	•••••••••••••••••••••••••••••••••••••••	AND HUMAN SERVICES			M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) DA	ATE SURVEY MPLETED
		345412	B. WING	0	6/26/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRANTV	VOOD NH & RETIREN			1038 COLLEGE STREET OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 253 SS=D	MAINTENANCE SI The facility must pr maintenance service		F 253	3	7/22/14
	by: Based on observative record reviews the adequate building r orderly and comfort halls (200 and 400 On 06/23/2014 a to conducted between During the tour and 208 was made. Th vertical edge of the bathroom had no st from the floor to ap The sheet rock app at some time in the revealed the wall's usually hidden under and exposed.	NT is not met as evidenced tions, staff interviews and facility failed to conduct maintenance to ensure an table interior on 2 of 2 resident halls). The findings included: ur of the facility was a 6:20 p.m. and 7:00 p.m. observation of resident room e observation revealed the wall by the adjoining heetrock covering the corner proximately 6 feet up the wall. beared to have been broken off past. The observation also internal metal corner bead, er the sheetrock being visible		Replaced molding which covers the vertical edge of the wall by the adjoining bathroom in room 208 on June 30, 2014. To assure that the deficient practice does not occur in other resident rooms, the Director of Plant Operations and facility administrator or their designees will make monthly rounds to assure that molding is intact in resident rooms. Any areas of noncompliance will be reported to the QA committee quarterly. The sinks in the men's and women's visitor bathrooms on 400 hall were removed from the wall and brackets remounted securing the sinks. Removed shelves and repaired wall	e
	bathrooms next to the were observed. But to have sinks that we and were observed not level. Each sin down ½-1 inch with bathroom had a me to be slanted on the	r the men's and women's the 400 hall's nursing station th bathrooms were observed vere loose on their wall mounts to be slanted downward and k could be moved up and very little pressure. Each etal shelf which was observed e wall (loose) and each shelf ved 1-2 inches up and down		<ul> <li>where shelves were removed in both the men's and women's visitor bathrooms on 400 hall.</li> <li>To assure that the deficient practice does not occur in other visitor bathrooms, a maintenance technician will include visito bathrooms in daily rounds to assure bathrooms are sanitary, orderly and comfortable.</li> </ul>	;
ABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIGN		TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

07/23/2014

PRINTED: 07/31/2014

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.

**Electronically Signed** 

				י יסו־			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		345412	B. WING			06/2	26/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	VOOD NH & RETIREN				038 COLLEGE STREET 0XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 253	Continued From pa	age 1	F 2	53			
	was made of reside was not repaired at still exposed. The bathrooms on the 4 station still had the the shelves still loo have been made.	00 a.m. a second observation ent room 208. The sheetrock nd the metal corner bead was men's and women's 400 hall next to the nurse's ir sinks loose on the walls and se - no repairs appeared to			To assure that the deficient practic not recur in visitor bathrooms, the of Plant Operations and facility administrator or their designees w monthly rounds to assure a sanita orderly and comfortable interior. A areas of noncompliance will be rep to the QA committee quarterly.	Director ill make ry, ny	
	On 06/25/2014, 8:30 a.m. a third observation was made of resident room 208. The sheetrock was not repaired and the metal corner bead was still exposed. The men's and women's bathrooms on the 400 hall next to the nurse's station still had their sinks loose on the walls and the shelves still loose - no repairs appeared to have been made.						
	was made of reside was not repaired at still exposed. The bathrooms on the station still had the	2:35 p.m. a fourth observation ent room 208. The sheetrock nd the metal corner bead was men's and women's 400 hall next to the nurse's ir sinks loose on the walls and se - no repairs appeared to					
	conducted with the technician concern procedures. The le indicated some of t the facility's mainte "Facility Dude." Th that if a staff memb reported a mainten receiving the repor computer program	8:04 p.m. an interview was facility's lead maintenance ing the facility's maintenance ead maintenance technician the facility's staff had access to nance request program called be lead maintenance technician over or family or resident ance issue and the person t did not have access to the the report would be forwarded d have access and the request					

