 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours for 6 of 53 days reviewed for staffing (2/15/2025, 3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025). Findings included: On 4/1/2025 the Daily Posted Staffing sheet was observed in the front lobby of the facility, it was dated 3/30/2025 and indicated no Registered Nurse (RN) hours for 7am -7pm and 7pm-7a shift. Review of the daily schedule book revealed a calendar from March 2025 labeled RN coverage, which indicated on 2/15/2025, 3/1/2025, 3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025 there was RN coverage.	F 727	Address how corrective action will be accomplished for those residents found to have been affected: The facility failed to ensure a Registered Nurse was present for 8 hours in the building daily for 7 days a week. 6 out of 53 days reviewed did not have a RN in the facility for a consecutive 8 hours. No residents were identified as being directly affected by this practice. A new full time RN was hired on 3/26/2025 that will work every other weekend. With this hire each weekend will have a full time RN for 12 hours a day. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility has identified all Residents admitted to the facility as having the potential to be affected by the same	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 6 Review of daily staffing sheets and posted daily staffing records indicated on 2/15/2025, 3/1/2025,3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025 there were no RNs listed on the daily staffing sheets, and no RN hours listed on the posted daily staffing sheets. On 4/2/25 at 3:30pm an interview with the Director of Nursing (DON) stated she was aware there should be 8 consecutive hours of RN coverage daily. The DON stated they had RN coverage and would provide a timecard for the days with missing coverage. The DON provided a timecard that supported on 3/1/2025 there was RN coverage for at least 8 consecutive hours in the facility. There were no additional timecards provided for 2/15/2025, 3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025 On 4/3/2025 at 12:55pm during a phone interview the current scheduler stated she was aware of the need to have RN coverage on the schedule but was unaware until 4/3/2025 that the coverage had to be for at least 8 consecutive hours. The current scheduler stated she had told the DON previously, when there was no RN coverage, that the DON needed to make rounds. The current scheduler stated that having an RN scheduled for 8 consecutive hours on every other weekend had been difficult since they had only one RN on staff that worked every other weekend, but recently hired a new RN who would be scheduled on the weekend that did not have RN coverage. The current scheduler stated the DON helped her with the schedule and was aware of the days without RN coverage.	F 727	deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing educated all administrative staff and the facility scheduler 4/7/2025 on the importance of monitoring 8 consecutive hours of RN coverage in the building daily. If an RN calls in the DON will be notified immediately to make additional arrangements to ensure RN coverage for the building. Education was completed by 5/1/2025. New administrative staff or scheduler will be educated to ensure RN coverage daily, if an RN calls in the DON will be notified immediately to make additional arrangements to ensure RN coverage for the building. Education will be provided on hire in orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A weekly audit on Monday of the future week's nursing schedule will be reviewed to ensure RN coverage by the facility scheduler for weekly for 12 weeks. The Director of Nursing or designee will present to QA committee the results of audit tools for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 7 On 4/3/2025 at 1:05pm during a telephone interview the previous scheduler stated was not aware that there had to be RN coverage for 8 consecutive hours a day. The previous scheduler stated prior to a RN being hired recently it was not uncommon for there to be no RN working on the weekends. The previous scheduler stated the DON helped with the schedule and was aware there were no RNs scheduled on the weekends. During a telephone interview on 4/4/2025 at 12:40pm the Administrator stated she was aware and expected the facility to have RN coverage for at least 8 consecutive hours each day. The Administrator stated she was now aware the facility had days without RN coverage between the dates of 2/7/2025 and 4/4/2025.	