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 11/08/2018

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

(X4) ID PREFIX TAG	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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F 637		11/30/18

§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident was admitted to Hospice care for 1 of 7 sampled residents (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 07/06/18 with diagnoses of non-Alzheimer's dementia, malnutrition, adult failure to thrive, and chronic obstructive pulmonary disease.

Review of the admission MDS dated 07/06/18 revealed Resident #1 was cognitively intact and was not receiving hospice services.

Review of the physician orders dated 08/16/18 revealed Resident #1 was admitted to Hospice on 08/16/18.

Glenbridge Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the ectent that the summay 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 Nursing and Rehabilitation Center□s 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, 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2018

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 637	Continued From page 1 The MDS Coordinator was interviewed on 11/08/18 at 10:56 AM about why a comprehensive assessment had not been completed within 14 days of Resident #1 being admitted to Hospice care. The MDS Coordinator reviewed Resident #1's medical record and stated he had over looked it and a Significant Change in Status Assessment should have been completed in August because Resident #1 was admitted to Hospice. An interview conducted on 11/08/18 at 11:20 AM with the Administrator revealed she had reminded the MDS Coordinator to do a Significant Change in Status Assessment for Resident #1 when she was admitted to Hospice. She stated the assessment should have been completed.	F 637	and/or any other administrative or legal proceeding. F637 What measures did the facility put in place for the resident affected: Resident #1 was admitted to Hospice on 08/16/18. MDS Coordinator did not complete a significant change assessment, assessment cannot be completed due to resident passing away on 10/22/18 What measures were put in place for residents having the potential to be affected: 11/10/18 100% audit was completed on all residents who are on hospice services to ensure accuracy of information on MDS's What systems were put in place to prevent the deficient practice from reoccurring: On 11/10/18 the MDS coordinator, MDS nurse, were in-serviced by the facility Administrator related to the Accuracy of information on an MDS. How the facility will monitor systems put in place: Beginning 11/10/18 the DON, and or administrator will audit MDS assessments to ensure accuracy using MDS accuracy audit tool. This audit will be completed weekly x 3 weeks and then monthly x 3	

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F 637	Continued From page 2	F 637	months. The DON and/or Administrator will present findings to the monthly QI committee. The monthly QI committee will review the results of accuracy Audit Tool monthly for 2 months for identification of trends, actions taken, and to determine the need 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 recommendations and oversight.	