		AND HUMAN SERVICES				FORM	07/31/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		345412	B. WING			06/;	26/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	WOOD NH & RETIREM	IENT CENT			038 COLLEGE STREET DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 253	computer system p would be generated technician indicated had an immediate s call the maintenanch he would send a ma the safety issue wo maintenance techn is placed into Facili would generate a w maintenance worke repair and/or replace and complete the e it out when the work or replacement of a part (deferred main indicate the part on maintenance techn placed the work or email that the work or replacement of a part (deferred main indicate the part on maintenance techn program keeps the when an item was r keeping. On 06/26/2014 at 3 conducted with the Nursing (DON). Th the facility report ar (something needing administrator and th the computer syste order is generated. On 06/26/2014 at 3 conducted with the management assis management assis	rogram and a work order d. The lead maintenance d if the maintenance request safety concern the facility will ce administrative assistant and aintenance worker to come do rk immediately. The lead ician indicated once the issue ty Dude the computer system work order number and the er assigned to the facility would ce the items needing repair electronic work order and close k was completed. The lead ician indicated the person that der would then be notified by had been completed. If repair an item required ordering a tenance) the work order would order/waiting parts. The lead ician indicated the software work order information as to repaired or replaced for record	F 2	253			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345412	B. WING			06/2	26/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	OOD NH & RETIREM				38 COLLEGE STREET (FORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 253 F 256 SS=D	orders that are not needing to be repai with the lead mainter maintenance mana facility's outstanding only 4 outstanding showing a need for None of the work of system included an found to be in need On 06/26/2014 at 4 and fifth observatio facility's administrat technician. The foll be in need of repair Resident room 208 The sheetrock was corner bead was st appeared to have b 400 hall's men's an The sinks were still shelves were still lo appeared to have b On 06/26/2014 at 4 conducted with both technician and the f facility's lead mainter facility's lead mainter facility's administrat knew about the item replacement. 483.15(h)(5) ADEQ LIGHTING LEVELS	completed and/or reported as red. A review was conducted enance technician and the gement assistant of the g work orders. There were work orders for the facility repair and/or replacement. rders in the facility's computer y of the issues observed and of repair. :10 p.m. a tour of the facility n was conducted with the tor and the lead maintenance lowing items were observed to : - not repaired and the metal ill exposed. No repairs een made. d women's bathrooms - loose on the walls and the ose and hanging. No repairs een made. : 25 p.m. an interview was n the lead maintenance facility's administrator. The enance technician and the tor indicated neither of them ns in need of repair or : :UATE & COMFORTABLE S	F 2				6/30/14

Facility ID: 943195

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY	
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED		
		345412	B. WING _			26/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
BRANTW	OOD NH & RETIREM			1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 256	Continued From pa	ge 4	F 25	56			
	This REQUIREMEN	NT is not met as evidenced					
	Based on observations, staff i record reviews the facility failed residents had adequate and co in 1 of 1 resident community sl (200 hall). The findings include	facility failed to ensure uate and comfortable lighting ommunity shower/bathrooms		Light bulbs were replaced for neon light over the sink and foot neon lights lighting the of dressing and bathtub area moperational.	2 sets of 4 rying,		
	conducted between During the tour and only resident comm located on the 200 revealed the 18 incl two sets out of four	ur of the facility was 6:20 p.m. and 7:00 p.m. observation was made of the unity shower/bathroom hall. The observation h neon lights over the sink and of 4 foot neon lights lighting and bathtub area were not		To assure that this deficient not occur in other resident co areas, a maintenance techni make daily rounds to identify that is not operational. The D Plant Operations and the fac administrator or their design monthly rounds to assure the operational. Non-compliance	ommunity cian will any lighting irector of ility ees will make at lighting is will be		
	was made of the re shower/bathroom. were still non-opera	0 a.m. a second observation sident community The neon lights over the sink itional and the two sets of 4 ne main room area were still		submitted to the QA committ	ee quarteny.		
	made of the resider shower/bathroom. were still non-opera	0 a.m. a third observation was nt community The neon lights over the sink itional and the two sets of 4 ne main room area were still					
	was made of the re shower/bathroom. were still non-opera	2:35 p.m. a fourth observation sident community The neon lights over the sink itional and the two sets of 4 ne main room area were still					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		). 0938-039 TE SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED		
		345412	B. WING			/26/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
BRANTV	OOD NH & RETIREN	IENT CENT		1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
F 256	Continued From pa	ge 5	F 2	56			
	conducted with the technician concerni- procedures. The le- indicated some of t the facility's mainter "Facility Dude." The that if a staff membre reported a mainten- receiving the report computer program to someone that did for maintenance work computer system p would be generated technician indicated had an immediate s call the maintenance he would send a mathematic the safety issue work maintenance techn is placed into Facili would generate a w maintenance worker repair and/or replace and complete the e it out when the work or replacement of a part (deferred main indicate the part on maintenance techn program keeps the	:04 p.m. an interview was facility's lead maintenance ing the facility's maintenance and maintenance technician he facility's staff had access to nance request program called e lead maintenance technician er or family or resident ance issue and the person did not have access to the the report would be forwarded the access and the request ould then be placed in the rogram and a work order d. The lead maintenance d if the maintenance request safety concern the facility will e administrative assistant and aintenance worker to come do rk immediately. The lead ician indicated once the issue ty Dude the computer system fork order number and the er assigned to the facility would be the items needing repair lectronic work order and close k was completed. The lead ician indicated the person that der would then be notified by had been completed. If repair in item required ordering a tenance) the work order would order/waiting parts. The lead ician indicated the software work order information as to repaired or replaced for record					

Facility ID: 943195

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU	TIDI		PRINTED: 07/31/2014 FORM APPROVED MB NO. 0938-039 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		345412	B. WING			06/2	26/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	VOOD NH & RETIREM				038 COLLEGE STREET DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 256	On 06/26/2014 at 3 conducted with the Nursing (DON). The the facility report and (something needing administrator and the the computer system order is generated. On 06/26/2014 at 3 conducted with the management assist their system, "Facilit orders that are not a needing to be repai with the lead mainter maintenance mana facility's outstanding only 4 outstanding only 4 outstanding showing a need for None of the work on system included an found to be in need On 06/26/2014 at 4 and fifth observation community shower/ over the sink were s two sets of 4 foot ne area were still non- appeared to have b On 06/26/2014 at 4 conducted with both technician and the f facility's lead mainter	2:35 p.m. and interview was facility's interim Director of the DON indicated the nurses in my maintenance related issue grepair) to her or the ney enter the information into m (Facility Dude) and a work 4:43 p.m. an interview was hospital's maintenance tant. The maintenance t indicated the work orders in ity Dude," tracks the work completed and/or reported as red. A review was conducted enance technician and the gement assistant of the g work orders. There were work orders for the facility repair and/or replacement. rders in the facility's computer by of the issues observed and of repair. 2:10 p.m. a tour of the facility n was made of the resident /bathroom. The neon lights still non-operational and the eon lights in the main room operational. No repairs	F 2	256			

