PRINTED: 11/12/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345575	B. WING		10/13/2021	
NAME OF PROVIDER OR SUPPLIER BRUNSWICK HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9600 NO 5 SCHOOL ROAD ASH, NC 28420	10.10202	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 000	INITIAL COMMENTS	3	F 00	00		
	survey was conducte	site complaint investigation ed on 10/13/21. One of the 6 was substantiated resulting ID# LGIE11				
F 686 SS=D	Treatment/Svcs to Pi CFR(s): 483.25(b)(1)	revent/Heal Pressure Ulcer (i)(ii)	F 68	66	11/10/21	
	resident, the facility r (i) A resident receive professional standard pressure ulcers and of ulcers unless the ind demonstrates that the (ii) A resident with pro necessary treatment with professional stan promote healing, pre new ulcers from deve This REQUIREMENT by: Based on observation interviews, the facility ulcer by not completi as ordered by the Ph observed for pressur Findings included: Resident #1 was adm 08/16/21. Diagnoses	ehensive assessment of a must ensure that- s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent indards of practice, to vent infection and prevent eloping. T is not met as evidenced ons, record review and staff of failed to treat a pressure ing a daily dressing change eysician for 1 of 2 residents included, in part, a left otheral vascular disease, and itrition.		Preparation and submission of thi of correction does not constitute an admission of or an agreement with required by State and Federal law executed and implemented as a montinuously improve the quality of comply with State and Federal requirements. 1.) Corrective action for affected real requirements. 1.) Corrective action for affected real result of dressing not being changed Director of Nursing and or, designed perform a skin audit of all current	n. It is . It is neans to f care to esident. I as a ed. The	
ADODATODY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	DE .	TITI F	(X6) DATE	

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

11/03/2021

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

Electronically Signed

program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345575	B. WING _				C / 13/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	10/2021	
DDIII)	OK HEALTH & DELIAD (NEWTER		96	600 NO 5 SCHOOL ROAD			
BRUNSWICK HEALTH & REHAB CENTER			Α	SH, NC 28420				
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 686	Continued From page	e 1	F	686				
	assessment) dated 0	8/22/21 revealed Resident			residents to ensure there are no new			
		nitively impaired and was not			issues present. No new areas were			
		as having a pressure ulcer			identified as a result of this audit. This			
		having a surgical wound			audit was completed on 10/27/2021			
		ited skin damage. Resident						
		ducing mattress to her bed			2.) How will the facility identify other lik			
	and pressure reducin	g pad to ner chair.			residents. All residents have the poten	itiai		
	On 00/00/21 a VOUE	A (facility wound consultant)			to be affected by the alleged deficient practice. The Director of Nursing, and	or		
	On 09/09/21 a VOHRA (facility wound consultant) consult was ordered for an unstageable pressure				designee will perform an audit of all	OI		
	ulcer to the left heel.				current residents requiring dressing			
					changes to ensure they are dated			
	A review of Resident			properly. This audit was completed on				
		d on 09/10/21 included a			10/27/2021			
		red skin integrity to left hip						
	surgical incision, mult	tiple venous (vascular) stasis			3.) What will be done to prevent			
		xtremities and left great toe			reoccurrence. The Director of Nursing			
	and a pressure ulcer				and or, designee will educate licensed			
		d, in part, to administer			nurses and certified nursing assistants			
		d and assess and document			basic skin care. Licensed nurses were			
	the status of the area	l .			educated on following physician orders	3		
	A physician ! a arder :	written on 00/11/21 for			and ensuring dressing are dated appropriately. The education was			
		written on 09/11/21 for eel was to cleanse with			completed on 10/19/2021.			
		calcium alginate to open			completed on 10/19/2021.			
		prep to eschar area and			Licensed nurses and certified nursing			
	wrap with gauze.	p. op 10 000.1.a. a. oa a. 1.a			assistants who have not received the			
					education will not take an assignment i	until		
	A review of the consu	ılt assessment by VOHRA			they receive the education from the			
	on 09/13/21 confirme	d the wound to the left heel			Director of Nursing and or designee.			
		X 2.4 X 0.1 was vascular						
		I flow) and the order was			Any agency nurses/certified nursing			
		ntment (a debriding agent			assistants and newly hired licensed sta	aff		
		aged tissues from a wound)			will receive the education during			
		left heel topically (on top of			orientation by the Director of Nursing a	nd		
	skin) and cover with o	clean dry dressing daily.			or designee.			
	Δ nhysician order writ	tten on 09/14/21 for the left			4.) How will the facility monitor and			
		cluded to cleanse area with			maintain ongoing compliance. The			

