DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345412	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	010112		TREET ADDRESS, CITY, STATE, ZIP CODE	01/31/2019
				038 COLLEGE STREET	
BRANTW	OOD NH & RETIREMENT	CENT		DXFORD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS	;	F 000		
	through 1/31/19. Imr identified at: CFR 483.21 at tag F6	vas conducted from 1/28/19 nediate Jeopardy was 656 at a scope and severity J 689 at a scope and severity J			
	Care. One additiona	uted Substandard Quality of I citation was identified survey at CFR 483.20 (Tag severity of D).			
F 641	removed on 1/31/19. was conducted.	began on 12/4/18 and was A partial extended survey	F 641		2/22/19
SS=D	•		1 041		2122115
	resident's status.	of Assessments. accurately reflect the is not met as evidenced			
	Based on staff interv facility failed to accur Data Set (MDS) asse resident 's balance of			Resident number 3 was discharged from the facility on 12/4/2018. The facility is unable to submit a correction to the inaccurate MDS Assessment.	om
	Accidents (Resident			A 100% audit was conducted by a third party MDS consultant of the most received MDS assessment completed for all	nt
	The findings included			residents current as of 2/2/2019 to ider areas of inaccuracy by 2/14/2019 with	
	6/1/17. Her cumulati Alzheimer ' s disease			areas of concern addressed with appropriate modifications completed.	
	depression, repeated abnormalities of gait	falls, and unspecified and mobility.		The previous MDS nurse is no longer employed with the facility and the curre	ent
ABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
	cally Signed				02/18/2019

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.

						FORM	D: 03/05/2019 APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				PLETED
		345412	B. WING _				C
	ROVIDER OR SUPPLIER	545412			TREET ADDRESS, CITY, STATE, ZIP CODE	01/	31/2019
	KOWDER OR SOLT EIER				038 COLLEGE STREET		
BRANTWO	DOD NH & RETIREMENT	CENT			XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Resident #3 ' s last a (MDS) assessment d resident had severely daily decision making resident required exte plus (2+) persons phy and transfers. Resid assistance with one p dressing, toilet use, a resident required sup locomotion on/off the G0300 of the MDS as resident ' s balance d walking. The coding "Activity did not occur areas: A. Moving from sea B. Walking (with as C. Turning around a direction while walk; D. Moving on and o E. Surface-to-surfac bed and chair or whe An interview was com AM with the facility ' s of the facility ' s Com interview, the nurse v were used to complet	e 1 nnual Minimum Data Set ated 6/5/18 indicated the impaired cognitive skills for g. Section G indicated the ensive assistance with two ysical assist for bed mobility ent #3 required extensive berson physical assist for und personal hygiene. The ervision only from staff for unit and for eating. Section assessment addressed the luring transitions and within this section indicated r" for each of the following ated to standing position; sistive device if used); and facing the opposite aff toilet; ce transfer (transfer between elchair. ducted on 1/29/19 at 11:00 a MDS Nurse in the presence pliance Officer. During the vas asked what resources te Section G of a resident ' s	TAG	641	CROSS-REFERENCED TO THE APPROPRIA	all nd t g to s or DS	DATE
	assistants and nurses review of the electron for the 7-day look bac A follow-up interview at 1:36 PM with the N of the facility ' s Com	using interviews with nursing s, observations, and a nic documentation of ADLs ck period. was conducted on 1/30/18 MDS Nurse in the presence pliance Officer. Upon rse reviewed Section G0300					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/05/2019 MAPPROVED	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
l	345412		B. WING				C 31/2019	
NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE				
BRANTWO	OOD NH & RETIREMENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	After reviewing the 6/ nurse confirmed all ar were coded to indicat During the interview, i this coding was corre- responded by stating MDS may not have w the time the assessm if it would be acceptal source of information (such as nursing staff answered, "You could the MDS Nurse repor activities coded as no occur for Resident #3 period for this MDS as An interview was com AM with the facility 's interview, the Adminis expectation for MDS of completing the assess consideration a holisti based on observation clinical records, and of feedback. When ask MDS coding to be acc stated, "Absolutely." 1-b) Resident #3 was 6/1/17. Her cumulation Alzheimer 's disease depression, repeated abnormalities of gait as Resident #3 's quarter (MDS) assessment day	three MDS assessments. 5/18 MDS assessment, the nswers within this section e the "Activity did not occur." the MDS Nurse was asked if ct. The MDS Nurse the person completing the itnessed these activities at ent was done. When asked ble to use an alternate to obtain this information report), the nurse I, yes." Upon further inquiry, ted "at least some" of the to occurring did actually during the 7-day look back ssessment. ducted on 1/31/19 at 10:20 Administrator. During the strator stated her coding was for the individual sment to take into ic picture of the resident us, documentation within the direct patient care staff ed if she would expect the curate, the Administrator admitted to the facility on ve diagnoses included , anxiety disorder, falls, and unspecified	F	641				

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DEPART CENTER	FORM	<i>I</i> APPROVED 0938-0391						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345412	B. WING				C 31/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTW	OOD NH & RETIREMENT	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)	ES OMB NO. 0 IRRCLA (2) MULTIPLE CONSTRUCTION (X1) DATE SU COMPLET A. BUILDING C B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE STREET OXFORD, NC 27565 SS ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECT TO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C ID F 641 F ID F 641 F ID ID ID ID ID	(X5) COMPLETION DATE				
F 641	resident required limit person physical assist extensive assistance assist for transfers, du personal hygiene. The supervision only from the unit and for eating assessment addressed during transitions and this section indicated each of the following A. Moving from sea B. Walking (with ass C. Turning around a direction while walk; D. Moving on and o E. Surface-to-surface bed and chair or when An interview was con AM with the facility 's of the facility 's Comp interview, the nurse w were used to complet MDS. She reported u assistants and nurses review of the electrom for the 7-day look back A follow-up interview at 1:36 PM with the M of the facility 's Comp request, the MDS Nur of Resident #3 's last After reviewing the 9/ nurse confirmed all an were coded to indicate	. Section G indicated the red assistance with one t for bed mobility and with one person physical ressing, toileting, and re resident required staff for locomotion on/off g. Section G0300 of the ed the resident 's balance walking. The coding within "Activity did not occur" for areas: ated to standing position; sistive device if used); and facing the opposite ff toilet; ce transfer (transfer between elchair. ducted on 1/29/19 at 11:00 MDS Nurse in the presence oliance Officer. During the vas asked what resources e Section G of a resident 's asing interviews with nursing s, observations, and a ic documentation of ADLs ek period. was conducted on 1/30/18 IDS Nurse in the presence	F	64				

Facility ID: 943195

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	3		
	345412 B. WING						
NAME OF PI	ROVIDER OR SUPPLIER	L	- I		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTWO	OOD NH & RETIREMENT	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	9 4	F	64	1		
	this coding was corre						
	the time the assessm	itnessed these activities at ent was done. When asked					
	source of information	ble to use an alternate to obtain this information					
	(such as nursing staff answered, "You could	report), the nurse I, yes." Upon further inquiry,					
	the MDS Nurse repor	ted "at least some" of the					
		ot occurring did actually during the 7-day look back					
	period for this MDS a	U					
		ducted on 1/31/19 at 10:20					
	AM with the facility ' s interview, the Adminis	Administrator. During the					
	expectation for MDS	coding was for the individual					
	completing the asses	sment to take into ic picture of the resident					
		is, documentation within the					
		direct patient care staff ed if she would expect the					
		curate, the Administrator					
	stated, "Absolutely."						
		admitted to the facility on					
	6/1/17. Her cumulativ Alzheimer 's disease	ve diagnoses included					
		falls, and unspecified					
	abnormalities of gait a	and mobility.					
	-	erly Minimum Data Set					
		ated 12/3/18 indicated the					
	-	impaired cognitive skills for Section G indicated the					
	resident required exte	ensive assistance with one					0. 0938-0391 SURVEY PLETED C (31/2019 (X5) COMPLETION
		t for bed mobility, dressing, I hygiene. The resident					
		sistance with 2+ person					

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DEPART	FORM	MAPPROVED					
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345412	B. WING				C /31/2019
NAME OF P	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BRANTW	OOD NH & RETIREMENT	CENT					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		OMB NO. 02 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE STREET OXFORD, NC 27565 ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE		
F 641	physical assist for traithe unit was reported or twice during the 7 only set-up help requi- supervision only for e assessment addressed during transitions and this section indicated each of the following A. Moving from sea B. Walking (with ass C. Turning around a direction while walk; D. Moving on and o E. Surface-to-surface bed and chair or when An interview was con AM with the facility 's of the facility 's comp interview, the nurse w were used to complet MDS. She reported u assistants and nurses review of the electron for the 7-day look back A follow-up interview at 1:36 PM with the M of the facility 's Comp request, the MDS Nur of Resident #3 's last After reviewing the 12 nurse confirmed all an were coded to indicat During the interview, this coding was corre- responded by stating	nsfers. Locomotion on/off to have occurred only once day look back period with ired. The resident needed ating. Section G0300 of the ed the resident 's balance I walking. The coding within "Activity did not occur" for areas: ated to standing position; sistive device if used); and facing the opposite ff toilet; ce transfer (transfer between elchair. ducted on 1/29/19 at 11:00 MDS Nurse in the presence bliance Officer. During the vas asked what resources te Section G of a resident 's using interviews with nursing s, observations, and a ic documentation of ADLs ck period. was conducted on 1/30/18 MDS Nurse in the presence bliance Officer. Upon rse reviewed Section G0300 three MDS assessments. 2/3/18 MDS assessment, the nswers within this section e the "Activity did not occur." the MDS Nurse was asked if	F	641			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/05/2019 // APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345412	B. WING				C 31/2019	
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTW	OOD NH & RETIREMENT	CENT			1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION NCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETION DATE	
F 641	the time the assessm if it would be acceptal source of information (such as nursing staff answered, "You could the MDS Nurse repor activities coded as no occur for Resident #3 period for this MDS at An interview was con- AM with the facility 's interview, the Adminis expectation for MDS of completing the assess consideration a holisti based on observation clinical records, and of feedback. When ask MDS coding to be acc stated, "Absolutely." 1-d) Resident #3 was 6/1/17 from another in Her cumulative diagn disease, anxiety disor falls, and unspecified mobility. A review of Resident Falls Scene Investiga revealed the resident 7/22/18. Resident #3 's quarter (MDS) assessment da resident had severely daily decision making	ent was done. When asked ble to use an alternate to obtain this information report), the nurse I, yes." Upon further inquiry, ted "at least some" of the t occurring did actually during the 7-day look back ssessment. ducted on 1/31/19 at 10:20 Administrator. During the strator stated her coding was for the individual	F	641				

