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 05/25/2023

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/22/2023 to 05/25/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #U2BV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/22/2023 through 05/25/2023. Event ID#U2BV11. The following intakes were investigated NC00190943, NC00193216, NC00196237, NC00198074, NC00198325, NC00198949, NC00201776, NC00202585, and NC00202579. 1 of the 18 complaint allegations resulted in deficiency.	F 000		
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	F 657		6/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/28/2023

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F 657	Continued From page 1 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 review, staff and Responsible Party (RP) interviews, the facility failed to invite the RP to the care plan meeting for 1 of 1 resident (Resident #81) reviewed for care plans. Findings included: Resident #81 was admitted to the facility on 1/26/23 with diagnoses which included Alzheimer's dementia and Diabetes Mellitus. Review of Resident #81's 2/2/23 admission Minimum Data Set assessment revealed resident had severe cognitive impairment and required extensive assistance or total dependence for most activities of daily living. An interview on 5/22/23 at 2:20 PM with Resident #81's RP revealed she had not been invited to a care plan meeting. An interview on 5/23/23 at 3:02 PM with the Social Worker (SW) revealed he was responsible for inviting the RP to the care plan meetings. He stated he did not keep records or documentation about inviting an RP to a care plan meeting. The SW stated that the RP should have been invited	F 657	The facility admitted a new Resident and did not properly advise the responsible party regarding a care plan meeting. This Resident at that time was his own responsible party. We did an audit to ensure that other new admissions would have a safe and orderly intake to make sure they were aware of the admission. The Facility has the ability to ensure we have the ability to conduct virtual/ in person meetings for a safe and orderly admission as well as any other needs will be met in a timely manner per the plan of care. The IDT has been educated regarding the timeliness and notifications of Residents and Responsible Party regarding care plan meetings in writing (which could include but not limited to email, US postal mail or a simple notice handed to them at the time the appointment is made) The corresponding meeting will conclude with scheduling the next meeting per the Resident and RP's preference. They will be informed that they may change this	

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F 657	Continued From page 2 to the care plan meeting and that Resident #81 had a care plan meeting on 3/07/23. An interview on 5/24/23 at 9:37 AM with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Administrator revealed Resident #81's RP should have been invited to the care plan meeting.	F 657	appointment time if necessary. Per the audit, the Facility staff will continue to ensure that all contact information remains up to date as possible for informational purposes. This encompasses all encounters, not limited to telephone calls, emails or any other forms of communication. The Facility will continue to audit and report this information and its results to the QAPI committee for at least the next 3 months.	
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, record review and staff interview, the facility failed to complete a smoking assessment for 1 of 1 resident (Resident #51) reviewed for smoking. Findings included: Review of the undated Smoking Policy read in part that the smoking evaluation will be performed upon admission and residents will be reevaluated on at least a quarterly basis.	F 689	The Resident affected by this has been evaluated. It was determined she was safe to smoke cigarettes without supervision. This Resident was admitted to our facility from home as was not evaluated as should have been. Every admission will be evaluated using an assessment tool at the time of admission regarding the smoking, vaping or any tobacco use of every Resident. In	6/1/23

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F 689	Continued From page 3 Resident #51 was admitted to the facility on 2/22/23 with diagnoses which included hypothyroidism and arthritis. The admission Minimum Data Set dated 2/28/23 indicated Resident #51 had moderately impaired cognition. She was coded as independent or supervision for activities of daily living. She was coded to be a current tobacco smoker. A smoking observation on 5/22/23 at 2:16 PM and 5/23/23 at 10:20 AM revealed resident out smoking with no concerns noted. Review of Resident #51's electronic health record and paper chart did not reveal a completed smoking assessment. An interview on 5/22/23 at 2:50 PM with Resident #51 revealed she was a smoker. She stated she kept her own cigarettes and lighter and was able to go smoke whenever she wanted. An interview on 5/23/23 at 2:59 PM with the Social Worker (SW) revealed he was responsible for completing the residents' smoking assessments and maintaining the resident list of smokers. He stated he did not have Resident #51 listed as a smoker and had not completed a smoking assessment for her. He stated he determined who was a smoker by observation of the smoking area and did not ask the residents on admission if they smoked. An interview on 5/24/23 at 9:37 AM with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Administrator revealed Resident #51 was on the resident list of smokers	F 689	addition the same will be evaluated by the interdisciplinary team annually, quarterly and as needed to ensure the resident is safe within the Facility. The IDT has been educated with the smoking assessment tool and are aware each Resident should be assessed at the time of admission, at care plan meetings and as needed if they smoke and if so to determine physical and cognitive safety. The IDT will bring this information to the QAPI meeting and present to the Medical Director for review for the next 90 days and continue to do so ongoing if irregularities are found.	

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F 689	Continued From page 4 and should have had a completed smoking assessment by the SW. They stated that the SW must have overlooked completing Resident #51's smoking assessment.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to date foods stored for use in one of one kitchen walk-in refrigerator. Findings included: A tour was conducted on 5/22/23 at 10:10 AM, with the Dietary Manager of the kitchen walk-in refrigerator. Observations were made of 4 prepared side salads with no date, 8 wrapped	F 812	Although this citation did not affect any Resident, the facility does understand how it could affect many. All Cooks now each have the responsibility of storing food properly. The Corporate RD is now charged with making sure all dietary staff is properly trained regarding food safety and storage per regulations and Facility policy.	6/1/23

