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 01/24/2020

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
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record reviews and Administrator interviews the facility failed to have a comprehensive emergency preparedness (EP) plan. The EP manual failed to include the role of the facility under the waiver declared by the Secretary. The EP communication plan did not include contact information of the State Licensing	E 001		

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

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	Continued From page 1 and Certification Agency and State Long Term Care Ombudsman and did not include an alternate means of communication if telephones were offline. The EP plan also indicated the facility had completed a tabletop exercise, but the facility had not participated in a full-scale community-based drill. Findings included: 1. A. Review of the EP manual provided by the facility revealed the plan did not include the role of the Long Term Care (LTC) facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. B. Review of the EP manual provided by the facility revealed the communication plan did not include contact information of the North Carolina Nursing Home Licensure and Certification Agency and contact information of Long-Term Care Ombudsman. C. Review of the EP manual provided by the facility revealed the communication plan did not include an alternate method of communication if telephone or paging systems were off-line. D. Review of the EP manual provided by the facility indicated the facility had participated in a tabletop exercise but had not participated in a full-scale community-based drill. An interview on 01/24/20 at 12:38 PM with the Administrator revealed she was responsible for the EP plan. She explained they had done a table-top exercise with the local fire department	E 001		

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E 001	Continued From page 2 on 06/12/19 but they had not participated in a full-scale community-based drill. She stated they had bought an emergency preparedness video to train staff as part of mandatory staff training and all new hires were trained on disaster preparation. She confirmed the EP plan did not have the regulatory requirement to establish the role of the LTC facility under a waiver declared by the Secretary, in the provision of care and treatment at an alternate care site identified by emergency management officials. She also confirmed the EP plan did not include phone numbers for North Carolina Nursing Home Licensure and Certification Agency and contact information of Long-Term Care Ombudsman. She explained she felt they had a partial communication plan in place and the plan indicated for staff to use cell phones for communication if internal communication went out but there was no plan if cell towers were out. She stated at some point after the former Administrator had left the facility, she realized the EP plan was gone. She further stated after she realized the EP plan was missing, she had tried to create the EP plan from scratch.	E 001		
F 000	INITIAL COMMENTS A complaint investigation was conducted from 01/21/20 through 01/24/20 in conjunction with the annual Recertification survey. There were a total of 4 allegations investigated and all were unsubstantiated. Event ID #RPFF11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		

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F 641	Continued From page 3	F 641		

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for hospice care for 1 of 2 residents reviewed for hospice (Resident #20).

Findings include:

Resident #20 was admitted to the facility 11/08/19 with diagnoses that included dysphagia, hypertension, heart failure, hemiplegia, and traumatic brain injury.

Resident #20's Admission MDS assessment dated 11/20/19 revealed the resident was cognitively intact, had a poor appetite, and displayed behaviors. The resident was not coded for hospice on the MDS assessment.

A telephone interview with the Compliance Officer with the county's Hospice office on 01/23/20 at 2:15 pm revealed Resident #20 was admitted to Hospice on 09/13/19 while the resident was at another facility and continued to be with Hospice at the time of admission to this facility on 11/08/19. She further stated the resident received nurse aide (NA) care twice a week, had volunteer services 1 to 4 times a month and whenever needed (PRN), Social Work 1 to 2 times a month and had a nurse for pain or symptom management when needed.

An interview with Nurse #5, Unit Supervisor, on 01/23/20 at 11:50 am revealed she thought Resident #20 was palliative care and not hospice care.

