STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSHIRE NURSING CENTER	300 MEADOWLAND DRIVE HILLSBOROUGH, NC 27278

(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 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to conduct a quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents selected to be reviewed for Resident Assessments. (Resident #36). The Findings Included: Resident #36 was admitted to the facility on 10/11/2006. A review of the Minimum Data Set (MDS) assessments for Resident #36 revealed the last assessment completed was an annual assessment completed on 6/22/2017. No other MDS assessments had been completed since 6/22/2017. An interview was conducted with the MDS Coordinator on 12/06/17 at 3:55 PM. During this interview, the MDS Coordinator stated she missed completing the quarterly assessment for Resident #36. She stated it was an oversight and should have been completed in September 2017. During an interview with the Administrator on 12/7/2017 at 4:25 PM, he stated it was his expectation that quarterly MDS assessments would be completed as required.	F 638	On 12/07/2017 Resident #36s September MDS assessment was completed by the MDS coordinator. The MDS assessment was transmitted on 12/07/2017 by the MDS Coordinator. Upon review of the MDS assessment scheduling for the month of September, it was determined that the new MDS Staff had inadvertently overlooked Resident #36s scheduled quarterly assessment. The QAPI team and the new MDS staff was made aware of the missed assessment and educated as to the requirement to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months by the administrator. In addition the MDS staff was educated on the DUE/OVERDUE assessment tracker located within the Electronic Health Record software on 12/08/2017. On 12/08/17, the previous 90 day period of admissions and discharges was audited by the MDS coordinator and the Director of Nursing for timely completion of all MDS assessments. All assessments reviewed were found to be in compliance.	1/2/18

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

Electronically Signed | 12/21/2017

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F 638	Continued From page 1	F 638	In order to prevent future recurrence,each month the MDS coordinator and Director of Nursing will run the Admission/Discharge list to review and assure that all assessments are being completed timely. The results will be reported on the MDS audit tool to the QAPI team monthly for review and monitoring. In addition, the DON or her designee shall review the Electronic EMR tracking mechanism for assesments DUE weekly. The QA committee will re-evaluate for ongoing monitoring and performance monthly for three months and quarterly there-after.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep the dumpster doors closed and failed to maintain the dumpster area free of debris. Findings included: During an observation on 12/04/17 at 8:20 am of the dumpster area there were bags of trash, ice cream lids, and gloves on the ground around the two dumpsters. Both dumpster doors were open. During the kitchen tour with Food Service Director (FSD) on 12/04/17 at 9:06 am, an observation of the dumpster area revealed 6 bags of trash sitting	F 814	On 12/06/2017, the dumpster area was cleaned and the lids shut on the dumpsters by the maintenance staff. Upon review the process that led to the deficient practice was a direct result of improper monitoring of the refuse/dumpster area. All staff were in-serviced in the proper handling and disposal of refuse and the closure of the dumpsters by the housekeeping director,dietary director, and the director of nursing. These in-services varied by date from	1/2/18

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F 814	Continued From page 2 on grass outside dumpster and ice cream lids and gloves on the ground around dumpster. Neither dumpster door could close due to trash bags hanging over the side of the dumpsters. An interview with the FSD on 12/04/17 at 9:06 am revealed that trash pick-up was on Mondays. The FSD further stated that the area around the dumpsters was swept whenever it needed to be swept. An observation of the dumpster area on 12/04/17 at 11:20 am revealed the dumpster had been emptied and the trash bags were no longer on the ground. The observation further revealed neither dumpster door was closed and the same ice cream lids and gloves remained on the ground around the dumpster. An observation of the dumpster area on 12/06/17 at 8:30 am revealed both dumpster doors were open and the same ice cream lids and gloves remained on the ground around the dumpster. An interview with the Administrator on 12/06/17 at 9:10 am revealed that his expectation for the dumpster area was for the dumpster doors to be shut and for there to be no debris on the ground around the dumpster.	F 814	12/13/2017-12/21/2013. In addition, the dumpster collection schedule was altered to include a third pickup day to ensure that the dumpsters do not overflow. New signs were also placed on the dumpster containment area, reminding personnel to keep the lids closed on the dumpster on 12/19/2017. In order to prevent future recurrence, the QAPI team has developed an audit tool for the monitoring of compliance. The audit tool will be filled out by the kitchen supervisors and the housekeeping director. The audit tool will be filled out daily x 12 weeks and the results turned over to the QAPI team on a weekly basis to be monitored and reviewed for compliance. The QAPI team will review monthly for ongoing compliance and quarterly there-after.	