

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

APR 12 2013
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PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2013
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NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE ST PO BOX 1006 OXFORD, NC 27565
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F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interviews, the facility failed to notify the attending</p>	F 157		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janet P. Mattie, LNA TITLE: Administrator (X6) DATE: 4/10/13

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 157	<p>Continued From page 1</p> <p>physician of elevated blood pressure readings for 1 of 11 sampled residents with hypertension (resident #138). Findings included:</p> <p>The facility's policy titled Notification of Change in Patient Status, revised 6/2010, read in part: "The patient's physician and/or family/significant other will be notified in the event of significant changes in the patient's condition/status/location."</p> <p>Resident #138 was admitted to the facility on 2/19/13 with multiple diagnoses including hypertension, chronic kidney disease, diabetes, and cerebrovascular accident.</p> <p>Review of the resident's clinical record revealed physician orders dated 2/19/13 for Coreg (carvedilol) 12.5mg (milligram) every twelve hours. Coreg is a beta-blocker indicated for the treatment of hypertension.</p> <p>Blood pressure is defined as the force exerted by blood inside the arteries and is measured by two readings: the systolic (highest) and the diastolic (lowest) pressure. The highest pressure occurs when the heart contracts, the lowest when the heart relaxes. The American Heart Association considers hypertension to occur when systolic blood pressure exceeds 140. Uncontrolled hypertension may increase the risk of heart attack, stroke, kidney disease, and heart disease.</p> <p>Record review of the Vital Sign Flow Sheet revealed routine blood pressure monitoring. Elevated blood pressure readings were documented on the following dates: 2/20/13 - 187/99 and 180/84, 2/22/13 - 194/90 and 195/99, 2/23/13 - 182/95, 2/25/13 - 195/115, 2/26/13 -</p>	F 157	<p>F157</p> <p>For resident #138, the physician was notified of the high blood pressures on 3/7/13. The physician responded on 3/11/13 with a medication increase. Effective 3/28/13, an RN designated by the DON will monitor resident's chart weekly for three months to assure proper notification of Blood Pressures to the physician. Noncompliance will require a new action plan.</p> <p>To insure that the deficient practice does not occur to other residents at risk, the following measures are being taken:</p> <p>DON discussed with GHS Nurse Educator on 3/8/13 staff in-service material and dates. Nursing staff in-services scheduled for April 9 and April 11, 2013, to review with staff when to report a low or high blood pressure, as well as, other critical measurements which should be reported to the physician.</p>	3/28/13	

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F 157	<p>Continued From page 2</p> <p>190/93, 2/27/13 - 189/83, 3/2/13 - 194/92, 3/5/13 - 192/84 and 189/82.</p> <p>Record review revealed no documentation that the physician was notified of the blood pressure readings.</p> <p>Record review of the resident's standing orders revealed no orders regarding physician notification of elevated blood pressure readings.</p> <p>In an interview on 3/7/13 at 1:55PM, nurse #1 stated the nursing assistants (NAs) checked vital signs routinely and charted the results on a clip board. The nursing staff transferred the results from the clip board to the Vital Sign Flow Sheet. Sometimes vital signs were documented in the nursing notes. If results were abnormally high or low, the nurse called or faxed the physician. Nurse #1 reviewed the Vital Sign Flow Sheet for resident #138 and acknowledged the elevated blood pressure readings. She stated "the physician should have been notified."</p> <p>In an interview on 3/7/13 at 3:24PM, nurse #2 stated the NAs routinely monitored vital signs every shift and wrote the results on a clipboard. The nurse on duty reviewed the clipboard every shift and then wrote the results on the Vital Signs Flow Sheet. The nurse called or faxed the physician if there were elevated blood pressures. Nurse #2 stated there were no standing orders for notifying the physician of elevated blood pressures. She stated "it's basically a nursing judgment." Nurse #2 reviewed the Vital Sign Flow Sheet for resident #138 and stated "the blood pressures should have been reported." The nurse reviewed the resident's chart but found</p>	F 157	<p>Policy H8 Notification of Change in Resident Status was revised on 3/26/13. Policy was posted for staff review on 3/27/13 and will be reviewed during in-services on April 9 and April 11.</p> <p>On March 26, 2013, DON posted a flyer at the time clock, each nurses station, and the break room titled, "FYI: Critical Thinking..." which reviews critical blood pressure measurements for both hypertension and hypotension.</p> <p>Effective 4/9/13, all vital sign sheets are to be reviewed and signed by the hall nurse who will turn them in daily to the Clinical Manager. A Second review will be done by the Clinical Manager or designated RN. The RN will verify that the physician was notified of any abnormal Blood Pressures. Any unreported abnormal Blood Pressures will then be reported to the physician. The monitoring results will be reported during each QAA Committee meeting for review for a minimum of 12 months. Noncompliance will require a new action plan.</p>	3/27/13	3/26/13	4/9/13

