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 02/24/2018

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

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F 000	INITIAL COMMENTS 1. 483.25 (F689) at J Immediate Jeopardy began on 02/22/18 when an oxygen tank was observed unsecured inside the back cargo area of a facility transportation van. Immediate Jeopardy was removed on 02/24/18 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. 2. 483.25 (F695) at J Immediate Jeopardy began on 02/22/18 when an oxygen tank was observed stored on its side and was unsecured in the back of a transportation van used for resident transports. Immediate Jeopardy was removed on 02/24/18 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. An extended survey was conducted in conjunction with the recertification and complaint survey from 02/19/18 through 02/24/18. No deficiencies were cited as a result of the facility's Complaint Investigation. Event ID # 4VD811.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		3/19/18

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

Electronically Signed | 03/19/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 1 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident (Resident #13) identified as a PASRR Level II and 1 of 1 resident reviewed for Hospice (Resident #59). Findings included: 1. Resident #13 was admitted to the facility on 11/20/13. A review of the PASRR Level II Determination Notification indicated Resident #13 was determined as PASRR Level II on 01/29/14. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. A review of Resident #13's annual Minimum Data Set (MDS) assessment dated 09/25/17 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. On 02/21/18 at 11:38 AM an interview was conducted with the MDS Coordinator who stated he was responsible for coding Section A of	F 641	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 and/or any other administrative or legal proceeding. F641 What measures did the facility put in place for the resident affected: Resident #13 was due to have MDS assessment dated for 09/25/18 that assessment was not coded correctly to	

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F 641	Continued From page 2 Resident #13's annual MDS assessment dated 09/25/17. The MDS Coordinator stated he was unaware that Resident #13 was determined as PASRR Level II. The MDS Coordinator stated he usually received resident PASRR Level II information from the Social Worker (SW). He stated the SW had not informed him that Resident #13 was determined as PASRR Level II and was missed for coding. The MDS Coordinator stated he would need to submit a modification to the annual MDS assessment dated 09/25/17 to reflect Resident #13 was PASRR Level II. On 02/21/18 at 11:51 AM an interview was conducted with the SW who stated Resident #13 was determined as PASRR Level II. The SW verified Resident #13 had a PASRR Level II Determination Notification from January 2014. The SW stated she was not aware that the MDS Coordinator had not been informed that Resident #13 was determined as PASRR Level II. On 02/21/18 at 11:53 AM an interview was conducted with the MDS Supervisor who stated her expectation was that the annual MDS assessment dated 09/25/17 would have been accurately coded to reflect Resident #13 was determined as PASRR Level II. The MDS Supervisor stated she was responsible for signing that Resident #13's annual MDS assessment dated 09/25/17 was completed and was not responsible for verifying the accuracy of the MDS assessment. The MDS Supervisor stated her expectation was that a modification to the annual MDS assessment dated 09/25/17 would be submitted to reflect Resident #13 was determined as PASRR Level II.	F 641	reflect Level II Passar. on 2/22/18 the MDS coordinator completed modification and resubmitted assessment. Resident # 59 was due to have a MDS assessment dated for 01/15/18 and that assessment was not coded to reflect hospice services. On 02/22/18 MDS Coordinator completed modification and resubmitted assessment. What measures were put in place for residents having the potential to be affected: 02/26/18 100% audit was completed on all residents who are on hospice services and level II Passar to ensure accuracy of information on MDSs. Administrator in-serviced MDS Nurses and Social Worker on accuracy of MDS section for hospice services and passar. What systems were put in place to prevent the deficient practice from reoccurring: On 2/26/18 the MDS coordinator, MDS nurse, DON, and Social Worker were in-serviced by the facility Administrator related to the Accuracy of information on a MDS. How the facility will monitor systems put in place: Beginning 03/05/18 the DON, SDC, and Social Worker will audit MDS assessments to ensure accuracy using MDS proper coding audit tool, audit tool will ensure hospice and passar is coded	

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F 641	Continued From page 3 On 02/21/18 at 11:59 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the annual MDS assessment dated 09/25/17 would have been accurately coded to reflect Resident #13 was PASRR Level II. The DON stated her expectation was that the MDS Coordinator would submit a modification to the annual MDS assessment dated 09/25/17 to indicate Resident #13 was determined as PASRR Level II. On 02/21/18 at 12:04 PM an interview was conducted with the Administrator who stated her expectation was that the annual MDS assessment dated 09/25/17 would have been accurately coded to reflect Resident #13 was PASRR Level II. The Administrator stated her expectation was that the MDS Coordinator would submit a modification to the annual MDS assessment dated 09/25/17 to indicate Resident #13 was determined as PASRR Level II. 2. Resident #59 was admitted to the facility on 10/21/05 with diagnoses including atrial fibrillation, hypertension, and peripheral vascular disease. A review of a physician's order dated 01/15/18 indicated Resident #59 was admitted to hospice services for congestive heart failure. A review of the Hospice Care Face Sheet dated 01/15/18 indicated Resident #59 was admitted to hospice care on 01/15/18 for diagnoses of chronic congestive heart failure. A review of the significant change Minimum Data Set (MDS) assessment dated 01/15/18 indicated Resident #59 was not coded under Section O as	F 641	correctly. This audit will be completed weekly x 5 weeks and then monthly x 3 months. The monthly QI committee will review the results of accuracy Audit Tool monthly for 3 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.	

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F 641	Continued From page 4 receiving hospice care On 02/22/18 at 2:53 PM an interview was conducted with the MDS Coordinator who stated he coded Resident #59's significant change MDS assessment dated 01/15/18. The MDS Coordinator stated he completed the significant change MDS assessment because Resident #59 was placed on hospice care on 01/15/18. The MDS Coordinator stated he missed coding hospice care under Section O on Resident #59's significant change MDS. The MDS Coordinator stated he would have to submit a modification to the significant change MDS assessment dated 01/15/18 to reflect Resident #59 was receiving hospice care. On 02/22/18 at 2:59 PM an interview was conducted with the Administrator who stated her expectation was that the significant change MDS assessment dated 01/15/18 would have been accurately coded to reflect Resident #59 was receiving hospice care. The Administrator stated her expectation was that the MDS Coordinator would submit a modification to the significant change MDS assessment to reflect Resident #59 was receiving hospice care. On 02/22/18 at 3:03 PM an interview was conducted with the MDS Supervisor who stated her expectation was that the significant change MDS assessment dated 01/15/18 would have been accurately coded to reflect Resident #59 was receiving hospice care. The MDS Supervisor stated she signed for completion of the significant change MDS assessment dated 01/15/18 but was not responsible for verifying the accuracy of the significant change MDS assessment. The MDS Supervisor stated her expectation was that the	F 641		

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F 641	Continued From page 5 MDS Coordinator would submit a modification to the significant change MDS assessment dated 01/15/18 to reflect Resident #59 was receiving hospice care. On 02/22/18 at 03:04 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the significant change MDS assessment dated 01/15/18 would have been accurately coded to reflect Resident #59 was receiving hospice care. The DON stated her expectation was that the MDS Coordinator would submit a modification to the significant change MDS assessment dated 01/15/18 to reflect Resident #59 was receiving hospice care.	F 641		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to provide a safe environment free from accident hazards during transportation of residents in a facility van when an oxygen tank was left unsecured in the back cargo area of the van which created the potential for injury for 3 of 3 sampled residents transported in a facility van (Resident #38, #9 and #294). The facility also	F 689	FTAG 689 What measures did the facility put in place for the resident affected: on 02/22/18 small van was noted to have o2 tank in cargo area of van laying on its side in a carrier. On 2/22/18 Maintenance Director removed o2 tank with no negative findings.	3/19/18

