

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 170090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2024
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NAME OF PROVIDER OR SUPPLIER THE COTTAGES OF SWANSBORO-COTTAGE IV	STREET ADDRESS, CITY, STATE, ZIP CODE 127 DOLPHIN BAY ESTATES CEDAR POINT, NC 28584
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(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/12/24.	C 000	The Cottages of Swansboro acknowledges receipt of a statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance. The Plan of Correction is submitted as a written allegation of compliance. The Cottages of Swansboro response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the deficiency is accurate. Further, the Cottages of Swansboro reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through the available administrative or legal proceedings.	
C 254	<p>10A NCAC 13G .0903(c) Licensed Health Professional Support</p> <p>10A NCAC 13G .0903 Licensed Health Professional Support</p> <p>(c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:</p> <p>(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;</p> <p>(2) evaluating the resident's progress to care being provided;</p> <p>(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and</p> <p>(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations identified all tasks for 1 of 1 sampled residents (#3) pertaining to urinary catheter care.</p>	C 254	<p>1.10A NCAC 13G .0903(c) Licensed Health Professional Support</p> <p>10A NCAC 13G .0903 Licensed Health Professional Support</p> <p>(c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:</p> <p>(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;</p> <p>(2) evaluating the resident's progress to care being provided;</p> <p>(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and</p> <p>(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Anna McLaughlin

TITLE

Administrator

(X6) DATE

10/2/24

STATE FORM

8999

UHXU11

If continuation sheet 1 of 8

Reviewed and Acknowledged

Nola G. Dixon 11/04/2024

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C 254	<p>Continued From page 1</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 02/15/24 revealed: -Diagnoses included acute kidney injury, hypothyroidism paroxysmal atrial fibrillation, sepsis, pneumonia, heart failure, depression and anxiety. -The resident had an indwelling external foley catheter.</p> <p>Review of Resident #3's previous FL-2 dated 01/10/24 revealed: -Diagnoses included acute kidney injury, hypothyroidism paroxysmal atrial fibrillation, clostridium difficile (also known as c.diff., is a bacteria that can cause diarrhea and inflammation of the colon), heart failure, sepsis and pneumonia -The resident had an indwelling external foley catheter.</p> <p>Review of Resident #3's Resident Register revealed there was no admission date listed.</p> <p>Observation of Resident #3's room on 09/12/24 at 9:07am during the initial tour of the facility revealed: -She was lying in a hospital bed with the side rails up. -There was a foley catheter drainage bag attached to the right foot of her bed.</p> <p>Interview with Resident #3 on 09/12/24 at 9:07am and 3:49pm revealed: -She lived at the facility since January 2024. -She was admitted to the facility with the foley catheter. -She had a private sitter daily from 7:30am to</p>	C 254	<p>Continued From Page 1</p> <p>On September 14,2024 corrective action was accomplished by the facility's LHPS nurse. A brand-new evaluation was completed on resident (#3) to include tasks pertaining to urinary catheter care. Additionally, reviews were completed on all other residents on this date, as due for the quarter, and no other residents were identified to be missing tasks.</p> <p>The Cottages of Swansboro's monitoring procedure to ensure that this plan of correction is effective and remains in compliance with the regulatory requirements is as follows:</p> <p>- Upon completion of each evaluation and quarterly review of residents done by LHPS nurse, the RN supervisor will review each one to ensure that all appropriate care tasks are selected, and form is completed with accurate information. The RN supervisor will have 5 business days to review said assessments.</p> <p>- After RN Supervisor has successfully reviewed the LHPS Evaluations and Reviews, RN Supervisor will initial, date and time the documents so that verification is recorded. RN Supervisor will be required to keep documentation of when her reviews are completed.</p> <p>- The administrator will perform a final verification after the LHPS nurse and RN supervisor for the next three quarterly reviews. Thereafter, frequency will become once every 6 months to monitor and insure completion and accuracy of LHPS Initial Evaluation & Quarterly Review of residents.</p>	

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C 254	<p>Continued From page 2</p> <p>8:00pm daily.</p> <ul style="list-style-type: none"> -The home health nurse changed her catheter each month. -Her private sitter emptied her catheter and provided perineal care. -When her sitter was not present, the facility staff emptied her catheter. <p>Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 02/05/24 revealed:</p> <ul style="list-style-type: none"> -This was Resident #3's initial LHPS evaluation. -The resident's primary diagnoses were documented as hypothyroidism, paroxysmal atrial fibrillation, heart failure acute kidney injury, sepsis, pneumonia, depression, anxiety and c. diff. -The resident was admitted to the facility on 01/10/24. -There were no vital signs documented. -Personal care tasks currently present were transferring semi-ambulatory on non-ambulatory residents and ambulation using assistive devices that required physical assistance. -The resident was alert and oriented and cooperative with the care assessment. -Her skin was warm to touch. -Her lungs were clear to auscultation. -Her abdomen was soft and non-tender. -Her diet was no added salt. -A family member was at the bedside. -She was on Xarelto (a medication used to thin the blood) and staff was made aware to watch for bleeding. -Changes and follow-up recommendations were documented as allow time for adjustment to surrounding and room and to follow provider orders. -The LHPS personal care tasks provided were ambulation and transfers with staff competency 	C 254		
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C 254	<p>Continued From page 3</p> <p>validated.</p> <ul style="list-style-type: none"> -The LHPS evaluation was signed by a Registered Nurse (RN). -There was no task identified for positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter. <p>Review of Resident #3's LHPS evaluation dated 05/08/24 revealed:</p> <ul style="list-style-type: none"> -The last LHPS evaluation was on 02/05/24. -The resident's primary diagnoses were documented as hypothyroidism, atrial fibrillation, heart failure, sepsis, pneumonia, and c. diff. -Her vital signs were documented as weight-190 lbs., pulse rate-72, temperature- 98.1, respirations-20, and blood pressure- 130/64. -Personal care tasks currently present were transferring semi-ambulatory on non-ambulatory residents, ambulation using assistive devices that required physical assistance, clean dressing changes excluding packing wounds and application of prescribed enzymatic debriding agents, and any other prescribed physical or occupational therapy. -The resident was alert, oriented, pleasant and cooperative with the care assessment. -The foley catheter was draining. -Her feet were swollen. -She used weights for upper arm strength. -She on Xarelto and received physical therapy (PT), occupational therapy (OT) and wound care. -Changes and follow-up recommendations were documented as continue present plan of care and follow providers' orders. -The LHPS personal care tasks provided were ambulation, transfers, wound care and PT/OT with staff competency validated. -The LHPS evaluation was signed by a RN. -There was no task identified for positioning and emptying of the urinary catheter bag and cleaning 	C 254		