Facility ID: 943195

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345412	B. WING				C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRANTW	OOD NH & RETIREMENT	CENT			038 COLLEGE STREET DXFORD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	AM with the MDS Nur facility 's Compliance MDS Nurse reviewed MDS assessment dat Section J of the MDS no falls were reported Resident #3 's prior a MDS Nurse reviewed medical record, she m Note dated 7/23/18 w had experienced a fai the MDS Nurse stated assessment should h had one fall since her An interview was con AM with the facility 's interview, the Adminis expectation for MDS completing the asses consideration a holist based on observation clinical records, and of feedback. When ask MDS coding to be aco stated, "Absolutely." 1-e) Resident #3 was 6/1/17 from another m Her cumulative diagn disease, anxiety disor falls, and unspecified mobility.	etion of her prior (5/18). ducted on 1/30/18 at 9:22 rse in the presence of the cofficer. Upon request, the Resident #3 's quarterly ed 9/5/18. After reviewing , the MDS Nurse confirmed I as having occurred since assessment. When the the resident 's electronic eported seeing a Nursing hich indicated the resident II on 7/22/18. At that time, d the 9/5/18 MDS ave reported the resident r prior assessment. ducted on 1/31/19 at 10:20 c Administrator. During the strator stated her coding was for the individual	F	641			

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/05/20 FORM APPROVE OMB NO. 0938-039		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	(X3) DATE SURVEY COMPLETED C			
		345412	B. WING		01/31/2019		
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP COE			
BRANTWO	OOD NH & RETIREMENT	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 PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 641	resident had severely daily decision making assessment indicated was not used for this An interview was con AM with the facility ' s of the facility ' s Comp request, the MDS Nu quarterly MDS assess reviewing Section P of confirmed the assess wander/elopement ala resident. The MDS N need to review Residu detail to determine wh	ated 12/3/18 indicated the r impaired cognitive skills for b. Section P of the d a wander/elopement alarm resident. ducted on 1/29/19 at 11:00 MDS Nurse in the presence obliance Officer. Upon rse reviewed Resident #3 ' s sment dated 12/3/18. After of the MDS, the MDS Nurse ment did not indicate a arm was used for this lurse reported she would ent #3 ' s records in more nether or not a arm was used during the	F 641				
F 656 SS=J	conducted on 1/29/19 Nurse. During the int reported Resident #3 place (a wander/elope the 12/3/18 MDS assi- reported the wander of resident 's care plan, correctly on the MDS Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac- implement a compreh- care plan for each res	guard was included on the but it had not been coded assessment. Comprehensive Care Plan ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and	F 656		1/31/19		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/05/ FORM APPRC OMB NO. 0938-0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345412	B. WING		C 01/31/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
BRANTW	OOD NH & RETIREMEN	T CENT		1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
F 656	Continued From pag	e 9	F 656	3		
		rames to meet a resident's	1 000			
	-	d mental and psychosocial				
	-	fied in the comprehensive				
		mprehensive care plan must				
	describe the followin					
	(i) The services that are to be furnished to attain					
		ent's highest practicable				
	physical, mental, and psychosocial well-being as					
		.24, §483.25 or §483.40; and				
		would otherwise be required				
		3.25 or §483.40 but are not				
	-	resident's exercise of rights				
	treatment under §48	ding the right to refuse				
		services or specialized				
		s the nursing facility will				
	provide as a result o	u				
	1 ·	a facility disagrees with the				
		RR, it must indicate its				
	rationale in the resid	ent's medical record.				
	(iv)In consultation wi	th the resident and the				
	resident's representa	ative(s)-				
		oals for admission and				
	desired outcomes.					
		eference and potential for				
		cilities must document 's desire to return to the				
		essed and any referrals to				
		es and/or other appropriate				
	entities, for this purp					
		in the comprehensive care				
		in accordance with the				
	requirements set for	th in paragraph (c) of this				
	section.					
		T is not met as evidenced				
	by:					
	-	physician interviews, and		On December 4, 2018, Res		
		ecord reviews, the facility		experienced a fall post-trans		
	failed to develop a co	omprenensive		person assist to the bed, at	which point	

Facility ID: 943195

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		ND HUMAN SERVICES			PRINTED: 03/05/2 FORM APPRO OMB NO. 0938-0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345412	B. WING		C 01/31/2019	
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
BRANTWO	OOD NH & RETIREMENT	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 PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETI TE APPROPRIATE DATE	
F 656	Continued From page	e 10	F 65	3		
	person-centered care		1 000	she sat on the bed as the nu	irse aide	
	-	eds and safety measures		discontinued hands-on phys		
		resident, including the need		assistance in order to slide t		
		ance with transfers and the		further back. At this time, this		
		mmediately after a transfer 1		leaned forward and fell onto		
	of 3 sampled residen	ts reviewed for accidents		Resident 3 was immediately		
		lent #3 experienced a fall		Emergency Department of C		
		ed, while being assisted by		Health System status post-f		
		ich resulted in a fall and the		on 12/4/2018. The staff that		
		an injury to her forehead.		resident sitting untouched w		
	Resident #3 was sen	t to the hospital for hent and passed away later		room is no longer working w 1. Resident 3 was sent to	2	
	that day from an intra	· · ·		Emergency Department as		
	(bleeding around or v	-		above incident. It was identi		
	(0.000			analysis on 1/29/2019 that t		
	Immediate Jeopardy	began on 12/4/18 when		failed to provide sufficient in	-	
		A) #1 transferred Resident		regarding the resident s tra	Insferring	
	#3 from her recliner to	o the bed with a stand and		needs and other safety need	ds as	
	pivot maneuver witho	out additional staff assistance		recommended by therapy vi		
		forward off of the bed,		evaluation documentation o		
	-	he floor. At the time of the		for a 2-person moderate to		
		are Plan did not specify she		assist during transfers. As a		
		assistance with transfers and		resident was transferred via	one person	
		on the side of the bed by Jeopardy was removed as of		assist.2. To address the particula		
	1/31/19 when the fac			leading to the deficiency, an		
		of Immediate Jeopardy		of resident care plans was in		
	· •	remains out of compliance at		be completed on 1/29/2019.		
	-	level "D" (no actual harm		residents□ care plans are a		
	-	e than minimal harm that is		facility staff in order to identi	ify areas of	
		dy) for the facility to continue		each resident⊡s care plan r		
		nsure monitoring systems		daily care and activities of d		
	put into place are effe	ective.		audit was conducted on 1/2	-	
	The finalize in the t	1.		Treatment Nurse, Staff Deve	-	
	The findings included	1:		Coordinator, Clinical Nurse	-	
	Decident #2 was adm			Director of Nursing to cross-		
1		nittod to the technity on 6/1/17				
		nitted to the facility on 6/1/17. loses included Alzheimer 's		transfer needs and other sa identified, such as sitting ba	-	

Facility ID: 943195

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/05/20 ⁻ MAPPROVE O. 0938-039	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DAT	E SURVEY PLETED		
		345412	B. WING		01	C / 31/2019	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTWO	OOD NH & RETIREMENT	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 PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 656	Continued From page	e 11	F 656				
	mobility. Resident #3 ' s last a	abnormalities of gait and nnual Minimum Data Set		information was correct and co with recommendations from th Rehabilitation Department. The consultant and Director of Nurs	e e MDS sing		
	resident had severely daily decision making resident required exte	ated 6/5/18 indicated the / impaired cognitive skills for g. Section G indicated the ensive assistance with two		corrected all resident care plan 1/29/2019 to reflect residents needs for transfer assistance a identified safety concerns, to in	accurate and nclude the		
	and transfers A review of the reside	ysical assist for bed mobility ent ' s Care Area		number of staff necessary to p tasks. On January 30, 2019, c updates reflecting residents	are plan accurate		
	of Daily Living) / Fund Potential (dated 6/8/1	Vorksheet for ADL (Activities ctional / Rehabilitation 18) included an analysis of ngs read, in part: "She is		concerns, to include number o necessary to perform the tasks completed and updated care g placed in each resident⊡s clos	s, were juides were		
	alert to self onlySh bed mobility, toileting of the CAA Workshee	e requires assistance with and transfers" A review et for Falls (dated 6/8/18)		administrative staff replacing the care guides. Education will be 1/30/2019 with all nurses and	he existing initiated on nurse aides,		
		hich noted the resident had a uarter without injury, had a		to include agency staff working facility, regarding the process to the residents are plan, th the care plan data, and the pro-	for updates e location of		
	exhibited daily confus	sion. A decision was made and Falls in the resident 's		recourse for accessing the nec information if the care plan dat contain pertinent information for	cessary ta does not or each		
	the following areas of Resident requires a	ssist with ADLs on a daily		resident⊡s care. Facility staff a agency staff are to be educate information upon orientation w facility and/or the nurse staffing	ed on this rith the g agency		
	care plan interventior "Can stand and pivot Plan did not indicate	gnosis of Alzheimer 's. The ns indicated the resident, with transfers." The Care how many staff members st the resident with transfers		prior to working directly with re within the facility. 3. Facility MDS nurse, Treat Staff Development Coordinato	ment Nurse, r, Clinical		
	Resident has a hist	st the resident with transfers. ory of falls. or falls. Has impaired safety		Nurse Manager and Director of were all educated on 1/30/201 Administrator on the expectation resident s care plan is to reflect resident s actual needs and a	9 by facility on that the ect the		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/05/2 FORM APPRO OMB NO. 0938-0
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345412	B. WING		C 01/31/2019
NAME OF PR	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CO	
				1038 COLLEGE STREET	
BRANTWO	OOD NH & RETIREMEN	TCENT		OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLET IE APPROPRIATE DATE
F 656	Continued From pag	e 12 : #3 ' s medical record	F 6	56 additional key safety measu	res required
	revealed a Therapy S nursing staff on 6/20 completed by a Phys 6/22/18. PT notation	Screen was requested by /18. The screen was sical Therapist (PT) on ns dated 6/22/18 indicated he		including transfer needs and concerns, based on observa documented assessments a direct care personnel, such a	d other safety ations, and data from as therapy
	#3 was having increa and would benefit fro evaluation. The PT	taff. Staff reported Resident ased difficulty with transfers om a Physical Therapy completed an evaluation on		evaluation documentation. A therapy recommendations w submitted to the Telephone review by the clinical and int	vill be Order box for terdisciplinary
	's sitting balance inc guard assist (CGA) f	al Assessment of the resident licated she required contact for both static and dynamic b balance) balance while		MDS team in order to comm changes in resident needs for well as safety concerns. A 1 in-service training of all thera	or transfers as 00%
	Plan for Resident #3 bed mobility, transfe	a bed. The PT 's Treatment read: "Pt (patient) performs rs and gait at baseline. No nysical therapy) is required at		the facility Rehabilitation De Director regarding the place copy of therapy documentat Telephone Order box for nur	ment of a ion in the
	this time. Recomme	nd NSG (nursing) perform chair daily by 2 person assist		management review was co 1/30/2019. No therapy staff be allowed to work until he c	mpleted on member will
	6/8/18 related to ADI revisions had been r	sident #3 ' s Care Plan dated _ care was conducted.No nade to the care plan		received the education. All residents receiving thera Physical, Occupational, and Therapy will be reviewed on	Speech a daily basis
	Therapy evaluation. continued to read, "C	sult of the 6/28/18 Physical The Care Plan interventions Can stand and pivot with Plan did not indicate the		with the MDS interdisciplinal changes to residents trans safety measures required be in each resident s care plar	fer and other eing updated
	resident needed two transfers (or a Hoyer	-person assistance with -lift) as recommended by PT, ety measures required based		by the Facility MDS nurse, T Nurse, Staff Development C Clinical Nurse Manager and	Freatment coordinator,
	on the PT 's assess instability while sittin which included her n	ment of Resident #3 ' s g on the side of the bed eed for contact guard assist		Nursing. All changes in trans and updated safety concern submitted to and reviewed b	sfer needs s will be by the Director
	-	erly Minimum Data Set		of Nursing, or designee, for months beginning 1/30/2019 changes will be communicat	9. Any ted to front
		dated 9/5/18 indicated the y impaired cognitive skills for		line staff in the morning hude Clinical Managers are to cor	