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F 689	Continued From page 6 failed to provide a comprehensive training program for transportation drivers which included safe transportation of oxygen tanks. Immediate Jeopardy began on 02/22/18 when an oxygen tank was observed unsecured inside the back cargo area of a facility transportation van. Immediate Jeopardy was removed on 02/24/18 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: The facility Administrator provided a copy of a document titled Maintenance of Oxygen Equipment and a section labeled Procedures indicated in part oxygen must be transported in an oxygen cart, secured on the back of a wheelchair or in the cylinder holder. A review of a document titled Safety Data Sheet for Oxygen indicated oxygen cylinders (tanks) contained gas under pressure and in a fire or if heated, a pressure increase would occur and the container may burst or explode. A section labeled handling and storage indicated cylinders should be stored upright with valve protection cap in place and firmly secured to prevent falling or being knocked over. a. Resident #38 was admitted to the facility on 12/20/16 with diagnoses which included chronic lung disease, heart disease, type 2 diabetes, anxiety, depression and end stage kidney	F 689	What measures were put in place for residents having the potential to be affected: 02/23/18 100% audit was completed by Maintenance Director on both vans with no negative findings. 02/23/18 Facility Administrator In-serviced maintenance Director on o2 tanks being secure at all times during transport. Maintenance Director in serviced all staff who transports residents in transportation vans to ensure that o2 is always appropriately secured. What systems were put in place to prevent the deficient practice from reoccurring: 02/23/2018 Transportation Aid was in serviced on how to do a walk thru on the van prior to going on a transport and reporting any issues to Administrator and or maintenance Director Immediately. How the facility will monitor systems put in place: The Maintenance Director or Designee will audit using the Daily Van Audit tool. The audit will be completed 5x a week for 4 weeks then weekly x 4 weeks then monthly thereafter. The monthly QI committee will review the results of the Van audit tool monthly for 3 months for identification of trends. The administrator and/or DON will present the findings and recommendations of the monthly QI	

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F 689	Continued From page 7 disease. A review of the most recent quarterly Minimum Data Set dated 01/06/18 revealed Resident #38 was cognitively intact for daily decision making and required limited assistance with transfers. During an interview on 02/21/18 at 02:06 PM Resident #38 stated he went to dialysis 3 days week and was transported to and from his appointments in the smaller transportation van of the 2 vans the facility used for transportation of residents. He explained the driver always secured the straps in the van to his wheelchair and he did not have any concerns about that but he was concerned about an oxygen tank he had seen in the past in the van that was not secured. He stated he saw the oxygen tank inside the van between the wall of the van and a seat but he could not recall how long it had been since he had seen it. He further stated he had seen the tank unsecured within the last several months and he had told a van driver about his concerns but could not recall her name. He explained he had been transported in the smaller facility van earlier today to his dialysis appointments but he did not see the oxygen tank during the transport. He stated Resident # 9 was also transported to dialysis on the same days and they had both been transported to and from dialysis earlier today in the smaller facility van. b. Resident #9 was admitted to the facility on 07/16/14 with diagnoses which included heart disease, type 2 diabetes and kidney disease. A review of the most recent annual MDS indicated Resident #9 was cognitively intact for daily decision making and required extensive assistance with transfers.	F 689	committee to the quarterly executive QA committee for further recommendations and oversight. Facility Administrator is responsible for Plan of Care.	

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F 689	Continued From page 8	F 689		

During an interview on 02/21/18 at 2:38 PM, Resident #9 confirmed he rode in the smaller facility van 3 days a week to his dialysis appointments and Resident #38 also rode in the van on the same days with him. He stated his wheelchair was secured in the van during transport but he was concerned about an oxygen tank that was stored in the back of the van. He explained he was not sure how the oxygen tank was secured and could not recall who had told him about the tank or how long it had been there or when he had last seen it but he did not observe it today because he could not see over the back seat of the van. He further stated he had asked a former van driver about it but was not sure what was done about it and he could not recall the name of the driver.

During an observation on 02/21/18 at 4:20 PM a large multi passenger van was located under a canopy at the front entrance of the facility but the smaller transportation van was not in the parking area.

During an interview on 02/22/18 at 10:14 AM, Transportation Aide (TA) #1 explained she had been transporting residents since July 2017 and transported residents daily. She stated the facility had 2 transportation vans and one was a large multi-passenger van used mostly for activities and a smaller mini-type van that she routinely used to transport residents to physician's appointments and to dialysis appointments. She confirmed she transported Resident #38 and #9 to dialysis 3 days a week at the same time and usually transported them in the small transportation van. She explained at the present time she was the only full-time TA but if she was transporting a resident to an appointment the

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F 689	Continued From page 9	F 689		

Activities Director (AD) or a Nurse Supervisor transported residents. She stated she had in-service training when she was hired to drive the van and took a test but the test did not include transport of oxygen tanks. She further stated she had to transport Resident #294 to a doctor's appointment today in the smaller transportation van.

c. Resident #294 was admitted to the facility on 02/04/18 with diagnoses which included difficulty walking, weakness, lack of coordination, muscle weakness and abnormal gait and mobility. A review of the admission (5 day) MDS dated 02/20/18 indicated Resident #294 was cognitively intact for daily decision making but and required extensive assistance with transfers.

During an observation on 02/22/18 at 10:29 AM, TA #1 secured Resident #294's wheelchair with the safety straps in the small transportation van. Resident #294 was not wearing oxygen and did not speak as she was secured in the van. Observations inside the passenger compartment of the van revealed there was no oxygen tank between the wall of the van and a seat. TA #1 then opened the back hatch door of the van and an oxygen tank was lying on its side inside a blue cover behind the back seat of the van. TA #1 did not move the oxygen tank or attempt to remove it from the back of the van and closed the back door of the van.

During an observation and follow up interview on 02/22/18 at 4:27 PM TA #1 was observed transporting Resident #294 in a wheelchair from the small transportation van parked at the front entrance of the facility to her room. TA #1 stated she did not know why the oxygen tank was in the

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F 689	Continued From page 10	F 689		

back cargo area of the van or who had placed it there or how long it had been there. She further stated she had never used the oxygen tank in the back of the van because oxygen tanks were usually transported in a rack on the back of the resident's wheelchair. She explained she had been trained to drive the facility vans by the Maintenance Director and TA #2 who no longer worked at the facility and the Maintenance Director was in charge of training van drivers.

During an observation and interview on 02/22/18 at 4:34 PM, the Maintenance Director opened the back hatch door of the small transportation van and verified an oxygen tank was lying in the cargo compartment in the back of the van behind the back seat. Upon further inspection, the oxygen tank was lying on its side and was partially covered inside a blue cover and had a gauge with a metal handle at the top of the tank and the top of the tank was lying on top of several small black cushions. Observations at the bottom of the tank revealed the end of the tank was next to a bucket with all purpose cleaning supplies inside and miscellaneous packages of briefs were lying next to the oxygen tank. The Maintenance Director picked up the oxygen tank and verified it was not secured to any type of rack or holder in the back of the van. He also verified the gauge on the tank had a needle positioned at 1,000 pounds per square inch (psi) which indicated the tank contained oxygen. The Maintenance Director stated the oxygen tank was not supposed to be stored in the back of the van unsecured and he was not sure who had left it there or how long it had been there but he would take it inside the facility to storage. He further stated when residents were transported in the van with oxygen they were supposed to have their oxygen tank

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F 689	Continued From page 11	F 689		

inside a holder on the back of their wheelchair. He confirmed he was assigned to provide training to van drivers but also confirmed the training materials did not cover transportation of oxygen tanks. He stated he checked the van for mechanical problems and he checked the van securement straps but he did not do periodic inspections to see what was stored in the storage compartments of the vans. He further stated he did not know who put the oxygen tank in the van or why it was there but a month or so ago he had seen an oxygen tank inside the small transportation van in the passenger area of the van and he had removed it. He explained at that time TA #2 had left the tank in the van after she had transported a resident and he had reminded TA #1 and TA #2 they could not transport oxygen tanks unsecured in the facility vans. He confirmed he did not document the incident or document any in-service training to the drivers at that time.

