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 _____	01/10/2019

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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E 000	Initial Comments An unannounced Recertification survey was conducted on 1/6/19 through 1/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# U55M11.	E 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to assess a resident for the ability to self-administer medications and failed to place the medication in a secure area for 1 of 1 residents self-administering medications (Resident #45). The findings included: Resident #45 was admitted to the facility on 8/12/16 and had a diagnosis of chronic obstructive pulmonary disease (COPD), and asthma. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 10/17/18 revealed the resident was cognitively intact, required limited assistance with activities of daily living and had no impairment of the upper extremities. Review of the resident ' s Care Plan initiated on 3/5/18 and last reviewed on 10/24/18 noted the resident may keep Proair inhaler at the bedside	F 554	To correct this specific deficiency for Resident #45, the interdisciplinary team completed an assessment with the Resident at the bedside. The team determined that this Resident was safe to administer the medication herself. A secure box has been provided for this resident to store her medication safely. To implement a revised policy and procedure, the interdisciplinary team will assess the Resident for fitness to self administer medications, provide safe storage for the medication, ensure the plan of care includes the medication self administration. The facility will provide an adequate secure location within the room to safely store medications. An order will be added to the MAR to check for compliance with safe storage and safe administration for each shift for 2 weeks. The interdisciplinary team will evaluate the	1/11/19

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

Electronically Signed | 01/25/2019

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F 554	Continued From page 1 and to monitor use of the medication to confirm the physician ' s orders were being followed and to evaluate quarterly to ensure she was capable of using inhalers correctly and at the appropriate time. Review of the physician ' s orders revealed an order that read: Proair 2 puffs by mouth 4 times a day. May keep at bedside. Shake well. Review of the clinical record revealed no assessment by the interdisciplinary team to determine if the resident was safe to self-administer the Proair inhaler. On 1/6/18 at 4:19 PM, Resident #45 was observed sitting on the side of her bed. A Proair inhaler was observed lying on the over bed table in front of the resident. The Resident stated she had COPD and kept the inhaler in her room. On 1/7/18 at 8:30 AM, Resident #45 was observed lying in bed. The Proair inhaler was observed lying on the over bed table beside the bed. On 1/9/19 at 11:43 AM the Director of Nursing (DON) stated in an interview they did not do assessments for self-administration of medications and that if the doctor wrote the order for the resident to self-administer medications, that was what they go by. On 1/9/19 at 2:13 PM an interview was conducted with the administrator who stated Resident #45 was the only resident in the facility that self-administered medications and the resident usually had the inhaler on her person as she was outside smoking a lot during the day. The	F 554	Resident at care plan meetings or if there is a status change that would make self administration unsafe. Currently this is the only Resident who meets this criteria. The plan of correction will be implemented by members of the interdisciplinary team; Social worker will conduct the assessment of the Resident, MDS will create plan of care, DON/ADON will monitor the Resident for demonstration of self administration and Resident education as needed. Any resident who has an order will be added to the MAR to check for compliance with safe storage and safe administration for each shift for 2 weeks. The interdisciplinary team will review the MAR weekly or more often as needed for the 2 week period. The results will be added to the plan of care. The facility policy has been updated to reflect the changes. This will be reviewed at the following QA meeting as it would only be a 2 week duration.	

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F 554	Continued From page 2 Administrator stated an assessment would be done and the resident given a locked box to store the medication.	F 554		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews, the facility failed to involve residents in their care plan and making decisions about their	F 657	Resident # 72 and #87 have been advised in verbally and in writing that they have regular care plan meetings and they	1/11/19

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F 657	Continued From page 3 care for 2 of 2 residents reviewed for care plan participation. (Resident #72 and Resident #87). The findings included: 1. Resident #72 was originally admitted to the facility on 7/27/17 and was readmitted on 10/29/18, with diagnoses including Osteomyelitis of the left shoulder, right ankle and foot, History of Diabetes, and Chronic Obstructive Pulmonary Disease. According to the most recent Annual Minimum Data Set (MDS) dated 10/14/18, Resident #72's cognition was intact. He required limited to extensive assistance in most areas of activities of daily living. Review of the Care Plan attendance form dated 10/18/18 and 10/31/18 revealed there was no signature for Resident #72 for Care Plan attendance. During an interview on 1/06/19 at 3:35 PM, Resident #72 stated he did not recall being invited to a care plan meeting to discuss goals or concerns. During an interview on 1/9/19 at 1:50 PM, the facility Social Worker stated he personally told residents when Care Plan meetings were held and he called family members to let them know but he did not document anything in the medical record. He revealed he used a calendar to note the dates and times of Care Plan meetings. He revealed he also gave family members the option of scheduling a different time for Care Plan meetings, whatever time was convenient for them to attend. The Social Worker stated Resident #72 did not have any family members. He stated he had not invited Resident #72 to his care plan	F 657	are encouraged to attend and participate. The responsible party/ family members have been notified via telephone and US mail. MDS will notify the interdisciplinary team of upcoming care plan meeting requirements. The Social Worker will then draft a notice in writing as well as verbally reaching out to the Resident and the RP/ Family. If either decline to attend the Social Worker will document their decision. Each care plan meeting will contain documentation of the attendees and brief notes regarding the content of the meeting including a copy of the written notification. These notes and documentation will be reviewed weekly at the interdisciplinary team meeting ongoing as a standard. The interdisciplinary team will review each months care plan meeting documentation at the monthly QA meeting for 3 months to ensure the required information is complete. The Social Worker will maintain and store these records for review.	