Facility ID: 943195

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OLIVILIN	5 FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		345412	B. WING			C 1/31/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		1/51/2015
				1038 COLLEGE STREET		
BRANTWO	DOD NH & RETIREMENT	CENT		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 C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 13	F 65	56		
	daily decision making resident required limit	 Section G indicated the ted assistance with one 		changes with their preser day.		
	person physical assis			4. Monitoring will be do		
	extensive assistance assist for transfers.	with one person physical		Administrator, or designe		
				the plan of correction is e the specific deficiency cit		
	A review of the reside	ent ' s Care Plan (dated		corrected and/or in comp		
		DL care was conducted. The		regulatory requirements t		
		ns continued to read, "Can		Medicare Worksheets us		
		ransfers." The Care Plan		Recommendation Audit T	ool 5 x weekly	
		ed to read, "Can stand and		for 4 weeks, then weekly		
	•	The Care Plan did not		monthly x 2 months to en		
	indicate the resident i	•		recommendations for res		
		fers (or a Hoyer lift) as on 6/28/18, nor did it		caseload have been revie interdisciplinary MDS tea	-	
	-	res required based on the		respective updates made		
		Resident #3 's instability		as appropriate. Should th		
		de of the bed which included		completing the care plan		
		guard assist with both static		concerns regarding the re		
	and dynamic balance			for resident assistance ne		
				given by the therapy depa	artment, the	
		erly Minimum Data Set		nurse will be required to o		
	. ,	ated 12/3/18 indicated the		assessment and/or ration		
		impaired cognitive skills for		changes to the care plan		
		 Section G indicated the ensive assistance with one 		upon nursing judgement, documentation from direct		
	person physical assis			personnel. This rationale		
		with 2+ person physical		validation of the assistant		
		She required extensive		resident⊡s activities of da		
		for all of her other ADLs,		appropriately meet the re		
		needing supervision only for		needs. The attending phy		
		lly dependent on staff for		be notified of the care pla	-	
	bathing.			generated based upon nu	-	
	The resident ' a Care	Plan, which was in place on		judgement, observation, a		
	12/4/18, related to AE	Plan, which was in place on		documentation from direct along with the recommen		
		ontinued to read, "Can stand		therapy as soon as possi		
		ers." The Care Plan did not		monitoring tool was deve		
		aff members were required		1/30/2019 following comp		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/05/2019 RM APPROVED IO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345412	B. WING			0.	C 1/31/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BDANTW/	OOD NH & RETIREMENT	CENT		10	038 COLLEGE STREET		
DRANTWO		CENT		0	XFORD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	resident 's instability the bed. Resident #3 date was scheduled f A review of Resident Service Plan (ISP) wh was provided by the f as a Care Guide) is a individual patient nee information for direct assistance required to for a resident. Each if posted on the inside of Resident #3 's ISP in Instructions" which re worsening dementia transfers" Addition included a section en Comments noted in th in its entirety, "Can st transfers." Review of Resident # included a Nursing Na Nurse #1 and dated 1 note indicated Nurse resident 's room at a Nursing Assistant (NA Resident #3 was lying She was responsive a	with transfers or any sures required due the while sitting on the side of s's next Care Plan review or 12/11/18. #3's (undated) Individual hich was in place on 12/4/18, facility. An ISP (also known printed summary of ds, which includes care nursing staff on the o meet the ADL care needs ndividual resident 's ISP is of his/her closet door. hcluded "Special ad, in part: "Resident with Can stand and pivot with hally, the resident 's ISP titled, "Transferring." he transferring section read and and pivot with 3's medical record ote for Falls, written by 12/4/18 at 11:25 PM. The	F	656	DEFICIENCY) Care Plan audit by facility Treatment Nurse, Staff Development Coordinato Clinical Nurse Manager and/or Direct Nursing. Monitoring of transfer assist and other identified safety concerns provided by direct patient care staff w conducted by Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing utilizing the Transfer Audit Tool (developed 1/31/2 5 x weekly for 4 weeks, then weekly 2 weeks, then monthly x 2 months to ei that the care plan is adhered to by dir patient care staff per resident needs a safety. The results of these audits are be reported to the QAPI committee. T QA committee was notified and signe acknowledgement of this plan 1/29/20 A third party was hired to audit the Mi process on at least a routine monthly basis to ensure that the care plan and MDS process are accurate and appropriate for the residents□ needs	or of ance vill be 2019) < 4 nsure rect and to The d DS d	
	resident was able to s appeared to be "shak above left eye." A pa	I respiration rate 18. The state her name. She en up and had a large knot rtial assessment was done moved to the bed with a					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345412	B. WING				C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	OOD NH & RETIREMENT	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 656	Hoyer lift so a thoroug achieved. Once the r her vital signs were ch her blood pressure wa respiration rate 20. T name again and she l but wasn't able to finis became unresponsive checked at 9:43 PM a noted to be 85/70; pu were reported to be la oxygen saturation (O2 to be 75%. The resid oxygen/minute. Her C and 95%, but began " 80-85%. Her physicia the fall and resident s received to send Resi Department (ED) for c Medical Services (EM resident was transpor A review of Resident 1 12/4/18 at 10:10 PM. resident was unrespo cardiac arrest. Additi records indicated the signs upon EMS arriv electrical activity (PE4 transport to the hospir arrest in which the ele heart rhythm that sho does not. The reside to the ED with cardiop (CPR) in progress. R discontinued on 12/4/ treating physician not	gh assessment could be resident was placed in bed, hecked again. At that time, as 111/92, pulse 95, and the resident was asked her begin to state her first name sh the rest because she e. Vital signs where again and her blood pressure was lse 69; and respirations abored. Resident #3 ' s 2 sat) was taken and noted ent was placed on 2 liters of D2 sat increased to 85% 'to plummet" back to an was called, informed of tatus, and an order was ident #3 to the Emergency evaluation. Emergency tevaluation. Emergency evaluation. Emergency (IS) were called and the ted to the hospital. #3 ' s hospital records arrived at the ED on Hospital notes indicated the nsive and experienced full onal details in the hospital resident had stable vital al, but had pulseless (A) on monitor prior to tal. PEA refers to cardiac ectrocardiogram shows a uld produce a pulse, but nt was reported as arriving pulmonary resuscitation tesuscitation was	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345412	B. WING				C /31/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRANTW	DOD NH & RETIREMENT	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	of bleeding that occur condition)." A review certificate indicated he intracerebral hemorrh within the brain itself); approximate interval of on the death certificat A review of Resident a Investigation Report f statement from the nu- was working with the incident. A review of the statem attached to Resident a Investigation Report f The statement read: assist stand and pivot on the side of the bed Patient tried to take or didn 't give me time to When patient leaned forward and couldn 't patient did not fall dur after leaning forward f Patient is very heavy and sometimes her w whatever direction shi head on the floor. Aft called my nurse. Nur shock but she started was trying to get up. up. Me and nurse go the floor. Patient was name again she said	ranial hemorrhage (a type is inside the skull or cranium of Resident #3 's death er cause of death was age (bleeding around or ; accidental fall. The of onset to death was noted as, "minutes." #3 's Fall Scene rom 12/4/18 included a ursing assistant (NA #1) who resident at the time of the hent written by NA #1 #3 's Fall Scene rom 12/4/18 was completed. "(The resident) was an t. After I helped get patient bed was in a low position. If her own shoes. Patient bed was in a low position. If her own shoes. Patient is top her from falling. The ring transfer. Patient fell trying to take off shoes. even though she is an assist	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345412	B. WING				C / 31/2019	
NAME OF P	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTW	OOD NH & RETIREMENT	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	Continued From page	2 17	F	656				
	on 1/28/19 at 8:15 PM worked at the facility in nursing assistant app from September 2018 hall assignments at the reported she had wore past. When asked ab 12/4/18, the NA report ready for bed "becaus NA #1 reported she the her recliner to the bed sitting on the side of the so weirdbecause signed and it was like she her shoes." The NA re the resident hit her her the resident fell, NA# the nurse (who was in talking to the resident her full name. When could not recall anyth She reported another lift. Resident #3 was and was reported to se transfer. However, N started shaking and w warm to the touch. S something was wrong told her to get another Upon further inquiry, usually seemed to be the bed. When the re and lean forward, the might have been her NA #1 stated she (the	was conducted with NA #1 A. The NA reported she as an Agency (temporary) roximately two times a week b to December 2018. Her he facility rotated, but the NA ked with Resident #3 in the out the resident 's fall on ted she was helping her get se she was 1 person assist." ransferred Resident #3 from d and positioned the resident he bed. She stated, "It was he was sitting down on the re reached down to take off reported she saw and heard ead on the floor. She noted w position. Immediately after 1 stated she went and got earby). The nurse started and she was able to say asked, NA #1 reported she ing else the resident said. NA went to get the Hoyer transferred onto her bed still be talking after the A #1 stated the resident vas getting cool and then he reported they knew g at that point, so the nurse r nurse (which she did). the NA reported Resident #3 stable sitting at the side of esident appeared to reach NA reported she thought it weight that made her fall. e NA) usually took the d socks off for her, so she						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED	
		345412	B. WING				C /31/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				1	1038 COLLEGE STREET			
BRANIW	OOD NH & RETIREMENT	CENT		0	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	was not sure why the take her shoes off her would know what a re- were for safe transfer "I would look at the ca that worked there mo #1 reported after the occurred on 12/4/18, nursing staff and look resident 's closet to b everything right. Whe guide noted, she report the resident was one She stated that "a lot resident was one-per- A follow-up telephone with NA #1 on 1/29/19 at 4:08 PM. During th reported Resident #3 way down when she sat her on the side of was transferred and s the NA tried to pull the reported she was star bed on the same side She stated the, "bed under her." When as 't think pulling those I resident would have r forward. Upon furthe thought the resident r move from under her them. NA #1 stated h covers at the time of the not touching the reside floor. When asked ho sitting on the bed before	resident would have tried to rself. When asked how she esident 's individual needs s, for instance, she stated, are guide, ask another aide re often, or the nurse." NA incident with Resident #3 she talked with other ed at the care guide in the be sure she had done en asked what the care orted she thought it indicated person assist for transfers. of people" told her the son assist. e interview was conducted 0 at 9:55 AM and on 1/29/19 he interviews, the NA 's bed covers were only ½ transferred the resident and the bed. After the resident sitting on the side of the bed, e covers down more. NA #1 hoding towards the foot of the e the resident was sitting. covers were just tiny bit ked, the NA stated she didn bed covers from under the	F	656				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
	OUNCOTON	BENTIFICATION NOWBER.	A. BUILDING	3		
			D M/NO			С
		345412	B. WING			1/31/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
BRANTW	OOD NH & RETIREMEN	I 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 PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	e 19	F 65	56		
		the NA had ever been made	1 00			
		unsafe for this resident to sit				
		d, she stated she had not.				
		NA #1 was asked what kind				
		eived before caring for				
		ty. She reported the Agency				
		red her to sign papers for				
	every facility with job	descriptions. However, the				
	NA stated when she	came to the facility, she did				
	not know the residen	ts.				
	-	was conducted on 1/29/19				
		PT who completed Resident				
	-	py screen on 6/22/18 and				
		3. During the interview, the				
		amiliar with the resident and				
	her history at the time	e the evaluation was				
		not great." He reported				
		y had shown that on one day				
		terrific and the next day she				
		h at all. The PT stated he				
		erson assist or Hoyer lift for				
	-	measure. He reported the				
	-	namic sitting balance was				
		ment of what he saw during				
		as the reason why he made				
		for transfers using 2-person				
		The PT noted sitting				
		ed on the side of a bed; and, nay not be holding on to a				
	grab bar or somethin					
	•	ce would have been in a				
		her with a back and arms, he				
	-	e much different and she did				
		safe. A follow-up interview				
		he PT on 1/30/19 at 11:45				
	AM. During this inter	view, the PT reported he				
		I to evaluate the resident for				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345412	B. WING				31/2019
NAME OF P	ROVIDER OR SUPPLIER				<u> </u>		
BRANTW	OOD NH & RETIREMENT	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)	BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
F 656	safety if her needs ha less assistance for tra- indicated it would hav Registered Nurse (RM the resident and make asked how results of evaluations would be 's staff, the PT report Manager would track of any PT recommend An interview was com- AM with the MDS Nur facility 's Compliance interview, the nurse w recommendations we resident 's direct care nurse reported a reco typically shared in the meeting and commun resident 's care plan. the care plan would g resident 's ISP as we information available When asked if the PT for Resident #3 on 6/2 resident 's care plan, were. Upon further in nurse was unable to I Resident #3 's care p An interview was com- PM with Nurse #2. N who reported she rou During the interview, it the resident 's need fit transfer. In response resident was usually of	d changed and she required ansfers. However, he also the been acceptable for a N) at the facility to assess the such a change. When resident screens and communicated to the facility ed the facility 's Rehab these so he would be aware dations made. ducted on 1/30/19 at 9:22 rese in the presence of the e Officer. During the vas asked how PT re communicated to the e nursing staff. The MDS immendation from PT was a administrative morning licated to the staff via the She reported a change in enerate a change in the ell as the electronic to the direct care staff. recommendations made 28/18 were reflected on the the MDS nurse stated they requiry, however, the MDS ocate this information on olan. ducted on 1/29/19 at 12:15 urse #2 was a hall nurse tinely cared for Resident #3. the nurse was asked about for staff assistance to	F	650	6		