During a follow up interview on 02/22/18 at 5:53 PM, the Maintenance Director provided copies of in-service materials he used to train van drivers. He explained the documents were copies from a presentation for training van drivers and contained information regarding maintenance and service of the vans and for loading and unloading of residents. He stated the materials also covered responsibilities of the van driver and if a van was involved in an accident the driver was expected to call 911 for assistance. He further stated he was not responsible for hiring van drivers but when a driver was hired the Administrator or Director of Nursing (DON) called him to provide the training to them. He explained the training did not take long and on the first day they reviewed the materials and he gave them a test based on the materials he had provided to

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 02/24/2018

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 689	Continued From page 12	F 689		

them and after that he or the previous van driver (TA #2) went out with the new driver during transports for approximately a week. He stated van drivers were expected to re-take the test annually. He further stated it was his expectation that drivers were not supposed to transport an unsecured oxygen tank in a facility van. He explained no one had reported to him the oxygen tank was in the back of the small transport van but he would have expected van drivers to remove the cylinder and report it so they could get to the bottom of how the oxygen tank got there.

During a telephone interview on 02/22/18 at 9:09 PM, TA #2 confirmed she left the facility a little more than 3 weeks ago but had worked at the facility as a van driver for 2 years. She explained she had in-service training when she was first hired as a van driver and she had to take a test annually and demonstrate how to secure a resident's wheelchair inside the van. She further explained she was aware oxygen tanks were supposed to be transported on the back of a wheelchair in a tank holder and were not supposed to be transported unsecured in the back of the van however, she confirmed she had taken an extra tank of oxygen on long transports because she did not want the resident to run out of oxygen before they got to their appointment. She stated when she took an extra tank it was usually stored in the back cargo area of the small transportation van. She explained she usually laid the oxygen tank down on its side and placed packages of supplies such as briefs, boxes of gloves and wipes around it. She confirmed there was also a bucket of cleaning supplies next to the oxygen tank in case a resident had an accident and they had to clean inside the van and there

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 02/24/2018

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F 689	Continued From page 13	F 689		

were also small cushions around the oxygen tank they used to put in resident's wheelchairs when they were uncomfortable. She stated she did not remember if anyone told her to transport the oxygen tank that way but she was afraid a resident might run out of oxygen on a long transport and she wanted to have an extra oxygen tank just in case she needed it. She further stated she could not say when she last saw an oxygen tank in the back of the small transportation van but recalled the drivers had been told by the Maintenance Director they were not supposed to carry an oxygen tank in the van that was unsecured and they were told they had to put the tank up inside the facility when they came back with the van but she did not recall when the Maintenance Director talked to them.

During an interview 02/23/18 at 10:17 AM, the Maintenance Director stated if there was a mechanical issue with the van he expected the drivers to report it to him. He further stated in the past oxygen issues was reported to the DON or Administrator and his concerns were for drivers to check the safety securement straps to the wheelchairs but not anything related to oxygen.

During a follow up interview on 02/23/18 at 10:38 AM the Maintenance Director verified the oxygen tank he removed from the small transportation van on 02/22/18 was a large Type E oxygen tank with capacity for 3000 PSI pressure. He repeated he was not responsible for oxygen or transport of oxygen tanks in the vans.

During a follow up interview on 02/23/18 at 11:55 AM, TA #1 confirmed she did not watch a video as part of van training. She explained she was in training for approximately 2 weeks and the first

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 02/24/2018

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(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 689	Continued From page 14	F 689		

day she spent with the Maintenance Director and after the first day she rode with TA #2 for the rest of the week and the following week. She further explained Resident #38 told her several months ago about an oxygen tank that was unsecured in the small transportation van and he was uncomfortable with it and TA #2 was present. She stated she reported it to the Maintenance Director and he took the oxygen tank out of the van and told TA #1 and TA #2 not to transport oxygen tanks in vans unless they were secure in a rack. She further stated she could not remember a specific date when the Maintenance Director told them not to transport oxygen tanks that were unsecured in the transportation vans.

During an interview on 02/23/18 at 1:03 PM, the Administrator stated the Maintenance Director was responsible for training drivers to transport residents in facility vans. She explained TA #2 who no longer worked at the facility had been expected to also train van drivers when she was employed by the facility since she was the senior driver. She also confirmed the training documents the Maintenance Director used to train van drivers were printed documents from a power point type presentation but the facility did not have a video for training van drivers.

During an interview on 02/23/18 at 3:45 PM, the DON stated she had worked at the facility for almost 2 years but was assigned less than 3 weeks as the acting DON. She explained she was aware the Maintenance Director was responsible for transportation and training of van drivers. She stated she had no knowledge there was an oxygen tank unsecured in the back of the small transportation van. She further stated it was her expectation for oxygen tanks to be

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 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 15	F 689		

secured when transported to prevent the potential for harm. She explained oxygen tanks should be transported in a metal rack on the back of a wheelchair or they could be in a cloth transport cover that was strapped and secured to the back of the wheelchair. She further stated she expected for van drivers to check supplies that were in the van and training should include transport of oxygen in a van.

During an interview on 02/24/18 at 9:18 AM, the Activity Director stated she was one of the back-up van drivers and had been a van driver for approximately 15 years. She explained when she first started driving the Maintenance Director rode with her and she had to take a test annually. She further explained she usually drove the large multi passenger van for activities or to pick up a resident if the smaller van was out on a transport. She stated she was aware oxygen tanks were supposed to be secured on the back of a resident's wheelchair and had not seen an unsecured oxygen tank in the large multi-passenger van that was unsecured.

During an interview on 02/23/18 at 8:52 AM, the Administrator stated it was her expectation that oxygen tanks should be secured if they were transported in a facility van. She further stated the training needed to be revised to include how oxygen tanks should be transported in facility vans.

During a follow up interview on 02/24/18 at 3:55 PM the Administrator confirmed there were no residents currently at the facility who were routinely transported with oxygen. She explained residents who usually were transported with oxygen were newly admitted residents from the

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 02/24/2018

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

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F 689	Continued From page 16	F 689		

hospital.

During an interview on 02/24/18 at 11:34 AM, a Nursing Supervisor confirmed she was a back-up van driver but only drove a facility van if TA #1 was out of the facility transporting another resident. She explained she drove the larger multi-passenger van because that was the one she was trained to drive. She further explained the smaller transportation van was the one that was usually used to transport residents to physician appointments or to dialysis. She stated she was trained to drive the multi-passenger van by a former Maintenance Director and she took a paper test after her initial training. She confirmed she had not had any retraining since her initial training and had only taken the paper test one time when she was first trained as a van driver. She explained if a resident required oxygen they had a cloth bag or a metal rack on the back of their wheelchair and that was where the tank was supposed to be stored. She stated she had not heard before that an oxygen tank was stored unsecured in the back of the small transportation van before now.

The Administrator and Director of Nursing were informed of Immediate Jeopardy on 02/23/28 at 1:52 PM.

The facility provided an acceptable credible allegation for immediate jeopardy removal on 02/24/18 at 04:57 PM.

