STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345318	A. BUILDING _____ B. WING _____	C 04/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	**1478 RIVER ROAD WINNABOW, NC 28479**

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to develop a care plan to identify contractures and initiate interventions to assure the contractures did not worsen for 1 of 2 sampled residents (Resident # 156) who was reviewed with contractures. Findings included: Resident #156 was admitted on 7/8/13 with diagnoses that included generalized muscle weakness and late effects of a stroke on his dominant side.	F 279	The resident care plan for the affected resident was updated before the surveyors left the building. In addition a screening was done by therapy to ensure adequacy of intervention that was in place on the TAR but was not reflected on the care plan. The affected resident did have a care plan and was being monitored as evident by the intervention that was put in place on the TAR. The care plan nurse forgot to update the plan of care but the	5/28/15

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

Electronically Signed | 05/18/2015

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.

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F 279	Continued From page 1 Review of the Quarterly Minimum Data Set (MDS) dated 3/2/15 indicated Resident # 156 was cognitively intact with no behaviors. The resident required extensive/total assist with activities of daily living. He was coded as having a functional limitation in range of motion unilaterally in his upper and lower extremities. The resident was coded as having received no therapy and was not identified as part of a restorative program. Physician progress notes, dated 3/18/15 indicated Resident # 156 had a cerebrovascular accident (stroke) with neuropathy and associated left hemiplegia with partial contracture of the left hand and immobility of the left upper extremity. The April 2015 physician's orders indicated the resident was to have a rolled washcloth in his left hand at all times and a heel protector on his left heel while in bed. The orders also indicated there should be a foot board on the bed. Review of the April 2015 Treatment sheet indicated an entry for the rolled washcloth in the left hand at all times and a footboard on the bed. The rolled washcloth had been initialed as in place for each shift. The footboard was listed as a FYI (for your information). Review of the care plan for Resident #156 revealed the left hand contracture with interventions to prevent further decline had not been identified. On 4/28/15 at 12:29 PM, an observation was made. Resident #156's feet were not placed against a footboard. There was no rolled washcloth seen in his left hand.	F 279	intervention was on the TAR for the nurses to ensure that the care was being provided. In-servicing will be done with all nurses, admin nurses, and therapy to ensure proper reporting of any new orders or order changes that would require a change in the plan of care to ensure changes are made promptly. This will be completed by 5/22/2015. A review of all resident care plans, MAR's, and TAR's to ensure continuity of care as well as efficacy of the plan of care will be done by DON and designated nursing staff. Any errors or omissions will be corrected at that time and be recorded to present to the QA team at the next quarterly meeting (June). Audits will be completed by 5/28/2015. The MDS staff will be responsible for reviewing ongoing to ensure that interventions and updates that occur between care plan meetings are being done. They will bring any issues that they find to the DON and that information will be reported at weekly IDT meetings and reviewed at the monthly QA for three months of consecutive 100% compliance. The reviews will be completed by 5/28/2015.	

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F 279	Continued From page 2	F 279		

An observation was made on 4/29/15 at 12:35 PM. There was no washcloth in the resident's right hand. The resident stated it had not been put in today. Resident #156 added at times, staff had tried to put the washcloth in and it would slip out.

An interview was held with Nursing Assistant (NA) #2 on 4/29/15 at 2:58 PM. NA #2 stated Resident #156's left hand would not completely open and he could not move his left leg. NA #2 stated she had not been instructed to place a washcloth in the resident's hand. She added she was unaware he was to have a footboard at all times.

An interview was held with Nurse #1 on 4/29/15 at 3:17 PM. She stated information about a resident's special needs, such as the use of hand rolls or foot boards were relayed to the NAs verbally or the NAs could read the care plan.

Nurse #2 was interviewed on 4/30/15 at 8:40 AM. Nurse #2 stated unless a NA removed a handroll that had been placed previously by another NA, there was no way to know a specific resident required the use of a handroll. Nurse #2 stated she was unaware Resident #156 required a washcloth in his hands at all times.