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		AND HUMAN SERVICES			FORM	07/31/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		345412	B. WING _		06/	26/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
BRANTW	OOD NH & RETIREN			1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 256	Continued From pa	age 7	F 25	56		
	replacement.					
F 278 SS=B			F 27	<sup>'8</sup>		7/30/14
	The assessment m resident's status.	ust accurately reflect the				
	A registered nurse each assessment v participation of hea					
	A registered nurse assessment is com	must sign and certify that the pleted.				
		o completes a portion of the sign and certify the accuracy of assessment.				
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each as willfully and knowin to certify a material resident assessme	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money e than \$5,000 for each				
	Clinical disagreeme material and false	ent does not constitute a statement.				
	by: Based on record re facility failed to acc	NT is not met as evidenced eviews and staff interviews the urately code Section I of the (MDS) when completing		Resident #'s 45, 13, 150 and during the survey, were disch to the correction date. For the	arged prior	

Facility ID: 943195

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		& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345412	B. WING		06/26/2014
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE
BRANTV	OOD NH & RETIREN			1038 COLLEGE STREET OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTIO
F 278	Continued From pa	ige 8	F 27	8	
	Section I - Active D blank or incomplete reviewed. (Residen 64, 65, 87, 112, and 1a. Resident # 52 v 01/19/2012. The re- information and mo Physician's Order S had listed diagnose mobility, Vitamin B deficiency Vascular Vascular Dementia disorder with Psych Hyperpotassemia, I Chronic Anemia, Co Cervical Disk disea Kidney Disease (sta During review of the dated 11/28/2013 it only one active diag diagnosis indicated disturbance/impairr resident's quarterly	est current (June 2014) Sheet indicated the physician es which included - Impaired -12 deficiency, Vitamin D-3 Dementia with Delirium, with Depression, Depressive notic features, Hypertension, Hyperlipidemia, Osteoarthritis, ervical Forominal Stenosis, ise, Osteoporosis, and Chronic		residents, #'s 21, 23, 24, 52 and 112, MDS Coordinator of section I of their respective include all active diagnoses Of the other 60 residents in from June 23, 2014 through 2014, 10 were discharged p correction date. To assure the deficient practice does not co- other residents, MDS Coord updated Section I of their re- to include all active diagnos remaining 50 residents. Note: Since nursing homes several auditing groups, the sometimes a conflict with he interpreted. "The new norm" pertains to "active diagnosis out with one of the auditing time, the interpretation was diagnosis was the residents meaning that the condition of and not "new", then it should as an active diagnosis. Base documentation changed sin	updated MDS to the facility a June 26, prior to the hat the occur affecting dinator espective MDS es for the are subject to ere is ow rules are " rule as it s" was pointed groups. At the that if a s "new norm" was ongoing d not be listed ed on this, our
	diagnoses listed in resident's most rec 05/15/2014 indicate	section I of the MDS. The ent MDS (quarterly) dated ed the resident to have no		assumption was that the inter- coincided with CMS guidelin	erpretation nes.
	current/active diagnoses listed in section I. The MDS reviews indicated there was no accurate picture of the resident's health status.			Now that additional informat provided by DHHS DHSR s ensure that the deficient pra recur, Brantwood Nursing a	urveyors, to actice does not nd Rehab
	order sheet (POS) signed by the physi	dent # 52's monthly physician dated 06/01-30/2014 and cian on 06/17/2014 revealed dered to receive medications		includes all active diagnose of the MDS for all residents ARD date of June 26, 2014	with a current
		g active diagnoses by the		Active diagnoses are diagno	oses that have

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TATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY	
		345412	B. WING _		06/	26/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 278	physician: Ferralet for Anemi. Boniva for Osteop Aspirin for Hyperter Vitamin B-12 for B 01/19/2012) Celexa for Demen 08/24/2012) Vitamin D-3 for D- 11/28/2012) Citracal for Vitamin 10/11/2013) Lipitor for Hyperlip Zyprexia for Deme (order date 10/27/2) A review of the resid to treat the followin physician - Anemia Vitamin B-12 defic Hyperlipidemia, Deme medication start dat the diagnoses and and 2013. A review of residen Living (ADLs) flow 06/25/2014 indicat assistance with AE diagnoses of - Imp Disease, Hyperter Osteoporosis.	a (order date 01/19/2012) orosis (order date 01/19/2012) ension (order date 01/19/2012) -12 deficiency (order date tia with Depression (order date 3 deficiency (order date n D deficiency (order date idemia (order date 01/19/2012) entia with Psychotic features	F 27	a direct relationship to the resid current functional, cognitive, mo behavior status, medical treatm nursing monitoring, or risk of de the 7-day look back period. Do conditions that have been resol affect the resident's current stat not drive the resident's plan of o the 7-day look-back period, as t would be considered inactive di	ood or ents, ath during not include ved, do not us, or do are during hese		