Credible Allegation of Immediate Jeopardy Removal
F689 Free of accident Hazards/ Supervision/Devices
On February 21, 2018 Resident #38 and Resident

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 02/24/2018

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

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F 689	Continued From page 17	F 689		

#9, voiced concerns of observing an unsecured oxygen tank in the facility's transport van #1 during a recent transport in this van. On February 22, 2018 at approximately 10:00 am Surveyor requested to speak to transport aid stated she wanted to see her secure a resident in the van, upon request to look in the van Transportation Aide (TA) #1 opened the back-hatch door of the van and surveyor observed an oxygen tank inside a blue cover laying on its side.

On February 22, 2018 at 4:34 PM Transportation Aide #1 returned to the facility with the resident that she transported in transport Van #1. Observations of the transport van at this time revealed the tank of oxygen was still laying on its side in bag noted in the van's rear interior storage compartment in same area. The oxygen tank was observed to be unsecured and improperly stored in the transport van. The facility's Maintenance Director immediately removed the oxygen tank from the transport van when it was brought to his attention. He then placed it in the dirty supply room in oxygen holder. Additionally, it was revealed facility transport staff were not adequately trained on how to properly transport oxygen, in the facility transport van. The training for the facility transporters includes a packet of training materials, a power point handout that they reviewed during orientation, and a final exam. Interviews with facility transport staff and the Maintenance Director revealed staff were not completing checks of the facility's transport van's interior or exterior to ensure the van was safe prior to transporting a resident.

As of 02/23/18 the facility's maintenance director and TA #1, activity director, LPN unit coordinator who are currently the only staff who transport

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 02/24/2018

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

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F 689	Continued From page 18	F 689		

residents in the two facility transport vans.

As of 02/23/18 the facility has a total of 5 residents who were regularly transported in the facility's two transport vans on a weekly basis. Facility Staff interviewed these 5 residents and there were no harmful effects or negative findings.

On February 23, 2018 the facility's Clinical Risk Manager put a system in place that included a new check off sheet for transportation aids to assess the van's interior and exterior for safety issues before and after each use. This check off sheet directs staff to observe for hazards including; observing for improper oxygen storage. On 02/23/18 the Administrator provided training to the maintenance director on how to fill out the check off sheet and assess the van for safety prior to resident transports. This training included that when staff conduct the van assessment and find any concerns they are to report these issues immediately to the Administrator and/or the Maintenance Director.

On 02/23/18 the facility's Administrator was Trained by Facility Nurse Consultant then Administrator trained maintenance director on how to implement the new audit titled Skill Check list, to assess the facility's vans for safety issues prior to transporting residents, on how oxygen should be properly secured in the van and how to report any safety issues identified.

On 02/23/18 Transportation aide #1 was in serviced by the Maintenance Director on how to securely strap oxygen in van if needed for a resident transport, on the new check off sheet to assess the van for safety prior to transporting a

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 02/24/2018

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

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F 689	Continued From page 19	F 689		

resident and the expectation that any issue identified must be reported immediately to the administrator and/or Maintenance Director. This training included completing an in-service entitled "Transport" which specifies all oxygen tanks must be secured in a holder either in the back of a wheelchair or secured in a van on the back of the wheelchair in an oxygen holder that is made to secure it to wheelchair.

On February 23, 2018 all other applicable staff members including; the Activity Director, LPN, Maintenance staff. were included on the in-service titled "Transport" and the Skills Check List to assess the facility vans for safety issues provided by the Maintenance Director. This training included that when staff conduct the van assessment and find any concerns they are to report these issues immediately to the Administrator and/or the Maintenance Director. Transportation Aid will be trained upon hire and annually thereafter. By the Maintenance Director

On 02/23/18 the facility's maintenance director utilized the new check off sheet to assess both of the facility's transport vans for safety issues. Both of the facility's transport vans were found to have no safety issues and to be in safe operating condition. During these checks no oxygen tanks were observed stored in either of the facility's transport vans.

On 02/24/18 the facility's licensed and unlicensed nursing staff were trained by the Maintenance Director on the facility's policy on the proper storage of oxygen and how to transport a resident with oxygen. No nursing staff will be allowed to work after 02/24/18 unless they have received this training. On 02/24/18 this training was added

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 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 20 to the Facility Orientation program for all newly hired nursing staff, transportation aides and maintenance staff. This training will include how to use the check off sheet to identify possible van transport safety issues and the need to report concerns immediately to the administrator and/or maintenance director. Beginning on 02/24/18 an administrative audit of Van checks off list, and Safety will be completed by the maintenance director five times a week for a month, then weekly for four weeks. Any concerns will be immediately reported to the facility's administrator. Then will continue as a monthly audit. All findings, concerns, and recommendations will be reported to the QI committee during monthly meetings. The facility's administrator is responsible for implementing the facility's Credible Allegation of Compliance. Immediate Jeopardy was removed on 02/24/18 when interviews with van transportation drivers and nursing staff validated they had received in-service training on transportation of oxygen tanks in facility owned transportation vans. An interviews with Maintenance Director revealed he had also received in-service training regarding transportation of oxygen tanks in facility owned vans.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		3/19/18

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 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 690	Continued From page 21 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure a resident's catheter bag was not in contact with the floor for 1 of 3 residents (#51). Findings included:	F 690	FTAG 690 What measures did the facility put in place for the resident affected: Resident # 51 was noted to have catheter bag position on the crossbars of his wheelchair and not on the frame of the chair which allowed it to move down,	

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 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 690	Continued From page 22 Resident #51 was admitted to the facility on 10/07/15 with diagnoses that included: sepsis, retention of urine, neuromuscular dysfunction of bladder and paraplegia among others. Review of Resident #51's most recent assessment (MDS) dated 01/11/18 and coded as a quarterly assessment revealed Resident #51 to be cognitively intact. Resident #51 was further coded as requiring limited assistance with personal hygiene and locomotion on/off unit and needed extensive assistance with toilet use, personal hygiene and transfer. Further review of the MDS revealed Resident #51 was coded as having an indwelling catheter. A review of Resident #51's care plan revealed a care plan area for: "[Resident #51] has an indwelling urinary catheter secondary to a neurogenic bladder from his paraplegia". Interventions included: "Position catheter bag and tubing below the level of the bladder. On 02/21/18 an observation of Resident #51 at 3:25 PM revealed the resident to be in his room conversing with visitors. Resident #51 was sitting in his wheelchair with his back to the door of his room. At this time, Resident #51's catheter bag was observed to be touching the floor as it was hung on the crossbar of his wheelchair underneath the seat. An observation made on 02/22/18 at 3:56 PM revealed resident to be sitting in his wheelchair outside of the facility in the designated smoking area. At the time of this observation, it was noted that Resident #51's catheter bag was touching the pavement. During an interview with Resident #51 on	F 690	Resident #51 was observed sitting in his Wheelchair with his catheter bag touching the floor, DON assessed placement of resident□s catheter bag with no negative findings. What measures were put in place for residents having the potential to be affected: 02/26/18 Don initiated 100% in-service to all nursing staff on Catheter Bags. Catheter Bags at no time can be touching the floor. In-service will be completed by 03/16/18 02/26/18 100 % audit was completed of all residents with Catheters to ensure no bags where touching the floor. What systems were put in place to prevent the deficient practice from reoccurring: 02/26/18 Don initiated 100% in-service to all nursing staff on Catheter Bags. Catheter Bags at no time can be touching the floor. In-service will be completed by 03/16/18. How the facility will monitor systems put in place: On 02/26/18 The Don, MDS Nurse, Treatment Nurse or Floor Nurse will audit Catheters to ensure they are not touching the floor 5x a week for 3 weeks then weekly x 3 weeks then monthly x 3 months. The monthly QI committee will review the results of the audit tool monthly	

