

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/30/2013
NAME OF PROVIDER OR SUPPLIER BRUNSWICK COVE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1478 RIVER ROAD WINNABOW, NC 28479	
(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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	<p>12/13/13 Based on team review of IDR submitted materials, the team lowered the F 309 G to a D.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, resident and family interviews, the facility failed to seek medical intervention for treatment of fractures for 1 of 3 sample residents (Resident #1) reviewed for falls.</p> <p>Findings included:</p> <p>Resident #1 was readmitted on 12/1/12 with diagnoses that included Osteoporosis, Cervical Spinal Stenosis, Spinal Cord Disease, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease. The quarterly Minimum Data Set (MDS) assessment dated 8/29/13 revealed Resident #1 was cognitively intact. Resident #1 required supervision or cueing with setup only for all activities of daily living (ADLs).</p> <p>Review of Fall Scene Investigation (FSI) report dated 10/10/13 revealed Resident #1 was found</p>	F 309	<p>Corrective action for affected resident:</p> <p>Injury was assessed by orthopedic doctor and facility ensured follow up appointment was made for continuity of care.</p> <p>Nursing staff continued to monitor resident's acute status and document findings.</p> <p>Any negative change in resident's condition was to be reported to MD and DON/ ADON</p> <p>Completed: 10/14/2013</p>	11/22/13

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

TITLE

(X6) DATE

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 309	<p>Continued From page 1</p> <p>on floor lying on her right side. The report revealed there was blood evident on the floor and lacerations to the resident's right wrist. The investigation report also revealed Physician #1 and the responsible party (RP) was notified on 10/10/13 at 10:50 PM.</p> <p>In an interview conducted on 10/28/13 at 3:14 PM, Resident #1 stated on 10/10/13 at 10:20 PM she decided to go to the bathroom and was getting up from her bed when she somehow rolled off her air mattress and landed on the floor. Resident #1 stated she could not reach her call bell for it was hooked up high on her bed and she could not reach it from where she had landed and the air conditioner noise prevented the staff from hearing her call for help. Resident #1 stated at 10:45 PM, NA#1 who was assigned to her care came into the room and found her lying on the floor, and called for assistance. The nurse came into the room, did an assessment and treated her injured right arm. Resident #1 stated she told the nurse her arm was broken at that time. Resident #1 stated she told the staff she was in pain, and nobody cared.</p> <p>In an interview conducted on 10/28/13 at 5:20 PM, NA #1 reported she was assigned to Resident #1 on the night of her fall. She stated on her last rounds to check on her residents; she found Resident #1 on the floor. She called for assistance and NA#2 and Nurse #1 came to assist her. The nurse did an assessment on Resident #1 before she was transferred back into her bed. NA#1 stated Resident #1 was talking but NA#1 could not understand her.</p> <p>In an interview conducted on 10/28/13 at 5:31 PM, Nurse #1 stated she was the nurse on duty</p>	F 309	<p>Corrective action for residents having potential to be affected:</p> <p>Nursing staff education has been completed for the following:</p> <ol style="list-style-type: none"> 1. Any resident fall will be assessed by nursing staff immediately by obtaining vital signs, and head- to -toe assessment. (including range of motion and pain) 2. The physician will be notified of the fall and the details of the assessment. The nurse will transcribe any new orders if given. 3. The responsible party will be notified of the fall. 4. The DON/ ADON will be notified of fall. 5. Resident will be monitored for the duration of the acute episode. Any significant changes will be reported to physician using assessment criteria as outlined in #1. <p>All resident falls will be discussed in dally team meeting. Documentation, interventions and new orders will be reviewed by administrative staff to ensure needs are met.</p> <p>Completed: 11/22/2013</p>		