Facility ID: 943195

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		AND HUMAN SERVICES				FORM	07/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345412	B. WING			06/	26/2014
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE STREET DXFORD, NC 27565	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	related to the reside coordinator indicate contracted auditor is supposed to put in unless it concerned had. b. Resident # 23 wa 01/18/2013. The re- information and mo- Physician's Order S physician had listed Diabetes, Hyperten Fibrillation, Reflux of Depression, Ulcera Dementia with beha of right shoulder Ar A review of residen assessments dated 01/23/2014 indicate current/active diago Resident # 23's mo- assessment dated resident #23 had no listed in section I. there was no accur health status. A review of the resi- order sheet (POS) signed by the physi- the resident was or to treat the followin physician:	as admitted to the facility on esident's ADLs. The MDS ed a previous facility had told her she wasn't any resident's diagnoses d an ADL area the resident as admitted to the facility on esident's admission ost current (June 2014) Sheet (POS) indicated the d diagnoses which included - nsion, Dementia, Chronic Atrial disease, Neuropathy, Anxiety, tive Colitis, Alzheimer's aviors, Agitation, and a history	F 2	278			

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		AND HUMAN SERVICES				FORM	: 07/31/2014 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION		e survey Ipleted
		345412	B. WING	;		06/	26/2014
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	VOOD NH & RETIREN				1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 278	Continued From pa	age 11	F	278	3		
	Amiodarone for Atr 01/25/2013)	ial Fibrillation (order date					
	02/12/2013) Cymbalta for depreneuropathy (order of Topamax for migradate 09/28/2013) Lactulose for const Zinc sulfate for word 01/24/2014) Klonopin wafer for anxiety (order date Restasis for dry eyev Vitamin C for woun 01/24/2014) Macular Protect Cod degeneration (order Azulfidine for ulcera 01/25/2013) Coumadin for Atria 03/19/2014) Artificial tears for d 01/25/2013) Tobradex suspensithe eye (order date Humalog Insulin for 11/11/2013) Levemir insulin for date 01/17/2014) A review of the reside to treat the followin physician - Diabete	12 deficiency (order date ession, anxiety, and diabetic date 08/02/2013) ine and seizure disorder (order ipation (order date 11/24/2013) und healing (order date seizures, panic disorder and 01/24/2014) es (order date 01/25/2013) id healing (order date omplete tablets for macular er date 07/03/2013) ative colitis (order date I Fibrillation (order date ry eyes (order date on for bacterial infections of					

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED
		345412	B. WING		06/26/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE
BRANTV	OOD NH & RETIREN			1038 COLLEGE STREET OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION OF THE APPROPRIATE DATE
F 278	Continued From pa	age 12	F 2	78	
	Colitis, Alzheimer's Major Depressive of medication start da the diagnoses and and 2014. A review of residen 01/18/2013 with mo 04/30/2014 indicate behavior problems Dementia, Anxiety, Psychotropic media	ty, Depression, Ulcerative Dementia with behaviors, disorder, and Agitation. The ates indicated the resident had began treatment during 2013 at 23's Care Plan dated ost recent update on ed the resident to have due to diagnoses of Depression and receiving cations. The Care Plan ent was at risk for side effects			
	included administe monitoring the resi medications, monit determining the ca providing calming t significant other an indicated in the car resident to make d and encouraging h also documented t psychiatric consult monitored with doc	ns. The facility's interventions ring medications as ordered, dent for side effects of the coring the resident's moods and uses of mood changes, echniques and include any d family members. The staff re plan they would allow the ecisions concerning her care er socialization. The facility he resident would receive s as needed and would be sumentation and changes in the attending physician.			
	06/05/2014 indicate Alzheimer's Demen Depressive disorde indicated the reside Disease. The physi indicated he was g	sician's progress notes dated ed resident #23 had ntia with Behaviors and Major er. The physician also ent had Stage III Kidney sician's documentation oing to continue the resident's s of Cymbalta and Klonopin.			

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		AND HUMAN SERVICES				FORM	07/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345412	B. WING	;		06/	26/2014
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRANTV	VOOD NH & RETIREN	IENT CENT			1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 278	indicated the reside blood sugar levels every three months times daily. The m the medication and the diagnosis of dia review also reveale other lab testing an levels every six mo (BMP) every six mo a Prothrombin Time Normalized Ratio (I resident's blood clo correct dose of Cou being used. On 06/25/2014 at 4 MDS/Care Plan coo not putting in any d resident's MDS unle related to the reside coordinator indicate contracted auditor I supposed to put in unless it concerned had. 2a. A record review MDS for Resident # 5/3/2014 and the an assessment dated active diagnosis in the medications con included the use of injections for 7 days period.	age 13 ent was being monitored for via lab testing (HBG A1C) and via accu-checks four onitored results determined strength the resident received abetic disease (DM). The ed resident # 23 was receiving d monitoring for magnesium nths, Basic Metabolic Panel onths, a Lipid panel ever year, e (PT) and International INR) monthly to monitor the titing ability to determine if the umadin (blood thinner) was 4:30 p.m. an interview with the ordinator was conducted. The ordinator indicated she was iagnoses in section I of the ess it concerned or was ent's ADLs. The MDS ed a previous facility had told her she wasn't any resident's diagnoses d an ADL area the resident w of the facility most recent #45 coded a quarterly dated nnual [comprehensive] 2/11/2014 did not include the section I to correspond with ded in section N. Section N an antidepressant and insulin s of the 7 day look back	F	278			