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 02/24/2018

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

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F 690	Continued From page 23 02/23/18 at 3:57 PM he reported hearing his catheter bag drag the floor "constantly" and did not know whether or not it was due to where the staff hang his bag on his wheelchair. He further stated he mainly heard the bag drag when he would cross door thresholds and when he would go out on the patio to smoke. He reported he was worried if his bag continued to drag that it might get "hung up somewhere" or that he may "wear a hole" in the bag. He stated he would prefer his catheter bag to be elevated more to keep it from dragging the ground. During an interview with the Director of Nursing on 02/23/18 at 6:57 AM she reported knowing that catheter bags were not to be on the floor and it was her expectation that catheter bags do not touch the floor. During an interview with the Administrator on 02/23/18 at 4:48 PM she reported it was her expectation that catheter bags not touch the floor and reported she would speak with her staff and have the problem fixed immediately.	F 690	for 3 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. Facility Administrator is responsible for Plan of Care.	
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		3/19/18

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 02/24/2018

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 695	Continued From page 24 Based on observations, record reviews and resident and staff interviews the facility failed to assure safe handling of an oxygen tank in a facility transportation van used for resident transports when an oxygen tank was observed stored on its side and unsecured in the back of a transportation van with the potential for injury for 3 of 3 sampled residents transported in the van (Resident #38, #9 and #294). Immediate Jeopardy began on 02/22/18 when an oxygen tank was observed stored on its side and was unsecured in the back of a transportation van used for resident transports. Immediate Jeopardy was removed on 02/24/18 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: The facility Administrator provided a copy of a document titled Maintenance of Oxygen Equipment and a section labeled Procedures indicated in part oxygen must be transported in an oxygen cart, secured on the back of a wheelchair or in the cylinder holder. A review of a document titled Safety Data Sheet for Oxygen indicated oxygen cylinders (tanks) contained gas under pressure and in a fire or if heated, a pressure increase would occur and the container may burst or explode. A section labeled handling and storage indicated cylinders should be stored upright with valve protection cap	F 695	F695 final What measures did the facility put in place for the resident affected: on 02/22/18 small van was noted to have o2 tank in cargo area of van laying on its side in a carrier. On 2/22/18 Maintenance Director removed o2 tank, with no negative findings. What measures were put in place for residents having the potential to be affected: 02/23/18 100% audit was completed by Maintenance Director on both vans with no negative findings. Facility Administrator In-serviced Maintenance Director to make sure that o2 is always appropriately secured when transported. Maintenance Director in serviced all Drivers of the transportation vans to make sure that o2 is always appropriately secured when transported. What systems were put in place to prevent the deficient practice from reoccurring: 02/23/2018 Facility Administrator In-serviced Maintenance Director on walk thru on van. Maintenance Director in serviced Transportation Aid on how to do a walk thru on the van prior to going on a transport and reporting any issues to Administrator and or maintenance Director. How the facility will monitor systems put in	

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 02/24/2018

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F 695	Continued From page 25 in place and firmly secured to prevent falling or being knocked over. a. Resident #38 was admitted to the facility on 12/20/16 with diagnoses which included chronic lung disease, heart disease, type 2 diabetes, anxiety, depression and end stage kidney disease. A review of the most recent quarterly Minimum Data Set dated 01/06/18 revealed Resident #38 was cognitively intact for daily decision making and required limited assistance with transfers. During an interview on 02/21/18 at 02:06 PM Resident #38 stated he went to dialysis 3 days week and was transported to and from his appointments in the smaller of 2 transportation vans the facility used for transportation of residents. He explained he did not have any concerns about how his wheelchair was secured in the van but he was concerned about an oxygen tank he had seen in the past in the van that was not secured. He stated he saw the oxygen tank inside the van between the wall of the van and a seat but he could not recall how long it had been since he had seen it but thought it was within the last several months. He further stated he had told a van driver about his concerns but could not recall her name. He explained he had been transported in the smaller facility van earlier today to his dialysis appointments but he did not see the oxygen tank during the transport. He stated Resident # 9 was also transported to dialysis on the same days and they had both been transported to and from dialysis earlier today in the smaller facility van. b. Resident #9 was admitted to the facility on 07/16/14 with diagnoses which included heart	F 695	place: On 02/23/18 Transportation Aid, and Maintenance Director, or Designee will monitor Vans to ensure no o2 on the van is unsecure. The Maintenance Director or Designee will audit using the Daily Van Audit tool. The audit will be completed 5x a week for 4 weeks then weekly x 4 weeks then monthly there after The monthly QI committee will review the results of the Van audit tool for identification of trends. 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. Facility Administrator is responsible for Plan of Care.	

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	345163	A. BUILDING _____ B. WING _____	C 02/24/2018

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F 695	Continued From page 26	F 695		

disease, type 2 diabetes and kidney disease. A review of the most recent annual MDS indicated Resident #9 was cognitively intact for daily decision making and required extensive assistance with transfers.

During an interview on 02/21/18 at 2:38 PM, Resident #9 confirmed he rode in the smaller facility van 3 days a week to his dialysis appointments and Resident #38 also rode in the van on the same days with him. He stated his wheelchair was secured in the van during transport but he was concerned about an oxygen tank that was stored in the back of the van. He explained he was not sure how the oxygen tank was secured and could not recall who had told him about the tank or how long it had been there or when he had last seen it but he did not observe it today because he could not see over the back seat of the van. He further stated he had asked a former van driver about it but was not sure what was done about it and he could not recall the name of the driver.

During an interview on 02/22/18 at 10:14 AM, Transportation Aide (TA) #1 explained she had been transporting residents since July 2017 and transported residents daily. She stated she usually transported residents in the smaller mini-type van provided by the facility to physician's appointments and to dialysis appointments and a larger multi-passenger van was available for activities or for back up drivers to use for resident transports. She confirmed she transported Resident #38 and #9 to dialysis 3 days a week at the same time and usually transported them in the small transportation van and she had to transport Resident #294 to a doctor's appointment today in the small

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 02/24/2018

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 695	Continued From page 27	F 695		

transportation van.

c. Resident #294 was admitted to the facility on 02/04/18 with diagnoses which included difficulty walking, weakness, lack of coordination, muscle weakness and abnormal gait and mobility. A review of the admission (5 day) MDS dated 02/20/18 indicated Resident #294 was cognitively intact for daily decision making but required extensive assistance with transfers.

During an observation on 02/22/18 at 10:29 AM, TA #1 secured Resident #294's wheelchair inside the passenger compartment of the small transportation van and there was no oxygen tank between the wall of the van and a seat. TA #1 then opened the back hatch door of the van and an oxygen tank was lying on its side inside a blue cover behind the back seat of the van. TA #1 did not move the oxygen tank or attempt to remove it from the back of the van and closed the back door of the van.

