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 _____	03/01/2012

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to promote dignity of residents seated together during two (2) of three (3) meal observations in the main dining room. The facility failed to serve and feed three (3) dependent residents watching while other residents ate. (Resident #76, #62, and #16). The findings are: 1. Resident #76 was readmitted to the facility with diagnoses including Alzheimer's Disease and Dementia. On the most recent Minimum Data Set, a quarterly dated 01/19/12, Resident #76 was assessed with short and long term memory problems, impaired cognition for daily decision making, and as requiring extensive assistance with eating. Observations on 02/27/12 at 12:00 PM revealed five (5) residents seated at adjoining tables in the main dining room. At 12:15 PM two (2) Nursing Assistant (NA) staff were observed feeding other residents at the table while Resident #76 waited to be served. During the observation Resident #76 removed a partially consumed glass of milk from the meal tray of a resident no longer at the table. After placing the glass to her mouth twice,	F 241	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Brookside Rehabilitation & Care** does not admit that the deficiency listed on this form exist, nor does Brookside Rehab & Care admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. Brookside Rehab & Care 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" F241 483.15(a), DIGNITY AND RESPECT OF INDIVIDUALITY 1. Resident #76, #62 , #16 and the 2 other residents are now all being fed at the same time.. 2. Residents residing in the facility, who are assisted dining members, have a potential to be effected. Tray service is now assigned to the dining room C.N.A to designate which residents are to be served. Hall trays will also be served prior to dining room service so that full attention can be on dining room service.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/27/12

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.

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F 241	Continued From page 1 as if to drink, NA staff retrieved the glass and removed the tray from the table. At 12:20 PM Resident #76 received her meal tray and was fed by staff. On 03/01/12 at 1:15 PM an interview was conducted with NA #1. During the interview NA #1 confirmed Resident #76 was required to wait while other residents at the table were served and fed. NA #1 confirmed, while waiting to be served Resident #76 obtained a partially consumed glass of milk, and appeared to drink. The interview further revealed it was common practice to serve and feed one resident at a time while one or two residents at the table wait to be served. On 03/01/12 at 2:10 PM an interview was conducted with the Director of Nursing (DON). The DON stated all residents seated at a table should be served and fed together so that no resident has to wait while others eat. The DON stated NA staff should feed more than one resident if necessary and report to the nurse when additional assistance is needed. 2. Resident #62 was admitted to the facility with diagnoses including Alzheimer's Disease and Anxiety. On the most recent Minimum Data Set, a quarterly dated 01/28/12, Resident #62 was assessed with short and long term memory problems, moderately impaired cognition for daily decision making, and as requiring extensive assistance with eating. Observations on 02/27/12 at 12:00 PM revealed five (5) residents seated at adjoining tables in the main dining room. Two (2) Nursing Assistant (NA) staff were observed feeding one resident	F 241	3. In services began immediately, nursing staff has been re-educated on serving the entire table at a time and to assist with feeding more than one resident at a time. Re-education was completed by the Director of Nursing/designee and will continue in order to enhance the dining experience and individuality to ensure immediate correction. 4. The Director of Nursing/designee will monitor the dining process at least 3 times a week during differing meal times. A weekly meal service meeting will be held to adjust dining service as needed. Audit will be monitored and the results will be reported in the weekly meeting and in the monthly QA meetings for 3 months and then quarterly until resolved Date of compliance: 03/26/2012	

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F 241	Continued From page 2 each while Resident #62 waited to be served. Resident #62 was observed shifting positions in her wheelchair, looking around the room, and calling out while waiting to be served. At 12:44 PM resident #62 received her meal tray and was fed by staff. Further observations on 03/01/12 at 12:05 PM revealed five (5) residents seated at adjoining tables in the main dining room. Two (2) NA staff were observed feeding other residents while Resident #62 waited to be served. At 12:34 PM Resident #62 received her meal tray and was fed by staff. On 03/01/12 at 1:15 PM an interview was conducted with NA #1. During the interview NA #1 confirmed, during the lunch meal on 02/27/12 and 03/01/12 Resident #62 was required to wait while other residents at the table were served and fed. NA #1 stated it was common practice to serve and feed one resident at a time while one or two residents at the table wait to be served. On 03/01/12 at 2:10 PM an interview was conducted with the Director of Nursing (DON). The DON stated all residents seated at a table should be served and fed together so that no resident has to wait while others eat. The DON stated NA staff should feed more than one resident if necessary and report to the nurse when additional assistance is needed. 3. Resident #16 was readmitted to the facility with diagnoses including Stroke, Malaise and Fatigue. Resident #16 was identified by the facility as interviewable and assessed on the quarterly Minimum Data Set, dated 12/26/11, as	F 241		

