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 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	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 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		9/5/14
	This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed follow a physician's order to record the colostomy output for 1 of 3 residents reviewed with colostomies (Resident #3) and failed to clarify the lack of orders on caring for a colostomy for 1 of 3 residents with colostomies (Resident #3). The findings included: Resident #3 was admitted to the facility on 3/15/12 and re-admitted on 7/9/14 with diagnoses including Malignant Neoplasm Colon/Rectum, Ileus and Status Post Colostomy on 6/30/14. Review of an undated facility protocol entitled " Colostomy/Ileosotmy Care " read in part, " equipment and supplies 1) skin cleansing preparation, 4) barrier creams and lotions (as indicated) Under " documentation " was listed the following information should be recorded in the resident ' s medical record or as indicated on		1) Address how corrective action will be accomplished for those residents found to be affected Resident #3 was discharged from the facility before the compliant team arrived to conduct the investigation. 2) Address how corrective action will be accomplished for those residents having potential to be affected Charts audits will be completed on all ostomy care patients to ensure a) ostomy care have doctors orders that have been clarified to include all necessary information including but not limited to frequency of appliance change and b) each ostomy patient will have a site assessment and documentation to describe condition of the ostomy site.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/28/2014

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.

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 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	**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 328	Continued From page 1 the Certified Nursing Assistant flow sheet: 1. date and time care was provided 2, any breaks in the resident ' s skin, signs of infection or excoriation of the skin, 3. how the resident tolerated the procedure, 4. if the resident refused the procedure, the reason why and the intervention taken and 5. the signature and title of the person recording the data. Review of the Admission Minimum Data Set (MDS) Assessment dated 2/14/14 identified Resident #3 as cognitively intact with no behaviors. He was continent of bowel and bladder. Review of the Care Plan dated 7/9/14 read in part, resident re-admitted with new colostomy. Approaches in meeting the goal of experiencing no complications from new colostomy included the following: Monitor intake and output and monitor for signs and symptoms of infection. Review of the Physician ' s Orders dated 7/9/14 revealed an order to empty the colostomy drain and record output, as specified every six hours. Review of the Medication Administration Record for 7/10/14 through 7/28/14 documented the colostomy was drained and the output recorded by the 11PM-7AM nurse. The drain was emptied by the 7AM-3PM and 3PM-11PM nursing staff but the output was not recorded. Review of the Admission orders did not reveal orders on how often to change the colostomy bag or the type of cleanser to be used in cleaning the area prior to applying a new bag. Review of the Treatment Administration Record	F 328	3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. All new admission or new ostomies on existing patients will have sites assessed at admission and all orders will reviewed and clarified as necessary to include frequency of appliance change and parameters. The chart will be audited within 72 hours in morning meeting by ADON or assignee to ensure that orders are correct. For all existing ostomy care patients,new admissions with ostomies and new ostomies, after initial assessment, skin assessments will be conducted weekly as is currently be done. Changes are being made to the weekly skin assessment sheet. The changes will be that the ostomy site will be documented not by exception (as is the current practice) but will include documentation that addresses the condition of the site even if it is intact. 4) How will facility notify staff of changes All nursing staff will be educated on the changes in the policy and procedures regarding proper care, documentation, and proper orders for ostomy care. We will include a reminder in all the mandatory in services for the next quarter as well as included it in the nursing orientation for new nurses. 5) How will facility monitor its performance	

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 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	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 328	Continued From page 2 (TAR) revealed there was not an order for cleaning the colostomy specifying how often to clean the colostomy, change the bag or what type of cleansing agent to use when cleaning the stoma area. Review of the Nursing Notes for 7/10/14 through 7/28/14 documented the following: 7/10/14 documented the colonoscopy bag was intact. 7/11/14 documented the bag was changed on 3PM-11PM shift. 7/12/14 documented the bag was changed on 11PM-7AM shift and colostomy care was given on 3PM-11PM shift. 7/13/14 documented colostomy care provided on 3PM-11PM shift. 7/14/14 documented 11PM-7AM changed colostomy. 7/15/14 documented 11PM-7AM changed colostomy. 7/16/14 documented 7AM-3PM shift provided colostomy care. 7/17/14 documented bag intact. 7/18/14 documented bag intact. 7/19/14 documented bag intact. 7/20/14 documented bag intact. 7/21/14 documented 3PM-11PM shift provided colostomy care. 7/22/14 documentation of bag intact. 7/23/14 documentation of bag intact. 7/24/14 documented bag emptied. 7/25/14 documented bag emptied.	F 328	to make sure that solutions are substained. All residents with ostomy will be reviewed weekly at our IDT (interdisciplinary team) meeting starting 8/29/2014 and continue for two months. After that all ostomies will be reviewed at the monthly QA meeting for one year.	

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 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	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 328	Continued From page 3	F 328		

7/26/14 documented 3PM -11PM shift provided colostomy care.
7/27/14 documented care given and bag changed.
7/28/14 documented sent to emergency room for evaluation.

During an interview with the hospital Wound and Ostomy nurse on 8/12/14 at 2:41PM she stated that the physician should have given specific orders regarding how to clean around the ostomy, how often to change the wafer and bag and what type of cleanser to use. She stated she works with Resident #3 ' s physician and if the specifics were not on the admission paperwork it should have been clarified by the facility nurse. She stated because the resident had an ileus two days prior to his discharge it was extremely important to document the drainage. Because he had already had an ileus he had a greater risk of developing another ileus or stenosis. She further stated that typically the bag and wafer are changed twice weekly and as needed. The more you change the bag the more irritated the area can become. If the seal is tight there is no reason to change more often than needed. The facility should have had specifics in place.

During an interview with the treatment nurse on 8/12/14 at 3:00PM she stated there should have been an order written to clarify what the treatment would have been for the colostomy, including how often to change the bag and what type of cleanser to use. If the resident does not come in to the facility with an order the Assistant Director of Nursing (ADON) calls and clarifies the order. She further stated that she would specifically be treating his surgical wounds and the floor nurses would be responsible for emptying and changing

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

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 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	**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 328	Continued From page 4 the colostomy bag and caring for the site. During an interview with the ADON on 8/13/14 at 8:05AM she stated she thought the order for wound care per facility protocol on the Treatment Administration Record were sufficient. During an interview with the Director of Nursing (DON) on 8/13/14 at 8:10AM she stated that no one clarified the admitting orders as far as how often and what to use to clean the new colostomy. Furthermore, there is also no treatment record to reflect any orders pertaining to the colostomy. The DON stated there should have been an order on how to care for the colostomy, including how often to change the bag and how to clean the area and this should have been documented on the TAR. During a follow up interview with the Director of Nursing on 8/13/14 at 8:15AM she stated it was her expectation that the nurses would document the colostomy output as ordered on the MAR or in the nursing notes. During an interview with the Admnistrator on 8/13/14 at 11AM he stated he agreed that the facility should have recorded the output as the physician ordered and there should have been clearer orders on how to care for the colostomy.	F 328		