During an observation and follow up interview on 02/22/18 at 4:27 PM, TA #1 was observed transporting Resident #294 in a wheelchair from the small transportation van parked at the front entrance of the facility to her room. TA #1 stated she did not know why the oxygen tank was in the back cargo area of the van or who had placed it there or how long it had been there. She further stated she had never used the oxygen tank in the back of the van because oxygen tanks were usually transported in a rack on the back of the resident's wheelchair but she had not thought to ask anyone about it. She explained she received training to drive and operate the safety securement straps in the facility vans but her training materials or test she received did not

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	345163	A. BUILDING _____ B. WING _____	C 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 28 include transportation of oxygen tanks in facility vans. During an observation and interview on 02/22/18 at 4:34 PM, the Maintenance Director opened the back hatch door of the small transportation van and verified an oxygen tank was lying in the cargo compartment in the back of the van behind the back seat. Upon further inspection, the oxygen tank was lying on its side and was partially covered inside a blue cover and had a gauge with a metal handle at the top of the tank and the top of the tank was lying on top of several small black cushions. Observations at the bottom of the tank revealed the end of the tank was next to a bucket with all purpose cleaning supplies inside and miscellaneous packages of briefs were lying next to the oxygen tank. The Maintenance Director picked up the oxygen tank and verified it was not secured to any type of rack or holder in the back of the van. He also verified the gauge on the tank had a needle positioned at 1,000 pounds per square inch (psi) which indicated the tank contained oxygen. The Maintenance Director stated the oxygen tank was not supposed to be stored in the back of the van unsecured and he was not sure who had left it there or how long it had been there but he would take it inside the facility to storage. He further stated when residents were transported in the van with oxygen they were supposed to have their oxygen tank inside a holder on the back of their wheelchair. He confirmed he was assigned to provide training to van drivers but also confirmed the training materials he provided to drivers did not cover transportation of oxygen tanks and he did not routinely check the facility vans for storage of oxygen tanks.	F 695		

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	345163	A. BUILDING _____ B. WING _____	C 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 29	F 695		

During a follow up interview on 02/22/18 at 5:53 PM, the Maintenance Director stated it was his expectation that van drivers were not supposed to transport an unsecured oxygen tank in a facility van. He explained no one had reported to him the oxygen tank was in the back of the small transport van but he would have expected van drivers to remove the cylinder and report it so they could get to the bottom of how the oxygen tank got there.

During a telephone interview on 02/22/18 at 9:09 PM, TA #2 confirmed she left the facility a little more than 3 weeks ago but had worked at the facility as a van driver for 2 years. She explained she was aware oxygen tanks were supposed to be transported upright on the back of a wheelchair in a tank holder and were not supposed to be transported unsecured in the back of the van however, she confirmed she had taken an extra tank of oxygen on long transports because she did not want the resident to run out of oxygen before they got to their appointment. She stated when she took an extra tank it was usually stored in the back cargo area of the small transportation van. She explained she usually laid the oxygen tank down on its side and placed packages of supplies such as briefs, boxes of gloves and wipes around it. She confirmed there was also a bucket of cleaning supplies next to the oxygen tank in case a resident had an accident and they had to clean inside the van and there were also small cushions around the oxygen tank they used to put in resident's wheelchairs when they were uncomfortable. She stated she did not remember if anyone told her to transport the oxygen tank that way but she was afraid a resident might run out of oxygen on a long transport and she wanted to have an extra

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 02/24/2018

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F 695	Continued From page 30	F 695		

oxygen tank just in case she needed it. She further stated she could not say when she last saw an oxygen tank in the back of the small transportation van but recalled the drivers had been told by the Maintenance Director they were not supposed to carry an oxygen tank in the van that was unsecured and they were told they had to put the tank up inside the facility when they came back with the van but she did not recall when the Maintenance Director had talked with them.

During an interview on 02/23/18 at 10:38 AM the Maintenance Director verified the oxygen tank he removed from the small transportation van on 02/22/18 was a large Type E oxygen tank with capacity for 3000 PSI pressure. He repeated he was not responsible for oxygen or transport of oxygen tanks in the vans.

During an interview on 02/23/18 at 3:45 PM, the DON stated she had worked at the facility for almost 2 years but had been assigned less than 3 weeks as the acting DON. She explained she was aware the Maintenance Director was responsible for transportation and training of van drivers. She stated she had no knowledge there was an oxygen tank unsecured in the back of the small transportation van. She further stated it was her expectation for oxygen tanks to be secured when transported to prevent the potential for harm. She explained oxygen tanks should be transported in a metal rack on the back of a wheelchair or they could be in a cloth transport cover that was strapped and secured to the back of the wheelchair.

During an interview on 02/24/18 at 9:18 AM, the Activity Director stated she was one of the

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 02/24/2018

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F 695	Continued From page 31	F 695		

back-up van drivers and had been a van driver for approximately 15 years. She explained she was aware oxygen tanks were supposed to be secured on the back of a resident's wheelchair but she had not seen an unsecured oxygen tank in the large multi-passenger van she occasionally drove when she transported residents out of the facility for activities.

During an interview on 02/23/18 at 8:52 AM, the Administrator stated it was her expectation that oxygen tanks should be secured if they were transported in a facility van. She further stated the training needed to include how to transport oxygen tanks in facility vans.

During an interview on 02/24/18 at 11:34 AM, a Nursing Supervisor confirmed she was a back-up van driver but only drove the larger multi-passenger facility van if TA #1 was out of the facility transporting another resident. She explained if a resident required oxygen they usually had a cloth bag or a metal rack on the back of their wheelchair and that was where the tank was supposed to be stored.

The Administrator and Director of Nursing were informed of Immediate Jeopardy on 02/23/28 at 1:52 PM.

The facility provided an acceptable credible allegation for immediate jeopardy removal on 02/24/18 at 04:57 PM.

Credible Allegation of Immediate Jeopardy Removal F695
Respiratory/tracheostomy care and suctioning
On February 21, 2018 Resident #38 and Resident #9, voiced concerns of observing an unsecured

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 02/24/2018

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F 695	Continued From page 32	F 695		

oxygen tank in the facility's transport van #1 during a recent transport in this van. On February 22, 2018 at approximately 10:00 am Surveyor requested to speak to transport aid stated she wanted to see her secure a resident in the van, upon request to look in the van Transportation Aide (TA) #1 opened the back-hatch door of the van and surveyor observed an oxygen tank inside a blue cover laying on its side.

On February 22, 2018 at 4:34 PM Transportation Aide #1 returned to the facility with the resident that she transported in transport Van #1. Observations of the transport van at this time revealed the tank of oxygen was still laying on its side in bag noted in the van's rear interior storage compartment in same area. The oxygen tank was observed to be unsecured and improperly stored in the transport van. The facility's Maintenance Director immediately removed the oxygen tank from the transport van when it was brought to his attention. He then placed it in the dirty supply room in oxygen holder. Additionally, it was revealed facility transport staff were not adequately trained on how to properly transport oxygen, in the facility transport van. The training for the facility transporters includes a packet of training materials, a power point handout that they reviewed during orientation, and a final exam. Interviews with facility transport staff and the Maintenance Director revealed staff were not completing checks of the facility's transport van's interior or exterior to ensure the van was safe prior to transporting a resident.

On February 23, 2018 the facility's Clinical Risk Manager put a system in place that included a new check off sheet for transportation aids to assess for correct placement of oxygen tanks.

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 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 33	F 695		

This check off sheet directs staff to observe for hazards including; observing for improper oxygen storage. On 02/23/18 the Clinical Risk Manager provided training to the maintenance director on how to fill out the check off sheet and assess the van for safety prior to resident transports. This training included that when staff conduct the van assessment and find any concerns they are to report these issues immediately to the Administrator and the Maintenance Director.

On 02/23/18 the facility's Administrator trained the maintenance director on how to implement the new audit titled Skill Check list, to assess the facility's vans for safety issues prior to transporting residents, on how oxygen should be properly secured in the van and how to report any safety issues identified.

On 02/23/18 Transportation aide #1 was in serviced by the Maintenance Director on how to securely strap oxygen in van if needed for a resident transport. Any identified issues must be reported immediately to the administrator and/or Maintenance Director.

On February 23, 2018 all other applicable staff members including; the Activity Director, LPN, Maintenance were included on the in- service tilted "Transport" provided by the Maintenance Director.