Facility ID: 943195

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	· /	TE SURVEY		
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED		
		345412	B. WING		06	/26/2014		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
BRANTV	OOD NH & RETIREN			1038 COLLEGE STREET OXFORD, NC 27565				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
F 278	every night, Novolii injection before me A record review of sheet for 5/1/2014 diagnosis listed as (cerebrovascular a (Prostate-specific a vascular disease), hypopharynx, statu amputation of foot, delirium, and CKD b. A record review MDS for Resident a 6/6/2014 did not in section I to corresp coded in section N an antidepressant days of the 7 day lo [comprehensive] as did not include the correspond with the N. Section N include antidepressant, an use of injections fo period. A record review of Sheet dated 6/1/20 daily, Cymbalta (ar Levaquin (antibiotio 6/9/2014. A record review of	<ul> <li>/4/2014 for Celexa</li> <li>aily, Lantus (insulin) injection</li> <li>n (insulin) sliding scale</li> <li>aals and at bed time.</li> <li>Resident #45 Physician order</li> <li>through 5/31/2014 included</li> <li>DM II (diabetes), CVA</li> <li>ccident), Increased PSA</li> <li>antigen), PVD (peripheral</li> <li>squamous cell carcinoma of</li> <li>s post transmetarsal</li> <li>peripheral neuropathy,</li> <li>(chronic kidney disease).</li> <li>of the facility most recent</li> <li>#21 coded quarterly dated</li> <li>clude the active diagnosis in</li> <li>bond with the medications</li> <li>Section N included the use of</li> <li>antibiotic and diuretic use for 7</li> <li>bok back period. The annual</li> <li>ssessment dated 3/14/2014</li> <li>active diagnosis in section I to</li> <li>e medications coded in section</li> </ul>	F 27	8				

Facility ID: 943195

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY IPLETED
		345412	B. WING		06/:	26/2014
NAME OF F	PROVIDER OR SUPPLIER	·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRANTW	VOOD NH & RETIREN			1038 COLLEGE STREET DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
TAG F 278	Continued From par diagnosis included Multiple Sclerosis, y Congestive Heart F Gastroesophageal c. A record review MDS for Resident # [comprehensive] as not include the active correspond with the N. Section N includ for 7 days of the 7 of not include the use A record review of F Administration record month of June 2014 (antipsychotic) at be and Bactrim (antibies started on 6/2/2014 A record review of F sheet was hand write diagnosis. d. A record review of F sheet was hand write diagnosis in the medications condincluded the use of anticoagulant, and the 7 day look back A record review of F	age 15 fracture, left medial londyl, weakness, hypertension, Failure, pre Diabetes, and reflux disease. of the facility most recent #112 coded admission ssessment dated 6/6/2014 did ve diagnosis in section I to e medications coded in section led the use of an antipsychotic day look back period but did of a diuretic of antibiotic. Resident # 112 Medication ord dated 5/31/2014 for the 4 included Seroquel edtime, Lasix (diuretic) daily, otic) twice daily for 10 days 4. Resident #112 Physician Order itten and did not include active of the facility most recent MDS oded annual [comprehensive] 3/26/2014 did not include the section I to correspond with ded in section N. Section N an antidepressant, insulin injections for 7 days of	F 278	DEFICIENCY)	RIALE	
	(antidepressant), C	Coumadin (anticoagulant), action, and Novolin (insulin)				

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		AND HUMAN SERVICES				FORM	07/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345412	B. WING			06/:	26/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	OOD NH & RETIREN	IENT CENT			038 COLLEGE STREET DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From pa injection.	ge 16	F 2	278			
	An interview with th 06/25/2014 at 4:30 putting in diagnoses concerned or was r of daily living (ADL) indicated a previous wasn't supposed to diagnoses unless it resident had. 3a. Review of Resi Minimum Data Set (comprehensive) as not include the activ correspond with the N. Section N includ and 7 antidepressa of the 7 day look ba A record review of F sheet for 6/2/2013 to orders written on 6/ Doxepin (antidepre (diuretic) given daily A record review of F sheet for 6/2/2014 to diagnosis listed as joint disease, CKD Depression. b. Review of reside Minimum Data Set MDS dated 6/5/201 diagnosis in sectior medications coded included the use of	e MDS coordinator on p.m. indicated she was not s in the MDS unless it elated to the resident's activity b. The MDS coordinator s auditor had told her she put in any resident's concerned an ADL area the ident #13's most recent (MDS) revealed the admission ssessment dated 6/9/2014, did ve diagnosis in section I to e medications coded in section ed the use of 2 Antianxiety nt and 3 antibiotic for 7 days ack period. Resident #13's Physician order through 6/30/2014 included '2/2014 for Ativan (antianxiety) ssant) daily and Lasix y and Novolog (antidiabetic). Resident #13's Physician order through 6/30/2014 included DM II (diabetes), Degenerative (chronic kidney disease) and ent # 24's most recent (MDS) revealed the quarterly 4 did not include the active n I to correspond with the in section N. Section N an antipsychotic and diuretic e 7 day look back period.					

