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 11/09/2023

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BRANTWOOD NH & RETIREMENT CENT	1038 COLLEGE STREET OXFORD, NC 27565

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E 000	Initial Comments An unannounced Recertification survey was conducted on 11/6/23 through 11/9/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # R81S11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 11/6/23 through 11/9/23. Event ID# R81S11. The following intakes were investigated NC00201996, NC00196023, NC00195908. Four (4) of (4) complaint allegations did not result in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		1/20/24

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

Electronically Signed | 12/01/2023

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F 553	Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to invite the resident or resident's responsible party to participate in the care planning process for 1 of 16 residents whose care plans were reviewed (Resident #42). Findings included: Resident #42 was originally admitted on 8/8/23 and readmitted on 9/19/23. Resident #42's comprehensive care plan was completed on 8/23/23, however there was no indication that the resident or a resident's representative had participated in the care plan meeting or in development of his care plan. Review of the admission Minimum Data Set (MDS) assessment dated 9/19/23 revealed Resident #42 had been assessed as cognitively intact. There was no documentation that indicated the plan of care was discussed with the resident or resident's representative or that they were invited	F 553	F553 Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility understands that no residents were harmed by this deficiency. As of 11/9/2023 all new admissions have participated in their care planning process. Signatures from resident or resident representative have been obtained on the baseline care plan within 72 hours of admission. Resident and/or resident representative are also made aware at this time of when the comprehensive care plan meeting will take place to support their participation in accordance with these requirements. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice	

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F 553	Continued From page 2 to a care plan meeting. During an interview on 11/06/23 at 9:22 AM, Resident #42 stated he had not been invited to attend a care plan meeting and did not recall participating in developing his plan of care since his admission into the facility. During an interview on 11/08/23 at 10:59 AM, the MDS Coordinator stated the resident's comprehensive care plan was completed on 8/16/23 and no care plan meeting was held with the resident or resident's family. The MDS coordinator indicated that care plan conference meetings were conducted only after quarterly assessments and/or when care plan review was completed. She indicated she was unaware that a care plan meeting should be conducted for comprehensive care plan as the families were updated about the baseline care plan during the meet and greet during admission. She stated if residents were admitted for short term stay then care plan meetings were not conducted. The MDS coordinator confirmed that a comprehensive care plan meeting was not held with the resident or resident representative. During an interview on 11/08/23 at 11:30 AM, The Administrator stated she was unaware that a comprehensive care plan meeting should be conducted with the residents and/or responsible party. She indicated she thought only quarterly care plan meetings were scheduled with the families and the residents.	F 553	Facility has reviewed all other current residents and confirm that no other residents were subject by this deficiency. As of 11/9/2023 all new admissions and readmissions have participated in their care planning process. Signatures from resident or resident representative have been obtained on the baseline care plan within 72 hours of admission. Resident and/or resident representative are also made aware at this time of when the comprehensive care plan meeting will take place to support their participation in accordance with these requirements. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur A calendar has been implemented in order to monitor when the baseline care plan, the comprehensive care plans, and quarterly care plans are to be completed by. The MDS coordinator, the Administrator and interdisciplinary team has been educated on this process and the requirements, including these resident/representative participation requirements, that must be followed in order to remain in compliance. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Starting 11/20/2023, Administrator, or designee will audit all baseline care plans for new admissions weekly for 4 weeks.	

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F 553	Continued From page 3	F 553	This audit will include participation of resident and/or resident representative and ensure signature was obtained and copy given. Resident Care Coordinator, or designee, will audit comprehensive care plans monthly for two months. Completion Date: 01/20/2024	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		1/18/24

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F 578	Continued From page 4 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate advanced directive (code status) information throughout the medical record for 1 of 26 residents reviewed for advanced directives (Resident #26). Findings included: Resident #26 was admitted on 7/28/2021. Review of Resident #26's paper medical record revealed a signed physician's order and a Do Not Resuscitate (DNR) form both dated 4/28/22 indicating Resident #26's DNR status. Resident #26's electronic medical record indicated DNR. Resident #26's most recent Minimum Data Set assessment dated 9/5/23 indicated she was cognitively intact. Review of Resident #26's care plans initiated on 8/1/21 and most recently noted as reviewed on	F 578	F578 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Facility understands that no residents were harmed by this deficiency. Resident #26’s code status order was corrected on 11/08/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Facility’s review indicates that no other residents were harmed by this deficiency. A 100% audit was completed by 11/13/2023 on all resident code status orders to ensure that the care plan reflected the correct status.	

