DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 11/02/2011

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 315 SS=D — 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interview and record review, the facility failed to secure catheter tubing for two (2) of three (3) residents with indwelling catheters. (Residents #2 and #4).

The findings are:

Review of the facility's policy regarding catheter care revised December 2007 revealed the following: "Ensure that the catheter remains secured with leg strap to reduce friction and movement at insertion site. "

1. Review of Resident #2's admission Minimum Data Set dated 09/02/11 assessed the resident as having no impairment in decision making, no memory problems and as needing extensive assistance in bed mobility.

Review of the Care Area Assessment revealed Resident #2 had an indwelling urinary catheter

F 315 (Plan of Correction)

"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"

F315 483.25(d) NO CATHERTER, PREVENT UTI, RESTORE BLADDER

1. Resident #2 and #4 were given the choice of securing devises for their catheter tubing.
2. Residents residing in the facility with catheters have a potential to be effected. Current residents with catheters have been checked to ensure securing device is in place
3. Immediate education of the nursing staff by the nursing management was provided to ensure immediate correction. Ongoing education and checks will be given to promote continued compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/15/11

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.

RECEIVED
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BY: [initials]

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F 315	Continued From page 1	F 315		

due to neurogenic bladder.

Review of the Resident #2's care plan revealed interventions which included "secure tubing to thigh to prevent pulling."

Observations were made on 11/02/11 at 9:50AM as Nurse Aide (NA) #1 performed catheter care for Resident #2. The resident remained in a supine position during care and no tension was noted on the catheter tubing as it lay across the bed and hung off the right side of the bed clipped to the mattress. The catheter tubing was not secured to Resident #2's leg.

During an interview on 11/02/11 at 10:00AM the resident stated she could not wear a leg strap because it would not stay on her leg. The resident further stated that in the past she had used a "tape like" securing device that had worked well but the facility did not provide this type of device. The resident said she would like to have the "tape like " device because sometimes the tubing was pulled during care.

During an interview on 11/02/11 at 10:45AM, the Assistant Director of Nursing (ADON) stated the catheter should have been secured and that she expected staff to report it when any resident's catheter tubing was not secured.

During an interview on 11/02/11 at 2:45 PM, NA #1 stated to her knowledge Resident #2 did not use leg straps to secure the catheter tubing. NA#1 stated she did not know why the resident did not use or have a securing device. NA #1 further stated she did not report it because the resident had never had a securing device.

4. Unit Managers will randomly audit 3 residents a week, watch catheter care and check to make sure tubing is secure. UM will also monitor basic ADL care to ensure all care is provided on a daily basis. The DON/Designee will weekly monitor the Unit Manager's audit and will report the findings in the Monthly QA meeting monthly x 3 months and then quarterly as needed.

Date of Compliance 11/21/2011

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F 315	Continued From page 2	F 315		

2. Review of Resident #4's annual Minimum Data Set dated 04/04/11 assessed the resident as having no impairment in decision making, no memory problems and as needing extensive assistance in bed mobility.

Review of the Care Area Assessment Summary revealed Resident #4 had an indwelling urinary catheter due to neurogenic bladder.

Review of the Resident #4's care plan revealed interventions which included "secure catheter to thigh".

During an interview on 11/02/11 at 10:45AM, Assistant Director of Nursing (ADON) stated all catheters should be secured and that she expected staff to report it when any resident's catheter tubing was not secured.

During observations on 11/02/11 at 11:05 AM, Resident #4 was in the hallway sitting in a chair. A catheter tubing was observed from underneath the resident's pant leg and the catheter bag hung on the chair frame. At this time the resident stated she did not have a leg strap and had never had one. The resident did not complain of the tubing pulling.

During an interview on 11/02/11 at 11:10 AM, Licensed Nurse #1 stated she did not know if the Resident #4 had a leg strap or not. LN #1 proceeded to take the resident into the shower room and check for a leg strap. Observations at this time revealed no leg strap noted. LN #1 stated she did not know why Resident #4 did not have a securing device but all residents with

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F 315	Continued From page 3 catheters should have the tubing secured.	F 315		
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and medical record review the facility failed to provide a lunch meal three times a week for two (2) of two (2) sampled residents receiving hemodialysis. (Residents #5 and #9). The findings are: 1. Resident #5 was admitted with diagnoses which included diabetes, end stage renal disease and dementia. The most recent quarterly Minimum Data Set (MDS) dated 09/23/11 for Resident #5 indicated a moderate cognitive	F 368	F368 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME 1. Resident #5 and resident #9 are being provided a bagged lunch three times a week while at dialysis. Transporter educated on the location of the meals and are not to leave the facility without the meals 2. Residents residing in the facility, who go to dialysis during a meal hour, have a potential to be affected. Schedules for current residents receiving dialysis have been reviewed and arrangements made with dietary for meals to be available when resident is transported. Transporter has been educated on the location of the meals. 3. Education began immediately by both the Dietary Manager and Nursing Management. The RD was called and assisted in developing a weekly menu for dietary to prepare for the needed diets. All dietary staff will be educated on the menu and the preparation of these meals. DON/Designee will develop a monitoring tool to ensure meals are being provided to our dialysis residents.	

