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
	345412	A. BUILDING _____ B. WING _____ FEB 2 8 2012	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANTWOOD NH & RETIREMENT CENT	1038 COLLEGE ST PO BOX 1006 OXFORD, NC 27565

(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, staff interviews and record review, the facility failed to provide a dignified dining experience for 1 of 20 residents as evidenced by providing the resident with plastic utensils. (Resident # 93). The findings included: Resident # 93 was admitted to the facility on 12/11/09. The resident ' s cumulative diagnoses included mental retardation, hypothyroidism, diabetes, hyperglycemia, gout, renal failure, and congestive heart failure. The Minimum Data Set (MDS) dated 11/3/11 indicated that Resident # 93 had short- and long-term memory deficit and required limited assistance with Activities of Daily Living. Resident # 93 needed set-up assistance only with eating, and her communication was difficult to understand. The Care Area Assessment dated 1/16/12 indicated that Resident # 93 had behavioral concerns related to resisting care, nutrition and communication. Review of the care plan dated 11/9/11 identified the problems as: Resident # 93 feeds self after set-up. Resident # 93 is on a pureed, therapeutic diet. The goal was to have the resident receive adequate calories, protein, and nutrients to strengthen the body and prevent significant	F 241	F241 Effective 2/2/12, Resident #93 will receive silverware at meals. To ensure that the deficient practice does not occur to other residents at risk, all residents will receive silverware at meals. Nursing staff was informed via e-mail on shift wizard on 2/1/12 and dietary staff was in-serviced on 2/2/12 and/or 2/3/12 that all residents are to receive silverware for meals. Nursing Staff was in-serviced on 2/23/12. Effective 2/27/12, the RD or designee will observe the tray line weekly for any plastic utensils being used. Non-compliance will be reported to the QAA Committee.	2/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joshua P. Mattingly	LNHA	2/27/12

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 weight loss and avoid signs and symptoms of dehydration during review period. The approaches included serving a diet as ordered by the physician, honoring food preferences, monitoring adequate calorie and food/fluid intake, and providing assistance/encouragement as needed. During a meal observation on 1/30/12 at 12:39 pm, Resident # 93 ' s tray was set up for lunch in the dining room. The meal included pureed pork chops, pureed turnip greens, pureed corn pudding, and iced tea. The resident was able to feed herself without cueing. Resident # 93 was observed eating with plastic ware (spoon and fork only). She did not have any difficulty handling spoon and fork and she did not demonstrate any attempts to harm herself or the aide in her presence. During an interview on 1/30/12 at 12:45 pm, NA #1 indicated that Resident # 93 was a little agitated and that she had tried to hurt a resident a long time ago. She added that the resident has not exhibited that behavior in awhile. NA #1 further added that Resident # 93 had not made any attempts to cause harm to her or the staff with the use of regular silverware. During a follow-up meal observation on 1/31/12 at 12:39 pm, Resident # ' s tray was set up for breakfast in the dining room. She was able to feed herself without cueing. Resident # was observed eating with plastic ware (spoon and fork only). She did not demonstrate any attempts to harm herself or the aide in her presence. During an interview on 1/31/12 at 12:44 am, NA	F 241		

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F 241	Continued From page 2 #2 stated that she set up the resident ' s meal tray and she indicated that the resident used plastic ware all the time. She stated that the resident has behavioral problems and has been receiving plastic ware for awhile. During an interview on 1/31/12 at 4:48 pm, Nurse #1 indicated that Resident # 93 was combative with care and has been known to be aggressive towards other residents when " they get in her space, and she gets upset. It has been awhile since this has happened. " Nurse #1 added that her combative behaviors were few and far between. During an interview on 2/1/12/ at 10:07 am, the MDS coordinator stated that the resident was not care-planned for plastic ware, because she exhibited combative behavior with another resident a long time ago. During an interview on 2/1/12 at 10:17 am, the director of nursing (DON) stated that " the resident was observed with a butter knife [from her meal tray] making threatening comments towards her roommates in March of last year. It was decided to begin using plastic ware during meals because of that threat. The resident has continued to have some behaviors such as hitting staff and other residents, cursing, and making threatening comments. A couple weeks ago, the use of the plastic ware was discussed during the nursing portion of the morning meeting, and it was decided that we would have plastic ware used only during meals when the resident ate in her room and was unattended by staff; she would use regular silverware when eating in the dining area with staff members present. Then last Friday	F 241		