Facility ID: 943195

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	E SURVEY PLETED
		345412	B. WING				C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BRANTW	OOD NH & RETIREMENT	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 656	Nurse #2 reported that time of day, Resident assistance for a trans would know whether was required for a trans would always tell a nu ISP located on the ins When informed the re- indicate whether she assistance with transf she herself could also to ask any questions inquiry as to whether safely sit on the side "For me, no." Nurse on the Resident #3 's confusion, Resident #3 forward or to get up u An interview was con PM with NA #2. NA # assigned to care for F interview, the NA was process she used to the her recliner to the bed "It depends." She rep having a good day, she resident herself. If Re such a good day, the 2-person assist. Whe assistant would know resident, NA #2 repor the off-going NA durir of the resident 's ISP Resident #3 's ISP, N not indicate how man required to transfer th asked about Residen	at depending on the day and #3 may need two-person fer. When asked how a NA 1 or 2 person assistance nsfer, the nurse stated she ursing assistant to look at the side of the resident ' s closet. esident ' s ISP did not required 1- or 2-person fers, the nurse added that to be a resource for the NAs they may have. Upon or not the resident could of the bed, the nurse stated, #2 reported that depending a state of mind and level of #3 could decide to lean insafely. ducted on 1/29/19 at 12:33 #2 reported she was routinely Resident #3. During the a asked to describe the transfer Resident #3 from d. The NA started by stating, ported if the resident was he could transfer the esident #3 wasn ' t having transfer would require en asked how a new nursing ' how to safely transfer the ted she may find out from ng shift report or from review	F	656	6		

Facility ID: 943195

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
	oonneonon	IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>		
		0.15.140				С
		345412	B. WING			1/31/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
BRANTWO	OOD NH & RETIREMENT	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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	a 99	F 65	56		
1 000			F 00	00		
	reported the resident	he side of the bed. NA #2				
	-	maneuver and to put her				
		ter she was transferred to				
		r inquiry as to whether or not				
		e safe sitting on the side of				
	the bed, NA #2 respo	nded by saying, "No, you				
	would have to do what then."	at you ' re going to do right				
	Upon request, a follow	w-up interview was at 10:25 AM with NA #2.				
		the NA was asked how				
	-	o safely transfer Resident #3				
		bed. The NA stated, "It				
		it may be 1 person and on 3				
	days of the week it m	ay be two people." She				
		necessarily dependent on				
		pendent on the moment and				
		resident 's dementia at the				
		ow a new NA or an Agency				
		her one or two people were nsfer the resident, the NA				
		a report from the off-going				
		so stated the report given at				
		ect the resident 's needs				
		tually needed to transfer her				
	at 5:00 PM. Upon fur	ther inquiry, NA #2 reported				
		esident ' s closet) should				
		sident could transfer by				
		assist of 1 person or 2."				
		d person would have been				
		extra man power. During the orted if the resident sat on				
	-	he would definitely have to				
		th of the nursing assistant.				
		e typically would not even do				
		ave left Resident #3 by the				

Facility ID: 943195

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/05/2019 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		ECONSTRUCTION	(X3) DATE	
				_			c
		345412	B. WING			01/	31/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTWO	DOD NH & RETIREMENT	CENT			038 COLLEGE STREET DXFORD, NC 27565		
							0(5)
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page		F	656			
	stated, "It was best to feet up."	go ahead and swing her					
	PM with NA #3. NA #	ducted on 1/29/19 at 3:35 3 reported she was familiar					
	on multiple occasions	had helped to care for her During the interview, the could usually transfer the					
	resident herself but w if the resident seemed	ould need a second person d to be weak at the time of					
	safely sit at the side o	sked if the resident could of the bed, NA #3 stated, "No					
		When asked to explain her ted she would be worried ing.					
	at 4:49 PM with Resid	was conducted on 1/29/19 lent #3 ' s Medical Doctor					
	Director. During the i	d as the facility ' s Medical nterview, the MD was asked					
	adverse event (such a	esident experienced an as a stroke) that may have 12/4/18. The MD stated it					
		ould be impossible to know					
	and included NA #1 '						
	having a large hemator response, the physicia						
	situation did not make	e it impossible that the stroke) prior to the fall, it					
	An interview was con PM with the facility ' s	ducted on 1/29/19 at 5:40 Administrator and					
	Administrator confirm	During the interview, the ed Resident #3 ' s care plan 12/4/18) did not reflect the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345412	B. WING				C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	OOD NH & RETIREMENT	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Physical Therapist's which indicated the re- with 2-person assist of s care plan indicated for transfers, with no in members were requir Additionally, there was another assessment if the staff assistance no resident safely or othe to ensure the resident the side of the bed. U Administrator reporter were discussed in the team meeting held ear meeting included ther nurse. The Administr should have immedia recommendation into care plan. She report The care plan update been incorporated into guide direct care staff required to safely meet A follow-up interview at 11:16 AM with the Compliance Officer. I asked if she would ex to reflect the staff assist a resident's safety, s The Administrator also s need for staff assist expect the change to documented, and the ISP) to be updated act A second follow-up in	6/28/18 recommendations esident should be transferred or a Hoyer lift. Resident #3 ' she could stand and pivot indication of how many staff ed to assist her. s no documentation of being completed to reflect eeded to transfer this er safety measures required t was safe when sitting on Jpon inquiry, the d PT recommendations e stand-up interdisciplinary ich morning. The morning rapy staff and the MDS ator stated the MDS nurse tely put the PT ' s the resident ' s electronic ted this had not been done. s would have automatically o the resident ' s ISP to f on the ADL assistance et the resident ' s needs. was conducted on 1/30/19 facility ' s Administrator and When the Administrator was pect a resident ' s care plan istance necessary to ensure she stated, "Absolutely." o stated that if the resident ' ance changed, she would be assessed and care plan (along with the	F	656			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345412	B. WING				C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRANTW	OOD NH & RETIREMENT	CENT					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	During this interview, expectation for care p information placed in consideration the holi based on observation resident ' s care need clinical records, and of feedback. She report completed in a way th patient care staff on th including needs for sa On 1/30/19 at 1:00 Pl Administrator and Co- informed of the imme- provided an acceptab Immediate Jeopardy 1 AM. The allegation of Brantwood Nursing an Credible Allegation of Jeopardy F656 Care Plans Resident 3 experience 1-person to the bed, a on the bed as the nur physical assistance to At this time, this resid onto the floor. Reside to the Emergency De Systems status post-1 12/4/2018. The staff t untouched while in the with the facility. 1. Resident 3 was s Department as a resu	the Administrator stated her plans was that all of the the care plan took into stic picture of the resident s and assessments of the s, documentation within the direct patient care staff ted care plans should be nat would thoroughly educate the resident ' s needs, afety. M, the facility ' s mpliance Officer were diate jeopardy. The facility le credible allegation of removal on 1/31/19 at 11:43 f compliance indicated: and Rehab (1/31/19) Removal of Immediate ed a fall post-transfer of at which point she was sat se aide removed her o slide the linen further back. ent leaned forward and fell nt 3 was immediately sent partment of Granville Health	F	654			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/05/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345412	B. WING		01/31/2019
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CC	
BRANTW	OOD NH & RETIREMENT	CENT		38 COLLEGE STREET (FORD, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 656	 care plan failed to prove regarding the resident recommended by the documentation on 6/2 moderate to maximur a result, the resident person assist. 2. To address the p the deficiency, an augular swas initiated ar 1/29/2019. The resided available to facility state of each resident 's care and activities of conducted on 1/29/20 Staff Development Commended to the resident of the deficiency and Director consultant and Director on 1/29/2019 to reflect needs for transfer assistance, to include the tasks were complupolated care guide h s closet replacing the on 1/30/2019. Facility MDS nur Development Coording Manager and Director on 1/30/2019. 	ovide sufficient information t ' s transferring needs as rapy via therapy evaluation 28/2018 for a 2-person m assist during transfers. As was transferred via one articular process leading to dit of 100% of resident care no to be completed on ent ' s care plan are aff in order to identify areas are plan needed for daily daily living. The audit was 019 by the Treatment Nurse, pordinator, Clinical Nurse or of Nursing to ent ' s care planned transfer the information was correct ecommendations from the ment. All issues are to be dent care plans by the MDS or of Nursing immediately ct residents ' accurate sistance, to include number e tasks. Care Plan updates accurate needs for transfer e number of staff to perform eted, and each resident ' s ave been placed in resident ' prior by administrative staff hator, Clinical Nurse	F 656		

