STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345305	A. BUILDING _____ B. WING _____	C 09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHABILITATION AND CARE	PO BOX 248 BURNSVILLE, NC 28714

(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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to invite two (2) residents and one (1) family from a sample of seven (7) residents to attend care plan meetings. (Residents #1, #4 and #6). The findings are: 1. Resident #4 was admitted to the facility on 1/4/11. Diagnoses included anemia, heart failure, hypertension, hyperlipidemia, anxiety disorder, depression, congestive heart failure, chronic		"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Brookside Rehabilitation and Care** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency" F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 1. Resident #4 and #6 were given an invitation to their next care plan meeting. Resident #4 attended his meeting on 09/08/11 and resident #6 plans on attending her meeting on 09/29/11. Resident #1 does not reside in the facility. 2. Residents residing in the facility have a potential to be effected. Care Plan invitations are set up on the computer to flag the resident's responsible party and to generate the invitation to be mailed. The process will now include the invitation to also be generated for both the responsible party and interviewable residents and/or they are their own responsible party.	

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

Administrator 9/30/11

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

Original Signature 9-27-11

RECEIVED
SEP 30 2011
BY: MH

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F 280	Continued From page 1 kidney disease and pneumonia. Review of the Minimum Data Sets (MDS) dated 1/11/11, 3/25/11 and 6/15/11, Resident #4 scored a "15" on the Brief Interview for Mental Status section. The score of 15 was the highest achievable and indicated Resident #4 was cognitively intact. In addition, each MDS coded Resident #4 as participating in the assessment. Resident #4 was identified as interviewable per a list provided by the facility on 9/8/11. On 9/8/11 at 9:42 a.m., Resident #4 stated that he had not been invited to care plan meetings. He stated he was aware that they held care plan meetings because he would sometimes ask to speak with a specific staff member and would be told they were unavailable because the staff member was in a care plan meeting. Resident #4 stated that if he were invited to his care plan meeting he would attend. On 9/8/11 at 9:50 a.m. MDS coordinator stated she sent out invitations for care plan meetings. She stated the computerized MDS program checked who should be invited to care plan meetings. Review of Resident #4's computerized MDS program showed that his family was checked as the person who should be invited to care plan meetings. MDS coordinator stated she has been sending invitations to care plan meetings to Resident #4's daughter. She confirmed Resident #4 was alert, oriented and able to participate in care plan discussions. MDS coordinator stated Resident #4 should have been invited to the care plan meetings, has never been invited, and she never thought to invite him in	F 280	3. Re-education of the MDS coordinators was completed by the administrator to ensure immediate correction and continued compliance. 4. The DON/designee will monitor the binder of invitations distributed to residents and/or responsible parties. Attendance/acceptance will be monitored and the results will be reported in the monthly QA meetings for 3 months and then quarterly until resolved Date of Compliance 09/15/2011	

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F 280	Continued From page 2 addition to family. 2. Resident #6 was admitted to facility with diagnoses which included muscle weakness. Review of the annual Minimum Data Set dated 7/8/11 assessed the resident as having no memory or cognitive problems. Review of the Minimum Data Set dated 7/8/11 revealed Resident #6 was assessed was independent in making daily decisions and has having no memory problems. During an interview on 9/8/11 at 11:30am Resident #6 stated she did not know anything about care plan meetings and had never been invited to attend a meeting about her care. During an interview on 9/8/11 at 1:00 pm, the MDS coordinator concurred that the resident #6 had not been invited to attend care plan meetings because she thought inviting the resident's family member was enough. 3. Resident #1 was admitted to the facility with diagnoses that included Alzheimer's disease, Hypertension, Diabetes and others. The most recent Minimum Data Set (MDS) 8/23/10 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making. Review of Resident #1's medical record revealed an initial care plan meeting was held on 7/1/10 that included the family. A quarterly care plan meeting was held on 8/26/10 and the medical record did not specify the family attended. In a written statement by the family of Resident #1 dated 6/1/11 they indicated they were not	F 280		

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F 280	Continued From page 3 invited to the care plan meeting held on 8/26/10. On 9/7/11 at 1:30 p.m. the MDS Coordinator was interviewed and reported she was responsible for developing care plans, scheduling care plan meetings and inviting families to attend. She added that letters were mailed to families at least seven (7) days prior to the scheduled meeting and a copy of the letter was kept in the Resident's medical record. She reviewed Resident #1's medical record and was unable to verify the family had been invited to the care plan meeting on 8/26/10. The MDS Coordinator was unable to recall if she had mailed a letter to the family and offered no explanation.			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to remove facial hairs for 1 of 7 residents who needed assistance with activities with daily living (ADL). (Resident #6). The findings are: Resident #6 was admitted to facility with diagnoses which included muscle weakness. Review of the annual Minimum Data Set (MDS) dated 7/8/11 assessed the resident as having no		F312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 1. Resident #6 was immediately taken on 09/08/11 for care and the facial hairs were removed as requested. 2. Residents residing in the facility have a potential to be affected. Unit Managers observed current residents for any need of ADL care and reminded CNA's as needed. 3. Re-education began 09/08/11 by the Unit Managers to the charge nurses and nursing assistants. The DON held a mandatory in-service on 09/20/11 to re-educate the staff on the importance of care, good hygiene and assistance with ADL's especially in the area of shaving both men and women. 4. The Unit Managers will randomly review at least 3 shower schedules a week, to ensure all care is provided, including but not limited to facial hair on men and women. The DON/Designee will weekly monitor the Unit Manager's audit and will report the findings in the Monthly QA meeting for at least 3 months and then quarterly as needed. Date of Compliance 09/26/11	

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F 312	Continued From page 4 memory or cognitive problems and needed one person limited assistance with ADL. Review of the Care Area Assessment Summary (CAAS) dated 7/8/11 revealed the resident triggered for assistance with ADL due to muscle weakness and the care plan documented staff was to keep resident clean and well groomed at all times. Observations on 9/8/11 at 9:30am revealed Resident #6 had several long facial hairs on her chin and above her upper lip. During an interview on 9/8/11 at 11:30am Resident #6 stated it had been about three weeks since the facial hair had been removed and that she did not like having "whiskers". The resident stated she would like to have her facial hair removed more often or at least when the hair started to grow back and started showing. During an interview on 9/8/11 at 1:15pm, NA #1 stated residents were usually shaved on shower days. NA #1 also stated she had not noticed the resident's facial hair today. During an interview on 9/8/11 at 1:30pm the ADON (assistance director of nursing) concurred that Resident #6 had long facial hairs on her chin and above her lip and that these should be removed as needed and more often than every three weeks.	F 312		