STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345445	A. BUILDING _____ B. WING _____	04/05/2018

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GLENAIRE	4000 GLENAIRE CIRCLE CARY, NC 27511

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review the facility failed to identify a right wrist fracture as an injury of unknown source and complete a 24 hour and 5 day report for 1 of 2 residents reviewed for accidents (Resident #46).	F 609	1. What corrective action will be accomplished for residents affected? All breaks and/or fractures will be reported to DHSR within 24 hours. GLenaire policy and procedures regarding breaks and fractures will be updated by May 3rd, 2018 by the Director of Nursing or her designee	5/3/18

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

Electronically Signed | 04/20/2018

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F 609	Continued From page 1 Findings included: Resident #46 was admitted to the facility on 1/9/18. Her active diagnoses included hypertension, hyperlipidemia, osteoporosis, and dementia. Review of Resident #46's most recent minimum data assessment dated 1/16/18 revealed the resident was assessed as severely cognitively impaired. Review of Resident #46's incident reports revealed on 2/6/18 Resident #46 attempted to stand from her wheelchair without assistance, lost her balance, and fell. It was documented on the incident report there were no injuries noted and the resident denied pain or discomfort. On 2/24/18 the resident scooted off her mattress to the floor and no injuries were noted. Resident #46 denied pain and discomfort. On 2/25/18 Resident #46 attempted to get into bed unassisted and slid to the floor. No injuries were noted and there were no further incident reports for Resident #46. Again the resident denied any pain or discomfort. Review of a Nursing Note dated 3/5/2018 at 4:30 PM revealed Nurse #1 documented Resident #46 had complained of mild discomfort to her right wrist area. The nurse documented the wrist had some slight swelling and Resident #46 told the nurse she hit her wrist on a rock. The nurse noted Resident #46 had not been outside. The nurse noted the resident had been practicing locking and unlocking her wheelchair with therapy. Pain medications was given which Resident #46 reported relieved the pain. Review of the physician's communication book	F 609	to reflect these changes. Nursing staff will be in-serviced by the Director of Nursing or her designee to report any injury of unknown origin immediately to the Administrator or to the Director of Nursing and this will be completed by May 3rd, 2018. The Administrator, Director of Nursing, or their designee will report any breaks or fractures of unknown origin to DHSR within 24 hours. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? The Director of Nursing, the MDS Coordinator, or their designee will review all current incident reports and all incident reports from 4-05-2018 to ensure all fractures and/or breaks that may have occurred were reported to DHSR and this will be completed by May 3rd, 2018. Incident reports, breaks and/or fractures will be reviewed daily by the Director of Nursing or her designee at Clinical Meeting for three months to ensure 24 hour and 5 day reports are sent timely. The Director of Nursing, the MDS Coordinator, or their designee will document the review of fractures and/or breaks and incident reports at Clinical Meeting for those three months, report to the QAPI committee monthly, and report any concerns immediately to the Administrator. 3. What measures will be put into place to ensure this practice does not recur? Incident reports, breaks and/or fractures will be reviewed daily at Clinical Meeting by the Director of Nursing or her designee	