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F 157	Continued From page 3 no documentation that the physician was notified. She stated "I was not aware the physician had not been called." Nurse #2 did not recall if she had reported the elevated blood pressure readings to the next shift. In an interview on 3/7/13 at 4:05PM, the Director of Nursing (DON) stated the NAs checked vital signs and recorded them on a clipboard. The nurses reviewed the vital signs and documented them in the residents' charts. The DON stated there was no written policy for notifying the physician if vital signs were abnormal. She stated it was a nursing judgment. For elevated blood pressure results, she expected the nurse to check the blood pressure again and notify the physician. The DON reviewed the blood pressure readings on the Vital Sign Flow Sheet for resident #138 and stated "the physician should have been called."	F 157			
F 371 SS=D	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 facility records, the facility failed to maintain	F 371	Effective 3/15/13, all equipment, shelves and walls within the hospital kitchen area will be cleaned on a daily, weekly or monthly cleaning schedule. Cleaning will be done by assigned kitchen staff. Cleaning will be monitored by and dietary staff will be checked off daily, by the Food Service Director, Executive Chef or their designee, prior to leaving their shift. A copy of the weekly cleaning schedule is provided to the QAA Committee. This monitoring will continue for a minimum of 12 months.	3/15/13	

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F 371	<p>Continued From page 4</p> <p>sanitary conditions in the hospital kitchen by failing to clean the hood over the stove, kitchen floor, and floor in the dish washing area, and debris covering the food in the dry storage area of the nursing facility kitchen. The facility failed to date and label condiments, fresh produce, loaves of bread and hot dog and hamburger buns, large bins of chicken flour, baking flour, sugar, rice and starch. The bins were covered with debris. The facility also failed to clean and defrost the ice cream freezer in the hospital kitchen.</p> <p>Findings included:</p> <p>On 3/4/13 at 7:00 am an observation of the nursing facility kitchen revealed the food in the dry storage area had a thin film of debris covering the shelves and on top of the containers. An observation at 7:10 am of the food brought from the hospital for the steam table was not labeled and dated. Interview with the Food Service Director revealed he was not aware that the food needed to be labeled.</p> <p>Observation on 3/4/13 at 8:00 am of the hospital kitchen which served the residents in the nursing facility revealed the kitchen floor had a thick brown substance under the fryer and along the back wall where the fryer and stove was placed. There was a piece of metal above the stove which had a thick greasy substance and covered with a fuzzy like substance. The kitchen area floors had debris with a sticky brown and white substance covering the whole area of the kitchen floor. The floor in the sink area had sticky debris and standing water throughout the area, especially under the sink area. The dish machine was not running at the time of the observation</p>	F 371	<p>Floors in hospital kitchen area to be regouted on 4/30/13 .Effective 3/15/13, floors in hospital kitchen will be cleaned after each shift per cleaning schedule by assigned staff. Cleaning will be monitored by the Food Service Director, Executive Chef or their designee. Dietary staff is checked off daily by the Food Service Director, Executive Chef or their designee prior to leaving their shift. A copy of the weekly cleaning schedule is provided to the QAA Committee. This monitoring will continue for a minimum of 12 months</p> <p>Effective 3/15/13, dry storage bins exterior to be cleaned daily by assigned dietary staff. Dry storage bins interior to be cleaned prior to adding new product by assigned dietary staff. Monitoring will be done by the Food Service Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to leaving their shift by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAA Committee.</p>	<p>4/30/13</p> <p>3/15/13</p> <p>3/15/13</p>	