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F 657	Continued From page 4	F 657		

meetings or involved the resident in developing his plan of care.

During an interview on 1/9/19 at 4:27 PM, the Administrator stated going forward they planned to start having the Social Worker mail or email invitations to Care Plan meetings as a way of tracking them.

2. Resident #87 was originally admitted to the facility on 4/18/08 with diagnoses including Cerebrovascular Accident, Hypertension and Seizure Disorder. According to the most recent Quarterly Minimum Data Set (MDS) dated 11/21/18, Resident #87's cognition was intact. He required limited assistance to supervision in most areas of activities of daily living.

Review of Resident #87's Care Plan meeting attendance form dated 3/15/18, 5/30/18, 8/30/18 and 11/27/18 revealed there was no signature from Resident#87 attending his Care Plan meetings.

During an interview on 1/6/19 at 3:00 PM, Resident #87 revealed he had never been invited to attend his Care Plan meeting.

During an interview on 1/9/19 at 1:50 PM, the facility Social Worker stated he personally told residents when Care Plan meetings were held and he called family members to let them know but he did not document anything in the medical record. He revealed he used a calendar to note the dates and times of Care Plan meetings. He revealed he also gave family members the option of scheduling a different time for Care Plan meetings, whatever time was convenient for them to attend. The Social Worker stated Resident

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F 657	Continued From page 5 #87's family member worked out of town. He stated he had not invited Resident #87 to his care plan meetings or involved the resident in developing his plan of care. During an interview on 1/9/19 at 4:27 PM, the Administrator stated going forward they planned to start having the Social Worker mail or email invitations to Care Plan meeting as a way of tracking them.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to monitor a resident ' s room by failing to identify an extension cord as a possible hazard for 1 of 1 residents observed to have an extension cord in the room (Resident #42). The findings included: Resident #42 was admitted to the facility on 5/8/17 and had a diagnosis of lower extremity paralysis and seizure disorder. The Significant Change Minimum Data Set Assessment dated 10/17/18 revealed the resident had moderate cognitive impairment and was	F 689	The Maintenance Director removed the extension cord from Resident #42's bed as soon as he was made aware (1/9/19). The Resident and her family were made aware immediately that there could not be extension cords in the facility, nor could they be attached to the bed in a any way. An audit was completed of the entire facility for and other extension cords or other similar safety hazards. None were found. The staff nurse will inspect Resident #42's room daily for 2 weeks to monitor for any other similar safety concerns.	1/31/19

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F 689	Continued From page 6 totally dependent on staff for bed mobility and transfers and was not ambulatory. The MDS revealed the resident had impaired range of motion of both upper and lower extremities. On 1/7/19 at 1:17 PM, Resident #42 was observed lying in bed in her room. The right side of the bed was against the wall. On the left side of the bed a portable circulating fan was observed to be sitting on the nightstand beside the bed and was blowing cool air towards the resident ' s bed. The fan was plugged into a brown extension cord which was plugged into an outlet on the wall on the right side of the bed. The end of the extension cord was draped over the lower section of the one quarter bed rail on the left side of the bed. On 1/8/19 at 3:29 PM the resident was observed lying in bed. The fan was observed to be plugged into a brown extension cord as described above. On 1/9/19 at 8:25 AM, an observation was made of the resident ' s room with Maintenance Man #1. The Maintenance Man saw the extension cord and stated: "Oh no. I did not know this was in here." The Maintenance Man reached under the bed and unplugged the extension cord and stated the cord was not grounded and should not be in the room. On 1/9/18 at 8:28 AM Maintenance Man #2 stated in an interview he had told the resident ' s family they could not use an extension cord but they continued to bring things in as the resident has several devices to plug in such as a cell phone. Maintenance man #2 stated they have to use a health care grounded extension cord and they did not have any in the facility and would have to order them.	F 689	At admission, the facility will advise the new Residents and their RP/ family members of safety issues such as non-use of extension cords. The current Residents of the facility have been informed while the Maintenance Director was auditing the entire facility. This safety information will be posted at the main entrance and secondary entrance for visitors to observe. The Maintenance Director and Assistant will continue to audit the facility weekly to ensure there are no other similar safety concerns. The Staff Development Coordinator will educate all staff regarding similar safety risks. The weekly audits will be presented at the Monthly QA meeting for 3 months to ensure compliance.	