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C 254	<p>Continued From page 4</p> <p>around the urinary catheter.</p> <p>Review of Resident #3's LHPS evaluation dated 08/21/24 revealed:</p> <ul style="list-style-type: none"> -The last LHPS evaluation was on 05/08/24. -The resident's primary diagnoses were documented as hypothyroidism, atrial fibrillation, sepsis, pneumonia, acute kidney injury, and depression, and anxiety. -Her vital signs were documented as weight-189 lbs., pulse rate-74, temperature- 97.6, respirations-18, blood pressure- 128/76 and oxygen saturation of 99%. -Personal care tasks currently present were transferring semi-ambulatory on non-ambulatory residents, ambulation using assistive devices that required physical assistance, inhalation medications by machine (inhaler as needed was documented), and any other prescribed physical or occupational therapy. -The resident was alert and oriented, pleasant and cooperative. -She received foley catheter care from home health. -She was on Lasix (a medication used to treat high blood pressure, heart failure and build up fluid in the body) and Xarelto. -She continued to receive PT and OT. -Changes and follow-up recommendations were documented as continue present plan of care. -The LHPS personal care tasks provided were ambulation, transfers, inhaler and PT/OT with staff competency validated. -The LHPS evaluation was signed by a RN. -There was no task identified for positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter. <p>Interview with a personal care aide (PCA) on 09/12/24 at 3:17pm revealed:</p>	C 254		
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C 254	<p>Continued From page 5</p> <ul style="list-style-type: none"> -She was a certified nursing assistant (CNA). -She had worked at the facility for about one year in the role of a PCA. -She also worked part-time as a private duty sitter for Resident #3. -She emptied Resident #3's catheter and provided perineal care for her. -She had been a CNA since 1994 and had been trained in the past on catheter care. -She had been trained and checked off by the facility's RN supervisor on catheter care when she was hired. <p>Interview with the medication aide (MA) on 09/12/24 at 3:23pm revealed:</p> <ul style="list-style-type: none"> -She did not empty Resident #3's catheter or provide catheter care. -The facility's PCAs or Resident #3's private sitters emptied her catheter and provided perineal care around the catheter. <p>Interview with the home health RN on 09/12/24 at 5:07pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was admitted to home health for catheter management on 01/12/24. -Resident #3 was seen by the home health RN monthly for catheter change and every 2 weeks to change the catheter drainage bag. -Resident #3's catheter was last changed on 09/04/24. <p>Interview with the facility's RN Supervisor on 09/12/24 at 4:14pm revealed:</p> <ul style="list-style-type: none"> -The MAs, PCAs or Resident #3's private sitters were responsible for emptying Resident #3's catheter and providing catheter care. -The home health nurse came monthly to change Resident #3's catheter. -She trained new staff and did the LHPS skills checklist with all the MAs and PCAs upon hire. 	C 254		

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C 254	<p>Continued From page 6</p> <ul style="list-style-type: none"> -The RN with the facility's contracted pharmacy performed the LHPS evaluations for the residents upon admission and quarterly. -It was her responsibility to review with residents' LHPS evaluations for tasks and completeness. -She did not realize that catheter emptying, positioning and cleaning around the catheter was a LHPS task. -It was an oversight on her part that she had not realized there was no LHPS task listed on Resident #3's LHPS evaluations for catheter care. <p>Interview with the RN with the facility's contracted pharmacy on 09/12/24 at 5:17pm revealed:</p> <ul style="list-style-type: none"> -She performed the residents' LHPS evaluations for the facility upon admission and quarterly. -When she performed the LHPS evaluation for a resident, she did an exam of the resident which included vital signs, interview, assessing lung and bowel sounds and skin integrity among other things. -She also reviewed the resident's record. -She had performed Resident #3's current and previous LHPS evaluations and was aware that Resident #3 had a foley catheter. -She had instructed the facility staff on catheter care which included emptying, positioning and cleaning. -She was not sure why she had not included catheter care as a task on Resident #3's LHPS evaluations. <p>Interview with the Administrator on 09/12/24 at 4:29pm revealed:</p> <ul style="list-style-type: none"> -The RN with the facility's contracted pharmacy performed the LHPS evaluations for the residents. -The facility's RN Supervisor was responsible for reviewing the LHPS evaluations for the residents. 	C 254		
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C 254	Continued From page 7 -She expected all LHPS tasks to be identified for the residents.	C 254		