On 4/30/15 at 9:08 AM, NA #1 was interviewed. NA #1 stated she had not been instructed to place a washcloth in Resident #156's hand.

The MDS nurse was interviewed on 4/30/15 at 11:30 AM. She stated Resident #156's contracture and the ordered use of the washcloth in his hand at all times should have been care

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F 279	Continued From page 3 planned. The nurse stated without the use of the washcloth as ordered, the contracture had the potential to worsen. She stated it was her mistake the resident's contracture and the physician's order had not been care planned.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to remove the facial hair for 1 of 1 sampled resident (Resident # 139) reviewed for personal hygiene. Findings included: Resident # 139 was readmitted on 6/30/14 with diagnoses that included pneumonia and dementia. The 3/10/15 Quarterly Minimum Data Set (MDS) indicated Resident # 139 had short and long term memory impairment with severely impaired cognitive skills for daily decision making. The MDS also revealed Resident # 139 required total assistance of staff for personal hygiene. The resident was not identified as rejecting care. On 4/28/15, during the initial resident observation,	F 312	The facial hair was removed from the affected resident's face before the survey team left the building. The DON and designated staff made walking rounds to ensure that there were no other residents that needed to be shaved. None were noted at that time. The DON and staff she designates will be responsible for reviewing shower sheets to ensure that shaving is being documented as well as following that up with walking rounds to ensure that the documented care has occurred as indicated by initialing the shower sheets. Reiteration of shaving policy as well as other ADL care requirements will done at next mandatory in-service. This should occur before 5/22/2015.	5/22/15

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F 312	Continued From page 4 Resident # 139 was observed with white chin hair that was approximately 1/4 inch to 1/2 inch long. Review of nurse's notes for 4/28/15 did not reveal the resident had rejected care. An observation was made on 4/29/15 at 10:16 AM. White chin hair was still present. The resident was sitting in a wheelchair in her room and dressed. An observation was made on 4/29/15 at 12:35 PM. The resident was being wheeled in the hall by Nursing Assistant (NA) #1 Facial hair was present on Resident #139's chin. Review of nurse's notes for 4/29/15 did not reveal the resident had rejected care. An interview was held with NA#1 on 4/29/15 at 1:28 PM. NA #1 stated Resident # 139 was dependent on staff for bathing, dressing and hygiene. She added she had been taught that female residents should be shaved when facial hair was present. NA #1 observed Resident # 139 at 1:40 PM and stated without her glasses she could not see the chin hair, but she was able to feel the chin hair. The NA stated she had worked with the resident the prior day as well and had not shaved the resident. There was no reason given for not shaving Resident # 139. The Assistant Director of Nursing (ADON), observed Resident # 139 on 4/29/15 at 1:42 PM. She stated the resident needed to be shaved. The ADON stated the expectation was for staff to shave all residents as needed. NA #2 was interviewed on 4/29/15 at 2:55 PM.	F 312	Any noted differences in the documentation vs. observations will be corrected immediately and results will be reported and discussed at the weekly IDT meeting and followed up at monthly QA meeting beginning in June. This will occur until there are three consecutive months of 100% compliance in this area. All corrective actions for this tag will be completed by 5/22/2015.	

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F 312	Continued From page 5 She stated she had been taught to shave female residents when facial hair was noticed. She stated she worked with Resident # 139 on the 3-11 shift, but had not noticed her facial hair. Nurse #2 was interviewed on 4/30/15 at 8:42 AM. She stated residents were to be shaven on shower days and as needed. Nurse #2 added she had not noticed Resident # 139's facial hair. An interview with the Director of Nursing (DON) was held on 4/30/15 at 1:17 PM. The DON stated the expectation was for residents to be shaven as needed.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to consistently use physician ordered interventions for treatment of contractures in 1 of 2 sampled residents (Resident #156) reviewed for contractures. Findings included: Resident #156 was admitted on 7/8/13 with	F 318	The resident that was affected had the washcloth put in his hand immediately. In addition, based on a comprehensive review of this patient, therapy was asked to evaluate the effectiveness of current interventions. As documented by therapy in the therapy notes subsequent to the 3/18/2015 note, therapy still believes this is not a partial contracture but is in fact a flexion problem. It was determined that	5/28/15