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F 371	<p>Continued From page 5</p> <p>and no one was washing pots and pans. Observation of the hood over the stove in the main kitchen area had a greasy like substance covering the inside and outside of the hood.</p> <p>Observation on 3/4/13 at 8:15 am of the walk -in refrigerator in the hospital kitchen revealed several boxes of fresh produce; green peppers, squash, tomatoes, green beans, scallions, lettuce, lemons, onions, cabbage, carrots, celery, mushrooms were not labeled with a use by date. Packages of green grapes were open with no use by date and packages of strawberries, crates of oranges and other assorted fruit were not labeled with use by date. The Director indicated he was not aware of labeling the raw fruit and vegetables.</p> <p>Further observation of the kitchen area revealed racks of loaves of bread (4) were opened with no labeling and hot dog and hamburger rolls. Packages of corn meal (2), dry gravy (1) and one gallon bottle of light corn syrup, were opened and had no use by date. There was a sticky and crumb like debris covering a large (gallon size) black pepper, parsley flakes, garlic, and basil. The container of basil had a sticky saran wrap covering. Large bins of sugar, flour and rice were not labeled with a use by date and were covered with a crumb like debris. A large bag of granola was opened and not labeled. Packages (2) of hot dog rolls, 1 hamburger rolls, and assorted sliced bread, were opened and not dated. A large bottle of yellow food coloring, was opened and not labeled and was covered with a sticky substance. Observation of the spice rack with seasonings (30) had a greasy film covering the containers, and no use by dates.</p>	F 371	<p>This monitoring will continue for a minimum of 12 months.</p> <p>Vent hoods were cleaned on 3/21/13 by an independent contractor and will be cleaned every six months going forward by an independent contractor. Food Service Director responsible for schedule.</p> <p>The ice cream freezer at the hospital with frost on all sides was thrown away on 3/8/13.</p> <p>The piece of metal above the stove in the hospital kitchen which was covered by a greasy substance and fuzzy substance was thrown away on 3/4 /13.</p> <p>Effective 3/15/13 nursing facility store room shelves to be cleaned daily by assigned dietary staff. Monitoring to be done by the RD or supervisor. RD to report any noncompliance to the QAA Committee with new action plan. Monitoring to continue for a minimum of 12 months.</p>	3/21/13	3/8/13	3/4/13	3/15/13

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F 371	<p>Continued From page 6</p> <p>Interview with the Director on 3/4/13 at 8:45 am revealed he was not aware of fresh produce needing to be labeled with a use by date as well as the large bins of assorted flour, and rice. Further observation of the kitchen area revealed the ice cream freezer had 1/4 inch frost on all sides of the freezer.</p> <p>On 3/4/13 at 8:50 am an interview with the Head Chef of the hospital kitchen revealed the spice rack with spices should be cleaned daily and labeled. He further stated that the floors should be cleaned. He further stated the hood over the stove area and fryer should be cleaned every Tuesday and Friday. He further stated "It must have been missed."(Referring to the hood over the stove) He further stated there was a cleaning schedule for the entire kitchen pointing to a schedule on the bulletin board on the wall. He also stated the spice rack should be cleaned daily and the produce in the refrigerator needed to be labeled. The Head Chef stated he was responsible for assigning tasks and overseeing the tasks is completed.</p> <p>Review of the schedule dated March 1, 2013 thru March 7, 2013 revealed: " Label all food items with no description on package, Label and date all items that are open after use, and all employees are responsible for assigned task, Shift supervisor is responsible for task being completed. "</p> <p>Review of a policy dated 5/95 and revised 1/12 entitled, " Suggested Storage times for Intact, Raw, and Unwashed fruit, Vegetables, Dry ingredients or Products ", revealed the following: Apples - 7-21 days</p>	F 371	<p>In serviced dietary employees on cleaning schedule on 3/11/13 and 3/12/13. This was a detailed review. Dietary staff made aware to sign off only if cleaning was completed. Dietary staff had to be checked off prior to clocking out at the end of their shift.</p> <p>Inserviced dietary employees on dating and labeling fresh produce on 3/11/13 and 3/12/13. Reviewed Morrison's policy on proper dating and labeling. A copy of this policy is posted on the outside door of the main walk in cooler in the hospital kitchen. All fresh produce is to be labeled and dated according to policy. Monitoring will be done by the Food Service Manager, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAA Committee. This monitoring will continue for a minimum of 12 months.</p> <p>In serviced dietary staff on dating and labeling policy on 3/11/13 and 3/12/13. Policy is posted. AM</p>	3/12/13	3/12/13

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F 371	<p>Continued From page 7</p> <p>Berries - 2 days All other fruit - 7 days Greens, Lettuce, Peppers and Squash - 5 days Mushrooms and Tomatoes - 3 days Cabbage, Carrots and Celery - 7-14 days Dry ingredients or products, once opened, must be stored in airtight containers with name and expiration date Bread, Buns, Rolls - 3 days White flour - 6-8 months Spices whole - 12 months, Spices ground - 6 months Rice - 6 months</p> <p>The Policy indicated information on food storage items was from: Food Safety and Inspection Services, and Food Marketing Institute as referenced by the Food and Drug Administration.</p> <p>Review of a Policy dated 5/95, revised 1/12, entitled, " Required Cleaning and Sanitation, Nonfood Contact Surfaces ", revealed the following: Nonfood contact surfaces of equipment shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. (" Nonfood contact surfaces " means exposed surfaces other than food-contact surfaces ")</p> <p>On 3/4/13 at 8:45 am an interview with the Director of Food Service, revealed the staff needed to take care of cleaning the kitchen, labeling, and cleaning food storage containers. The Director also stated there was no schedule for cleaning.</p>	F 371	<p>supervisor is responsible for verifying date and label for all items, including, produce, bread, spices and food in storage bins. Monitoring will be done by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAA Committee. This monitoring will continue for a minimum of 12 months.</p> <p>Effective 3/15/13, all food coming from the hospital for the steam table is labeled and dated. The cooks or designated dietary staff is responsible for labeling. The Food Service Director, Executive Chef or their designee is responsible for monitoring. Any noncompliance will be reported to the QAA committee for a minimum of 12 months.</p> <p>On 3/26/13 the Granville Health System Infection Control nurse inspected the main kitchen at the hospital and Brantwood. This was the first of monthly inspections to be made by the Infection Control Nurse. This inspection includes sanitation, storage and labeling/dating. This report will be sent to the Administrator and</p>	<p>3/15/13</p> <p>3/26/13</p>	