On 02/24/18 the facility's licensed and unlicensed nursing staff were trained Maintenance Director on the facility's policy on the proper storage of oxygen and how to transport a resident with oxygen. No nursing staff will be allowed to work after 02/24/18 unless they have received this training. On 02/24/18 this training was added to

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	345163	A. BUILDING _____ B. WING _____	C 02/24/2018

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F 695	Continued From page 34 the Facility Orientation program for all newly hired nursing staff, transportation aides and maintenance staff. This training will include how to use the check off sheet to identify possible van transport safety issues and the need to report concerns immediately to the administrator and/or maintenance director. The facility's administrator is responsible for implementing the facility's Credible Allegation of Compliance. Immediate Jeopardy was removed on 02/24/18 when interviews with van transportation drivers and nursing staff validated they had received in-service training on transportation of oxygen tanks in facility owned transportation vans. An interviews with Maintenance Director revealed he had also received in-service training regarding transportation of oxygen tanks in facility owned vans.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior	F 700		3/19/18

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 02/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 35 to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to assess the need for a side rails for a resident who was using half bedrails to both sides of his bed. This was evidenced in 1 of 1 residents (Resident #92) who was reviewed for side rail usage. Findings Included: Resident #92 was admitted to the facility on 1/17/18 with diagnoses that included: muscle weakness, cognitive communication deficit, chronic pain, difficulty walking, hemiplegia and hemiparesis among others. Review of Resident #92's Admission Minimum Data Set (MDS) dated 1/29/18 revealed resident to be mildly cognitively impaired. Resident #92 was also coded as not utilizing side rails at the time of MDS completion. A review of Resident #92's care plan on 2/22/18 revealed no care plan area for side rail use. A review of Resident #92's medical chart revealed no current side rail assessment for the resident. An observation of resident on 2/22/18 at 1:37 PM revealed him to be in his room, in bed and watching television while visiting with his spouse. It was observed at this time that Resident #94	F 700	F700 What measures did the facility put in place for the resident affected: Resident #92 was admitted on 01/17/18 no side rail assessment was completed on admission. on 02/22/18 Resident was observed in bed with half side rails in upright position, Resident #92 did not have a side rail assessment completed in point click care. On 02/27/18 side rail assessment was completed for resident #92. What measures were put in place for residents having the potential to be affected: 03/13/18 Admin Nurses completed 100% audit on all residents to ensure they have a side rail assessment. What systems were put in place to prevent the deficient practice from reoccurring: On 03/01/18 Don initiated an in-serviced for all licensed Nurses on completing Side Rail Assessments on all new admissions. in-service completed by 03/16/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 700	Continued From page 36 had half side rails on both sides of his bed. Further observations on 2/20/18 at 3:41 PM and 2/21/18 at 9:47 AM revealed the half side rails to continue to be in the upright position while Resident #94 was in bed. During an interview with Nurse Aide #3 on 2/22/18 at 2:53 PM, she reported to her knowledge, Resident #92 had always had side rails on his bed while a resident at the facility. During an interview with Hall Nurse #1 on 2/23/18 at 3:19 PM, she reported Resident #92's most recent admission to the facility was on 1/17/18. She further stated that hall nurses were responsible to do side rail assessments on residents upon admission or readmission into the facility. When asked if she could locate Resident #92's assessment upon his reentry into the facility she stated "I don't see it ... it's not in here". During an interview with the Director of Nursing on 2/23/18 at 12:03 PM she verified there was no side rail assessment for Resident #92. 1/17/18 admission. During a follow up interview with the Director of Nursing on 2/23/28 at 3:41 PM she stated that a side rail assessment should have been completed for Resident #92. She verified that hall nurses were responsible for completing side rail assessments on residents when they are admitted or readmitted to the facility. She further reported it was her expectation that all necessary assessments were to be completed upon a resident's entry into the facility. An interview with the Administrator on 2/23/18 at 3:52 PM revealed she expected the hall nurses to start the assessment of residents upon their admission into the facility but that the	F 700	How the facility will monitor systems put in place: Beginning 02/26/18 the DON, or designee will audit side rail assessments to ensure accuracy using side rail audit tool. This audit will be completed weekly x 5 weeks on all new admissions and then monthly x 3 months on all new admissions. The DON and/or ADON will present findings to the monthly QI committee. The monthly QI committee will review the results of accuracy Audit Tool monthly for 3 months for identification of trends. 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. Facility Administrator is responsible for Plan of Care.	

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 02/24/2018

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F 700	Continued From page 37 administrative nurses should have followed up to ensure the completion of all assessments. She further stated it was her expectation that "assessments were to be completed in a timely manner".	F 700		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard 1of 1 multi-dose tuberculin vaccine vial that was	F 761	F761 What measures did the facility put in place	3/19/18

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F 761	Continued From page 38 opened and undated and was available for use in 1 of 2 medication refrigerators. Findings included: A review of the manufacturer's recommendation for multi-dose tuberculin vaccine indicated that once opened the product was to be discarded after 30 days. A review of the facility policy entitled Storage of Medications (revised 04/2007) indicated the facility shall not use outdated or deteriorated drugs or biologicals. All such drugs were to be returned to the dispensing pharmacy or destroyed. On 02/21/18 at 9:08 AM 1of 1 multi-dose vial of tuberculin purified protein derivative with lot # C5471AA and a manufacturer's expiration date of 08/09/2020 was observed opened and undated in the 300-400 hall medication refrigerator. Nurse #2 verified the tuberculin vaccine was opened and undated and remained in the medication refrigerator ready for resident use. Nurse #2 stated the facility policy was to date the tuberculin vial when opened. Nurse #2 stated because the tuberculin vaccine had not been dated when opened then it could not be determined when the tuberculin vaccine would expire. Nurse #2 immediately removed the undated tuberculin vaccine vial from the medication refrigerator. On 02/21/18 at 9:18 AM an interview was conducted with the Director of Nursing (DON) who verified that the tuberculin vaccine multi-dose vial was opened and ready for resident use in the 300-400 hall medication refrigerator. The DON stated the tuberculin vaccine should	F 761	for the resident affected: On 02/21/18 in the med room refrigerator surveyor noted a vial of tuberculin that had been opened but had no open date on the vial. 02/21/18 The vial was immediately removed with no negative findings. What measures were put in place for residents having the potential to be affected: 02/21/18 DON completed 100% audit of all med rooms to ensure all medication was properly labeled. 02/21/18 100% in service was initiated by DON on proper labeling of drugs. In-service will be completed by 03/16/18. What systems were put in place to prevent the deficient practice from reoccurring: Don initiated an in-serviced on 02/26/18 for all licensed Nurses on proper labeling of drugs, it will be completed by 03/16/18. How the facility will monitor systems put in place: On 02/21/18 the DON and Admin Nurse began auditing med rooms and med carts for proper labeling. Audit will be completed 5x a week for 3 weeks then weekly x 3 weeks then monthly x 3 months. The monthly QI committee will review the results of the audit tool monthly for 3 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	

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F 761	Continued From page 39 have been dated when opened as per facility policy. The DON stated the tuberculin vaccine per manufacturer's instructions was good for 30 days once opened. The DON stated because the tuberculin vaccine was not dated when opened it could not be determined when the vaccine would expire. The DON stated she did not have a system in place to check for out dated medication in the medication refrigerator. On 02/21/18 at 10:48 AM an interview was conducted with the Administrator who stated her expectation was that the tuberculin vaccine located in the 300-400 hall medication refrigerator would have been dated when opened per manufacturer's recommendation and facility policy. The Administrator stated the tuberculin vaccine was good for 30 days once opened but because it was not dated it could not be determined when the vaccine would expire.	F 761	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. Facility Administrator is responsible for implementing plan of correction	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions.	F 865		3/19/18