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F 318	Continued From page 6 diagnoses that included generalized muscle weakness and late effects of a stroke. Review of the Quarterly Minimum Data Set (MDS), dated 3/2/15, indicated Resident #156 was cognitively intact with no behaviors. The resident required extensive/total assistance with activities of daily living. He was coded as having a functional limitation in range of motion unilaterally involving both the lower and upper extremity. The resident received no therapy and was not identified as part of a restorative program. Review of the care plan, with a review date of March 2015 revealed the left hand contracture and the limitation in lower extremity range of motion with interventions to prevent further decline were not addressed. Physician progress notes, dated 3/18/15 indicated Resident #156 had a stroke with neuropathy and associated left hemiplegia with partial contracture of the left hand and immobility of the left upper extremity. The April 2015 physician's orders indicated Resident #156 was to have a rolled wash cloth in his left hand at all times and a heel protector on his left heel while in bed. The orders also indicated there should be a foot board on the bed. On 4/28/15 at 12:29 PM, an observation was made. Resident #156 was observed in bed with bilateral foot drop. His feet were not observed to be placed next to a foot board to prevent further foot drop. The resident was observed to be unable to extend his left hand fully. There was no rolled wash cloth observed present in the resident's left hand.	F 318	the that washcloth was to be in place to keep his hand dry. Since the resident was unable to keep washcloth in his hand, a splint was ordered and the order for the washcloth was D/C. This occurred before the survey team left the facility. In-services will be conducted for the nurses, admin nurses, and therapy to ensure that they are aware of the types of interventions and orders that may be used to treat contractures and the proper protocol to follow if the interventions were not appropriate for the resident as well as documentation requirements. The in-services will be conducted by 5/22/2015. In addition to staff education, administrative nurses will be assigned certain halls and will review all diagnosed contractures in the building and review efficacy of interventions as well as visually inspect that they are properly in place. Documentation that interventions are being used will be reviewed weekly for two months and visual inspections will occur randomly to ensure compliance. This will be completed by 5/22/2015. All residents will have a contracture risk assessment (see attached) completed and any resident that triggers at high risk will be assessed for appropriate interventions. This will be completed by 5/28/2015. Any discrepancies or issues will be reported to the DON and discussed at the	

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F 318	Continued From page 7 An observation of Resident #156 was made on 4/29/15 at 12:35 PM. There was no washcloth in the resident's left hand. Hs feet were not resting next to a foot board. The resident stated staff had not put a rolled wash cloth in his hand that day. Resident #156 added, at other times, staff had tried to put the wash cloth in his hand and it would slip out. Nursing Assistant (NA) #1 was interviewed on 4/29/15 at 1:34 PM. The NA stated Resident #156 was unable to move his left upper and lower extremities. She added the resident could not extend his left hand. She stated she had not been instructed to do anything special for his left hand or his feet. NA #1 stated Resident #156 was alert and oriented and knew what was going on. An interview was held with NA #2 on 4/29/15 at 2:58 PM. NA #2 stated she had worked with Resident #156 since his admission on the 3-11 shift. She added the resident was alert, oriented and reliable in answering questions. The NA stated Resident #156 could not move the extremities on the left side. She added the resident's left hand would not open all the way and the resident complained of pain in his left hand and left leg. The NA stated Resident #156's left foot did not bend in a normal manner. NA #1 stated when a resident needed a hand roll or a splint, the nurses informed the NAs. An observation was made with NA #2 on 4/29/15 at 3:05 PM. Resident #156's left hand did not fully extend. There was not a rolled wash cloth observed in his left hand. The resident's right foot was hanging off the right side of the bed and his left foot was against the footboard of the bed.	F 318	weekly IDT meetings and followed up on at the next monthly QA meeting (June). We will continue until we have three months of 100% compliance with this monitoring.	