F 727		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, Pharmacist, Nurse Practitioner, and staff interviews, the facility failed to prevent a significant medication error when they failed to administer five daily doses of Metoprolol Succinate (medication to treat heart failure) and Quetiapine Fumarate (an antipsychotic medication that helps regulate mood behaviors and thoughts) for 1 of 3 residents reviewed for medications (Resident #36). The findings included:	F 760	Address how corrective action will be accomplished for those residents found to have been affected: The facility failed to ensure a resident was free from a medication error. Resident missed five doses of metoprolol succinate ER and Quetiapine Fumarate from when resident was admitted on 3/21/25 to when the medication arrived 5 days later. NP was notified the morning of 3/24/2025. Resident was assessed by NP 3/24/2025 with no noted concerns. Medication was reordered and delivered to the facility on	5/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 8 Review of the hospital discharge summary dated 3/20/2025 revealed orders for Metoprolol Succinate 25 milligrams 24 hr tablet. Take 0.5 tablets (12.5 milligram total) by mouth nightly, and Quetiapine 25 milligram tablet. Take 1 tablet (25mg total) by mouth nightly. Resident #36 was admitted to the facility on 3/21/2025 with diagnoses that included chronic systolic (congestive) heart failure, type 2 diabetes mellitus with diabetic peripheral angiopathy (the presence of diabetes which involves damage to the blood vessels particularly to the extremities), hypertensive heart disease with heart failure, unspecified dementia with agitation. Review of Resident #36's medical record revealed on 3/21/2025 the Assistant Director of Nursing (ADON) entered admission orders for Resident #36 into the electronic medical record, which included Metoprolol Succinate, and Quetiapine Fumarate. The admission Minimum Data Set (MDS) assessment dated 3/25/2025 revealed Resident #36 had moderate impairment in cognition. The MDS indicated Resident #36 received an antipsychotic medication during the assessment reference period. A physician order dated 3/25/2025 read Metoprolol Succinate ER tablet Extended Release 24 hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime HOLD if heart rate less than 60 beats per minute. Review of Resident #36's medication administration record (MAR) dated March 2025 revealed the following:	F 760	3/26/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility DON completed an audit on 4/7/2025 of all admissions for the past two weeks, to ensure all residents received medications and all orders are confirmed. No other residents were identified as missing their medication, and all orders were current and confirmed. A Pharmacy representative audited the pyxis machine on 4/27/2025 to ensure it is stocked with all prior approved medications. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Facility Staff Development Nurse educated all nurses and medication aids by 5/1/2025 on the facility guidelines on missing medications, notification of a provider and pulling missing medications from the pharmacy back-up pyxis machine. All new nurses and medication aides will be educated during orientation. On 4/25/25 the Assistant Director of Nursing was educated by the Director of Nursing on daily monitoring (Monday through Friday) of the 24/72-hour report to ensure all medications that are labeled as unavailable have a documented progress note ensuring a provider was aware and that the pharmacy was called with date of arrival. These findings will also be included in the QA process. The Director of Nursing will ensure all in-house nurses will have access to pull	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 9 a. Documented by Nurse #1 that on 3/21/2025 Resident #36 did not receive the metoprolol due to the medication not being available. b. Documented by Nurse #2 that on 3/22/2025, 3/23/2025, 3/24/2025, Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available. Nurse #2 documented on 3/27/2025 Resident #36 did not receive Quetiapine Fumarate due to medication not being available. c. Documented by Nurse #3 that on 3/25/2025 Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available. Review of Resident #36's medical record revealed multiple electronic Medication Administration Record (eMAR) progress note regarding Metoprolol Succinate and Quetiapine Fumarate which included: An eMAR progress note dated 3/21/2025 at 10:28 pm written by Nurse #1 read "Metoprolol Succinate ER Tablet by mouth at bedtime for heart. Awaiting pharmacy". An eMAR progress note dated 3/22/2025 at 10:13 pm written by Nurse #2 read "Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligram. Give 0.5 (half) tablet by mouth at bedtime for heart on order". An eMAR progress note dated 3/22/2025 at 10:13 pm written by Nurse #2 read "Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order". An eMAR progress note dated 3/23/2025 at 10:30	F 760	medication from the pyxis machine by 5/1/2025. Agency staff will be educated prior to the shift to call the administrative nurse on-call if unable to locate medication. The administrative nurse will ensure in house staff will pull medication from RX now machine or ensure pharmacy is notified and provider. Administrative nurses were educated on this process on 5/1/2025 by the Director of Nursing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: All new admissions are being audited by the Director of Nursing or Assistant Director of Nursing to ensure that all orders are signed and confirmed, and medication has arrived two times a week for 4 weeks then monthly for 2 months The Director of Nursing or designee will present to QA committee the results of Audit Tools, identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 10	F 760		