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F 865	Continued From page 40 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the recertification survey of 02/03/17. This was for two recited deficiencies which were originally cited in February 2017 and were subsequently recited on the current recertification survey of 02/24/18. The repeat deficiencies were in the areas of accuracy of assessments and respiratory care. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. a. F641 Accuracy of Assessments: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident (Resident #13) identified as a PASRR Level II and 1 of 1 resident reviewed for Hospice (Resident #59). During the recertification survey of February 3, 2017 the facility was cited for failure to accurately assess residents' dental status on the Minimum Data Set (MDS) assessment for 3 of 22 residents (Resident's #27, #38 and #60).	F 865	F-865 On 2/27/18 the facility Executive QI Committee held a meeting. Administrator, DON, MDS Nurse, Treatment nurse, Staff facilitator, Maintenance Director, and Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 2/27/18 the facility consultant in-serviced the facility administrator. Facility administrator in-serviced director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. As of 2/27/18, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant	

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F 865	Continued From page 41 b. F695 Respiratory Care: Based on observations, record reviews and resident and staff interviews the facility failed to provide and assure safe handling of oxygen in a facility transportation van used for resident transports when an oxygen tank was observed stored on its side and unsecured in the back of a transportation van with the potential for injury for 3 of 3 sampled residents transported in the van (Resident #38, #9 and #294). During the recertification and complaint survey of February 3, 2017 the facility was cited for failure to administer oxygen at the physician ordered liters per minute for 1 of 6 residents reviewed for oxygen therapy (Resident #141). During an interview on 02/24/18 at 5:08 PM, the Administrator explained the facility conducted monthly Quality Assessment and Assurance meetings and the Administrator, Director of Nursing, Medical Director and various department managers attended the meetings. She further explained the Pharmacist attended the meetings quarterly. She stated the Quality Assessment and Assurance Committee had discussed the deficiencies and the plan of correction after the last annual recertification survey. She explained they had also reviewed the past deficiencies in preparation for the current recertification survey. She stated it was her expectation for the facility to not have repeat deficiencies.	F 865	recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Facility Administrator is responsible for implementing plan of correction.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		3/19/18

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F 880	Continued From page 42	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 43 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to disinfect 2 glucometers (blood glucose meter used for blood sugar monitoring) according to manufacturer's recommendations for 1 of 1 finger stick blood sugar (FSBS) observed (Resident #30). Findings included: A review of a facility policy for Glucometer Cleaning and Disinfection dated 11/01/17 indicated (in part) the glucometer needed to be cleansed according to manufacturer's recommendation.	F 880	F880 What measures did the facility put in place for the resident affected: on 2/21/18 Nurse #1 was observed not following the manufacturers instructions on cleaning glucometer. on 02/21/18 Administrator / DON initiated In-service on proper cleaning of glucometer. What measures were put in place for residents having the potential to be	

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F 880	Continued From page 44 A review of the manufacturer's package instructions entitled Sani-Cloth Bleach Germicidal Disposable Wipe indicated the wipe was to be unfolded and the surface of the glucometer was to be wiped and left thoroughly wet. Use additional wipe (s) if needed to assure continuous 4 minute of wet contact time. The treated surface was to remain visibly wet for a full 4 minutes and allowed to air dry. During a continuous observation on 02/21/18 at 4:09 PM Nurse #1 was observed obtaining a FSBS on Resident #67. Nurse #1 disposed of the used supplies in the trash and sharps container located on the medication cart and laid the glucometer on top of the medication cart. Nurse #1 washed her hands and removed another glucometer from the medication cart and gathered supplies and was observed obtaining a FSBS on Resident #51. Nurse #1 disposed of the used supplies in the trash and sharps container located on the medication cart. She laid the glucometer that was used on Resident #51 on top of the medication cart next to the glucometer that was used for Resident #67. Nurse #1 donned gloves and removed an individual packet of germicidal disposable wipe from the medication cart and opened the package and wiped the front, sides, and back of the glucometer that was used on Resident #51 for approximately 30 seconds and laid the glucometer on top of the medication cart. Nurse #1 immediately picked up the glucometer that was used to obtain a FSBS on Resident #67 and used the same germicidal wipe and wiped the front, sides, and back of the glucometer for approximately 30 seconds and laid the glucometer on top of the medication cart. Nurse #1 obtained 2 paper towels from the	F 880	affected: 02/21/18 100% in service was initiated by DON on proper cleaning of glucometers. In-service will be completed by 03/16/18. What systems were put in place to prevent the deficient practice from reoccurring: Don initiated an in-serviced for all licensed Nurses on proper cleaning of glucometer, it will be completed by 03/16/18. On 2/21/18 Don and Admin Nurses began auditing Glucometer cleaning using audit tool named Glucometer Audit. How the facility will monitor systems put in place: On 02/21/18 the DON and Admin Nurse began auditing glucometer cleaning. Using Audit tool named Glucometer audit. will be completed 5x a week for 3 weeks then weekly x 3 weeks then monthly x 3 months. The monthly QI committee will review the results of the audit tool monthly for 3 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. Facility Administrator is responsible for implementing plan of correction.	

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F 880	Continued From page 45	F 880		

restroom that was located by the medication cart and used the paper towels to wipe off the observed wetness located on each glucometer. Nurse #1 discarded the germicidal wipe, paper towels, and gloves in the trash receptacle on the medication cart and indicated she was ready to obtain a FSBS on Resident #30. Nurse #1 gathered supplies and picked up one of the glucometers form the top of the medication cart and carried the glucometer and supplies into Resident #30's room. Nurse #1 informed Resident #30 that she was ready to obtain a FSBS. Nurse #1 was stopped by the observer prior to obtaining a FSBS on Resident #30

On 02/21/18 at 4:35 PM an interview was conducted with Nurse #1 who stated she was unsure of the exact process to disinfect the glucometer. Nurse #1 stated she used the germicidal wipe that was located on the medication cart to disinfect the glucometer. Nurse #1 obtained a germicidal wipe from the medication cart and read the manufacturer's instructions for use and verified the germicidal wipe was required to have 4 minutes of continuous wet contact time with the glucometer and allowed to air dry. Nurse #1 stated she had not provided continuous 4 minutes of wet contact time to each glucometer and had not allowed each glucometer to air dry. Nurse #1 stated she had briefly wiped each glucometer using the same germicidal wipe and then wiped the surfaces of each glucometer with a paper towel. Nurse #1 stated she should have used an individual germicidal wipe to disinfect one glucometer and obtained another germicidal wipe to disinfect the other glucometer. Nurse #1 stated she should not have used the same germicidal wipe to disinfect both glucometers and should not

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F 880	Continued From page 46	F 880		

have wiped each glucometer with a paper towel because each glucometer was required to remain wet for 4 minutes. Nurse #1 stated she should have read the manufacturer's instructions prior to disinfecting the glucometers.

On 02/21/2018 at 4:39 PM an interview was conducted with the Unit Manager (UM) who stated Nurse #1 had been in-serviced on how to disinfect the glucometer. The UM stated it was her expectation that Nurse #1 would have followed the facility policy and the manufacture's recommendations located on the germicidal wipe to disinfect the glucometer.

On 02/21/18 at 4:50 PM an interview was conducted with the Administrator who stated her expectation was that Nurse #1 would have disinfected the glucometer per facility policy and manufacturer's recommendations. The Administrator stated Nurse #1 had been trained on cleaning and disinfecting the glucometer.

On 02/21/18 at 4:59 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that Nurse #1 would have disinfected the glucometer per facility policy and manufacturer's recommendations. The DON stated it was her expectation that after Nurse #1 obtained the FSBS on Resident #67 then she should have immediately disinfected the glucometer per manufacturer's recommendations.