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F 578	Continued From page 5 9/28/23 included: Resident's Advanced Directives. Goal: Wishes Will Be Known. Interventions included in part; Residents code status is: FULL CODE. An interview with the Minimum Data Set (MDS) Coordinator was conducted on 11/08/23 at 11:18 AM. She stated care plans were reviewed with every MDS assessment and the resident or family would be asked if this is still what they want to do or if they want to change things. She explained the last care plan meeting had been conducted with Resident #26's daughter and she had indicated no changes. She further stated the care plan and information in the record should match. On 11/08/23 at 3:34 PM an interview with the Director of Nursing (DON) was conducted. She stated the information on the care plans should not contradict the information in the medical record.	F 578	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/13/23 Administrator educated the Resident Care Coordinator, Minimum Date Set (MDS) Nurse, and clinical managers on the procedure for advance directives. Upon admission, the resident care coordinator, or designee, will discuss advance directive with resident and/or resident representative. The Resident Care Coordinator, or designee will notify the admitting nurse of the code status. Code status order will be entered into the electronic medical record and paper copy (full code form or DNR form) will be placed in the residents' paper chart. The following working day after an admission, the clinical team will review the chart during daily clinical meeting and validate that the code status is reflected in the care plan. The Director of Nursing (DON), or designee, will review any changes in orders to ensure no code status changes occurred. If there are changes, the DON or designee will ensure that the clinical team is notified and care plan is updated. Code status will be reviewed at each quarterly care plan or as needed, per facility policy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; MDS nurse, or designee, will audit all new admission's code status, including that the	

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F 578	Continued From page 6	F 578	care plan and the medical record match, weekly for 3 weeks and monthly for 2 months. Completion date: 1/18/2024	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		1/18/24

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F 623	Continued From page 7	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 8 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party (RP), and staff interviews the facility failed to notify the RP and the Ombudsman in writing when 1 of 1 sampled residents was discharged to the hospital (Resident #6). Resident #6 had originally been admitted to the facility in 2009. She had been discharged to the hospital on 1/27/2023 and readmitted on 1/30/23. Resident #6's most recent Minimum Data Set assessment dated 8/2/2023 indicated she had severe cognitive impairment.	F 623	F 623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Facility understands that no residents were harmed by this deficiency. Facility believes that while there was not documentation of written notification, all	

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F 623	Continued From page 9 An interview with Resident #6's Responsible Party (RP) was conducted on 11/07/23 at 1:29 PM. She stated she had been present when Resident #6 had been transferred to the hospital in January, but she had not received any a written explanation of the reason for discharge to the hospital. On 11/07/23 at 3:45 PM an interview with the Resident Care Coordinator was conducted. She explained she was new to the position and was unaware that anything had to be sent to the family in writing or to the Ombudsman regarding discharges. An interview on 11/08/23 at 3:36 PM was conducted with the Director of Nursing (DON). She stated she thought contacting the RP during an emergency was adequate for notification and was unaware of needing to send a written notice for discharge to the RP or the Ombudsman.	F 623	the Responsible Party was notified verbally of the January 2023 transfer. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Facility understands that no other residents were harmed by this deficiency. Facility reviewed progress notes of the other residents. In each case, although there is not documentation of written notification to resident representatives as to the reason, the progress notes indicate that responsible parties were notified verbally of recent transfers/discharges. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Resident Care Coordinator, the DON and other relevant personnel were educated on these requirements. Moving forward, Resident Care Coordinator, or designee, will notify in writing the Ombudsman of all facility-initiated transfers or discharges which notice shall include the reasons for this transfer or discharge and the other required elements. Resident Care Coordinator, or designee, will provide written notification to the responsible party and the resident (as applicable) of any facility-initiated transfer/discharge via email or mail. The notice will align with the Ombudsman notice and all include the reasons for this transfer or discharge and the other	

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F 623	Continued From page 10	F 623	required elements. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Resident Care Coordinator, or designee, will audit all transfers/discharges weekly for 4 weeks to ensure proper notification is given to Ombudsman and responsible party and residents, and thereafter as needed. Completion date: 01/18/2024	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		1/31/24

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F 625	Continued From page 11 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, responsible party, and staff interviews the facility failed to provide written notice of bed hold policy upon transfer to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #6). Resident #6 had originally been admitted to the facility in 2009. She had been discharged to the hospital on 1/27/2023 and readmitted on 1/30/23. Resident #6's most recent Minimum Data Set assessment dated 8/2/2023 indicated she had severe cognitive impairment. An interview with Resident #6's Responsible Party (RP) was conducted on 11/07/23 at 1:29 PM. She stated she had been present when Resident #6 had been transferred to the hospital in January, but she had not received any information regarding bed hold. On 11/07/23 at 3:45 PM an interview with the Resident Care Coordinator was conducted. She explained she was new to the position and recently learned the bed hold information needed to be given to the family when residents were discharged to the hospital. An interview on 11/08/23 at 3:36 PM was	F 625	F 625 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Facility understands that no residents were harmed by this deficiency. Resident #6 was readmitted in due course on 1/30/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Bed holds have been sent to all resident representatives as of 11/21/2023. Facility will send bed notice policies to all residents by 01/31/2024. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The bed hold policy will continue to be a	

