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 _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANTWOOD NH & RETIREMENT CENT	**1038 COLLEGE STREET 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
E 000	Initial Comments An unannounced Recertification survey was conducted on 08/29/22 through 9/1/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # ZWRD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/29/22 through 9/1/22. Event ID# ZWRD11 . 1 of 11 complaint allegations was substantiated. Intake #NC00186410, NC00188379, NC00191388, NC00191464	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		9/16/22

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

Electronically Signed | 09/15/2022

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain walls in resident rooms in good repair (Room 405 and Room 206) and failed to secure the call bell box to the wall (Room 405). This was for 2 of 14 resident rooms reviewed for homelike environment. The findings included: 1. An observation on 8/30/22 at 9:39 AM of Room 405 revealed the wall behind the bed had a hole approximately measuring 11"X 3" long. Observation also revealed the call bell box near Bed A was not properly mounted to the wall. The cover of the call bell box was not attached to the wall. The call bell was tested and was working. During an interview on 8/31/22 at 10:51 AM, Nurse Aide #1 stated the call bell was working	F 584	F584 Safe/Clean/Comfortable/Homelike Environment Plan of Correction The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices relative to permitting residents to return to the facility. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed by this deficiency. On 9/12/22, the walls in room 206 and Room 405 were patched and repaired. On 9/2/2022, the call bell box	

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F 584	Continued From page 2	F 584		

and she had not noticed the call bell box not mounted correctly on the wall. Nurse Aide further stated she had not noticed the hole on the wall behind the resident's bed. Nurse Aide #1 indicated when any repair were needed to be done in resident's rooms the Nurse was notified. Nurse Aide confirmed she had not notified the nurse as she had not observed it.

During an interview on 8/31/22 at 11:08 AM, Nurse #2 stated the management was notified when any repairs were needed in resident's rooms. Nurse #2 further stated she was unaware of these repairs and the Nurse Aide had not notified her. Nurse #2 indicated the Administrator or Director of Nursing (DON) would place a work order for these repairs.

During an interview on 8/31/22 at 11:15 PM, Interim DON stated the nurses would notify the Administrator or any management team when any repairs were needed in resident's rooms. The interim DON stated she was not notified of these repairs and there was no work order placed for these repairs.

During an interview on 08/31/22 12:00 PM, The Director of Facility Services stated when any work order was received from the facility, the jobs were completed accordingly. The Director of Facility Services further stated all resident's rooms were inspected quarterly by the maintenance staff. Quarterly inspections were done to ensure that the resident's rooms were maintained in good condition. The Director of Facility Services indicated the staff moved the resident's beds too close to the wall resulting in the wall plaster getting peeled and walls damaged. The Director of Facility Services further indicated most the

was repaired and properly mounted to the wall in room 405.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 9/2/22, The Director of Facility Services inspected all other resident rooms to ensure there were no holes in the walls behind the beds and the call bell boxes were properly mounted to the wall to ensure the resident's safety. No other residents were harmed by the results of this inspection.

3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:
All other rooms noted to have holes in the walls behind the bed or the call bell box not mounted properly during the inspection completed on 9/2/22 had repairs to the walls and/call bell box completed by 9/16/2022. More protector sheets for the walls behind the beds were ordered by the Director of Facilities Services on 9/13/2022. The wall protectors are on backorder but will be installed upon arrival.

All Nursing Assistants, Licensed Nurses, and Maintenance employee (full time, part time, and contract) were educated by the Staff Development Coordinator on how to report any needed repairs in the resident's room, file a work order, and to keep the beds away from the walls. This education

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F 584	Continued From page 3	F 584		

resident's room walls behind the bed were mounted with a protector sheet to prevent wall damage. This was an antimicrobial plastic sheet protector that protected the walls. The Director of Facility Services stated she would be ordering more of these sheets to ensure all resident's rooms had these sheets on the wall. The Director of Facility Services further stated the screws of the call bell box were tightened so that it was properly mounted on the wall.

The Administrator was unable to be interviewed during the survey.

During an interview on 09/01/22 03:05 PM, The Chief Nursing Officer stated she oversees the nursing home operation, and the Administrator reports/consults her. The Chief Nursing Officer further stated if any staff saw anything that needed to be repaired, it should be reported immediately so that appropriate action could be taken. She indicated the Director of Facility Services had ordered a few more wall protectors and these were on backorder.