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F 609	Continued From page 2 revealed on 3/5/18 a request was made by nursing for the physician to evaluate Resident #46 for wrist pain and swelling. Review of a physician's progress note dated 3/5/18 revealed the resident was assessed by a physician's assistant for right wrist pain and swelling. Resident #46 was noted to have stated she was not having any pain at that time and did note she broke the right thumb many years ago and it occasionally felt uncomfortable. Resident #46 was documented to move her right, arm, and hand without any issues. The physician documented the pain and swelling was not present upon the exam that day and Resident #46 denied any pain or swelling. The physician wrote to continue to monitor the right wrist at that time. Review of a Nursing Note dated 3/12/18 at 3:11 PM revealed Nurse #1 documented Resident #46 had complaints of mild pain to her right wrist. Tylenol was given as prescribed and Resident #46 stated it gave her relief and she was not in pain. Review of a physician's progress note dated 3/15/18 revealed Resident #46 was seen again per nursing request by Physician #1 for wrist pain which was mild and did not seem to limit her activity. Physician #1 noted Resident #46 told him she fell and her hand was swollen. The physician documented that given the reproducible tenderness in the right wrist, an x-ray was ordered to evaluate for possible fracture. Review of a mobile x-ray result dated 3/16/18 revealed Resident #46 had an acute fracture of the right wrist.	F 609	for three months to ensure 24 hour and 5 day reports are sent timely. The Director of Nursing, the MDS Coordinator, or their designee will document the review of fractures and/or breaks and incident reports at Clinical Meeting for those three months, report to the QAPI committee monthly, and report any concerns immediately to the Administrator. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All nursing staff will be in-serviced by the Director of Nursing or her designee on reporting injuries of unknown origin immediately to the Administrator or to the Director of Nursing by may 3rd, 2018. All breaks and/or fractures will be reported to DHSR within 24 hours. The Director of Nursing or her designee will update its reporting policies and procedures to reflect these changes by May 3rd, 2018. The Administrator, Director of Nursing, or their designee will report any injuries of unknown origin to DHSR within 24 hours. The Director of Nursing, the MDS Coordinator, or their designee will document the review of fractures and/breaks and incident reports at Clinical meeting for those three months, report to the QAPI committee monthly, and report any concerns immediately to the Administrator or to the Director of Nursing. The QAPI committee will review this report and make the determination to either continue or desist the monitoring process after three months.	

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F 609	Continued From page 3	F 609		

Review of a Nursing Note dated 3/16/2018 at 10:46 PM revealed Nurse #2 documented for Resident #46 the x-ray result reveled the resident had an acute distal fracture of the wrist. The nurse practitioner was notified, family was notified, and an appointment was made with an orthopedic physician. Resident #46 denied pain, refused pain medication offered by the nurse, and yelled "I'm not hurting!"

During observation on 4/4/18 at 8:18 AM Resident #46 was observed to have a splint placed to her right wrist.

During an interview on 4/4/18 at 8:19 AM Resident #46 stated she did not know what she had done to her wrist but she had to wear the splint. She then stated she believed she hit her hand on her dresser and sprained it. She further stated the doctor made her get an x-ray and wear the splint which was silly because nothing had been wrong with her hand.

During an interview on 4/4/18 at 8:52 AM Nurse #1 stated Resident #46 was alert and oriented to herself but her cognition level varied. She further stated Resident #46 originally told her the right wrist was hurting because she hit it on a rock. The nurse then stated the resident told her yesterday she was sitting in her wheelchair and it just happened and she didn't know why. The nurse stated to her knowledge they were never able to figure out exactly when or how she developed the injury because Resident #46 denied any pain except the two times she requested one Tylenol for wrist "achiness." She further stated when they did not know how or when an injuries occurred, and the resident was

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F 609	Continued From page 4	F 609		

not a reliable historian, the nurse was to notify the family, notify the doctor, and do an incident report. She further stated the managers would then follow up on the injury to try and identify where it came from.

During an interview on 4/4/18 at 11:00 AM the Central House Nursing Manager stated when injuries were reported to her she insured the family and doctor were notified immediately. She further stated if they did not know where the injury came from she would interview the staff about the injury to try and identify what caused the injury. The nurse stated an incident report would be done as soon as the injury was identified. She further stated they did not know where the fracture on Resident #46's wrist came from and they could not accurately connect it to any incident prior because the resident was a poor historian. She concluded that an incident report should have been done on Resident #46's fracture but it was an unusual situation due to the timing and the resident indicated nothing was wrong after initially reporting pain in her wrist.

During an interview on 4/4/18 at 11:17 AM Nurse #3 stated when a resident had an injury and she didn't know the origin she let her manager know and contacted the family, the doctor, and completed an incident report. She further stated she did not know how Resident #46 got the fracture. She stated she did not believe she needed to do an incident report because Resident #46 had multiple falls in February. She continued to state that because these falls were likely the cause of the fracture she did not do an incident report.