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F 318	Continued From page 8 The NA found a soft, foam square pillow in the resident's room stated she used the pillow under the resident's heels. The NA stated she was unaware the resident was supposed to have a rolled wash cloth in his hand at all times. She stated she was unaware he was to have a footboard at all times. NA # 2 stated she had not seen a footboard on the bed to keep the resident's feet in a more upright position. At 2:50 PM on 4/29/15, Nurse #1 was observed coming out of Resident #156's room. Nurse # 1 was interviewed at 3:17 PM. She stated instructions related to resident care was relayed verbally to the NAs or they could read the care plan. Nurse #1 added information related to hand rolls, splints and method of transfer was included on the care plan. Nurse #1 identified Resident #156 as a resident that required a rolled wash cloth in his contracted hand. The nurse added the order for a rolled wash cloth for Resident # 156 was added to the treatment sheet. The nurse stated she had just been in the resident's room. Review of the treatment sheet at this time revealed Nurse #1 had signed the treatment sheet verifying the rolled wash cloth was present in Resident #156's left hand. The nurse acknowledged she signed the treatment sheet verifying the presence of the rolled washcloth without making sure the wash cloth was actually present in the resident's hand. The Assistant Director of Nursing (ADON) was interviewed on 4/29/15 at 3:29 PM. The ADON stated staff had not reported the wash cloth fell out of the resident's hand when placed. The ADON reviewed the treatment sheets and stated Nurse #1 should not have signed Resident #156's rolled wash cloth was in his hand prior to	F 318		

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F 318	Continued From page 9	F 318		

verification. The ADON stated she was unaware the ordered footboard was not on Resident #156's bed.

Nurse #2 was interviewed on 4/30/15 at 8:40 AM. Nurse #2 cared for Resident #156 on the 7:00 AM to 7:00 PM shift. The nurse stated unless the NA removed the wash cloth during care and saw the wash cloth in the resident's hand, there was really not a way to communicate which residents needed hand splints or rolled wash cloths in their hands. The nurse stated she was aware the resident was to have a washcloth in his hand at all times, but had been unaware the rolled washcloth had not been in the resident's hand during the last shift she worked with the resident. Nurse #2 stated she could not remember if she had verified the presence of the rolled wash cloth in the resident's hand on 4/28/15 when she last worked.

NA #1 was interviewed on 4/30/15 at 9:08 AM. NA #1 had worked with Resident #156 during the 7 to 3 shift on Tuesday, Wednesday and Thursday. The NA stated Tuesday was her first day working with Resident #156. She stated she had not used a rolled wash cloth in his hand on any of those days. She added no one had instructed her that Resident # 156 required a rolled wash cloth in his hand or a foot board on his bed.

The MDS nurse was interviewed on 4/30/15 at 11:30 AM. She stated Resident #156's contractures and the ordered use of the washcloth in his hand at all times and the footboard should have been care planned. The nurse stated without the use of the wash cloth and footboard as ordered, the contractures had

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F 318	Continued From page 10 the potential to worsen. She stated it was her mistake the resident's contractures and the physician's orders had not been care planned. An interview was held with the Director of Nursing (DON) on 4/30/15 at 1:24 PM. The DON stated nurses were responsible to make sure the washcloth and foot board for Resident #156 were used as the physician ordered. The DON added without the use of the rolled wash cloth in the resident's hand and the use of the footboard, the resident's skin integrity could be compromised and the contractures had the potential to worsen. The DON added she expected for staff nurses to verify the use of the footboard and the rolled wash cloth prior to signing the treatment sheets.	F 318		