2. An observation on 8/31/22 at 1:20 PM of Room 206 revealed the wall behind both beds (Bed A and Bed B) had holes and damaged dry wall. The wall behind Bed A and Bed B had overlapping rectangular marks of exposed dry wall measuring approximately 1-2 inches in width by 4-10 inches in length. Observation also revealed an additional hole behind Bed B measuring approximately 8 inches by 12 inches and was rectangular in shape.

An interview was conducted with Nurse Aide #1 on 8/31/22 at 1:20 PM. She stated she had not known the walls in Room 206 were damaged. She indicated she typically reported damaged

will be added to new employee orientation. Any Nursing Assistant, Licensed Nurse, or Maintenance Employee that did not receive the education by 9/16/2022, will not be allowed to work until they receive the education.

4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:
Starting on 9/12 and continuing for 4 weeks, the Administrator/designee will conduct environmental rounds to ensure any holes in the walls behind the beds have been repaired timely and call bell boxes are properly mounted to wall. Any needed repairs will be submitted via work orders to Facility Services to ensure timely completion. The results of these audits will be submitted to Quality Assurance Committee in the next meeting for review.

Completion date: 9/16/22

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F 584	Continued From page 4	F 584		

walls to the Administrator or to the Resident Care Coordinator (RCC).

An interview was conducted with the RCC on 8/31/22 at 1:20 PM. She stated protective wall covers were on back order and that was why Room 206 did not have one behind the beds.

During an interview on 08/31/22 12:00 PM, The Director of Facility Services stated when any work order was received from the facility, the jobs were completed accordingly. The Director of Facility Services further stated all resident's rooms were inspected quarterly by the maintenance staff. Quarterly inspections were done to ensure that the resident's rooms were maintained in good condition. The Director of Facility Services indicated the staff moved the resident's beds too close to the wall resulting in the wall plaster getting peeled and walls damaged. The Director of Facility Services further indicated most the resident's room walls behind the bed were mounted with a protector sheet to prevent wall damage. This was an antimicrobial plastic sheet protector that protected the walls. The Director of Facility Services stated she would be ordering more of these sheets to ensure all resident's rooms had these sheets on the wall. The Director of Facility Services further stated the screws of the call bell box were tightened so that it was properly mounted on the wall.

The Administrator was unable to be interviewed during the survey.

During an interview on 09/01/22 03:05 PM, The Chief Nursing Officer stated she oversees the nursing home operation, and the Administrator

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F 584	Continued From page 5 reports/consults her. The Chief Nursing Officer further stated if any staff saw anything that needed to be repaired, it should be reported immediately so that appropriate action could be taken. She indicated the Director of Facility Services had ordered a few more wall protectors and these were on backorder.	F 584		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to	F 640		9/15/22

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F 640	Continued From page 6 the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a Discharge Minimum Data Set (MDS) assessment and failed to transmit Quarterly MDS assessments within the required time frame for 3 of 3 residents (Resident # 1, Resident # 7, and Resident # 8) selected to be reviewed for Resident Assessments. Findings included: 1. Resident #1 was admitted on 3/28/22. The last MDS assessment completed and transmitted was Medicare - 5-day Admission MDS dated 4/4/22. Record review dated 4/12/22 revealed the resident was discharged home with home health.	F 640	F640 Encoding/Transmitting Resident Assessments Plan of Correction The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices relative to permitting residents to return to the facility. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed or affected by this deficiency. The Discharge MDS Assessment with an Assessment Reference Date of 4/12/22 for resident #1	