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		AND HUMAN SERVICES				FORM	): 07/31/2014 1 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345412	B. WING			06	/26/2014
NAME OF F	PROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	OOD NH & RETIREN	IENT CENT			1038 COLLEGE STREET		
					OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	Continued From pa	age 17	F 2	278	3		
	Order Sheet dated	Resident # 24's Physician 6/1/2014 include Haldol 5mg mood disorder and Lasix y.					
	Order Sheet dated included a list of dia	cord review of Resident #24's Physician er Sheet dated 6/4/2014 through 6/30/2014 uded a list of diagnosis Congestive Heart ure, Mood Disorder.					
	Minimum Data Set admission [compre 5/21/2014 did not in section I to corresp coded in section N	ent # 64's most recent (MDS) revealed the ehensive] assessment dated nclude the active diagnosis in bond with the medications . Section N included the use of and diuretic for 7 days of the 7 bd.					
	Administration recommonth of June 201 (antidepressant) ar						
	Order sheet was had diagnosis5/15/2014	Resident #64's Physician and written the include active 4 that included Coronary Artery pronic Kidney Disease (CKD), sorder.					
	6/25/2014 at 4:30 p putting in diagnose concerned or was p of daily living (ADL)	ne MDs coordinator on b. m. indicated she was not is in the MDS unless it related to the resident's activity ). The MDS coordinator is auditor had told her she					

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## PRINTED: 07/31/2014 FORM APPROVED

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
	U CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	3	CON	IF LE I ĽV	
		345412	B. WING			06/	26/2014	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTV	OOD NH & RETIRE	MENT CENT			1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 278	Continued From pa	age 18	F 2	278	3			
	wasn't supposed to diagnoses unless i resident had. 4a. Resident #150 diagnoses that incl	o put in any resident's it concerned an ADL area the was admitted on 6/3/14 with luded diabetes (DM), deep vein and cerebrovascular accident						
	admission assessr Resident #150 had	nimum Data Set (MDS) ment dated 6/10/14 revealed an active diagnosis of CVA nti-coagulant 7 of 7 back days.						
	Medication Admini revealed diagnose DVT. The June M	Resident #150's June stration Record (MAR) s that included DM, CVA, and AR indicated Resident #150 ks daily and Amaryl [an daily for diabetes.						
	06/25/2014 at 4:30 put diagnoses in the or were related to the living) ADLs. The M previous auditor to put in any resident concerned an ADL	w with the MDS coordinator on opm she indicated she did not he MDS unless they concerned the resident's (activities of daily MDS coordinator indicated a ld her she wasn't supposed to diagnoses unless they area for the resident. She was also told if it is their new but it on the MDS."						
	diagnoses that incl	as admitted on 1/22/14 with luded hypertention (HTN), , and diabetes (DM).						
	admission assessr	nimum Data Set (MDS) nent dated 1/29/14 revealed y active diagnosis was arthritis.						

Facility ID: 943195

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		AND HUMAN SERVICES				FORM	07/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345412	B. WING			06/	26/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRANTW	VOOD NH & RETIREM	IENT CENT			038 COLLEGE STREET DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 19	F	278			
	Zestril every mornir twice a day for hype	cated Resident #87received ng for hypertension and Coreg ertension. The June physician esident #87 was on a t.					
	06/25/2014 at 4:30 put diagnoses in the or were related to the living) ADLs. The M previous auditor tolo put in any resident of concerned an ADL	with the MDS coordinator on pm she indicated she did not e MDS unless they concerned he resident's (activities of daily IDS coordinator indicated a d her she wasn't supposed to diagnoses unless they area for the resident. She as also told if it is their new ut it on the MDS."					
	diagnoses that inclu	s admitted on 4/25/14 with uded left tibia fracture, ritis, and chronic pain.					
	admission assessm Resident #36's only and she received and	imum Data Set (MDS) nent dated 5/1/14 revealed / active diagnosis was fracture; n anti-coagulant, physical ational therapy 7 of 7 ack days.					
	Accuchecks every r diabetes, Neurontin B-12 daily for neuro for chronic pain, Tyl	d Resident #36 received morning, Glucophage daily for a daily for neuropathy, Vitamin opathy, Naproxen as needed lenol as needed for chronic me as needed for chronic pain.					
	06/25/2014 at 4:30	with the MDS coordinator on pm she indicated she did not e MDS unless they concerned					

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	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
	JI CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G	CON	
		345412	B. WING _		06/	26/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE STREET		
BRANTV	VOOD NH & RETIREN					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 278	Continued From pa	age 20 he resident's (activities of daily	F 27	8		
	living) ADLs. The N previous auditor tol put in any resident concerned an ADL	IDS coordinator indicated a d her she wasn't supposed to diagnoses unless they area for the resident. She vas also told if it is their new				
F 431 SS=D	483.60(b), (d), (e) I		F 43	1		8/4/14
	a licensed pharmac of records of receip controlled drugs in accurate reconcilia records are in orde	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically				
	labeled in accordar professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the ory and cautionary e expiration date when				
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys.				
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit				