pm written by Nurse #2 read "Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime for heart on order".

An eMAR progress note dated 3/23/2035 at 10:30 pm written by Nurse #2 read "Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order".

An eMAR progress note dated 3/24/2025 at 10:47 pm written by Nurse #2 read "Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime for heart on order".

An eMAR progress note dated 3/24/2035 at 10:47 pm written by Nurse #2 read "Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order".

An eMAR progress note dated 3/25/2025 at 10:19 pm written by Nurse #3 read "Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime for heart HOLD IF Heart Rate <60 beats per minute waiting for delivery from pharmacy".

An eMAR progress note dated 3/25/2025 at 10:20 pm written by Nurse #3 read "Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion Waiting for delivery from pharmacy".

An eMAR progress note dated 3/27/2025 at 10:11 pm written by Nurse #2 read "Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 11	F 760		

Review of Resident #36's vital signs contained in the electronic medical record from 3/21/2025 through 3/31/2025 revealed Resident #36's heart rate and blood pressure were within normal limits.

Review of Resident #36's medical record revealed visit notes from the Nurse Practitioner dated on 3/24/2025 and 3/25/2025 which read in part "Heart is regular in both rate and rhythm" and on 3/25/2025 which read in part "resident is calm, smiling and in good spirits".

During a telephone interview on 4/2/2025 at 10:59 am Pharmacist #1 stated, it was significant if a resident missed Metoprolol Succinate for five days because it could cause elevated blood pressure and had the potential to worsen heart failure. Pharmacist #1 stated missing quetiapine fumarate for five of seven days was not as significant. Pharmacist #1 stated if a new order was not entered when a resident was admitted the pharmacy would not be aware to send the medication to the facility.

During a telephone interview on 4/3/2025 at 12:05 pm the Assistant Director of Nursing (ADON) stated she started at the facility in January of 2025 and was new to long term care. The ADON stated she was still learning but she did try to help the unit managers and enter orders for new admissions. The ADON stated she reviewed Resident #36's hospital records on 3/21/2025 and she entered some new orders and reactivated Resident #36's orders in the electronic health record for Metoprolol Succinate and Quetiapine Fumarate from a previous admission in January 2025. The ADON stated she thought if a resident had an old order in the pharmacy system that was the same, the old order could be reactivated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 12	F 760		

and a new date added. The ADON stated on 3/21/2025 she had entered new orders and reactivated several old orders in the electronic medical record for Resident #36, which included Metoprolol Succinate and Quetiapine The ADON stated the Director of Nursing had told the ADON on the morning of 4/3/2025 that old orders could no longer be updated, that new orders had to be entered.

During a telephone interview on 4/2/2025 at 4:27 pm, Nurse #1 stated he was an agency nurse and 3/21/2025 was the only day he worked at the facility. Nurse #1 stated Resident #36 was admitted to the facility on the evening of 3/21/2025 and at the 9:00 pm medication pass, not all of Resident #36's medications had been received from the pharmacy. Nurse #1 stated after the midnight pharmacy delivery, not all of Resident #36's medications had arrived. Nurse #1 stated he reported that to the oncoming nurse for first shift regarding the medication that had not been delivered. Nurse #1 thought Resident #36's medication had not been delivered since she had just been admitted. Nurse #1 stated since he was an agency nurse, and it was his first shift he was unaware of the process for using the pyxis (back up supply of medication).