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F 241	Continued From page 3 usually able to understand others. Resident #16 was also assessed as requiring extensive assistance with eating. Observations on 03/01/12 at 12:05 PM revealed five (5) residents seated at adjoining tables in the main dining room. Two (2) Nursing Assistant (NA) staff were observed feeding other residents at the table while Resident #16 waited to be served. While waiting to be served Resident #16 was observed at the table looking around the table and room as other residents were fed. At 12:32 PM resident #16 received her tray and was fed by staff. On 03/01/12 at 1:15 PM an interview was conducted with NA #1. During the interview NA #1 confirmed Resident #16 was required to wait while other residents at the table were served and fed. NA #1 stated it was common practice to serve and feed one resident at a time while one or two residents at the table wait to be served. On 03/01/12 at 2:10 PM an interview was conducted with the Director of Nursing (DON). The DON stated all residents seated at a table should be served and fed together so that no resident has to wait while others eat. The DON stated NA staff should feed more than one resident if necessary and report to the nurse when additional assistance is needed. On 03/01/12 at 2:50 PM an interview was conducted with Resident #16. During the interview Resident #16 reported, during lunch on most days, she waited approximately thirty (30) minutes to be served while other residents at the table were served and fed by staff. Resident #16	F 241		

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F 241	Continued From page 4 stated she was bothered by and she did not like waiting while other residents were eating.	F 241	F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431	1. Expired PPD vial was discarded immediately upon discovery. 2. All residents have the potential to be affected. Medication rooms and stock areas were inventoried to ensure no other vials/meds were expired. 3. Under the direction of the DON, the unit managers/designee re-educated the licensed staff on the policy: "Storage of Medications". Re-education began immediately by the Unit Managers/designee to the licensed staff on the policy: "Storage of Medications". Included in the in-service was quick reference sheets, from pharmacy, on medication expiration dates and storage information, which are available on each med cart and visible in the med rooms. 4. Our monthly monitoring process of medications has been modified from monthly to weekly to continue compliance and eliminate expired meds and ensure proper mediation storage. DON/Designee will audit weekly to ensure compliance. Audit findings will be reported in the Monthly QA meeting for at least 3 months and then quarterly. Date of compliance: 03/26/2012	

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F 431	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review, and staff interviews the facility failed to ensure that one (1) Tuberculin Purified Protein Derivative (PPD) vial in one (1) of two (2) medication storage refrigerators was discarded thirty (30) days after opening. The Findings are: Observations of north hall medication refrigerator on 03/01/12 at 9:50 AM revealed one (1) vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of Tuberculosis). A label affixed to the vial indicated it had been opened on 01/25/12. Interview with Nurse Manager (NM) #1 on 03/01/12 at 10:00 AM revealed Tuberculin PPD should be discarded thirty (30) days after the date opened. NM #1 also revealed nursing staff are assigned to perform audits of the medication rooms, including refrigerators, once a month. Interview with Director of Nursing (DON) on 03/01/12 at 3:30 PM revealed medication rooms, including medication storage refrigerators, are audited by licensed nursing staff for expired medications monthly. The DON stated she expected licensed nursing staff to discard Tuberculin PPD vials thirty (30) days after the date opened per the drug storage information sheet located on each medication cart. The interview further revealed the licensed nurse assigned the monthly audit of the north hall medication room and refrigerator usually	F 431		

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F 431	Continued From page 6 completed the audit the first week of the month.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1.A. Each resident with orders for FSBS were assigned their own blood glucose meters. B. Resident #76 was redirected immediately and completed meal trays to be removed more timely. 2.A. Any residents with order for FSBSs and any cognitively impaired residents have a potential to be affected. 3.A. Under the direction of the DON, the unit managers/designee re-educated the licensed staff on the policy: "Cleaning and Disinfection of Blood Glucose Meters". B. Nursing staff was also re-educated on serving the entire table at a time and removing used items at meal completion.	

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F 441	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to disinfect/sanitize blood glucose meters (glucometers) between residents, after use, and prior to storage in medication carts during two (2) of six (6) six observations of finger stick blood sugars. The facility also failed to monitor a resident and remove a partially consumed meal tray from the table to prevent the resident from drinking after another. (Resident #76). The findings are: 1. Review of an undated policy, provided by the facility, titled "Cleaning and Disinfection of Blood Glucose Meters" revealed cleaning and disinfecting was required between residents, after use, and prior to storage. Review of a 01/27/12 facility in-service record revealed Licensed Nursing (LN) were trained to disinfect glucometers after each use. a. On 02/27/12 during continuous observations from 4:15 PM to 4:35 PM Licensed Nurse (LN) #1 was observed completing finger stick blood sugars (FSBS). LN #1 exiting a resident's room, with a used lancet and test strip, and placed the used glucometer on top of the medication cart. LN #1 removed her gloves, cleansed her hands, and without disinfecting the unit placed the glucometer in the medication cart in direct contact with another glucometer. At 4:35 PM LN #1	F 441	4. .Initiation of a monitoring process for Blood Glucose Meters has been implemented on 03/19/12. FSBS procedure audit will be completed 3x's a week to ensure each resident has their own glucometer and the glucometer is cleaned and stored properly by DON/Designee. The Director of Nursing/designee will monitor the dining process at least 3 times a week during differing meal times for removal of completed items/dishes. Audit/monitoring findings will be reported in the Monthly QA meeting for at least 3 months and then quarterly. Date of compliance: 03/26/2012	