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F 371	<p>Continued From page 8</p> <p>A Second observation on 3/5/13 at 8:30 am of the hospital kitchen revealed the kitchen floor had greasy debris under the fryer and a corner of the leg had a 2-3 inch build up of grease. The greasy like substance was observed across the floor along the wall. The surface of the entire floor of the kitchen had debris and a white substance caked on the tiles and the grout. On 3/5/13 at 8:45 am an interview with the Head Chef and Director of Food Services stated they had cleaned the floor on 3/4/13 and the rest of the floor would be done, (no date given). An observation of the hood over the stove which covered the back wall of the kitchen had 1/4 of the hood cleaned at the left end of the kitchen. The rest of the hood was covered with a greasy like substance. Observations of the walk-in refrigerator revealed produce and fruit; were not labeled with a use by date. Packages of green grapes were open with no use by date. Loaves of bread (4) were opened with no labeling for use by date. On 3/5/13 at 8:45 am an interview with the Director of Food Service and the Head Chef revealed it was their expectation that food should be labeled and the floor and hood should be cleaned according to the schedule.</p> <p>On 3/6/13 at 4:45 pm a second observation of the nursing facility kitchen revealed the dry storage area had debris on the shelves and tops of containers. On 3/6/13 at 4:50 PM an interview with the RD (Registered Dietician) and the Director of Food Service revealed that the Director stated the floors at the hospital kitchen had not been cleaned of grease for many years. The Director of Food Service also stated the staff had been in-serviced regarding the cleaning</p>	F 371	<p>hospital Chief Nursing Officer each month. The report will be submitted to the QAA Committee monthly for a minimum of 12 months. Any noncompliance will have an action plan attached.</p>		

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F 371	Continued From page 9 schedule and labeling of food. The RD stated it was her expectation was that the kitchens should be kept clean according to the schedule and foods needed to be labeled. On 3/16/13 at 5:15 pm revealed that it was her expectation that the kitchens needed to be clean, and food products labeled. It was also her expectation that the Food Service Director was responsible for overseeing and managing the kitchens.	F 371			

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

PRINTED: 03/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345412	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED APR 05 2013 03/19/2013
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NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE ST PO BOX 1006 OXFORD, NC 27565
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(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
K 000	INITIAL COMMENTS	K 000		
K 018 SS=D	<p>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system.</p> <p>The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 03/19/2013 the</p>	K 018	<p>K018</p> <p>Adjustments made to doors for rooms 104, 106, 109, 117 and 205 to insure proper closing. To assure that the deficient practice does not occur affecting other residents, maintenance will do monthly rounds checking doors on the hallways for proper latching. Corrective action will be taken as needed. An audit form will be submitted monthly to the Administrator, who will report to QAA any concerns.</p>	4/2/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jamie M. Mattingly, LNHHA</i>	TITLE Administrator	(X6) DATE 4/2/13
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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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NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE ST PO BOX 1008 OXFORD, NC 27565
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(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
K 018	Continued From page 1 following doors failed to latch when closed, 104, 106, 109, 117 and 205. 42 CFR 483.70 (a)	K 018	K147	3/20/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 03/19/2013 the generator failed to crank and transfer within the allowed amount of time (10 sec.). 42 CFR 483.70 (a)	K 147	The exchange heater was replaced on 3/20/13. To ensure the deficient practice does not recur, we will have a backup heat exchanger on hand should it fail again. We will continue with monthly generator load tests. The results of the load tests will be forwarded to the Director of Plant Operations. Any deficiencies will be reported to the Facility Administrator with a plan of correction. Note: The process in place for identifying such problems was effective. The alarm sounded, maintenance had identified the problem and was in the process of ordering the exchange heater at the time of our life safety survey.	4/15/13