Nurse #3 was interviewed on 4/2/2025 at 6:00 pm. Nurse #3 stated she was an agency nurse and was not normally assigned to the hall Resident #36 was on. Nurse #3 stated if a resident did not have a medication that was ordered, she would verify the medication had been reordered and indicate on the eMAR the medication was not available, indicated by the number 9, then make a note in the MAR, and notify the unit manager. Nurse #3 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 13	F 760		

3/25/2025 was the only night she was assigned to work with Resident #36. Nurse #3 stated she did not notify the provider. Nurse #3 stated she did not recall if she had notified the unit manager, since a new order had been written on 3/25/2025 and was supposed to be delivered. Nurse #3 stated she was not aware the medication had been missed on previous shifts. Nurse #3 was aware that some staff nurses had access to the pyxis, she did not know which ones. Nurse #3 was not aware she could call the on-call nurse to pull medication from the pyxis.

Nurse #2 was interviewed on 4/2/2025 at 7:53 pm and verified she had worked with Resident #36 on 3/22/2025, 3/23/2025, 3/24/2025 and 3/27/2025. Nurse #2 stated if she had entered a number 9, in the eMAR, that the medication was not given and there would be a note to correspond with the reason the medication was not administered. Nurse #2 stated she did not have access to the pyxis since she was an agency nurse. Nurse #2 stated she knew some non-agency nurses had access that worked on other halls, but she did not ask them to pull medication from the pyxis. Nurse #2 stated Resident #36's medication would not be in pyxis because the medications in the pyxis were specific to each resident, not general medications.