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F 640	Continued From page 7 Discharged note from physician dated 4/12/22 revealed the resident was discharged home with home health services. There was no discharge MDS completed for this resident. During an interview on 9/1/22 at 1:51 PM, the MDS coordinator indicated the resident was discharged on 4/12/22 and the discharge MDS was not completed. MDS coordinator further indicated it was during the transition period when the old MDS staff resigned. The MDS coordinator stated the assessment must have slipped through the cracks. Administrator was unavailable for interview. During an interview on 9/1/22 at 3:02 PM, The Chief Nursing Officer stated she oversees the nursing home operation, and the Administrator reports/consults her. The Chief Nursing Officer stated all assessment should be completed and transmitted on time. 2. Resident #7 was admitted on 1/13/22. A review of resident's most recent MDS assessment revealed an Assessment Reference Date (ARD) of 7/25/22 and was coded as a quarterly assessment. The MDS was signed as completed by the MDS Coordinator on 8/7/22 and indicated as ready to export. The MDS assessment was not transmitted to the national database. During an interview on 9/1/22 at 1:51 PM, the MDS coordinator stated the assessment was	F 640	was completed on 9/12/2022 and transmitted on 9/12/2022. The Quarterly MDS Assessment with an Assessment Reference Date of 7/25/22 for resident #2 was transmitted on 9/1/2022. The Quarterly MDS Assessment with an Assessment Reference Date of 7/26/22 for resident #3 was transmitted on 9/1/2022. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Administrator completed an audit on 9/13/2022 of all current residents to ensure all required MDS assessments have been completed and transmitted to the national database. They were all transmitted and accepted. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: On 9/2/2022, The Director of Nursing educated the MDS Nurse on the requirement to complete all required MDS assessments and transmit the MDS assessments to the CMS national database timely. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained: The Director of Nursing will audit the MDS Nurse weekly for 4 weeks to ensure the no other MDS assessments have been missed and all completed MDS assessments have been transmitted timely. The Director of Nursing will report the findings to the next Quality Improvement Committee on 9/22/2022 for	

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F 640	Continued From page 8 completed and signed on 8/7/22. The MDS coordinator further stated the assessment should have been transmitted within 14 days of completion. The submit by date was 8/21/22. MDS coordinator indicated she was unsure why the assessment was not transmitted. She further indicated all completed MDS assessments were transmitted every other week. Administrator was unavailable for interview. During an interview on 9/1/22 at 3:02 PM, The Chief Nursing Officer stated she oversees the nursing home operation, and the Administrator reports/consults her. The Chief Nursing Officer stated all assessment should be completed and transmitted on time. 3. Resident #8 was readmitted on 1/26/22. A review of resident's most recent MDS assessment revealed an ARD of 7/26/22 and was coded as a quarterly assessment. The MDS was signed as completed by the MDS Coordinator on 8/7/22 and indicated as ready to export. The MDS assessment was not transmitted to the national database. During an interview on 9/1/22 at 1:51 PM, the MDS coordinator stated the assessment was completed and signed on 8/7/22. The MDS coordinator further stated the assessment should have been transmitted within 14 days of completion. The submit by date was 8/21/22. MDS coordinator indicated she was unsure why the assessment was not transmitted. She further indicated all completed MDS assessments were transmitted every other week.	F 640	evaluation and review. The Committee will decide on further continuation of the weekly checks or to discontinue the ongoing monitoring. Completion date: 9/15/2022	

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F 640	Continued From page 9 Administrator was unavailable for interview. During an interview on 9/1/22 at 3:02 PM, The Chief Nursing Officer stated she oversees the nursing home operation, and the Administrator reports/consults her. The Chief Nursing Officer stated all assessment should be completed and transmitted on time.	F 640		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews, Physician interview, family interview, and record review, the facility failed to transport a resident (Resident #108) to scheduled oncologist (cancer doctor) appointments resulting in the resident missing two appointments. This was for 1 of 1 resident reviewed for medically related social services. The findings included: Resident #108 was admitted to the facility on 5/28/21 with diagnoses that included orthopedic aftercare (right lower leg fracture) and malignant neoplasm (breast cancer). She was discharged to the hospital on 11/27/21. The quarterly Minimum Data Set (MDS) dated 9/29/21 revealed Resident #108 was cognitively intact. A nurse progress note dated 10/5/21 revealed	F 745	F745 Provision of Medically Related Social Service Plan of Correction The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices relative to permitting residents to return to the facility. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 108 was scheduled for an appointment on 11/24/2021 at 0830 for her oncology appointment. Transportation was unable to transport her and EMS was contacted and agreed to take her later in the day but the physician was already	9/15/22

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Resident #108 had an appointment with her oncologist. Resident #108 did not go to the appointment because she had covid at the time. The appointment was rescheduled for 11/8/21.