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F 241	Continued From page 3 the administrator and I discussed this further, and we decided that the resident should receive silverware during all meals-not to receive plastic ware on her meal tray. A message has been sent to all facility nursing and nursing assistant staff to make sure they all are aware that no plastic ware is to be used during mealtime with any of our residents. The resident has not exhibited that behavior in a long time. " The DON further stated that " the incident happened before March of last year. I did not know she was still receiving plastic ware. " During an interview on 2/1/12/ at 10:27 am, the dietitian indicated that giving the resident plastic ware was a mistake; she was not supposed to receive it. Sometimes plastic ware was given to the resident based on a request from nursing, but it was supposed to be discontinued 2 weeks ago. In an interview on 2/1/12 at 12:12 pm, the administrator stated that " during the nursing morning meeting, we discussed the use of plastic ware for the resident. The use of plastic ware began in February 2010 after an incident in which the resident threatened her roommate with a butter knife. We determined to discontinue the use of plastic in the dining room but to continue the use of plastic in her room where she is unsupervised. This communication was sent to the dietitian on 1/17/12 via e-mail by me. " The administrator further indicated that on 1/27/12 the DON discussed this matter further and determined than since this resident had not exhibited threatening behaviors towards her roommates in quite some time, " we would discuss the use of plastic utensils entirely and monitor the resident for any threatening	F 241		

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F 241	Continued From page 4 behaviors. This was also communicated to the dietitian on 1/27/12 via e-mail by the DON. "	F 241	F371	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility: failed to, 1) remove 8 dented cans from the kitchen ' s dry-storage area, 2) failed to ensure food items in the one of one walk-in refrigerator were labeled when taken out of the original container, and 3) failed to ensure one of one can opener holder in the food preparation area was clean and in sanitary conditions. Findings include: During the initial tour of the kitchen ' s dry-storage area on 2/1/12 at 11:10 am, the following canned foods were damaged with significant dents at their rims and/or seals: 2 cans of pinto beans, 2 can of diced tomatoes, 2 cans of pasta sauce, and 2 cans of broccoli soup. They were observed stocked among and intermingled with undamaged canned products ready for resident	F 371	All damaged cans were removed from dietary stock on 2/1/12. A designated area for damaged cans was established on 2/1/12. Dietary staff was in-serviced on designated area on 2/2/12 and/or 2/3/12. Dietary staff will check all cans for damage upon delivery, placing damaged cans in designated area. Dietary staff will also randomly check cans on shelf when restocking and when pulling cans for meal preparation. Monitoring will be done by the Executive Chef or designee weekly for all canned goods. RD will report to QAA effectiveness of this process. F371 On 2/1/12, all refrigerated food items were labeled with item description and expiration date when removed from the original packaging. Dietary staff	2/27/12 2/27/12

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F 371	Continued From page 5 use. During an interview on 2/1/12 at 11:15 am, the director of food services stated that " If the cans are dented when we receive them, we normally return them. If they are dented here, they should be placed on a designated shelf in the dry-storage room. " He added that the sign was not up, and apparently the staff stopped removing the dented cans. During the kitchen tour on 2/1/12 at 11:20 am, the following items were observed in one of one walk-in refrigerator: 5 large rolls of turkey breasts (as identified by director of food services) that were unlabeled. During an interview on 2/1/12/ at 11:20 am, the director of food services stated, " I know what they are; they are turkey breasts. " He added, " They were put in the refrigerator yesterday after they came off the truck. One of my workers took them out of the box, and we never label turkey breasts. " He further added, " Everyone knows what they are. " During kitchen observation on 2/1/12 at 11:30 am, the following was observed: one can opener holder with built-up black matter and grease-like substance on the inside and around the surface. During an interview on 2/1/12 at 11:30 am, the director of food services stated, " the can opener holder should be cleaned once a week, and apparently it has not been cleaned in awhile; we will have it cleaned. "	F 371	was in-serviced on this process on 2/2/12 and/or 2/3/12. Weekly inspection of package labeling for such items by dietary staff will begin on 2/27/12. The Executive Chef or designee will monitor compliance. Non-compliance will be reported to the QAA committee by the RD with a new action plan and continued monitoring. F371 Weekly sanitation schedule for dietary equipment will be followed by dietary staff. Dietary staff was in-serviced on the weekly sanitation schedule on 2/2/12 and/or 2/3/12. Effective 2/27/12, the Executive Chef or designee will monitor the weekly sanitation of dietary equipment for compliance. RD will report any non-compliance to the QAA committee with a	2/27/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on review of the facility ' s policy on medications expiration dates, observation and	F 431	new action plan and continued monitoring. See attached monitoring schedules for all F371 tags. F431 The contents of the Emergency Controlled Substance Box will be checked monthly for expired controlled substances by Granville Medical Center (GMC) Pharmacy staff who supplies the Controlled Substance Box in which the out of date controlled substance was found. Controlled substances will be replaced by pharmacy according to GMC Policy. This will be added to the pharmacy's Monthly Medication Area Inspection Record. Effective 2/27/2012, the	2/27/12