During a telephone interview on 4/3/2025 at 10:06 am, the Nurse Practitioner (NP) stated he had been notified on 3/24/2025 that Resident #36 had missed doses of Metoprolol Succinate and Quetiapine. The NP evaluated the Resident on 3/24/2025 and 3/25/2025 and documented no acute distress noted. The NP stated missed doses of Metoprolol Succinate could result in an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 14 increased heart rate or elevated blood pressure and could cause a decrease in the strength of the heart contraction. The NP stated he had observed her heart rate was regular and from his assessment there did not appear to be any signs of cardiac distress. The NP stated Resident #36 had no behavioral issues when he saw her. During an interview on 4/2/2025 at 5:30pm the Director of Nursing (DON) stated she would expect residents to receive medications as ordered. The DON stated the Pyxis contained general medication for all residents. The DON stated agency nurses do not have access to the pyxis but some staff nurses do and the on call nurses could be called and come to the facility to pull medication from the pyxis. The DON stated she had spoken with the Pharmacy Manager regarding the electronic health record and why old orders were able to be updated, and the Manager was looking into it. The DON stated all new admission orders should be entered in as new orders. During an interview on 4/4/2025 at 12:40pm the Administrator stated she expected the residents to receive medication as ordered.	F 760		
F 801 SS=C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment	F 801		5/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 15 required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 16 nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to employ a director of food and nutrition services that met the minimum qualifications, and it affected 108 of 111 residents. Findings included:	F 801	Address how corrective action will be accomplished for those residents found to have been affected: All facility residents were identified as being affected. The facility hired a Certified Dietary Manager who started 4/28/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 17 On 04/01/2025 at 11:00 AM, the Assistant Dietary Supervisor was interviewed and revealed that he did not have any of the following: certification as a dietary manager or food manager, national certification for food service management and safety, an associate's or higher degree in food service management or in hospitality, 2 or more years of experience in the position of Director of Food and Nutrition Services in a nursing facility setting. The Assistant Dietary Supervisor stated that he did have a dietician that he could consult and call if needed. He revealed that he had been at this facility in this kitchen for a little over six months and that he left for a while and then came back. On 04/01/2025 at 11:56 AM, an interim Dietary Manager at a sister facility was interviewed and stated that she was a Certified Dietary Manager and a Certified Food Protection Professional. She stated that she was at the facility once weekly to help the Assistant Dietary Supervisor. She denied having any regular scheduled meetings with the facility Assistant Dietary Supervisor, but he could call her if needed. She added that she had recently resigned her position and her last day with the company would be 4/16/25. An Administrator interview on 04/04/2025 at 12:40 PM revealed that she was aware of the facility's need to have a certified Dietary Manager. She stated they had hired a certified Dietary Manager that was supposed to have started on 3/25/25 but was unable to start her position on that date due to a family emergency and was scheduled to start her position the week of 4/07/2025. She revealed in the meantime, an interim Dietary Manager from their sister facility had been coming to their facility at least once a week to oversee the kitchen and	F 801	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice. The facility hired a Certified Dietary Manager who started 4/28/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Administrator educated the Certified Dietary Manager on 4/28/2025 as part of the orientation process, the process for food storage and the monitoring tools implemented following recent deficiencies cited. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: No further monitoring is required due to the hiring of a Certified Dietary Manager and credentials were verified upon hire and are current. The Administrator or designee will present to QA committee the changes that have been made in the kitchen since hiring a Certified Dietary manager. The Certified Dietary Manager will present audit tools, identification of trends, actions taken, and determine further needs for the kitchen. Facility will continue to collaborate with the Registered Dietician during QA meetings to ensure resident needs are being met and preferences are followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 18 assist their Assistant Dietary Supervisor. The Administrator stated they also had a Registered Dietician they consulted with and could call if needed. A telephone interview with the Administrator on 04/16/25 at 2:12 PM revealed the certified Dietary Manager they had hired and was scheduled to begin her position the week of 04/07/2025 did not show and they rescinded the job offer. She stated they had made a job offer to another certified Dietary Manager this past week and were in the process of completing a criminal background and dietary certification check. She revealed as long as the criminal background and dietary certification checks cleared, they were hoping the new certified Dietary Manager would be able to start her position next week or the following week. The Administrator stated in the meantime, an interim Dietary Manager from their sister facility would continue coming to their facility at least once a week to oversee the kitchen and assist their Assistant Dietary Supervisor and their Registered Dietician would also be available for consultation if needed.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		5/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 19 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired food and failed to date perishable food stored for use in 1-of-1 walk-in cooler. This practice had the potential to affect food served to residents. The findings included: During the initial tour of the kitchen on 4/01/25 from 10:45 AM to 11:00 am an observation with the Assistant Dietary Supervisor of the walk-in cooler revealed the following: - a plastic container sealed with plastic wrap dated 3/28/2025 that was one quarter full of chicken breasts with seasoning dated 3/28/25 - a plastic container sealed with plastic wrap dated 3/27/2025 that was half full of chicken noodle soup that had started to separate - a plastic container sealed with plastic wrap dated 3/26/2025 that was half full of creamed corn - a metal tray of seven tuna salad sandwiches sealed with aluminum wrap with no date - a metal tray of 10 bologna sandwiches sealed with plastic wrap dated 3/27/2025 The Assistant Dietary Supervisor observed on	F 812	Address how corrective action will be accomplished for those residents found to have been affected: The facility kitchen manager discarded all the items that were expired or not labeled correctly immediately after it was brought to his attention. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Administrator educated all dietary staff 4/21/25 regarding proper food storage and all foods should be labeled, sealed, and dated and any foods that are found to be improperly stored or expired should be discarded immediately. This information will be included in the new hire orientation for dietary employees. Indicate how the facility plans to monitor its performance to make sure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	R-C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 20 4/01/25 at 11:15 AM the food stored inside of the walk-in cooler that were expired and perishable food items not dated. He revealed the process for food storage was making sure all foods were sealed, labeled, and dated with an opened date and discard date. He verbalized all food dates should be checked by all dietary staff on a regular basis and any expired foods should be properly discarded. He indicated she would have the food items discarded. An interview with the interim Dietary Manager on 4/01/25 at 12:00 PM revealed all food items should be sealed, labeled, and dated when being stored. She stated dietary staff should be checking food items on a regular basis and discard any items that are not sealed, labeled, dated, or have expired immediately. An interview with the Administrator on 4/04/25 at 12:40 PM revealed all dietary staff had been educated on food storage. She stated all food should be labeled, sealed, dated, and expired foods should be discarded immediately.	F 812	solutions are sustained: An audit will be performed by the Administrator or designee to ensure that walk-in refrigerator is free from any spoiled food items 3 times a week x 4 weeks, then weekly x 3 weeks, then monthly x 3 months. The Administrator or designee will present to QA committee will review the results of Audit Tool referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at the quarterly QAPI meeting.	