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F 368	Continued From page 4 impairment. The resident was identified by staff as alert and oriented and reliable for interview. The care plan dated 09/28/11 revealed the resident goes three times per week for dialysis treatments. During an interview on 11/01/11 at 3:32 PM, Resident #5 stated she did not ever take a lunch with her when she went to dialysis and that she had never asked but believed the facility would give her lunch if she requested it. The resident further stated she did not get hungry while at dialysis. Observations on 11/02/11 at 9:45 AM, revealed Resident #5 being assisted to the facility van in a wheelchair by the Transportation Aide for a hemodialysis treatment. The resident did not have any belongings with her and no lunch container was seen. Interview with the Transportation Aide (TA) on 11/02/11 at 9:50 AM, revealed Resident #5 missed her lunch on the days of dialysis. The TA stated the facility did not pack a lunch for Resident #5. The TA further stated that Resident #5 left the facility shortly after 9:30 the mornings of dialysis, and did not return to the facility until after 3:00 in the afternoon. The TA stated that she provided water and snacks for Resident #5 after she picked her up from dialysis and presented the water bottles and snacks that would be available after dialysis. Interview with the Food Service Director (FSD) on 11/02/11 at 11:00 AM, revealed it was her understanding that the TA would call the kitchen and let dietary staff know that residents would be	F 368	4. Unit Managers will randomly audit 3 residents a week, to ensure dietary is preparing the meal and that Transportation aide is taking the lunch with the resident. The DON/Designee will weekly monitor the Unit Manager's audit and will report the findings in the Monthly QA meeting monthly x 3 months and then quarterly as needed. Date of Compliance 11/14/11	

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F 368	Continued From page 5	F 368		

going to dialysis and needed a lunch packed by a certain time. The FSD stated she was not aware that residents were not getting a lunch when off campus at dialysis.

Further interview with the Transportation Aide on 11/02/11 at 11:35 AM, revealed the kitchen staff would pack a lunch if they were asked, but Resident #5 stated she didn't want to eat while at dialysis. The TA stated she had stopped asking Resident #5 if she wanted a lunch to take to dialysis because she continually refused.

Interview with the Assistant Director of Nursing (ADON) on 11/02/11 at 3:44 PM, revealed that she did not know Residents #5 was not getting lunch when off campus at dialysis. The ADON stated it was her expectation that any resident who were off campus during lunch time would be offered lunch everyday and that the TA would get a lunch from the kitchen to give to the residents. The ADON stated there was no monitoring tool in place to assure residents received a lunch when off campus at dialysis.

2. Resident #9 was admitted with diagnoses which included senile dementia, chronic kidney disease, end stage renal disease and hemiplegia. The most recent quarterly Minimum Data Set (MDS) for Resident #9, dated 09/14/11 indicated moderate cognitive impairment. The care plan dated 09/28/11 for Resident #9 revealed the resident goes three times per week for dialysis treatments.

Observations on 11/02/11 at 9:40 AM, revealed Resident #9 being assisted to the facility van in a geri-chair by the Transportation Aide for a

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F 368	Continued From page 6 hemodialysis treatment. Resident #9 had a blue bag with a pillow and blanket on her lap. No lunch container was seen. Interview with the Transportation Aide (TA) on 11/02/11 at 9:50 AM revealed that Resident #9 missed her lunch on the days of dialysis. The TA stated the facility did not pack a lunch for Resident #9. The TA further stated that Resident #9 left the facility shortly after 9:30 the mornings of dialysis and did not return to the facility until after 3:00 in the afternoon. The TA stated that she provided water and snacks for Resident #9 after she picked her up from dialysis and presented the water bottles and snacks that would be available after dialysis. Interview with the Food Service Director (FSD) on 11/02/11 at 11:00 AM, revealed it was her understanding that the TA would call the kitchen and let dietary staff know that residents would be going to dialysis and needed a lunch packed by a certain time. The FSD stated she was not aware that residents were not getting a lunch when off campus at dialysis. Further interview with the Transportation Aide on 11/02/11 at 11:35 AM, revealed the kitchen staff would pack a lunch if they were asked, but Resident #9 stated she didn't want to eat while at dialysis. The TA stated she had stopped asking Resident #9 if she wanted a lunch to take to dialysis because she continually refused. Interview with the Assistant Director of Nursing (ADON) on 11/02/11 at 3:44 PM, revealed she did not know Resident #9 was not getting lunch when off campus at dialysis. The ADON stated	F 368		

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F 368	Continued From page 7 that it was her expectation that any resident who were off campus during lunch time would be offered lunch everyday and that the TA would get a lunch from the kitchen to give to the residents. The ADON stated there was no monitoring tool in place to assure residents received a lunch when off campus at dialysis.	F 368		