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F 309	<p>Continued From page 2</p> <p>2nd shift for Resident #1. on 10/10/13. She reported an NA came to her and told her she needed to come to Resident #1 's room because she was on the floor. Nurse #1 stated she entered the room and found Resident #1 on the floor leaning sideways. There was cereal and blood spilled on the floor where she had landed. Nurse #1 stated she conducted an assessment, using range of motion, and Resident #1 was able to move her arms and fingers freely. She stated she administrated treatment to the two abrasions she had observed on Resident #1's right wrist. Nurse #1 stated she called Physician #1 and informed him that Resident #1 had been found on the floor, with two abrasions noted on her right wrist. She reported to Physician #1 she had conducted an assessment and treated her abrasions. Nurse #1 stated she reported also to Physician #1 that she was very lethargic and talking, but could not be understood. Nurse #1 stated Physician #1 told her he would address it in the morning. Nurse #1 stated she called the responsible party (RP) and informed her of Resident#1 ' s fall and that Physician #1 would see her in the morning.</p> <p>The interview with Nurse #1 continued on 10/28/13 at 5:31 PM. Nurse #1 stated she was working 1st shift, when Physician #1 came to visit Resident #1 on the morning of 10/11/13, and she accompanied him. Nurse #1 stated during his visit with Resident #1 there was a discussion of medication issues only. Nurse #1 stated she did not receive any orders from Physician #1 for Resident #1 for the rest of her shift. Nurse #1 stated that later Resident #1 asked her during medication pass if Physician #1 was going to do anything about her arm. She stated she told Resident #1 she did not have any orders yet.</p>	F 309	<p>The facility will monitor performance to ensure correction is achieved and maintained:</p> <p>All resident falls will be discussed in daily meeting. Documentation, interventions and new orders will be reviewed by department heads to ensure needs are met.</p> <p>All residents falls will be discussed weekly with the interdisciplinary team (consisting of Administrator, DON, ADON, Social Workers, Activities, Dietary, MDS and Therapy) to update careplans, discuss interventions and review documentation to ensure all efforts are made toward positive outcomes</p> <p>All resident falls will be reviewed at quarterly QA committee meeting.</p> <p>Completed 11/22/2013</p>	