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F 441	Continued From page 8 gathered a new test strip and lancet as well as the glucometer which had not been disinfected and proceeded to the room of Resident #30. At the entrance of Resident #30's room the surveyor intervened and stopped LN #1 from utilizing the un-sanitized glucometer. Further observations revealed disinfecting cloths were available on the medication cart. On 02/27/12 at 4:35 PM an interview was conducted with LN #1. During the interview LN #1 confirmed the glucometer was not disinfected after use on the first resident or prior to placement in the medication cart. The interview further revealed the glucometer was not disinfected prior to intended use for the second resident. LN #1 stated she was trained to disinfect after each use and should have sanitized the glucometer. During an interview, 03/01/12 at 2:10 PM, the Director of Nursing (DON) revealed an in-service was conducted 01/27/12 which included instructions for disinfecting glucometers. The DON stated LN staff were responsible for disinfecting glucometers after each use, as trained. The DON stated she did not monitor or delegate monitoring of FSBSs to ensure LN staff were disinfecting glucometers after each use. Review of the in-service records revealed LN #1 attended the 01/27/12 training which included proper disinfecting of glucometers. During an interview, 03/01/12 at 2:45 PM, the Infection Control Nurse (ICN) stated the facility had no system in place for monitoring to ensure glucometers were disinfected appropriately.	F 441		

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F 441	Continued From page 9 b. On 02/29/12 during continuous observations from 4:40 PM to 4:50 PM Licensed Nurse (LN) #2 was observed completing finger stick blood sugars (FSBS). LN #2 exiting a resident's room, with a used lancet and test strip, and placed the used glucometer on top of the medication cart. LN #2 removed her gloves, cleansed her hands, and without disinfecting the unit placed the glucometer in the medication cart in direct contact with another glucometer. LN #2 completed the medication pass and returned the cart to the nurse's station. On 02/29/12 at 4:50 PM an interview was conducted with LN #2. During the interview LN #2 confirmed the glucometer was not disinfected after use or prior to placement in the medication cart. LN #2 stated she was trained to disinfect glucometers after each use and should have sanitized the glucometer. During an interview, 03/01/12 at 2:10 PM, the Director of Nursing (DON) revealed an in-service was conducted 01/27/12 which included instructions for disinfecting glucometers. The DON stated LN staff were responsible for disinfecting glucometers after each use, as trained. The DON stated she did not monitor or delegate monitoring of FSBSs to ensure LN staff were disinfecting glucometers after each use. Review of the in-service records revealed LN #2 attended the 1/27/12 training which included proper disinfecting of glucometers. During an interview, 03/01/12 at 2:45 PM, the Infection Control Nurse (ICN) stated the facility had no system in place for monitoring to ensure	F 441		

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F 441	Continued From page 10 glucometers were disinfected appropriately. 2. Resident #76 was readmitted to the facility with diagnoses including Alzheimer's Disease and Dementia. On the most recent Minimum Data Set (MDS), a quarterly dated 01/19/12, Resident #76 was assessed with short and long term memory problems, impaired cognition for daily decision making, and as requiring extensive assistance with eating. On 02/27/12 at 12:15 PM Resident #76 was observed in the main dining room at a table with Nursing Assistant (NA) #1 and NA #2 who were feeding two other residents. A partially consumed meal tray, from a resident no longer in the dining room, was positioned on the table in front of and to the left of the resident. While waiting to be served Resident #76 removed a partially consumed glass of milk from the meal tray of a resident no longer at the table. After placing the glass to her mouth twice, as if to drink, NA staff retrieved the glass and removed the tray from the table. On 03/01/12 at 1:15 PM an interview was conducted with NA #1. During the interview NA #1 confirmed Resident #76 was observed with the partially consumed milk from another resident's tray that remained at the table. NA #1 stated residents were usually monitored during meals and as residents finish eating trays were removed from the table. The interview further revealed the partially consumed milk should not have been available or in reach for Resident #76. On 03/01/12 at 2:10 PM and interview was conducted with the Director of Nursing (DON).	F 441		

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F 441	Continued From page 11 During the interview the DON stated NA and Licensed Nursing staff were responsible for removing meal trays from the table after residents finish eating and for monitoring to prevent residents from drinking and/or eating after others.	F 441		