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 03/05/2019 FORM APPROVED IB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			B) DATE SURVEY COMPLETED
		345412	B. WING				C 01/31/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP COD	E	
				103	8 COLLEGE STREET		
BRANIWO	DOD NH & RETIREMENT	CENT		ох	FORD, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 656	transfer needs for ear resident 's actual need documented assess care personnel, such documentation. A cop recommendations will "Telephone Order" bo and interdisciplinary I communicate change transfers during busin in-service of all thera placement of a copy the "Telephone Order management review provided by the facilit Director to be comple working beyond that received the educatio caseload, to include I Speech Therapy will with the MDS interdis to resident 's transfe resident 's care plan MDS nurse, Treatme Coordinator, Clinical Director of Nursing. A will be submitted to a of Nursing, or design beginning 1/30/2019. on 1/30/2019 with all include agency staff or regarding the process s care plan, the locat the proper recourse f	to include the need for ch resident, are to reflect the eds based on observations, nents and data from direct as therapy evaluation by of all therapy I be submitted to the box for review by the clinical MDS team in order to es in resident needs for ness days. A 100% py staff regarding the of therapy documentation in	F	656			
	pertinent information Facility staff as well a	for each resident ' s care. Is agency staff are to be ation with the facility and/or					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/05/2019 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345412	B. WING		_	C 01/31/2019	
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	OOD NH & RETIREMENT	CENT	1	038 COLLEGE STREET			
DRANTW		CENT	c	OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	28 ncy prior to working directly	F 656				
		he facility on this information					
	plan of correction is e deficiency cited remain compliance with the re- auditing Medicare Wo Recommendation Aud weeks, then weekly x months to ensure that for residents on thera reviewed by the intero the respective update appropriate. Should the care plan updates have	e done by facility gnee, to ensure that the ffective and that the specific ins corrected and/or in egulatory requirements by orksheets using the Therapy dit Tool 5 x weekly for 4 4 weeks, then monthly x 2 t all new recommendations py caseload have been disciplinary MDS team with s made to the care plan, as he nurse completing the ve concerns regarding the esident assistance need					
	changes given by the nurse will be required assessment and/or ra the care plan made be judgement, observatio direct care personnel. include validation of th the resident 's activiti appropriately meet the The attending physici- the care plan update of nursing judgement, of documentation from of with the recommenda as possible. The mon on 1/30/2019 following Plan audit by facility T Development Coordin	therapy department, the to document an tionale for the changes to ased upon nursing on, and documentation from This rationale, should he assistance needed for es of daily living to e resident ' s care needs. an is to then be notified of generated based upon oservation, and lirect care personnel along tion from therapy as soon itoring tool was developed g completion of the Care Treatment Nurse, Staff lator, Clinical Nurse ctor of Nursing. The results					

Facility ID: 943195

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/05/20 FORM APPROVI OMB NO. 0938-03	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345412	B. WING		C 01/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
BRANTWO	DOD NH & RETIREMEN	I CENT		038 COLLEGE STREET XFORD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
F 656		e 29 committee was notified and ment of this plan 1/29/2019.	F 656			
F 689 SS=J	Jeopardy removal wa 1:20 PM. The valida interviews with both I non-licensed nursing information regarding for the transfer and A ensure a resident 's of persons required t Review of on-going in licensed and unlicens prior to working on the residents ' therapy re updated care plans a conducted as part of Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensi- §483.25(d)(1) The re	ecommendations along with nd ISP records was also the validation process. ards/Supervision/Devices (2)	F 689		1/31/19	
	supervision and assist accidents. This REQUIREMENT by: Based on staff and p facility and hospital re failed to use two staff resident and provide immediately after the resident sat safely or	esident receives adequate stance devices to prevent T is not met as evidenced ohysician interviews, and ecord reviews, the facility f members to transfer a the required assistance transfer to ensure the n the side of her bed for 1 of reviewed for accidents		On December 4, 2018 Resident 3 experienced a fall post-transfer of one person assist to the bed, at which poi she sat on the bed as the nurse aide discontinued hands-on physical assistance in order to slide the linen further back. At this time, this residen	nt	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/05/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345412	B. WING				C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	OOD NH & RETIREMENT	CENT			038 COLLEGE STREET IXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	(Resident #3). Resid from the side of her b one staff member wh the resident 's foreher the hospital for evalue passed away later tha hemorrhage (bleeding itself). Immediate Jeopardy Nursing Assistant (N/ #3 from her recliner to pivot maneuver and a #3 fell forward off of t the floor. Immediate of 1/31/19 when the f acceptable allegation removal. The facility of a scope and severity with potential for more not immediate jeopar staff education and el put into place are effec The findings included Resident #3 was adm Her cumulative diagn disease, anxiety diso falls, and unspecified mobility. Resident #3 's last al (MDS) assessment d resident had severely daily decision making resident required external	ent #3 experienced a fall eed, while being assisted by ich resulted in an injury to ead. Resident #3 was sent to ation and treatment and at day from an intracerebral g around or within the brain began on 12/4/18 when A) #1 transferred Resident to the bed with a stand and assist of one and Resident he bed, striking her head on Jeopardy was removed as acility implemented an of Immediate Jeopardy remains out of compliance at level "D" (no actual harm e than minimal harm that is dy) for the facility to continue nsure monitoring systems active.	F	689	leaned forward and fell onto the floor. Resident 3 was immediately sent to the Emergency Department of Granville Health System status post-fall and ex on 12/4/2018. The staff that left the resident sitting untouched while in the room is no longer working with the fact 1. Resident 3 was sent to the Emergency Department as a result of above incident. It was identified by analysis on 1/29/2019 that the resider was not provided necessary balancin assistance post-transfer to prevent accidents and incidents per the recommendations provided by therap therapy evaluation documentation on 6/28/2018 for a 2-person moderate to maximum assist during transfers. The staff working directly with the resident during the incident was not directly m aware of the safety concerns with sitt balance while on the side of the bed f this resident. 2. To address the particular process leading to the deficiency, an audit of of resident care plans are available to facility staff in order to identify areas of each resident s care plan needed fo daily care and activities of daily living audit was conducted on 1/29/2019 by Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager, Director of Nursing to cross-references transfer needs and other safety concer identified, such as sitting balance on resident s care plan to ensure that th	ne pired cility. the nt g y via y via de ing for ade ing for ade ing for ade ing for ade to for the and to f r the and	
	staff education and e put into place are effe The findings included Resident #3 was adm Her cumulative diagn disease, anxiety diso falls, and unspecified mobility. Resident #3 ' s last at (MDS) assessment d resident had severely daily decision making resident required exte	nsure monitoring systems ective. : nitted to the facility on 6/1/17. oses included Alzheimer 's rder, depression, repeated abnormalities of gait and nnual Minimum Data Set ated 6/5/18 indicated the impaired cognitive skills for j. Section G indicated the			 balance while on the side of the bed f this resident. To address the particular process leading to the deficiency, an audit of of resident care plans was initiated an be completed on 1/29/2019. The residents□ care plans are available to facility staff in order to identify areas of each resident□s care plan needed fo daily care and activities of daily living audit was conducted on 1/29/2019 by Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager, Director of Nursing to cross-reference transfer needs and other safety conce 	for 100% 100% 100% of r The the and erns each ne	