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F 812	Continued From page 5 sandwiches with no date, 2 blocks of cheese with no date, and an opened bag of sliced turkey with no date. During an interview on 5/22/23 at 10:15 AM, the Dietary Manager revealed that it was everyone in the kitchen's responsibility to ensure foods stored in the walk-in refrigerator were labeled and dated. She revealed she rounded frequently to ensure things were labeled in the walk-in refrigerator. During an interview on 5/25/23 at 8:30 AM, the Registered Dietitian indicated food and nutrition staff received frequent in-servicing on labeling and dating foods stored in the walk-in refrigerator. During an interview on 5/25/23 at 11:15 AM, the Administrator revealed she monitors the kitchen walk-in refrigerator occasionally. She revealed it was the responsibility of food and nutrition staff to ensure foods stored in the walk-in refrigerator were dated.	F 812	The cooks will ensure all food is stored properly and labeled, maintaining logs before leaving the shift. All Dietary staff has been educated by Facility policies as well as materials obtained from FDA.gov regarding food safety, storage and possible illness that could result. (https://www.fda.gov/consumers/consumer-updates/are-you-storing-food-safely). All newly hired dietary staff will receive this same education in their orientation information. To correct this issue, the facility has put in place an audit tool for each cook each meal an audit before leaving the shift to inspect the contents of the food storage areas of the dietary department for any improperly stored food items. The cook (or designee) will initial the log after inspection of said area to ensure all items are properly stored per protocol. Logs will be checked for accuracy by the Dietary Manager (or designee) daily and inspect the accuracy of the information daily. The Registered Dietician will inspect and oversee this process at least weekly ongoing. The logs will be submitted by the Dietary Manager or designee and reviewed weekly at IDT meeting then reviewed and discussed with the QAPI committee monthly for 90 days to ensure this process is being monitored.	

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F 851	Continued From page 6	F 851		
F 851 SS=B	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each	F 851		6/1/23

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F 851	Continued From page 7 category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review and Administrator interview, the facility failed to submit the Payroll Based Journal (PBJ) data for the 3rd, and 4th quarters in fiscal year (FY) 2022 and 1st quarter in fiscal year 2023. Findings included: Review of the Centers for Medicare and Medicaid Services (CMS) PBJ Staffing Data Report Certification and Survey Provider Enhanced Reports (CASPER Report 1705D) revealed no data was submitted for: - April 1 - June 30 (FY Quarter 3 2022) - July 1 - September 30 (FY Quarter 4 2022)	F 851	There is no one person affected by this. As the Administrator I have selected a designee in my absence and collaborate with that designee to correct this from happening again. I have assigned a designee and trained that person in my absence to report this information correctly and accurately. The designee has the proper sign on information and has been properly educated on how to communicate that information per iQIES which we did not have at the time of failure to transmit.	

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F 851	Continued From page 8 - October 1 - December 31 (FY Quarter 1 2023) An interview with the Administrator on 5/23/23 at 2:30 PM revealed she was aware that the data had not been submitted. She stated she was responsible for submitting the staffing. She stated she was aware of the problem and had contacted the CMS help desk but had been unable to resolve the issue.	F 851	The Administrator or designee will ensure to begin this process no later than 14 days prior to the deadline to be sure the information is sent timely so that it will be received and acknowledged before the deadline. The Administrator or designee will print out the acceptance verification before the deadline to ensure the information has been transferred and accepted before the deadline and leaving enough time to retransmit before the deadline. If the transmission has not been accepted, the Administrator or designee will reach out to the help desk for assistance. The printed documentation of acceptance for the quarterly transmission will be kept on file for at least 4 quarters. As this is a quarterly process, the documentation will be reviewed and discussed quarterly at the QAPI meeting for 4 quarters to ensure the information is accurate, submitted timely and accepted.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		6/1/23

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F 867	Continued From page 9 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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F 867	Continued From page 10 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).	F 867		

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F 867	Continued From page 11 Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility ' s Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in February of 2022. This was for one recited deficiency in the area of food and nutrition services. The continued failure of the facility during the two federal surveys of record shows a pattern of the facility ' s inability to sustain and effective QAPI program. Findings included: This tag is cross referenced to:	F 867	Upon entry to the walk in refrigerator, the facility staff failed to properly label the contents of a food item. To correct this issue, the facility has put in place an audit tool for each cook each meal an audit before leaving the shift to inspect the contents of the food storage areas of the dietary department for any improperly stored food items. The cook (or designee) will initial the log after inspection of said area to ensure all items are properly stored per protocol. Logs will be checked for accuracy by the Dietary Manager (or designee) daily and inspect	

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BRUNSWICK COVE NURSING CENTER	1478 RIVER ROAD WINNABOW, NC 28479

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F 867	Continued From page 12 F812: Based on observation and staff interviews, the facility failed to date foods stored for use in one of one kitchen walk-in refrigerator. This had the potential to affect 106 of 106 residents. During the recertification survey of 2/10/22, the facility was cited for F812 for failure to date and discard foods from the walk-in refrigerator and nourishment room refrigerators. During an interview on 5/25/23 at 8:30 AM, the Registered Dietitian (RD) indicated that she attended QAPI meetings when she was able. She indicated that labeling foods in the refrigerator was an ongoing issue, but she believed the facility had made progress. The RD indicated she checked the walk-in refrigerators frequently to ensure foods were labeled and dated. During an interview on 5/25/23 at 11:15 AM, the Administrator revealed food and nutrition issues were discussed each month in QAPI meetings. She indicated that she checked the refrigerators in the kitchen frequently and had not found any issues.	F 867	the accuracy of the information daily. The Registered Dietician will inspect and oversee this process at least weekly ongoing. The logs will be submitted by the Dietary Manager or designee and reviewed weekly at IDT meeting then reviewed and discussed with the QAPI committee monthly for 90 days to ensure this process is being monitored.	