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			() (0)			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		345412	B. WING		06/:	26/2014
AME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP (	CODE	
RANTW	OOD NH & RETIREM	IENT CENT		1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 431	Continued From page 21 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.		F 4	31		
	by: Based on observat interviews the facilit supplies were remo resident medication secured for 1 of 4 n medication cart) and (100 hall medication included:	NT is not met as evidenced tions, record reviews, and staff ty failed to ensure expired oved from service and current as were properly stored and nedication carts (100 hall d 1 of 2 medication rooms in storage room). The findings		For residents #'s 44, 83, 94 149, 151 152, and 53 Nurse counseled on June 23, 201 the facility's administrator a DON regarding securing all within the locked medicatio medication cart left unatten voiced understanding. After 2567, the facility's administ	# #1 was 4 at 9:50PM by nd interim medications n cart when ded. Nurse #1 r reviewing the rator and new	
	Included: On 06/23/2014 at 9:15 p.m. an observation w made of the 100 hall's unattended medication cart that was parked by the physical therapy gym's door across from room 111. Observed top of the cart were 2 plastic bins of medication which included 9 vials of insulin for resident # 44, 83, 94, 136, 145, 149, 151, 152, and 153 a bottle of Megace for resident # 145. There were no staff members on the hall or in close proximity (view) of the cart. A resident sitting wheelchair next to the medication cart indicat the hall's nurse was in room 115. The door to room 115 was shut and the medication cart w out of the sight of the nurse. Other facility residents and family members were observed moving up and down the 100 hall passing the medication cart and unsecured medications, going to and from the 100 and 200 halls. After minutes of observing the medication cart and unsecured medications nurse # 1 came out of	Ill's unattended medication d by the physical therapy from room 111. Observed on 2 plastic bins of medications als of insulin for resident #'s 5, 149, 151, 152, and 153 and for resident # 145. There bers on the hall or in close the cart. A resident sitting in a the medication cart indicated in room 115. The door to and the medication cart was he nurse. Other facility y members were observed in the 100 hall passing the d unsecured medications, he 100 and 200 halls. After 4		DON determined that further involving the new DON was On July 18, 2014 at 3:45PM administrator reviewed the to F431 with Nurse #1, point she left the medication cart with medications on top mut which is against facility pro- time the DON also reviewe pharmacy inservice with Nu- she was out on medical lear inservices held on July 14, 2014. Nurse #1 apologized acknowledging her error by unattended. Nurse #1 article correct process for medicar administration, storage and Provided Nurse #1 with a c pharmacy inservice. Progre	s warranted. A the facility's 2567 relating out that unattended litiple times tocol. At this d the urse #1 since we during the 15 and 16, a leaving cart ulated the tion l security.Don opy of the	

Facility ID: 943195

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	05 DEELC		0.00			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	. ,	E SURVEY PLETED
		345412	B. WING		06/2	26/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
BRANTW	OOD NH & RETIREN			1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 431	Continued From pa	age 22	F 4	31		
	On 06/23/2014 at 9 conducted with nur about the unsecure indicated she didn't unsecured on top of should not have lef medication cart this excused herself an something for one of concerning the resi down the 100 hall p station by the front sight of the medica unsecured medicat cart for an addition gone. There were attending the cart. cart nurse #1 was to room 115, shutting unattended/unsecut the medication cart room for another 3 while residents pas unattended/unsecut could not indicate w medications when s 115. A review of the medica 3, 94, 136, 145, 14 conducted. The re- had a current physi	9:22 p.m. an interviewed was se #1. The nurse was asked ed medications. Nurse #1 thormally leave medications of her medication cart and the medications on top the stime. The nurse then d indicated she needed to get of the residents in room 115 dent's dripping IV then walked past the 100 hall's nursing hall entrance (again out of tion cart) leaving the cions on top of the medication al 3 minutes while she was no other staff members Upon Nurse #1's return to the then observed to go back into the door, still leaving the ared medications on the top of the nurse remained in the minutes with the door shut		<ul> <li>pharmacy inservice p consulting pharmacy Standards for Medica Term Care" on July 2</li> <li>To assure that the de not occur affecting ot were inserviced by ph on July 14, 2014, July 16, 2014 regarding pr medications on their of The inservice was als by staff who were una scheduled times.</li> <li>The DON or designat medication carts on 1 insusre that insulin ar left unattended on me times per week for 3 compliance. If deficie during this time, staff and the monitoring pe 3 months until no defi A report of deficiencie QA committee quarte designated RN for co</li> <li>The expired medical</li> </ul>	for "Professional ation Pass in Long 8, 2014. ficient practice does her residents, staff harmacy consultants / 15, 2014 and July roperly securing carts at all times. so posted for review able to attend at the ted RN will monitor st and 2nd shifts to nd megace are not edication carts 3 months for ncies are noted will be re-educated eriod will be extended iciencies are noted. es will be made to the rly by the DON or mpliance.	
	a current order for 1 06/26/2014 at 10:43	5 a.m. an observation was		Aquacel Alginate dres Polyskin dressing, IV Catheter 22G were al medication storage ro the survey.	Catheter 20G, IV Il removed from the	