The care plan dated 10/14/21 revealed a focus area for Resident #108 receiving breast cancer treatment. Interventions included assisted with transportation arrangements and discussed issues with the resident and family regarding treatments.

A progress note dated 10/29/21 by the former social worker revealed Resident #108's family was informed of the upcoming appointment with her oncologist on 11/8/21.

A nurse progress note dated 11/8/21 revealed Resident #108 was unable to attend her oncology appointment due to transportation issues. The family was made aware.

A nurse progress note dated 11/9/21 revealed the nurse notified Resident #108's family of the new appointment that had been rescheduled following the missed appointment on 11/8/21. The family expressed concern that the appointment was two weeks or more out. The appointment had been rescheduled for 11/24/21.

Review of the transportation arrangement notification dated 11/19/21 and sent to the transportation company by the Director of Nursing (DON), revealed Resident #108 was scheduled for an appointment with the oncologist on 11/24/21 at 8:30 AM. She was to be transported to the appointment by stretcher.

Resident #108 was transferred to the hospital on 11/27/2021 to ER and did not return to Brantwood.

booked. The resident was transported on

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 1/6/2022, the Director of Nursing audited all appointments for December 2021 to identify any other missed appointments. The results concluded that no residents missed any appointments.

3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:

The Administrator and Director of Nursing met with the transportation company and went over the missed appointments in early November 2021 and discussed the need to get all residents to and from scheduled appointments. Nursing staff were in-serviced on 11/17 on documenting appointments in PCC. After reviewing the schedule book, the Administrator and Director of Nursing determined all upcoming appointments for the week would be sent to the transportation on Thursday and any changes or additions would be made by phone call. The Quality Improvement Committee, monitored this process for 90 days and it was determined that scheduling was going well without missed appointments during this timeframe. Additionally in-services were provided on 4/20/2022

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F 745	Continued From page 11 11/27/21 and assessed for a urinary tract infection. An interview was conducted with Resident #108's family member on 8/29/22 at 9:42 AM. The family member stated Resident #108 had "uncurable" breast cancer and she received periodic infusions for treatment. The resident missed several appointments with her oncologist while she was admitted at the facility. During an interview with Nurse #1 on 8/30/22 at 2:30 PM, she stated Resident #108 had missed doctor's appointments. She did not recall the details of the missed appointments but stated it was an issue with the transportation company not picking up the resident. An interview was conducted with the resident care coordinator on 8/30/22 at 12:00 PM. She stated nursing staff made medical appointments and transportation arrangements for residents at the facility. On 8/31/22 and 9/1/22 multiple attempts to contact the transportation company manager were unsuccessful. During an interview with the DON on 9/1/22 at 9:45 AM, she stated at the time of Resident #108's missed appointments, the former social worker oversaw transportation arrangements. The DON took over the responsibility for arranging transportation sometime in November 2021. The DON stated Resident #108 missed her doctor's appointment on 11/8/21 due to transportation issues and the appointment was rescheduled for 11/24/21. The transportation company was aware of Resident #108's	F 745	and 9/13/2022 to all nursing staff on scheduling process in PCC and reviewing in Stand up daily. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained: The Director of Nursing or designee will audit the appointments weekly x 4 weeks to ensure the current process for requesting transportation is adequate and appointments are not missed. The results of the audits will be reviewed by the Quality Assurance Committee during the next QA meeting. Completion date: 9/15/2022	

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 _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 745	Continued From page 12	F 745		

appointment on 11/24/21 but they did not pick up the resident that morning. On 11/24/21, the facility attempted to transport Resident #108 with emergency medical services (EMS) after the transportation service did not come get her for her oncology appointment. The doctor's office was unable to accommodate a different appointment time for Resident #108 on 11/24/21.

During an interview with Physician #2 on 9/1/22 at 1:35 PM, he stated he did not recall Resident #108 missing doctor appointments. The Physician indicated he didn't think the missed appointments would have affected her outcome or prognosis.

The Administrator was unable to be interviewed during the survey.

An interview was conducted with the Chief Nursing Officer (CNO) on 9/1/22 at 3:24 PM. She stated residents should be transported to their medical appointments. She indicated there had been improvement with the transportation services that were contracted with the facility.