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 _____	C 08/23/2012

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

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID # JJ4I11.	F 000	F 281 Resident #56 had no adverse effects from not receiving Ranitidine. The MD was notified and deemed this medication was no longer necessary since there were no observed	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to administer medications as ordered for two (2) of ten (10) residents reviewed for unnecessary drugs. (Resident #56 and #200). The findings are: 1. Record review revealed Resident #56 was admitted to the facility on 5/4/12 with diagnoses which included GERD (gastro esophageal reflux disease). The Physician Orders Sheet for August 2012 revealed an order for Protonix 40 milligram (mg) every morning for GERD and an order for Ranitidine 150 mg at bedtime for acid reflux. The August 2012 MAR (Medication Administration Record) was reviewed. The Protonix was documented as given every morning, however, there was no transcription on the MAR for Ranitidine to be administered and no documentation that Ranitidine had been given for the month of August. Review of the previous MARs for May, June and July 2012 revealed the Ranitidine had been given as ordered.	F 281	symptoms to indicate the need. The error was appropriately documented. Resident # 200 has been monitored and had no adverse effects from the change in Advair. The MD was notified and the order clarified to continue bid. Residents who have the potential to be affected by this practice have been identified and MARS audited for any incorrect orders. All resident MARS will be reviewed and any deficient practice identified and corrected. Systemic changes made to ensure the deficient practice will not occur include the following. Inservice will be given to all staff who administer medications. MAR reconciliation has a 3 point check . 1. Staff check the orders at the end of the month with current orders. 2. A second check is done the last day of the month to assure any new orders are included on the current MARS from month ending and month beginning. 3. The third check is done by the night shift staff to compare the ending month and beginning month MARS. All staff checking the orders will initial both MARS and initial both MARS to ensure each medication order is checked as correct.	

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

Katie Cogar RN Dow for Scott Borum LNHA — 9/14/12

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.

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F 281	Continued From page 1 An interview was conducted with the Assistant Director of Nursing (ADON) #1 on 8/22/12 at 3:30 PM. The ADON #1 verified the physician order for the Ranitidine 150mg at bedtime was correct and confirmed the medication had been missed the month of August. A follow up interview with the ADON on 8/23/12 at 9 AM revealed the resident had not complained of any increased symptoms of reflux and the physician had discontinued the Ranitidine once made aware the resident had not received it during the month of August. 2. Record review revealed Resident #200 was admitted to the facility 8/4/12 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Review of the MAR (Medication Administration Record) for August revealed the resident had received Advair 250/50 microgram one puff daily on 8/4, 8/5, and 8/6 and twice a day beginning on 8/7/12. Review of an Acute Episode fax sheet dated 8/6/12 revealed an order clarification that requested whether the physician wanted the Advair twice a day or daily. Review of the physician's response on the bottom of the Acute Episode fax sheet revealed "Advair 250/50, 1 inhalation daily" and was signed by the physician 8/7/12. An interview was conducted with the ADON (Assistant Director of Nursing) #2 on 8/23/12 at 11:30 AM. The ADON #2 verified the physician	F 281	All MARS will be checked daily for new orders. Daily new fax orders will remain on the 24 hour nurses worksheet. The 7 P to 7 A nurse will check the acute fax against the written telephone order and MARS and initial to indicate this has been done. All change of shift reports will include any new orders for medications. A form to audit this will be devised to include each resident and by signing this will indicate that the nurse has completed a review of the chart for new orders and correct transcription. New orders and fax orders will be checked nightly to assure compliance is attained and sustained. The QA program will evaluate for effectiveness the monitoring weekly x 1 mo., then q 2 wks, then q mo.until correction is achieved and sustained. Monitoring of the solutions will be ongoing by the QA program. Corrective action will be completed by 9/20/2012	

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F 281	Continued From page 2 order dated 8/7/12 was for one time daily and confirmed the medication had been transcribed incorrectly on the MAR as twice a day. A follow up interview with the ADON #2 on 8/23/12 at 1:00 PM revealed the physician had been informed and had ordered the Advair to be continued twice a day in order to be effective.	F 281	F328 Resident #80 coughed up a plug of mucous shortly after the O2 sat dropped. O2 sat returned to normal on room air. O2 sats were checked on room air after the O2 was off for 5 minutes. It was determined that the O2 sat remained normal on room air. The MD was notified and order changed from continuous to PRN. Resident has remained stable.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, staff interviews and observations the facility failed to ensure physician orders for oxygen therapy were carried out for one (1) of seven (7) sampled residents reviewed for oxygen administration (Resident #80). Findings are: Resident # 80 was readmitted to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD) and congestive heart	F 328	All residents on O2 cylinders have been evaluated for continuous need based on O2 sats at room air after being off O2 for 5 min. MD notified of the results for further orders as indicated. Systemic changes: Inservice on O2 cylinders use to all staff including all departments and therapy. A log to check cylinders on a routine and regular basis will be placed on the O2 cylinders. All staff are responsible for checking O2 cylinders. O2 cylinders will be checked on daily rounds, during therapy and at shift change to assure deficient practice does not occur. Logs will be turned in to the QA nurse when they are full and new sheets added. Monitoring by the QA program will be done daily x 1 wk, weekly x 1 mo. Then q 2 mo. then q mo. until performance and solutions are sustained. The effectiveness of the program will be reviewed in the QA meetings. Corrective action will be completed by 9/20/2012.	

