STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BUILDING _____ B. WING _____	C 02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 202	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(ii) If a client is to be either transferred or discharged, the facility must provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies). This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to provide client #4 and the guardian with the level of assistance necessary to prepare for a successful transfer from the current group home to an alternative placement. The finding is: Interview with the facility nurse on 2/14/22 revealed that client #4 has had declining health over the past few years. The facility nurse revealed that client #4 has had recent falls and seizure activity that has led to an increased number of emergency department (ED) visits. Continued interview with the nurse revealed that client #4 was transported to the hospital on 10/31/21 and sustained a fracture of the 4th and 5th toe on the left foot. Upon evaluation at the hospital, client #4 had low oxygen levels and was placed on oxygen during her hospital stay. Further interview with the nurse revealed that client #4 was in the hospital for a few days and returned to the group home. Interview with the nurse also revealed that client #4 returned to the hospital on 11/3/21 and 11/4/21 due to a seizure and remained in the hospital until she was transferred to a rehabilitation facility on 11/8/21. Subsequent interview with the facility nurse on 2/14/22 revealed that she once attempted to contact the guardian to discuss the client's health status in the rehabilitation facility. The nurse	W 202		

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

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W 202	Continued From page 1	W 202		

revealed that she contacted the rehabilitation facility on 11/29/21 to discuss client #4's care plan and was not able to secure an update. Interview with the facility nurse also revealed that client #4 is in a wheelchair, remains on oxygen and the facility would not be able to accomodate her medical needs based on the current status of the client. The nurse revealed during the interview that she attempted to contact the rehabilitation facility on 12/15/21 to get an update on client #4's health status and to coordinate placement options and a current update was not provided. The nurse could not confirm if client #4 had an osteoporosis diagnosis. Additional interview with the facility nurse revealed that she had not attempted to contact the guardian or rehabilitation facility since 12/15/21 to support the client's transition from the rehabilitation facility to an alternate placement.

Review of internal records on 2/14/22 revealed the following documentation: medication administration records from 10/2021-1/2022, physician's orders dated 12/2021, nurse's notes from 10/2021-12/2021, email correspondence from the qualified intellectual disabilities professional (QIDP), interdisciplinary team (IDT) meeting minutes, incident reports from 9/2021-2/2022, investigative summaries and a facility discharge policy.

Review of nurses' notes from 10/2021-12/2021 revealed the following: a nurse's note dated 10/18/21 revealed client #4 was transported to the ED due to localized swelling in her left hand; a nurse's note dated 10/25/21 revealed that client #4 was transported to the ED due to not being able to stand on her right foot; a nurse's note dated 10/31/21 revealed that client #4 was seen

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W 202	Continued From page 2	W 202		

at the ED for fractures in the right foot. Review of nurse's notes dated 11/3/21 and 11/4/21 revealed client #4 fainted and was transported to the hospital due to a seizure during the night.

Review of the 11/8/21 IDT meeting minutes revealed an internal recommendation for a higher level of care due to client #4's declining health, multiple falls and hospitalizations. Review of the nurse's notes did not reveal documentation to support client #4's transition from the rehabilitation facility to an alternate placement.

Review of QIDP email correspondence dated 9/30/21 and 10/27/21 revealed the MCO was seeking collaboration from the facility in order to secure alternative placement for client #4 as requested by the guardian. Review of the QIDP email correspondence dated 11/4/21 revealed client #4 was transported again to the hospital via EMS due to a seizure during the night. Review of the nurse's note dated 11/8/21 revealed a call to the to discuss a 60-day discharge notification for client #4. Review of a 12/17/21 USPS tracking receipt revealed that the facility sent a discharge notification letter for client #4 to the guardian via mail carrier.

Interview with the QIDP revealed client #4 was sent to the hospital on 10/31/21 due to pain in the left foot. Interview with QIDP also revealed that client #4 sustained a fractured left toe due to a fall on 11/4/21. Continued interview with the QIDP revealed that client #4 remained in the hospital and was later transferred to a rehabilitation facility. The QIDP also revealed during the interview that client #4 remained in the rehabilitation facility and would be formally discharged from the group home on 2/24/22.

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W 202	Continued From page 3 Further interview with the QIDP revealed that she did not communicate with the guardian or the rehabilitation facility to support client #4's transition from the rehabilitation facility to an alternate placement. Subsequent interview with the QIDP revealed that a team meeting was held on 11/8/21 to discuss client #4's medical needs and a 60-day discharge notification letter was sent to the guardian via mail on 12/17/21. Additional interview with the QIDP revealed that the MCO is involved and was assisting the guardian in securing an appropriate placement for client #4 once she is discharged from the rehabilitation facility. The QIDP revealed during the interview that the facility has not been seeking an alternative placement for client #4. The QIDP also revealed that the last contact with the MCO was on 12/15/21 to discuss client #4's medical needs. Further interview with the QIDP revealed that the facility had not been working with the MCO, guardian or rehabilitation facility to secure an alternative placement or support transition planning for client #4 once she is discharged from the rehabilitation facility.	W 202		