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F 309	<p>Continued From page 3</p> <p>Nurse #1 stated she reported to the on-coming nurse for 2nd shift about Resident #1 ' s fall incident and that she had not received any new orders for Resident #1. Nurse #1 said she also informed the Director of Nursing (DON) and the Assistant Director of Nursing (ADON); she had not received any orders from the physician regarding Resident #1. She stated she asked the DON and ADON to please address the issue of the arm with Physician #1. Nurse #1 stated the physician did not examined Resident #1 ' s arm when he was in her room.</p> <p>In an interview conducted on 10/29/13 at 10:10 AM, Nurse #3 stated he was the oncoming nurse for 2nd shift on 10/11/13 and had received full report from Nurse #1 regarding Resident #1's fall. After receiving report Nurse #3 went to Resident #1 room to do an assessment. He assessed her right arm and found it to be red and swollen. Nurse #3 stated he located Physician #1 who was still in the building and asked him for an order for x-ray for Resident #1 ' s arm. Physician #1 gave a verbal order for an x-ray to Resident #1 ' s right wrist. Nurse #3 said he placed the x-ray order and then informed Resident #1 about the order.</p> <p>During an interview on 10/30/13 at 12:15 PM, Physician #1 stated he received a call on the night of 10/10/13 and was informed Resident #1 had fallen. He stated he saw Resident #1 after the fall and at that time he had not noted any swelling on her right arm. He issued an order for the x-ray when he was informed later in the day by the nurse that Resident #1 ' s arm was red and swollen.</p> <p>A review of physician progress report dated 10/11/13 indicated the patient did have severe</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>osteoarthritis. She also had some impingement possibly of the ulnar nerve.</p> <p>A review of the nursing notes revealed Resident #1 ' s x-ray on the right wrist was done on 10/11/13 at 6:00 PM.</p> <p>In the interview conducted on 10/29/13 at 10:10 PM, Nurse #3 stated the x-ray results for Resident #1 came in on 10/11/13 at 11:00 PM during shift report. The on-coming nurse was informed the x-ray results for Resident #1 had just been received.</p> <p>Review of the facility records revealed Resident #1 ' s x-ray report was received by the Nurse #2 at 11:00 PM on 10/11/13. The report revealed two fractures of the right ulnar (forearm).</p> <p>A review of a nursing note dated 10/11/13 at 11:00 PM revealed Nurse #2 who was working 3rd shift had received the x-ray result and she would report the findings in the morning.</p> <p>During an interview conducted on 10/29/13 at 1:21PM, Nurse #2 stated she was the nurse who received the x-ray results for Resident #1. She stated she decided to report the findings in the morning to the on-coming nurse. Nurse #2 stated she had read the results and was aware of the fracture. She stated it was midnight and she did not like to call anyone at midnight. Nurse #2 stated she monitored the resident throughout the night. The Nurse stated she informed the on-coming nurse the x-ray results had been received and Resident #1 had slept well during the night.</p> <p>In an interview conducted on 10/29/13 at 4:28</p>	F 309		
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F 309	Continued From page 5 PM, Nurse #4 reported she relieved Nurse #2 on the morning of 10/12/13, and was informed of the x-ray results. Nurse #4 stated she placed a call to the on-call physician on duty for 11/12/13, and left a message for the physician to call the facility. Nurse #4 stated she informed Resident #1 about the x-ray results. She commented that the family came into the facility and she informed them she was waiting on orders from the on-call physician. Nurse #4 stated the on-call physician returned her call, and gave her an order for a wrist stabilizer splint to be used for positioning Resident #1 ' s right arm and wrist until her orthopedic appointment on 10/14/13. Nurse #4 stated she was instructed to call and find out which pharmacy had the specific splint he had ordered and then make arrangements to pick it up or have it delivered. Nurse #4 stated she had called several locations and had not been able to locate the specific splint the on-call physician had order. Nurse #4 stated she called the on-call physician back and received an order for another type of splint that she was able to locate, and made arrangement for staff to pick it up. Nurse #4 stated it was around noon when she informed Resident #1 about the on-call physician ' s order. She stated Resident #1 declined the physician orders and informed her of the decision to follow the recommendations from a Physician's Assistant (PA) on duty at her orthopedic office. The PA had recommended the family take Resident #1 to an urgent care facility; for she needed her bones to be aligned until the office could see her Monday morning. Nurse #4 stated Resident #1 made a complaint of pain at that time, and she told her she would talk to the on-call physician about her pain needs. Nurse #4 stated she called the on-call physician and informed him of the family ' s decision to decline	F 309		

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F 309	<p>Continued From page 6</p> <p>his order and Resident #1 ' s complaint of pain. She stated she read to him the list of Resident #1's scheduled pain medications and asked him if there was anything else she should give her. She stated the on-call physician did not give her an order for additional pain medication and felt the medication she was receiving was enough.</p> <p>In an interview conducted on 10/29/13 at 2:15 PM via phone, the RP stated she received a call on the night of 10/10/23 and was informed of Resident #1's fall and injury. She was told her physician had been called and would see Resident #1 in the morning. The next day the RP said she called the resident in the morning to check on her. Resident #1 told her that her right arm was throbbing and hurting. The RP stated Resident #1 told her she had told the staff she was in pain. She stated Resident #1 complained of pain when the nurse came into the room to tell her about the on-call physician orders. The Resident stated she was told the on-call physical said no, if she need anything else urgent care could give it to her. The RP stated Resident #1 called her orthopedic doctor office for a recommendation because she was very concerned about her arm.</p> <p>Review of a nursing note dated 10/12/13 revealed Resident #1 ' s family declined the on- call physician ' s order. It revealed Resident #1 ' s family decided to take her to an emergency department (ED) for treatment on her wrist.</p> <p>A review of the urgent care report revealed Resident #1 was treated on 10/12/13. The report revealed the right forearm bone was aligned and then stabilized with a brace.</p>	F 309			

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F 309	Continued From page 7 On 10/29/13 during an interview at 4:48 PM, the DON reported she had received report of Resident #1 's fall in the morning meeting on 10/11/13. She stated the staff informed her later an x-ray had been ordered by Physician #1 for Resident #1. The DON stated when a positive acute report was received she expected the nurse to call the physician and call the DON at that time.	F 309			