Facility ID: 943195

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D		ONSTRUCTION		
	_DING		(X3) DATE SURVEY COMPLETED	
B. WIN	G		0,	C 1/31/2019
•	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
L PRE	EFIX	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO DATE
ities of e is ith iew) had a a ade t's uded ly The , re s sfers. afety / d he dent		with recommendations from the Rehabilitation Department. The consultant and Director of Nurs corrected all resident care plan 1/29/2019 to reflect residents needs for transfer assistance a identified safety concerns, to ir number of staff necessary to p tasks. On January 30, 2019, ca updates reflecting residents a needs for transfer assistance a concerns, to include number of necessary to perform the tasks completed and updated care g placed in each resident sclos administrative staff replacing th care guides. Education will be 1/30/2019 with all nurses and r to include agency staff working facility, regarding the process f to the residents care plan, the the care plan data, and the pro- recourse for accessing the neo- information if the care plan dat contain pertinent information for resident scare. Facility staff a agency staff are to be educate information upon orientation wi facility and/or the nurse staffing prior to working directly with re within the facility. 3. Facility MDS nurse, Treatr Staff Development Coordinator Nurse Manager and Director or were all educated on 1/30/2015	e MDS sing as on accurate and hclude the erform the are plan accurate and safety f staff s, were uides were set by he existing e initiated on nurse aides, g within the for updates e location of oper cessary a does not or each as well as d on this ith the g agency sidents ment Nurse, r, Clinical f Nursing 9 by facility	
	LL PRI	LL DN) ID PREFIX TAG F 689 rities of ne is ith riew p) nad a a de t 's uded ily The rs sfers. afety y ed he dent ers on	LL DN) PREFIX TAG (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) F 689 with recommendations from th Rehabilitation Department. The consultant and Director of Nur- corrected all resident care plan 1/29/2019 to reflect residents identified safety concerns, to in number of staff necessary to p tasks. On January 30, 2019, c updates reflecting residents ade ada needs for transfer assistance a concerns, to include number o necessary to perform the tasks completed and updated care g placed in each resident's clos administrative staff replacing th care guides. Education will be 1/30/2019 with all nurses and to include agency staff working facility, regarding the process information if the care plan, th the care plan data, and the pro- resident's care. Facility staff agency staff are to be educated information if the care plan, th the care plan data, and the pro- resident's care. Facility staff agency staff are to be educated information upon orientation wf facility and/or the nurse staffing prior to working directly with re within the facility. y 3. Facility MDS nurse, Treat Staff Development Coordinato Nurse Manager and Director of were all educated on 1/30/201 on wree sident's care plan is to reflect resident's care plan is to reflect	OXFORD, NC 27565 LL DN) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 with recommendations from the Rehabilitation Department. The MDS consultant and Director of Nursing corrected all resident care plans on 1/29/2019 to reflect residents] accurate needs for transfer assistance and identified safety concerns, to include the number of staff necessary to perform the tasks. On January 30, 2019, care plan updates reflecting residents] accurate needs for transfer assistance and safety concerns, to include number of staff necessary to perform the tasks, were completed and updated care guides were placed in each resident] s closet by administrative staff replacing the existing care guides. Education will be initiated on 1/30/2019 with all nurses and nurse aides, to include agency staff working within the facility, regarding the process for updates to the residents] care plan data, and the proper recourse for accessing the necessary information if the care plan data does not contain pertinent information for each resident] s care. Facility staff as well as agency staff are to be educated on this information upon orientation with the facility and/or the nurse staffing agency prior to working directly with residents within the facility. y 3. Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and Director of Nursing were all educated on 1/30/2019 by facility Administrator on the expectation that the resident] is acre plan is to reflect the resident] is acre plan is to reflect the

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		ID HUMAN SERVICES MEDICAID SERVICES			FC	ED: 03/05/2019 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) D/	ATE SURVEY MPLETED
		345412	B. WING _			C 01/31/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
				1038 COLLEGE STREET		
BRANIW	OOD NH & RETIREMENT	CENT		OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 689	guard assist (CGA) for (gentle challenges to sitting on the side of a Plan for Resident #3 bed mobility, transfer further skilled PT (phy this time. Recommer OOB (out of bed) to c or Hoyer lift." A review of Resident 6/8/18 related to ADL changes had been m interventions as a res evaluation. The Care continued to read, "C	 icated she required contact or both static and dynamic balance) balance while a bed. The PT 's Treatment read: "Pt (patient) performs s and gait at baseline. No ysical therapy) is required at nd NSG (nursing) perform thair daily by 2 person assist #3 's Care Plan dated care was conducted. No ade to the care plan sult of the Physical Therapy 	F 6	including transfer need concerns, based on of documented assessm direct care personnel, evaluation documenta therapy recommendat submitted to the Telep review by the clinical a MDS team in order to changes in resident nee well as safety concern in-service training of a the facility Rehabilitation Director regarding the copy of therapy docum Telephone Order box f management review w 1/30/2019. No therap	bservations, ents and data from such as therapy tition. A copy of all ions will be shone Order box for and interdisciplinary communicate eeds for transfers as as. A 100% Ill therapy staff by on Department placement of a nentation in the for nurse vas completed on	
	resident with transfer A review of the reside include another asses specifically related to assistance required to #3. Resident #3 ' s quarte (MDS) assessment d resident had severely daily decision making resident required limit person physical assis extensive assistance assist for transfers. Further review of the 9/12/18) related to AD	ent ' s medical record did not ssment (from any discipline)		be allowed to work un received the education All residents receiving Physical, Occupationa Therapy will be review with the MDS interdisc changes to residents safety measures requi in each resident s cal by the Facility MDS nu Nurse, Staff Developm Clinical Nurse Manage Nursing. All changes in and updated safety co submitted to and revie of Nursing, or designe months beginning 1/30 changes will be comm line staff in the mornin Clinical Managers are changes with their pre	til he or she has h. g therapy, including al, and Speech yed on a daily basis ciplinary team, with transfer and other ired being updated re plan immediately urse, Treatment hent Coordinator, er and/or Director of n transfer needs boncerns will be ewed by the Director the, for a period of 4 0/2019. Any bunicated to front ig huddle meeting. to communicate	

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/05/201 FORM APPROVE MB NO. 0938-039	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345412	B. WING				C 01/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CO	DE		
BRANTW	OOD NH & RETIREMEN	CENT			8 COLLEGE STREET FORD, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	E (X5) COMPLETION DATE	
F 689	did not indicate how in required to assist the Resident #3 's quarter (MDS) assessment diversident had severely daily decision making resident required exter person physical assist extensive assistance assist for transfers. Se assistance from staff with the exception of eating and being total bathing. The resident 's current care included interver read, "Can stand and Care Plan did not ind members were require with transfers. Resident Individual Service Plat facility. An ISP (also printed summary of in which includes inform staff on the assistance care needs for a resident Instructions" which re- worsening dementia transfers" Addition included a section enti-	transfers." The Care Plan many staff members were resident with transfers. erly Minimum Data Set ated 12/3/18 indicated the y impaired cognitive skills for g. Section G indicated the ensive assistance with one st for bed mobility and with 2+ person physical She required extensive for all of her other ADLs, needing supervision only for Ily dependent on staff for ent Care Plan related to ADL ntions which continued to I pivot with transfers." The icate how many staff red to assist the resident ent #3 's next Care Plan eduled for 12/11/18. #3 's most recent (undated) an (ISP) was provided by the known as a Care Guide) is a ndividual patient needs, nation for direct care nursing be required to meet the ADL dent. Each individual sted on the inside of his/her it #3 's ISP included "Special ead, in part: "Resident with Can stand and pivot with nally, the resident 's ISP	F 6		day. 4. Monitoring will be done Administrator, or designee, t the plan of correction is effect the specific deficiency cited corrected and/or in complian regulatory requirements by a Medicare Worksheets using Recommendation Audit Tool for 4 weeks, then weekly x 4 monthly x 2 months to ensur recommendations for reside caseload have been reviewed interdisciplinary MDS team w respective updates made to as appropriate. Should the n completing the care plan up concerns regarding the reco for resident assistance need given by the therapy departr nurse will be required to doc assessment and/or rationale changes to the care plan ma upon nursing judgement, ob documentation from direct c personnel. This rationale show validation of the assistance need indeds. The attending physic be notified of the care plan u generated based upon nursi judgement, observation, and documentation from direct c along with the recomponent therapy as soon as possible monitoring tool was develop 1/30/2019 following complet Care Plan audit by facility Tr	to ensure that ctive and that remains note with the auditing the Therapy 5 x weekly weeks, then re that all ne nots on therapy with the the care pla outse dates have mmendation I changes ment, the current an a for the ade based servation, ar are ould include needed for the living to ent s care cian is to then update ng are personnet tion from . The ed on ion of the	at it n w py n, n n n n	

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TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
					С	
		345412	B. WING		01/31/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	DOD NH & RETIREMENT	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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI	
F 689	Continued From page	e 34	F 689			
	Nurse #1 and dated 'note indicated Nurse resident 's room at a Nursing Assistant (N/ Resident #3 was lying She was responsive Her vital signs were con the floor. Her blood 142/73; pulse 86; and resident was able to a appeared to be "shak above left eye." A pa and the resident was Hoyer lift so a thoroug achieved. Once the the her vital signs were con her blood pressure w respiration rate 20. T name again and she but wasn't able to fini became unresponsive	3's medical record ote for Falls, written by 12/4/18 at 11:25 PM. The #1 was called to the pproximately 9:20 PM by a A). Upon entering the room, g on the floor on her left side. and attempting to get up. checked while she was lying od pressure was noted to be d respiration rate 18. The state her name. She sen up and had a large knot urtial assessment was done moved to the bed with a gh assessment could be resident was placed in bed, hecked again. At that time, as 111/92, pulse 95, and he resident was asked her begin to state her first name sh the rest because she e. Vital signs where again		Nurse, Staff Development Coordin Clinical Nurse Manager and/or Din Nursing. Monitoring of transfer as and other identified safety concern provided by direct patient care stat conducted by Facility MDS nurse, Treatment Nurse, Staff Developm Coordinator, Clinical Nurse Manag and/or Director of Nursing utilizing Transfer Audit Tool (developed 1/3 5 x weekly for 4 weeks, then weel weeks, then monthly x 2 months t that the care plan is adhered to by patient care staff per resident nee safety. The results of these audits be reported to the QAPI committe QA committee was notified and si acknowledgement of this plan 1/2	rector of sistance ns ff will be ent ger the 31/2019) dy x 4 o ensure r direct ds and are to e. The gned	
	noted to be 85/70; pu were reported to be la oxygen saturation (O to be 75%. The resid oxygen/minute. Her and 95%, but began 80-85%. Her physicia the fall and resident s received to send Res Department (ED) for	an was called, informed of status, and an order was ident #3 to the Emergency evaluation. Emergency 1S) were called and the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			LETED
		345412	B. WING			C 01/31/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTWO	OOD NH & RETIREMENT	CENT		1	038 COLLEGE STREET		
		- SERT		OXFORD, NC 27565			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	N) TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)					DATE
					DEFICIENCY)		
F 689	Continued From page	35	Г	589			
1 000	Continued i rom page	500		209			
	A review of the 12/4/1	8 EMS Records for					
	Resident #3 was cond						
		spatched to the facility at					
		ived to the facility at 9:43 on the EMS report indicated					
		ad injury after experiencing					
	a fall, with respiratory	failure and progression to					
		eft the facility at 10:10 PM					
	With Resident #3, arri	ving at the hospital at 10:11					
	1 101.						
	A review of Resident	#3 ' s hospital records					
	indicated the resident						
		Hospital notes indicated the nsive and experienced					
	cardiac full arrest. Ac	•					
		ated the resident had stable					
		arrival, but had pulseless					
	electrical activity (PE)	, .					
		tal. PEA refers to cardiac ectrocardiogram shows a					
		uld produce a pulse, but					
		nt was reported as arriving					
	to the ED with cardior (CPR) in progress. R	oulmonary resuscitation					
	discontinued on 12/4/						
		ed, "Given large trauma to					
	the forehead and quid	ck decline, I suspect she					
		cranial hemorrhage (a type					
		rs inside the skull or cranium of Resident #3 ' s death					
	-	er cause of death was					
		age (bleeding around or					
	within the brain itself)						
	approximate interval on the death certificat	of onset to death was noted te as. "minutes."					
		,					
	A review of Resident	#3 ' s Fall Scene					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			F	NTED: 03/05/201 ORM APPROVE 3 NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345412	B. WING			01/31/2019
	ROVIDER OR SUPPLIER	I CENT		STREET ADDRESS, CITY, 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	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	statements from the i who was working with the incident. It also in the hall nurse who ini- request for help after A review of the stater attached to Resident Investigation Report The statement read: assist stand and pivo on the side of the bear Patient tried to take of didn 't give me time of When patient leaned forward and couldn ' patient did not fall du after leaning forward Patient is very heavy and sometimes her w whatever direction sh head on the floor. Af called my nurse. Nur shock but she started was trying to get up. up. Me and nurse go the floor. Patient was name again she said went unresponsive. PM." A telephone interview on 1/28/19 at 8:15 Pf worked at the facility nursing assistant app from September 2018 hall assignments at the	from 12/4/18 included hursing assistant (NA #1) in the resident at the time of included a statement from itially responded to the NA 's the fall. ment written by NA #1 #3 's Fall Scene from 12/4/18 was completed. "(The resident) was an t. After I helped get patient d. Bed was in a low position. off her own shoes. Patient to put her feet on bed. forward all her weight went t stop her from falling. The ring transfer. Patient fell trying to take off shoes. even though she is an assist	F 6	89		