		IDENITIEICATION NILIMPED		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345575	B. WING _	B. WING			C / 13/2021	
	NAME OF PROVIDER OR SUPPLIER BRUNSWICK HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9600 NO 5 SCHOOL ROAD ASH, NC 28420			113/2021	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	normal saline, apply 5 gram to left heel topic care and cover with a A VOHRA wound ass 09/20/21 and now individual heel was a pressure under the measuring 2.5 X 3.5 X A VOHRA wound ass left heel pressure ulcomeasuring 2.2 X 2.5 X was improving and to area with normal salinand cover with clean of A VOHRA wound ass revealed the wound with the left heel measuring 2.2 X 2.5 X was improving. The treatricleanse with normal salinand calcium alginate, dressing every day. A Physician order writh order to cleanse left hormal saline, apply 5 and calcium alginate, dressing every day. An observation of worleft heel was conduct 10/13/21 at 1:50 PM. change the dressing the foot. The current dressing the treatment of the current dressing the the treatment of the current dressing the current dressing the treatment of the current dressing the current dre	Santyl ointment 250 units per ally every day for wound clean dry dressing. essment was completed on icated the wound to the left ulcer (deep tissue injury) (0.1. essment on 09/27/21 for the er deep tissue injury (0.1 indicated the wound continue with cleansing he, apply Santyl ointment dry dressing. essment on 10/11/21 was a stage 4 pressure ulcer ring 1.8 X 1.8 X 0.1 and ment was changed to haline, apply Santyl ointment and cover with a clean dry ten on 10/11/21 revealed an heel pressure ulcer with Santyl 250 units per gram cover with a clean dry und care to Resident #1 's heed with Nurse #1 on Nurse #1 proceeded to to the left heel for Resident honskid sock from her left essing was in tact and dated	Fé	886	Director of Nursing and or designee will monitor all treatments completed to ensure the appropriate date is present. Director of Nursing and or designee will perform audits 5x a week for 3 weeks, then 2x a week for 3 weeks, then week for 3 weeks. Results of the audit will be reviewed monthly for 4 months by the Quality Assessment Process Improvement Committee for recommendations and or additional auditional auditi	II dy e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245575	B. WING	A. BUILDING		С	
NAME OF P	ROVIDER OR SUPPLIER	345575	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	13/2021
BRUNSWICK HEALTH & REHAB CENTER			96	500 NO 5 SCHOOL ROAD SH, NC 28420			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	10/13/21 at 2:00 PM. dressing change for F be done daily. Nurse dressing that was in F her initials and she late 10/11/21 as ordered. Not assigned to Reside not know why the drest the nurse that was as An interview was comphone on 10/13/21 at confirmed that she was on 10/12/21 and stated dressing as ordered to the stated that the st	ducted with Nurse #1 on Nurse #1 reported the Resident #1 was ordered to #1 confirmed the current blace dated 10/11/21 were st changed the dressing on Nurse #1 stated she was dent #1 on 10/12/21 and did ssing was not changed by signed to her. ducted with Nurse #2 via #2:22 PM. Nurse #2 as assigned to Resident #1 and she did not change the to the left heel pressure ulcer y busy and had passed it on	F	686			
F 842 SS=D	Nursing (DON) on 10 DON reported she sp Nurse #3 reported sh being asked to do the Resident #1 's left he and Nurse #2 reported the treatment order wassess the wound da have changed the dre 10/12/21 per the physical Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resident (i) A facility may not resident-identifiable to	eel on 10/12/21 when she d off. The DON reported ras in place to monitor and ily and Nurse #2 should essing for Resident #1 on sician order. dentifiable Information 483.70(i)(1)-(5) nt-identifiable information. elease information that is to the public. elease information that is	F	842			11/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		345575	B. WING	B. WING			C 13/2021
NAME OF PROVIDER OR SUPPLIER BRUNSWICK HEALTH & REHAB CENTER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE 9600 NO 5 SCHOOL ROAD ASH, NC 28420	1 10/	13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	agrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In according professional standard must maintain medical that are- (i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically org. §483.70(i)(2) The factual information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, part operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research permedical examiners, for a serious threat to he by and in compliance	ntract under which the agent disclose the information he facility itself is permitted cords. rdance with accepted dis and practices, the facility all records on each resident ented; e; and ganized ility must keep confidential hed in the resident's records, in or storage method of the in release isor their resident permitted by applicable law; yment, or health care ted by and in compliance	F	842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345575	B. WING		C 10/13/2021	