During an interview on 4/4/18 at 1:17 PM the

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F 609	Continued From page 5 Administrator stated if an injury is assessed as an injury of unknown source based on the investigation of the nurse mentors he would perform a 24 hour and 5 day report. He further stated he had not completed any reports on Resident #46. The Administrator stated since the physician noted the fracture was likely due to her falls in February based on the physician's interview with the resident, her diagnoses of osteoporosis, and recent falls in February he did not feel a 24 hour and 5 day report was appropriate and did not do a written investigation of the injury. He further stated the resident was a poor historian, but due to the evidence, he felt the injury did not qualify as an injury of unknown source. During an interview on 4/4/18 at 2:10 PM Physician #1 stated without having been there to witness the break and the resident being a poor historian he could not say with one hundred percent certainty the fracture was from a previous fall. He continued to state a fall seemed to be the most likely explanation. He stated the injury was consistent with being caused by an impact from a fall. He further stated on his assessment of the resident on 3/15/18 Resident #46's right wrist presented with mild tenderness to pressure and he decided to order an x-ray to rule out a fracture, however the resident had no complaints and did not have any decline of function as a result of the fracture. He stated when the physician's assistant first saw the resident on 3/5/18 there were no signs or symptoms of a fracture upon exam and they were lucky to have identified the break as Resident #46 did not present with signs and symptoms of a fracture to facility staff.	F 609		
F 656	Develop/Implement Comprehensive Care Plan	F 656		5/3/18

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F 656 SS=D	Continued From page 6 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 (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.	F 656		

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F 656	Continued From page 7 (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, observations and interviews with family and staff the facility failed to develop a care plan to address a resident's edema for 1 (Resident #63) of 18 residents' care plans reviewed. The findings included: Resident #63 was admitted to the facility on 3/5/18 with diagnoses which included hip fracture, left hip pain, Alzheimer's dementia and hyponatremia (low sodium level in the blood). A review of the 14 day Minimum Data Set (MDS) dated 3/19/18 revealed Resident #63 was severely cognitively impaired and required extensive assistance for activities of daily living (ADLs) except she was independent with eating. The care plan with an effective date of 3/5/18 revealed problems which included that she required total to extensive assistance for ADLs, had a surgical wound on her left hip, was on a 1000 milliliter fluid restriction, required intermittent catheterization, had behavioral problems of yelling out for help or "I want to go to my room." and potential for weight changes but none of the problems or potential problems or interventions addressed the edema in her lower extremities. During an interview on 4/2/18 at 11:56 AM her responsible party stated the resident had swelling of her ankles which was present prior to admission to the facility.	F 656	1. What corrective action will be accomplished for the residents affected? A care plan was developed by the MDS Coordinator to address Resident #63's edema on April 4th, 2018. All nursing managers, nurses, and household leadership members will be in-serviced by the Director of Nursing or her designee by May 3rd, 2018 on Care Plans to ensure that they reflect services that are being furnished to residents and completed in a manner that promotes the residents highest practicable physical, mental, and psychosocial well-being. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? The MDS Coordinator will review all resident Care Plans of residents being treated for edema to ensure there is an accurate and up to date Care Plan in place. This review will be completed by May 3rd, 2018. All nursing managers, nurses, and household leadership members will be in-serviced by the Director of Nursing or her designee by May 3rd, 2018 on Care Plans to ensure that they reflect services that are being furnished to residents and completed in a manner that promotes the residents highest practicable physical, mental, and psychosocial well-being.	

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F 656	Continued From page 8 A review of the doctor's orders revealed an order dated 3/20/18 which said to apply compression stockings to bilateral lower extremities every morning and remove evening. Observations of the resident on 4/4/18 at 10/29 AM revealed she was sitting in a reclining chair watching TV in the common area. She was reclined and was wearing compression stockings. On 4/4/18 at 11:05 AM Nurse #1 stated Resident #63 continued to wear compression stockings but her swelling was not as severe as it was last week. She said the resident usually sat in the recliner in the common area with her feet elevated until lunch then after lunch she would go back to her room and sit in her recliner with her feet elevated. On 4/5/18 at1:25 PM the nurse house mentor reviewed the care plan and was unable to locate a care plan that addressed Resident #63's edema. She added the resident wore compression stockings due to edema in her lower extremities and they monitored her weight due for edema so, she should have a care plan that addressed the resident's edema. During an interview with the administrator on 4/5/18 at 2:30 PM he stated Resident #63 should have a care plan that addressed her edema.	F 656	3. What measures will be put into place to ensure this practice does not recur? The MDS Coordinator will review all resident Care Plans of residents being treated for edema to ensure there is an accurate and up to date Care Plan in place. This review will be completed by May 3rd, 2018. The Director of Nursing, the MDS Coordinator, or their/her designee will review all completed or updated resident Care Plans post May 3rd, 2018 to ensure compliance for three months. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All nursing managers, nurses, and household leadership members will be in-serviced by the Director of Nursing or her designee by May 3rd, 2018 on Care Plans to ensure that they reflect services that are being furnished to residents and completed in a manner that promotes the residents highest practicable physical, mental, and psychosocial well-being. The Director of Nursing, the MDS Coordinator, or their/her designee will review all completed or updated resident Care Plans post May 3rd, 2018 to ensure compliance for three months. The Director of Nursing, the MDS Coordinator, or their/her designee will report their results to the QAPI committee on a monthly basis for three months. The QAPI committee will determine, at the end of the three months, if the quality assurance practice should remain in place or be discontinued. Any concerns or compliance issues	