Facility ID: 943195

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/05/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345412	B. WING			_		C 31/2019
NAME OF PI	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
					1038 COLLEGE STREET			
BRANIWO	OOD NH & RETIREMENT	CENT			OXFORD, NC 27565			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	IX	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	9 37	F	689				
	past. When asked ab	out the resident ' s fall on						
	12/4/18, the NA repor	ted she was helping her get						
	-	se she was 1 person assist."						
	-	ansferred Resident #3 from						
		and positioned the resident						
		he bed. She stated, "It was he was sitting down on the						
		e reached down to take off						
		eported she saw and heard						
		ad on the floor. She noted						
	the bed was in the low	v position. Immediately after						
		1 stated she went and got						
		earby). The nurse started						
	-	and she was able to say						
		asked, NA #1 reported she						
		ing else the resident said. NA went to get the Hoyer						
		transferred onto her bed						
		still be talking after the						
		A #1 stated the resident						
	started shaking and w	as getting cool and then						
		he reported they knew						
		at that point, so the nurse						
		r nurse (which she did).						
		the NA reported Resident #3						
	-	stable sitting at the side of sident appeared to reach						
		NA reported she thought it						
		weight that made her fall.						
	NA #1 stated she (the	-						
		socks off for her, so she						
	was not sure why the	resident would have tried to						
		rself. When asked how she						
		sident 's individual needs						
		s, for instance, she stated,						
		are guide, ask another aide						
		re often, or the nurse." NA						
	· ·	ncident with Resident #3						
	occurred on 12/4/18,							

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	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	E SURVEY IPLETED
			A. BUILDING	·		С
		345412	B. WING			1/31/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		1/31/2019
				1038 COLLEGE STREET	-	
BRANTWO	DOD NH & RETIREMENT	CENT		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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 689	U U	ed at the care guide in the	F 68	9		
	 resident 's closet to be sure she had done everything right. When asked what the care guide noted, she reported she thought it indicated the resident was one person assist for transfers. She stated that "a lot of people" told her the resident was one-person assist. A follow-up telephone interview was conducted with NA #1 on 1/29/19 at 9:55 AM and on 1/29/19 at 4:08 PM. During the interviews, the NA reported Resident #3 's bed covers were only ¹/₂ way down when she transferred the resident and 	en asked what the care orted she thought it indicated person assist for transfers. of people" told her the				
	sat her on the side of was transferred and s the NA tried to pull the reported she was stat	the bed. After the resident sitting on the side of the bed, e covers down more. NA #1 nding towards the foot of the				
	She stated the, "bed under her." When as	the resident was sitting. covers were just tiny bit ked, the NA stated she didn bed covers from under the made the resident fall				
	forward. Upon furthe thought the resident r move from under her	r inquiry, the NA stated she nay have felt the bed covers when the NA tried to fix her hands were on the bed				
	not touching the resid floor. When asked he sitting on the bed before	the resident ' s fall; she was lent when she fell to the ow long the resident was ore falling forward, NA #1				
	bed." When asked if aware that it may be on the side of the bed	ally just sat her down on the the NA had ever been made unsafe for this resident to sit I, she stated she had not.				
	of orientation she rec	NA #1 was asked what kind eived before caring for y. She reported the Agency				

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/05/2019 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		345412	B. WING				C 01/31/2019
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
BRANTW	DOD NH & RETIREMENT	CENT			38 COLLEGE STREET KFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	NA stated when she on the know the resident A review of the stater attached to Resident Investigation Report of The statement read, if documentation which at approx. (approxima 12/4/18. I was called CNA (certified nursing resident lying on the f assessment was perf was able to move bot upper extremities, pu appeared WNL (within able to speak and giv floor nurse called EM Party) simultaneously Between 2120 (9:2) residents changing co obtained the lift, reside throughout the transfe placed in bed V/S (vit resident was still resp name. Upon entering back." An interview was con PM with Nurse #1. N the hall nurse who was Resident #3 on 12/4/ The nurse reported s around 9:20 PM when out Resident #3 's ro Upon entering her roo was on the floor lying	came to the facility, she did ts. ment written by Nurse #1 #3 's Fall Scene from 12/4/18 was completed. in part: "Follow-up on is noted in Residents chart ately) 2120 (9:20 PM), into resident 's room by the g assistant) and found the floor on left side partial formed on Resident. She th lower extremities and both pils were checked and n normal limits) resident was re me full name. [Name] a S and RP (Responsible y at approx. 2147 (9:47 PM) 20 PM) and observing ondition an assisting aid lent was still responsive er. Once resident was tal signs) were re-obtained bonsive being able to state g room sheets were pulled ducted on 1/28/19 at 5:45 lurse #1 confirmed she was as assigned to care for 18 at the time of her fall. he was passing meds n NA #1 peeked her head form and called for the nurse. om, she saw the resident on her side. She was a bit and trying to get up.	F	689			

Facility ID: 943195

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/05/2 FORM APPRO OMB NO. 0938-0	VED
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345412	B. WING		C 01/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CC		
BRANTW	OOD NH & RETIREMENT	CENT		038 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET HE APPROPRIATE DATE	TION
F 689	responsive. Nurse #" to get up; she was ab lower extremities. Nu mini-assessment and the resident was on the mini-assessment inclu- check of the resident extremities and pupils her name. The nurse Hoyer lift to get Reside #1 reported the resident another set of vital signormal limits and stat Resident #3 was still she was in the bed an start another assessm started shaking a little needed more assistant came to help. Nurse still breathing but was eyes were open. A the and administered 2 litt nasal cannula. The ministres and were notified of the sin resident was taken to A telephone interview at 4:09 PM with the P #3 's Physical Therap evaluation on 6/28/18 PT reported he was fa her history at the time completed. The PT m "sitting balance was minister Resident #3 's histor	A stated the resident wanted ble to move her upper and urse #1 reported she did a one set of vital signs while he floor. The uded a check for bleeding, a 's grips, movement of s, and asked the resident and NA #1 then used a lent #3 onto the bed. Nurse ent was still responsive up in the Hoyer lift. Once onto the bed, she got gns, which were within ble. The nurse reported able to state her name while hd as the nurse began to nent. When Resident #3 e bit, the nurse felt she nce and another floor nurse #1 recalled the resident was s no longer responsive; her hird nurse brought in oxygen ters per minute of oxygen via esident 's code status was lied, and the MD and RP tuation. EMS arrived and the the hospital.	F 689			