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F 431	Continued From page 7 staff interview, the facility failed to discard expired medications in 1 of 2 medication rooms and 1 of 1 emergency carts. The facility ' s policy titled, " Medication Management Expiration Dates " with a revised date of 5/2010 was reviewed. The policy indicated that expiration dates of medications and devices would be checked during the routine medication area inspections and all medications and devices scheduled to expire during the next month would be removed from stock. 1. On 2/01/2012 at 5pm along with Nurse #1 the medication room on 200 hall was observed. During the observation the secured stack of medication drawers were observed. One of the drawers contained 10 single unit packages of Oxycodone 10/325mg (milligrams). Further observation revealed that 8 out of the 10 Oxycodone pills had an expiration date of 11/2011. Nurse #1 was interviewed on 2/01/2012 at 5:30pm. The Nurse said that the hospital Pharmacy checks the medications regularly for out of dates. 2. On 2/01/2012 at 6:00 pm the medication room for 200 hall and the Emergency Cart was observed. Accompanied by Nurse #2, the Emergency cart drawers were unlocked by Nurse #2 and a kit in one of the drawers contained a 10ml vial of Normal Saline. The vial had an expiration date of 6/01/2011. Nurse #2 was not sure who was responsible for checking the Emergency Cart.	F 431	Pharmacy Director will monitor this process for compliance. Non-compliance will be reported to the QAA Committee by the Pharmacy Director or designee with a new action plan and continued monitoring. F431 An Emergency Cart Monthly Inspection will be conducted for any expired medications by DON or designee. The Emergency Cart Monthly Inspection checklist will be submitted to the QAA committee for any non-compliance.	2/27/12

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F 431	Continued From page 8 During a telephone conversation with the Administrator on 2/08/2011 at 2pm the Administrator said that the Clinical Manager and/or the DON is responsible for checking the Emergency Cart. The Administrator said the out of date medications just slipped through their processes.	F 431		

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	345412	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/02/2012

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 03/02/2012 the delayed egress exit out of the kitchen failed to continue the irreversible process if the code was entered into the key pad. 42 CFR 483.70 (a)	K 038	K 038 The key pad will be reprogrammed or replaced to adhere to the irreversible process. The irreversible process will be checked monthly to assure proper operation in an emergency. The system is monitored by engineering to assure compliance.	4/2/12
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 03/02/2012 the ball valves on the sprinkler accelerator were not electrically supervised. 42 CFR 483.70 (a)	K 061	K 061 The alarms for the ball valves on the sprinkler accelerator will be installed to comply with code. The alarms will be tested quarterly thereafter by an outside provider.	4/2/12
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 26, 9.7.5	K 062		

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

Jacquelyn Mattisonly, LNHA — Administrator — 3/16/12

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K 062	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 03/02 2012 there was no high and low pressure alarm switch on the dry side of the system. 42 CFR 483.70 (a)	K 062	K 062 The high and low pressure alarm switch on the dry side of the system will be installed to comply with code. This will be tested annually by an outside provider.	4/2/12
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 03/02/2012 the 02 cylinders stored out side the facility were not protected fully and they were setting on concrete. 42 CFR 483.70 (a)	K 076	K 076 O2 outside storage cage has been enclosed for full protection. O2 cylinders in outside storage have been elevated off of the concrete pad.	3/9/12