Facility ID: 943195

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED
		345412	B. WING		06/	26/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	VOOD NH & RETIREN	IENT CENT		1038 COLLEGE STREET DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 431	found to be commi	owing medical supplies were ngled with unexpired supplies	F 431	not recur, The DON or designate monitor the medication storage r	ooms for	
	2261 Expired 05/20 Kendall Polyskin dr permeable 1 box o Expired 01/2011 IV Catheter 20G x Expired 08/2013	ressing - 4 packages Lot #		expired medical supplies on a me basis. A report will be submitted committee on a quarterly basis b DON or designated RN for comp	to the QA y the	
F 468 SS=D	conducted with the concerning her exp medications and re usable stock. The expectation that all secured in the med rooms when not be nurse. The DON a expectation that all supplies are remov and either turned b pharmacy or destro 483.70(h)(3) CORF SECURED HANDF	RIDORS HAVE FIRMLY RAILS quip corridors with firmly	F 468			7/30/14
	by: Based on observa	NT is not met as evidenced tions, staff interviews and facility failed to ensure		Gaps between the plastic railing and the end caps were closed ar		

Facility ID: 943195

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         ND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345412		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		A. BUILDING	001	06/26/2014		
		B. WING	06/2			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTV	VOOD NH & RETIREN	IENT CENT		1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 468	Continued From pa	ige 24	F 468	3		
	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)			<ul> <li>end caps secured by attaching t the handrais with screws to insu gaps do not recur. The handrail 115 was secured by replacing bo screws. The handrail by the sold room and 200 hall nurses station disassembled and remounted by new mounting holes. The handra room 303 was disassembled an remounted by using new mounti To assure that the deficient prace not occur in other areas, mainte checking all handrails to ensure are secured.</li> <li>To assure that the deficient prace not recur, the Director of Plant C and the facility administrator or t designees will make monthly rou assure that all handrails are firm secured in corridors. Report will submitted to QA Committee qua noncompliance.</li> </ul>	re that the by room oth ed utility n was / using ail next to d ng holes. tice does nance is that they tice does operations heir unds to ly be	

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		(X2) MULTIPLE CONSTRUCTION			0MB NO. 0938-039 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING			MPLETED
		B. WING			06/26/2014	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRANTV	VOOD NH & RETIREN			1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 468	Continued From pa	age 25	F 46	68		
	utility room - hand railing still moves up/down 2 - 3 inches.					
	moves up/down 5-0	oom 303 - short hand railing still 6 inches.				
	On 06/26/2014, at 2:35 p.m. a fourth observation was made of the resident hall's hand railing. The following hand rails were observed to still loose					
	and not repaired: 100 halls next to room 115 - hand railing still moves up/down 2 - 3 inches.					
	200 halls by the nu utility room - hand	rse's station next to the soiled railing still moves up/down 2 -				
	3 inches. 300 halls next to ro moves up/down 5-0	oom 303 - short hand railing still 6 inches.				
	conducted with the	3:04 p.m. an interview was facility's lead maintenance ing the facility's maintenance				
	procedures. The le indicated some of t	ead maintenance technician the facility ' s staff had access				
	called "Facility Dud technician that if a	ntenance request program le." The lead maintenance staff member or family or				
	person receiving th	n maintenance issue and the ne report did not have access ogram the report would be				
	forwarded to some the request for mai	one that did have access and intenance would then be puter system program and a				
	work order would b maintenance techr	e generated. The lead lician indicated if the				
	concern the facility	est had an immediate safety will call the maintenance stant and he would send a				
	maintenance worke work immediately.	The lead maintenance d once the issue is placed into				

Facility ID: 943195

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	IMENT OF HEALTH		FORM	: 07/31/2014 APPROVED . 0938-0391					
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
		345412	B. WING			06/	26/2014		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
BRANTWOOD NH & RETIREMENT CENT			1038 COLLEGE STREET OXFORD, NC 27565						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 468	Facility Dude the co generate a work or maintenance worker repair and/or replace and complete the e it out when the work or replaced the work or email that the work or or replacement of a part (deferred main indicate the part on maintenance techn program keeps the when an item was r keeping. On 06/26/2014 at 3 conducted with the Nursing (DON). The the facility report ar (something needing administrator and the the computer syste order is generated. On 06/26/2014 at 3 conducted with the management assiss their system, "Facili orders that are not needing to be repaid with the lead mainter maintenance mana facility's outstanding only 4 outstanding of showing a need for	binputer system would der number and the er assigned to the facility would be the items needing repair lectronic work order and close k was completed. The lead ician indicated the person that der would then be notified by had been completed. If repair an item required ordering a tenance) the work order would order/waiting parts. The lead ician indicated the software work order information as to repaired or replaced for record content of the nurses in by maintenance related issue g repair) to her or the ney enter the information into m (Facility Dude) and a work	F	468					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 07/31/2014 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345412	B. WING			<b>06/</b> :	26/2014	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTV	VOOD NH & RETIREN	IENT CENT			038 COLLEGE STREET DXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 468	found to be in need On 06/26/2014 at 4 and fifth observatio hall's hand railing. observed to still loo 100 halls next to ro moves up/down 2 - 200 halls by the nur utility room - hand r 3 inches. 300 halls next to ro moves up/down 5-6 On 06/26/2014 at 4 conducted with both technician and the facility's lead mainter	y of the issues observed and of repair. :10 p.m. a tour of the facility n was made of the resident The following hand rails were se and not repaired: om 115 - hand railing still 3 inches. rse ' s station next to the soiled ailing still moves up/down 2 - om 303 - short hand railing still	F	468				

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