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F 656	Continued From page 9	F 656	related to Care Plans will be immediately reported to the Administrator. All in-services will be completed by the Director of Nursing or her designee and will be completed by May 3rd, 2018.	
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 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 interviews the facility failed to discard outdated milk from 1 of 2 walk in coolers. The findings included: On 4/2/18 at 10:28 AM during the initial observations of the kitchen with the dietary manager, the dining services coordinator and the dining services director, 3 cartons of 1% milk were observed in a box on the shelf along with 4	F 812	1. What corrective action will be accomplished for residents affected? The outdated milk was thrown out immediately. Any milk in the cooler that is past the Used By Date will be discarded by the dining staff. All dining staff will be in-serviced by the Dining Services Coordinator, The Dining Director, or their designee regarding outdated milk by May	5/3/18

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F 812	Continued From page 10 other boxes of milk. The milk was dated 3/27/18. Additional observations revealed another box of milk which was dated 4/11/18 on the outside of the box and contained 8 more cartons of 1% milk dated 3/27/18. During an interview on 4/5/18 at 12: 54 PM with the production manager he stated he did not work on 4/2/18 so he was not present to monitor the walk in cooler for expired milk. He said the milk should have been labeled "expired milk" or it should have been discarded. During an interview on 4/5/18 at 12:54 PM the dining services director said "We should not have outdated milk."	F 812	3rd 2018. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? At the start of each shift the Production Manager, Director of Dining Services, Dining Services Coordinator, or their designee will check, observe, and monitor the coolers to ensure no outdated milk is in the coolers. If outdated milk is found in the coolers it will be discarded and reported to the Administrator. This will occur on a daily basis for one month, then upon each food truck delivery (no less than twice a week) for one month, then once a week for one month. This process will be monitored by the API team monthly for three months, At the end of the three months the QAPI team will determine the necessity to continue monitoring this process. 3. What measures will be put into place to ensure this practice does not recur? All dining staff will be in-serviced by the Dining Services Coordinator regarding outdated milk by May 3rd, 2018. At the start of each shift the Production Manager, Director of Dining Services, Dining Services Coordinator, or their designee will check, observe and monitor the coolers to ensure no outdated milk is in the coolers. If outdated milk is found in the coolers it will be discarded and reported to the Administrator. This will occur on a daily basis for one month, then upon each food truck delivery (no less than twice a week) for one month, then once a week for one month. This process	

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GLENAIRE	4000 GLENAIRE CIRCLE CARY, NC 27511

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F 812	Continued From page 11	F 812	will be monitored by the QAPI team monthly for three months, At the end of the three months the QAPI team will determine the necessity to continue monitoring this process. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All dining staff will be in-serviced by the Dining Services Coordinator, The Dining Director, or their designee regarding outdated milk by May 3rd 2018. At the start of each shift the Production Manager, Director of Dining Services, Dining Services Coordinator, or their designee will check, observe and monitor the coolers to ensure no outdated milk is in the coolers. If outdated milk is found in the coolers it will be discarded and reported to the Administrator. This will occur on a daily basis for one month, then upon each food truck delivery (no less than twice a week) for one month, then once a week for one month. This process will be monitored by the QAPI team monthly for three months, At the end of the three months the QAPI team will determine the necessity to continue monitoring this process. The Dining Management Team will discuss comments or concerns related to the monitoring of the outdated milk weekly at the Dining Managers meeting. Any concerns related to this process will be reported immediately to the Administrator.	