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F 689	Continued From page 7 On 1/9/19 at 2:10 PM the Administrator stated in an interview the resident ' s family brought things to the facility excessively and it was her expectation to not have extension cords in the room and the cord had been removed from the room.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		1/12/19

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F 732	Continued From page 8 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the daily nurse staffing forms, observations and staff interviews the facility failed to accurately report the number of licensed staff scheduled to provide resident care for 73 of 73 daily nurse staffing forms reviewed. The findings included: The daily nurse staffing form was observed posted upon entrance to the facility on 1/6/19 at 02:34 PM and noted 2 RNs (Registered Nurse) were working from 7AM to 7PM. However, review of the actual nursing schedule revealed only 1 licensed nursing staff were scheduled on 01/06/19 to provide resident care and the other RN was a nursing supervisor. Daily nurse staffing forms and nursing schedules from August 1 through August 31, 2018, December 1 through December 31, 2018 and January 1 through January 11th, 2019 were reviewed. The review of the nursing staffing forms and nursing schedules revealed the total number of licensed staff documented on the staffing forms exceeded the number of licensed staff that were scheduled to provide resident care for each day reviewed. During an interview on 1/10/19 at 9:26 AM the Director of Nursing revealed the Assistant	F 732	At the time this deficiency was brought to the Administrative Team's attention, the posting was removed and corrected. (1/8/19) The DON, ADON, Staff Development Coordinator, Weekend Supervisor and MDS team have reviewed the regulation and now have a clear understanding of the posting requirements. A copy of the regulation will be posted adjacent to the daily posting. (1/10/19) The DON, ADON and/ or Administrator will review the staffing posting daily to ensure accuracy for 2 weeks then weekly thereafter. The Weekend Manager on duty will have this responsibility on weekends. The results will be discussed at the monthly QA meeting for 2 months.	

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F 732	Continued From page 9 Director of Nursing (ADON), MDS (minimum data set) Nurse and SDC (Staff Development Coordinator) Nurse were included in the staff posting as they assisted with care as needed when they were in the building. During an interview on 1/10/19 at 10:32 AM the ADON who completed the daily staff posting indicated all Administration nurses, who were not assigned to patient care were expected to answer call lights, so she included them on the daily staffing sheet.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		1/18/19

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F 761	Continued From page 10 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the temperature for 1 of 3 medication refrigerators reviewed (station 2 medication refrigerator). Findings included: On 1/7/19 at 9:49 AM the Station 2 medication room refrigerator was reviewed with Nurse #1. The temperature was observed to be 32 degrees Fahrenheit (F). The refrigerator temperature log was observed with daily notations of temperatures ranging from 38-40 F. Instructions at the bottom of the daily temperature log indicated "Please note- if the temperature is colder than 36 or warmer than 46 all contents must be removed and relocated immediately then fill out a maintenance request to repair." The contents of the refrigerator included: #69- individual doses of influenza vaccine, package instructions indicate to store between 36-46 degrees F, do not freeze. #1- vial of pneumonia vaccine 23, package instructions indicate to refrigerate between 36-46 degrees F. #19- acetaminophen suppositories 650 milligrams (mg), package instructions indicate to refrigerate. #4- tuberculin 5 milliliter (ml) vials, package instructions indicate to store between 35-46 degrees F. #8- lorazepam 2 mg/1ml vials, package instructions indicate to refrigerate. #3- hepatitis B vaccines, package instructions indicate to refrigerate between 36-46 degrees F,	F 761	The medication refrigerator inside the medication room was emptied of all contents and replaced (1/9/2019). The medications were discarded. The night shift nursing staff has been re-educated regarding proper refrigerator temperature ranges as well as the procedure to discard all contents if the temperature is out of range. They will also inform the Maintenance Director of the need for repair or replacement. The DON or a designee will be responsible for observing the temperatures and documentation daily. The Maintenance Director will observe each weekly. A consultant from the pharmacy will check monthly. Results will be included in the QA process monthly for 3 months or until resolved.	

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F 761	Continued From page 11	F 761		

do not freeze.
#1- insulin lispro pen, package instructions indicate to refrigerate between 36-46 degrees F, do not freeze.
#2- insulin lispro 10 ml vials, package instructions indicate to refrigerate between 36-46 degrees F, do not freeze.
#2- insulin detemir pens, package instructions indicate to refrigerate between 36-46 degrees F, do not freeze.

An interview with Nurse #1 was conducted on 1/7/19 at 10:00 AM. She stated the night shift nurse checked and recorded the temperatures for the refrigerators. She also stated when any concerns were discovered, maintenance would be notified.

An interview with the Director of Nursing (DON) was conducted on 1/7/19 at 3:17 PM. The DON stated she would expect nursing staff to notify maintenance if any concerns were observed with the refrigerator temperatures.