Facility ID: 943195

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CENTERS FOR MEDICARE & MEDIC					FORM): 03/05/2019 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PF	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
	345412	B. WING		_		C 31/2019
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		1	038 COLLEGE STREET			
BRANTWOOD NH & RETIREMENT CENT			OXFORD, NC 27565			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 Continued From page 41 would barely do much at all, recommended a 2-person a transfers as a safety measu CGA for static and dynamic technically an assessment of the evaluation and was the the recommendation for tran- assist or a Hoyer lift. The P balance was evaluated on th the resident may or may not grab bar or something. Whe Resident #3 's balance wou- regular chair or recliner with reported this would be much not need CGA to be safe. A was conducted with the PT AM. During this interview, t would have preferred to eva safety if her needs had char- less assistance for transfers indicated it would have been Registered Nurse (RN) at th the resident and make such An interview was conducted AM with the MDS Nurse in t facility 's Compliance Office interview, the nurse was asl recommendations were com resident 's direct care nursi nurse reported a recommen typically shared in the admin meeting and communicated resident 's ISP and the elec available to the direct care s the PT recommendations m on 6/28/18 were reflected of	Assist or Hoyer lift for Ire. He reported the sitting balance was of what he saw during reason why he made insfers using 2-person PT noted sitting he side of a bed; and, t be holding on to a en asked how uld have been in a in a back and arms, he in different and she did A follow-up interview on 1/30/19 at 11:45 the PT reported he aluate the resident for inged and she required a. However, he also in acceptable for a he facility to assess in a change. d on 1/30/19 at 9:22 the presence of the er. During the ked how PT inmunicated to the ing staff. The MDS indation from PT was instrative morning I to the staff via the reported a change in te a change in the ctronic information staff. When asked if inade for Resident #3	F 689				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/05/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345412	B. WING		C 01/31/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE
		0-11-		1038 COLLEGE STREET	
BRANTW	OOD NH & RETIREMENT	CENT		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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 689	plan, the MDS nurse further inquiry, howev unable to locate this is s care plan. The nurse though PT made a re have been a discussi recommendations we resident ' s care plan should actually do. We assessment was don ADLs (including trans completed, the MDS it was, but she was u would have been doo An interview was com PM with Nurse #2. No who reported she rou During the interview, the resident ' s need transfer. In response resident was usually from her recliner chai Nurse #2 reported that time of day, Resident assistance for a trans would know whether was required for a trans would always tell a nu ISP located on the ins When informed the re indicate whether she assistance with transis she herself could also to ask any questions inquiry as to whether "For me, no." Nurse	stated they were. Upon ver, the MDS nurse was nformation on Resident #3 ' se then reported that even commendation, there may on that the ere not appropriate and the would reflect what staff /hen asked if another e to ensure the resident ' s offers) could be safely nurse indicated she thought nsure where the assessment cumented. ducted on 1/29/19 at 12:15 furse #2 was a hall nurse tinely cared for Resident #3. the nurse was asked about	F 6		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/05/201 ORM APPROVE 3 NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION		DATE SURVEY COMPLETED
		345412	B. WING				C 01/31/2019
NAME OF P	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, Z		EET ADDRESS, CITY, STATE, ZIP CO	DE	
BRANTW	OOD NH & RETIREMEN	I CENT			COLLEGE STREET		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 689	forward or to get up u An interview was com PM with NA #2. NA # assigned to care for F interview, the NA was process she used to her recliner to the bea "It depends." She rep having a good day, s resident herself. If R such a good day, the 2-person assist. Who assistant would know resident, NA #2 repor the off-going NA durin of the resident 's ISF Resident #3 's ISP, I not indicate how man required to transfer th asked about Resident side of the bed, the N not be left sitting on t reported the resident assistant to finish the legs up on the bed af the bed. Upon further Resident #3 would be the bed, NA #2 respon would have to do what then."	#3 could decide to lean unsafely. ducted on 1/29/19 at 12:33 #2 reported she was routinely Resident #3. During the s asked to describe the transfer Resident #3 from d. The NA started by stating, ported if the resident was he could transfer the esident #3 wasn ' t having transfer would require en asked how a new nursing v how to safely transfer the rted she may find out from ng shift report or from review P. Upon review of the NA #2 confirmed the ISP did by staff members were ne resident safely. When it #3 ' s ability to sit on the VA stated Resident #3 could he side of the bed. NA #2 needed the nursing e maneuver and to put her fter she was transferred to er inquiry as to whether or not e safe sitting on the side of onded by saying, "No, you at you ' re going to do right	F	589			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		OMB	ORM APPROVED NO. 0938-0391 DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMPLETED C
345412	B. WING		01/31/2019
NAME OF PROVIDER OR SUPPLIER		S, CITY, STATE, ZIP CODE	
BRANTWOOD NH & RETIREMENT CENT	1038 COLLEGE S OXFORD, NC 2		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 F 689 Continued From page 44 days of the week it may be two people." She reported this was not necessarily dependent on the day, but more dependent on the moment and circumstances of the resident 's dementia at the time. When asked how a new NA or an Agency NA would know whether one or two people were required to safely transfer the resident, the NA stated they would get a report from the off-going NA. However, she also stated the report given at 3:00 PM may not reflect the resident 's needs when the next NA actually needed to transfer her at 5:00 PM. Upon further inquiry, NA #2 reported the ISP (kept in the resident 's closet) should have indicated the resident could transfer by "stand and pivot with assist of 1 person or 2." She noted the second person would have been there for safety and extra man power. During the interview, NA #2 reported if the resident sat on the side of the bed, she would definitely have to be within arms ' reach of the nursing assistant. NA #2 added that she typically would not even do that and would not have left Resident #3 by the side of the bed if she had to do something. She stated, "It was best to go ahead and swing her feet up." An interview was conducted on 1/29/19 at 3:35 PM with NA #3. NA #3 reported she was familiar with Resident #3 and had helped to care for her on multiple occasions. During the interview, the NA reported that she could usually transfer the resident herself but would need a second person if the resident seemed to be weak at the time of the transfer. When asked if the resident could safely sit at the side of the bed, NA #3 stated, "No ma ' amnot at all." When asked to explain her response, the NA stated she would be worried about the resident falling. 	F 689		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345412	B. WING				C /31/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
		0.5.V.T			1038 COLLEGE STREET		
BRANIW	OOD NH & RETIREMENT	CENI			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	A telephone interview at 4:49 PM with Resid (MD), who also server Director. During the i if it was possible the r adverse event (such a caused her to fall on was possible, but it w for sure. At that time, resident 's fall were b and included NA #1 ' hearing Resident #3 r having a large hemate response, the physical situation did not make resident had a CVA (s made this scenario le An interview was com PM with the facility 's Compliance Officer. If Administrator confirm (dated 6/6/18 through Physical Therapist 's which indicated the re- with 2-person assist of s care plan indicated for transfers, with no i members were requir Additionally, there wa another assessment b the staff assistance no resident safely or othe to ensure the resident the side of the bed. L Administrator reported were discussed in the team meeting held ea	was conducted on 1/29/19 dent #3 's Medical Doctor d as the facility 's Medical interview, the MD was asked esident experienced an as a stroke) that may have 12/4/18. The MD stated it ould be impossible to know staff accounts of the riefly discussed with the MD is report of seeing and hit her head and the resident oma on her head. In an reported while this e it impossible that the stroke) prior to the fall, it ss likely. ducted on 1/29/19 at 5:40 Administrator and During the interview, the ed Resident #3 's care plan 12/4/18) did not reflect the 6/28/18 recommendations esident should be transferred or a Hoyer lift. Resident #3 ' she could stand and pivot ndication of how many staff ed to assist her. s no documentation of being completed to reflect eeded to transfer this er safety measures required t was safe when sitting on	F	689	9		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/05/2019 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		345412	B. WING				C 31/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	OOD NH & RETIREMENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	nurse. The Administr should have immedia recommendation into care plan. She report The care plan updates been incorporated into guide direct care staff required to safely med A follow-up interview of at 10:20 AM with the <i>J</i> interview, the Adminis expectation was that is safety needs would be updated as needed. Se expected the resident utilized by the patient that residents ' care r would be met. On 1/30/19 at 1:00 PM Administrator and Con informed of the immed provided an acceptab Immediate Jeopardy of AM. The allegation of Jeopardy F689-Accidents On December 4, 2018 fall post-transfer of on at which point she saf aide discontinued har in order to slide the lir	ator stated the MDS nurse tely put the PT 's the resident 's electronic ted this had not been done. s would have automatically o the resident 's ISP to o n the ADL assistance et the resident 's needs. was conducted on 1/31/19 Administrator. During this strator stated her the resident care needs and e assessed and care plans She also reported she is ' plan of care to be care staff in order to ensure needs and safety needs M, the facility 's mpliance Officer were diate jeopardy. The facility le credible allegation of removal on 1/31/19 at 11:43 f compliance indicated:	F	689	9		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345412	B. WING				C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER		I	;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BRANTW	OOD NH & RETIREMENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Emergency Departmet System status post-fa The staff that left the in while in the room is not facility. 1. Resident 3 was as Department as a result was identified by anal- resident was not prove assistance post-trans- incidents per the reco- therapy via therapy et 6/28/2018 for a 2-per- assist during transfers with the resident durind directly made aware of sitting balance while of this resident. 2. To address the p- the deficiency, an audit plans was initiated and 1/29/2019. The reside available to facility sta- of each resident 's ca- care and activities of conducted on 1/29/20 Staff Development Co- Manager, and Director cross-reference trans- concerns identified, s- each resident 's care information was corre- recommendations fro- Department. The MD2 Nursing corrected all	was immediately sent to the ent of Granville Health and expired on 12/4/2018. resident sitting untouched to longer working with the sent to the Emergency and the above incident. It ysis on 1/29/2019 that the ided necessary balancing fer to prevent accidents and mmendations provided by valuation documentation on son moderate to maximum s. The staff working directly ing the incident was not of the safety concerns with on the side of the bed for articular process leading to dit of 100% of resident care d to be completed on ents ' care plans are aff in order to identify areas are plan needed for daily daily living. The audit was 19 by the Treatment Nurse, pordinator, Clinical Nurse or of Nursing to fer needs and other safety uch as sitting balance on plan to ensure that the ict and consistent with	F	689			

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DEPARTI	FORM	APPROVED 0. 0938-0391						
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE	SURVEY	
AND FLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDI	NG _		COMPLETED		
		345412 B. W				01/31/2019		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
BRANTWO	OOD 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 PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 689	2019, care plan updata accurate needs for tra- concerns, to include r perform the tasks, we care guides were place closet by administrative existing care guides. on 1/30/2019 with all include agency staff v regarding the process residents ' care plan, data, and the proper r necessary information not contain pertinent i 's care. Facility staff a to be educated on this orientation with the fa staffing agency prior t residents within the fa staffing agency prior t residents within the fa 3. Facility MDS num Development Coordin Manager and Director educated on 1/30/201 the expectation that th reflect the resident 's additional key safety to including transfer nee concerns, based on o assessments and dat personnel, such as th documentation. A cop recommendations will "Telephone Order" bo	e and identified safety he number of staff the tasks. On January 30, tes reflecting residents ' ansfer assistance and safety number of staff necessary to are completed and updated ced in each resident 's ve staff replacing the Education will be initiated nurses and nurse aides, to vorking within the facility, a for updates to the the location of the care plan recourse for accessing the n if the care plan data does information for each resident as well as agency staff are s information upon cility and/or the nurse to working directly with acility. se, Treatment Nurse, Staff nator, Clinical Nurse r of Nursing were all 9 by facility Administrator on he resident 's care plan is to actual needs and any measures required, ds and other safety observations, documented a from direct care erapy evaluation by of all therapy I be submitted to the box for review by the clinical	F	589				
	personnel, such as th documentation. A cop recommendations will "Telephone Order" bo and interdisciplinary M	erapy evaluation by of all therapy I be submitted to the bx for review by the clinical						

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/05 FORM APPRO MB NO. 0938-	OVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345412		(X1) PROVIDER/SUPPLIER/CLIA	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/31/2019		
		345412	B. WING					
NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT				STF	REET ADDRESS, CITY, STATE, ZIP COD	E.		
					38 COLLEGE STREET (FORD, NC 27565			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	FIX (EACH CORRECTIVE ACT		N SHOULD BE	COMPLE	(X5) COMPLETION DATE
F 689	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/05/2019 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED			
		345412	B. WING					C / 31/2019
NAME OF P	ROVIDER OR SUPPLIER		1		IREET ADDRESS, CITY, STATE	, ZIP CODE		
BRANTW	OOD NH & RETIREMENT	CENT			38 COLLEGE STREET XFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	x	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B D TO THE APPROPRI/ ICIENCY)		(X5) COMPLETION DATE
F 689			F	589				

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		ID HUMAN SERVICES				FORM	APPROVED	
					E CONSTRUCTION). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE COMF	SURVEY		
			A. BUILDI	ING _				
		245410	B. WING			С		
345412			B. WING	_		01/31/2019		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTWO	OOD NH & RETIREMENT	CENT			1038 COLLEGE STREET			
					OXFORD, NC 27565			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX (EACH DEFICIENCY		Y MUST BE PRECEDED BY FULL	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI			
IAO	REGULATORY OR LSC IDENTIFYING INFORMATION)				DEFICIENCY)			
F 689	Continued From page	51	E .	689				
1 000				009				
		censed nursing staff and staff on where to locate						
		safety measures necessary						
		DL assistance needed to						
		safety, including the number						
		o safely transfer a resident.						
		n-service records revealed						
		sed staff were in-serviced						
	prior to working on the							
		ecommendations along with						
		nd ISP records was also						
	conducted as part of	the validation process.						

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