	NAME OF PROVIDER OR SUPPLIER BRUNSWICK HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9600 NO 5 SCHOOL ROAD ASH, NC 28420	10/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 842	for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 years legal age under State §483.70(i)(5) The media (ii) A record of the resident informatic (ii) A record of the resident review of the resident reviews, and resident reviews, radio services reports as resident reatment administration that the reatment administration that the reatment reatment administration that the reatment administration that the residents observed for the residents observed for the resident was administrationally of the r	required by State law; or e date of discharge when ent in State law; or ars after a resident reaches e law. dical record must containton to identify the resident; sident's assessments; ve plan of care and services by preadmission screening evaluations and lacted by the State; e's, and other licensed es notes; and logy and other diagnostic equired under §483.50. To is not met as evidenced entire transcurately documented entire transcurately documented entire transcurately documented entire transcurately documented entire transcurated entir	F 84	1. Corrective action for affected resides Resident #1 was not harmed as a resident earlier the alleged deficient practice of inaccudocumentation. The treatment was completed and appropriately documer on 10/13/2021 per the physician order 2. How will the facility identify other like residents. The Director of Nursing and designee will audit current residents with dressing change orders to ensure appropriate documentation was completed. This audit was completed 10/27/2021 and no discrepancies were found. 3. What will the facility do to prevent the side of the sid	ult of urate nted c ke d or vith on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345575	B. WING		C
NAME OF D	ROVIDER OR SUPPLIER		B: Willo	STREET ADDRESS, CITY, STATE, ZIF	10/13/2021
NAME OF PI	ROVIDER OR SUPPLIER				CODE
BRUNSWI	CK HEALTH & REHA	AB CENTER	9600 NO 5 SCHOOL ROAD		
OURMADY CTATEMENT OF DEFICIENCES			ASH, NC 28420		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE COMPLETION DITHE APPROPRIATE DATE
F 842	Continued From p	page 6	F 8	342	
	order to cleanse length normal saline, app	written on 10/11/21 revealed an eft heel pressure ulcer with ply Santyl 250 units per gram ate, cover with a clean dry		from reoccurring. The Di and or designee will educ on following physician or and document appropriat correct date in the medical education was completed	cate licensed staff ders as written rely with the al record. This
	An observation of wound care to Resident #1's left heel was conducted with Nurse #1 on 10/13/21 at 1:50 PM. Nurse #1 proceeded to change the dressing to the left heel for Resident #1 and removed the nonskid sock from her left foot. The current dressing was intact and dated 10/11/21 with Nurse #1's initials. The measurements were recorded as 1.8 X 1.8 X 0.1 and Nurse #1 proceeded to complete the dressing change as ordered.			Licensed nurses and cert assistants who have not education will not take an they receive the education Director of Nursing and of Any agency nurses/certificant assistants and newly hire will receive the education orientation by the Director or designee.	received the nassignment until nassignment until no from the national received for designee. The second received for the seco
	10/13/21 at 2:00 ff dressing change in be done daily. No dressing that was her initials and sh 10/11/21 as order not assigned to R not know why the the nurse that was phone on 10/13/2 confirmed that sho on 10/12/21 and so dressing as order because she was to be done with N #2 stated she did on the Treatment	conducted with Nurse #1 on PM. Nurse #1 reported the for Resident #1 was ordered to urse #1 confirmed the current in place dated 10/11/21 were e last changed the dressing on ed. Nurse #1 stated she was esident #1 on 10/12/21 and did dressing was not changed by a sasigned to Resident #1. conducted with Nurse #2 via 1 at 2:22 PM. Nurse #2 e was assigned to Resident #1 stated she did not change the ed to the left heel pressure ulcer very busy and had passed it on urse #3 on the next shift. Nurse not know why her initials were Administration Record (TAR) ate the dressing had been done.		How will the facility monit ongoing compliance. The nursing and or designeed treatments that require a to ensure the are properly documented in the medical documented in the medical Director of Nursing and operform audits 5x a week then 2x a week for 3 week for 3 weeks. Results of the reviewed monthly for 4 m Quality Assessment Proclimprovement Committee recommendations and or	e Director of will monitor dressing change y dated and cal record. or designee will to for 3 weeks, cks, then weekly he audit will be conths by the dess for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345575	B. WING			C 10/13/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 10/	13/2021	
BDIINGWI	CK HEALTH & REHAB (PENTED		9600	NO 5 SCHOOL ROAD			
BRONOWICK HEALTH & REHAB CENTER				ASH	, NC 28420			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Nurse #2 stated if she she would not have so An interview was con Nursing (DON) on 10 DON reported she sp Nurse #3 reported she being asked to do the Resident #1 's left he and Nurse #2 reported the treatment order wassess the wound date of the she would date to the she would be she would b	e did not to the treatment signed off on it. Inducted with the Director of 1/13/21 at 3:40 PM. The boke with Nurse #3 and the had no knowledge of the dressing change to the electron 10/12/21 when she had off. The DON reported was in place to monitor and the had Nurse #2 should the essing for Resident #1 on	F	342				