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F 641	Continued From page 4 An interview with the MDS Coordinator on 01/23/20 at 3:15 pm revealed he did not know until 01/23/20 the resident received hospice services. He further revealed he immediately modified the resident's assessment to include Hospice care. An interview with the Director of Nursing (DON) on 01/23/20 at 3:20 pm stated she heard Resident #20's 11/20/19 MDS was not coded for hospice. She stated her expectation was for hospice to be coded on the MDS for this resident. An interview with the Administrator on 01/24/20 at 11:30 am revealed the resident was admitted for rehabilitation to the facility on 11/08/19 and the resident was private pay hospice until rehabilitation was finished. The Administrator stated she expected hospice to be coded on Resident #20's 11/20/19 MDS.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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F 656	Continued From page 5 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and an interview with hospice staff, the facility failed to development a hospice care plan for 1 of 2 residents reviewed for hospice care (Resident #20). Findings Include: Resident #20 was admitted to the facility 11/08/19 with diagnoses that included dysphagia, hypertension, heart failure, hemiplegia, and traumatic brain injury.	F 656		

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F 656	Continued From page 6 Resident #20's Admission Minimum Data Set (MDS) assessment dated 11/20/19 revealed the resident was cognitively intact, had a poor appetite, and displayed behaviors. The resident was not coded for hospice services on the MDS assessment. Resident #20's current care plan dated 11/26/19 revealed a care plan for hospice was not developed. A telephone interview with the Compliance Officer with the county's Hospice on 01/23/20 at 2:15 pm revealed Resident #20 was admitted to Hospice on 09/13/19 while a resident at another facility and continued to be with Hospice at the time of admission to this facility on 11/08/19. She further stated the resident received nurse aide (NA) care twice a week, had volunteer services 1 to 4 times a month and whenever needed (PRN), Social Work 1 to 2 times a month and had a nurse for pain or symptom management when needed. An interview with Nurse #5, Unit Supervisor, on 01/23/20 at 11:50 am revealed she thought Resident #20 was palliative care and not hospice care. An interview with the Care Plan Coordinator on 01/23/20 at 3:10 pm revealed there was not a care plan for hospice because she did not know until 01/23/20 the resident was receiving hospice services. During an interview with the Director of Nursing (DON) on 01/23/20 at 3:20 pm she stated her expectation was for hospice to be on the care plan for Resident #20.	F 656		

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F 656	Continued From page 7 An interview with the Administrator on 01/24/20 at 11:30 am revealed the resident was admitted for rehabilitation to the facility on 11/08/19 and the resident was private pay hospice until rehabilitation was finished. The Administrator stated she expected a care plan for hospice to be developed for Resident #20.	F 656		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews and Administrator interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March 2019. This was for one recited deficiency which was originally cited it March 2019 on a Recertification survey and subsequently recited in January 2020 on the current Recertification and complaint survey. The repeat deficiency was in the area of emergency preparedness. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to:	F 867		

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F 867	Continued From page 8 E-0001: Based on record reviews and staff interviews the facility failed to have a comprehensive emergency preparedness (EP) plan. The EP manual failed to include the role of the facility under the waiver declared by the Secretary. The EP communication plan did not include contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman and did not include an alternate means of communication if telephones were offline. The EP plan also indicated the facility had completed a tabletop exercise, but the facility had not participated in a full-scale community-based drill. During the recertification and complaint survey of 03/07/19, this regulation was cited for failing to have an Emergency Preparedness (EP). The EP plan did not include procedures that addressed the patient population, subsistence needs for staff and patients, procedures for tracking of staff and patients, procedures for sheltering in place, procedures for medical documentation, provisions for volunteers, a communication plan, contact information, primary/alternate means of communication, methods of sharing information, EP training or testing requirements. An interview on 01/24/20 at 2:03 PM with the Administrator revealed the Quality Assessment and Assurance (QA) committee met monthly and consisted of the Administrator, Director of Nursing, Medical Director and Department Heads. She stated the Pharmacist attended the quarterly meetings. She explained they had agenda items they covered at each meeting and they had discussed survey preparedness and went tag by tag to complete their audits. She	F 867		

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F 867	Continued From page 9 further explained routine audits were in place for repeat deficiencies. we do routine audits of med rooms and carts. We recently changed Pharmacies. She stated after the former Administrator left the facility, she realized there was no EP plan in the facility, and she had to create it from scratch and had tried to reconstruct it.	F 867		