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F 328	Continued From page 3 failure. Medical record review revealed a significant change Minimum Data Set dated 03/27/2012 assessed the resident with long and short term memory problems and revealed extensive assistance required by staff for activities of daily living care. Resident #80's care plan initiated on 07/18/2011 documented the resident was to be on Oxygen 2 liters per minute via nasal cannula related to her COPD. Review of the Medication Administration Record confirmed a physician's orders for administration of continuous oxygen to include oxygen saturation levels to be checked every shift. Observation of Resident #80 on 08/22/2012 at 10:30 AM revealed her sitting up in her wheelchair with her portable oxygen tank on empty and nasal cannula on the back of her chair. She was observed to have shallow, rapid respirations. Interview on 08/22/2012 at 10:33 AM with Nurse #1, who was standing nearby, confirmed the tank was empty and the nasal cannula was not in place. He revealed Resident #80 was to have her oxygen on at all times. Nurse #1was observed as he removed the empty tank and replaced it with a full one. Just before replacing the nasal cannula on Resident #80 he checked her oxygen saturation level and confirmed a reading of 83%, however once the nasal cannula was replaced her level was rechecked and registered 93%. Nurse #1 stated all the direct care staff were responsible for checking oxygen tanks to make sure they were adequately filled and ensure those with orders for continuous oxygen had their nasal cannulas in place.	F 328		

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F 328	Continued From page 4 Interview on 08/23/2012 at 8:30 AM with nurses aide #1 (NA#1), who was a care giver on the hall where Resident #80 lives, revealed it was the direct care staff's responsibility to check to see if oxygen tanks are adequately filled and make sure residents' nasal cannulas are in place. Interview on 08/23/2012 at 10:30 AM with Assistant Director of Nurses #2 (ADON), who manages the unit Resident #80 resides on, revealed her expectations are that all staff would be responsible to check oxygen tanks to be sure they are adequately filled and ensure nasal cannulas are in place on those residents with physician orders for continuous oxygen.	F 328	F441 Infection Control NA#2 was counseled and reeducated regarding infection control and handwashing. There was no adverse effects from lack of handwashing past removal of gloves. Potential: All residents have been assessed for signs and symptoms of infections. The infection control program monitors daily for any signs and symptoms of infection and appropriate precautions put into place.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	Systemic Change: Inservice to all staff will be done. Demonstrations and observations of resident care will be accomplished to determine any infection requiring other than standard precautions. 100% handwashing audit of employees will be done. An audit including the employee, date, pass/fail, the observer. Any person who doesn't perform within accepted standards will be re-educated. Each employee will have 3 opportunities to pass. Any person who doesn't pass after 3 attempts will be evaluated for continued employment. This will include all departments and contract therapies. Emphasis on use of soap and water vs. alcohol gel to prevent infections that do not respond to alcohol gel. Random observations during daily rounds to assure compliance.	

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F 441	Continued From page 5 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide hand washing between residents (Residents #121 and #68). The findings are: Medical record review revealed Resident #121 was re-admitted to the facility on 08/21/2012 from an acute care hospital. Admission diagnoses included Urosepsis and Clostridium difficile (C-diff) infection. On 08/22/12 at 8:20 AM a precaution sign was observed on Resident #121's door which indicated the following: "Special Enteric Precautions - Perform hand hygiene before entering room and wash hands with soap and water before leaving room."	F 441	Monitoring: Daily observation of resident care will be done weekly x1 by the administrative staff on rounds, then q 2 weeks, then monthly with re-inforcement of infection control. Evaluation of the effectiveness will be done during QA meetings. Correction action will be completed by 9/20/2012.	

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F 441	Continued From page 6 On 08/22/12 at 8:20 AM, nursing assistant # 2 (NA) was observed donning gloves and entering Resident #121's room. NA #2 repositioned the resident's indwelling urinary catheter tubing to promote drainage and placed the urine collection bag into a privacy sleeve. NA #2 removed her gloves, placed the gloves in the trash and exited the resident's room without washing her hands. NA #2 removed a washcloth from the linen cart located in the hallway, walked into Resident #68's bathroom and wet the washcloth in Resisdent # 68's bathroom sink. Prior to exiting Resident #68's bathroom NA #2 was immediately interviewed and she indicated the wet washcloth was to wash Resident #68's face. NA #2 acknowledged she did not wash her hands prior to leaving Resident #121's room and indicated she should have performed hand hygiene prior to leaving Resident #121's room, removing the washcloth from the linen cart and entering Resident #68's room. On 08/23/12 at 12:00 PM with the Director of Nurses (DON) revealed she expected staff to wash their hands between resident care.	F 441		

GLENBRIDGE HEALTH AND REHABILITATION ACKNOWLEDGES RECEIPT OF THE STATEMENT OF DEFICIENCIES AND PROPOSES THIS PLAN OF CORRECTION TO THE EXTENT OF THE SUMMARY OF FINDINGS IS FACTUAL CORRECT AND IN ORDER TO MAINTAIN COMPLIANCE WITH APPLICABLE RULES AND PROVISIONS OF THE QUALITY OF CARE OF THE RESIDENTS. THE PLAN OF CORRECTION IS SUBMITTED AS A WRITTEN ALLEGATION OF COMPLIANCE.

GLENBRIDGE HEALTH AND REHABILITATION'S RESPONSE TO THIS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DOES NOT CONSTITUTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY DEFICIENCY IS ACCURATE. FURTHER, GLENBRIDGE RESERVES THE RIGHT TO SUBMIT DOCUMENTATION TO REFUTE ANY OF THE STATE DEFICIENCIES THROUGH INFORMAL DISPUTE RESOLUTION, FORMAL APPEAL PROCEDURE AND /OR OTHER ADMINISTRATIVE OR LEGAL PROCEEDINGS.