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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
F 625	Continued From page 12 conducted with the Director of Nursing (DON). She stated she had recently become aware of the bed hold policy needing to be sent with the resident or to the RP upon transfer to the hospital.	F 625	part of the admission packet and will now be provided to nurses in their “hospital discharge packet”. This will be sent to the hospital with the resident. The Resident Care Coordinator, or designee, will provide written notification to the resident representative of the bed hold policy upon hospital or therapeutic leave. Facility will conduct education as need to operationalize the foregoing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Resident Care Coordinator, or designee, will audit any hospital or therapeutic discharges weekly for at least 3 weeks and monthly for at least 2 months, and thereafter as needed. Completion date: 01/31/2024	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to accurately code nutrition and Pre-Admission Screening and Resident Review (PASRR) on the Minimum Data Set (MDS) assessments for 2 of 16 residents	F 641	F 641 Accuracy of Assessments CFR(s): 483.20(g) 1. Address how corrective action will be accomplished for those residents found to	1/18/24

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F 641	Continued From page 13 (Residents #63, and #53) reviewed for MDS accuracy. Findings included: 1. Resident #63 was admitted to the facility on 7/18/23 with diagnoses that included dementia, anxiety disorder and neuromuscular dysfunction of the bladder. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/10/23 revealed Resident #63 was assessed as severely cognitively impaired and needed substantial /maximal assistance to partial / moderate assistance for Activities of Daily living. Assessment indicated for eating the resident needed setup or clean up assistance only. The assessment indicated the resident had significant weight loss. Assessment indicated the resident was on tube feeding and on mechanically altered diet. On 11/6/23 at 1:16 PM during an observation and interview, Resident #63 was observed during lunch. Resident #63 was eating her lunch in her room and was able to self-feed. The resident was monitored during meals and encouraged to consume her food. The resident was on a low sodium, pureed meat diet. The resident consumed 25% of her meals at the time of observation. Nurse Aide (NA) #1 was observed sitting with the resident during lunch and encouraging the resident to consume her food. NA #1 stated the resident could feed self but needed a lot of encouragement and cues to eat. NA #1 further stated, during meals a staff member would sit with the resident to encourage meal intake. NA #1 indicated the resident was assisted with feeding as needed.	F 641	have been affected by the deficient practice Facility understands that no residents were harmed by this deficiency. Resident #63's assessment was corrected on 11/09/2023. At no time did Resident #63 receive tube feeding. On 11/09/2023, resident #53's MDS was corrected to reflect level II PASRR. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice No other residents were harmed by this deficiency. MDS nurse completed an 100% audit on 11/24/2023 of all Level II PASRR to ensure correct MDS was marked. MDS nurse will complete an audit by 11/13/2023 to ensure nutrition is marked corrected in MDS] 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/22/2023 MDS nurse was educated on the requirement to enter correct information in the MDS. Systems were put in place by creating a spreadsheet of all current PASRRs. MDS nurse will ensure each PASRR is reflected in the care plan. MDS nurse or other personnel will ensure nutrition is accurately reflected in MDS assessment. The following working day after an admission, the clinical team will	

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F 641	Continued From page 14 During an interview on 11/7/23 at 3:17 PM, the Registered Dietitian (RD) stated the resident was on a low sodium, mechanical soft, pureed meats, thin liquids diet. The resident could self-feed, however needed some encouragement and cues at mealtime. The RD indicated the resident did not receive any tube feeding and consumed 25-75% of her meals. During an interview on 11/8/23 at 11:50 AM the MDS Coordinator indicated it was an error that Resident #63 was marked for tube feeding. She indicated Resident #63 was not on tube feeding. The resident should be marked for therapeutic diet and mechanically altered diet in the MDS. During an interview on 11/8/23 at 2:45 PM, the Administrator stated it was a MDS error and would be corrected immediately. The Administrator further stated resident's MDS assessments should reflect current status of the resident. 2. Resident #53 had been admitted on 12/14/21 with diagnoses including moderate intellectual disabilities and major depressive disorder. An undated care plan noted Resident #53 had a Level 2 Preadmission Screen and Annual Record Review (PASRR determination) related to moderate intellect disability. Resident #53's most recent annual MDS assessment dated 9/3/23 did not indicate she was considered by the state Level II PASRR process to have intellectual disability. An interview with the MDS Coordinator was conducted on 11/08/23 at 11:18 AM. She	F 641	review the chart during daily clinical meeting to ensure correct information is entered into resident assessment, including nutrition and PASRR information. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained MDS, or designee, will audit correct nutrition and PASRR and Assessment information weekly for at least 3 weeks and monthly for at least 2 months, and thereafter as needed. Completion Date: 1/18/2024	

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F 641	Continued From page 15 explained Resident #53 was technically considered as Level II PASRR, but she did not mark it on the MDS because there were no restrictions noted on the PASRR determination letter. An interview with the Director of Nursing (DON) was conducted on 11/08/23 at 3:36 PM. The DON stated the PASRR information should be correct on the MDS assessment.	F 641		