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 02/19/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 resident (Resident #159) reviewed with level II Preadmission Screening and Resident Review (PASRR). The findings included: | F 278 | | 3/1/16 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 3/12/2016 |

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 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 resident (Resident #159) reviewed with level II Preadmission Screening and Resident Review (PASRR). The findings included: | F 278 | See attachment for all PoC's Related to this 2567. | |

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| F 278 | Continued From page 1<br><br>Resident #159 was admitted to the facility on 12/5/14 with multiple diagnoses that included depression.<br><br>His annual MDS dated 12/4/15 indicated a "No" to question A1500 which asked if Resident #159 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition.<br><br>Record review indicated Resident #159 was a level II PASRR. Resident #159 received a Level II PASRR with no expiration date on 4/14/15.<br><br>An interview was conducted on 2/17/16 at 3:00 PM with Social Worker (SW) #1. The process for coding the MDS for PASRR level II residents was reviewed. SW #1 stated the MDS Coordinators asked the assigned SW to verify a resident's PASRR status. He indicated MDS Coordinator #1 was responsible for coding the MDS for Resident #159. SW #1 also indicated he was the assigned the SW. The PASRR level II for Resident #159 was reviewed with SW #1. The annual MDS dated 12/4/15 for Resident #159 was reviewed with SW #1. He revealed the MDS was coded incorrectly and should have indicated Resident #159 was a level II PASRR. SW #1 stated he was unable to recall if MDS Coordinator #1 asked him about Resident #159's PASRR status prior to completing the 12/4/15 annual MDS. He revealed he did not maintain a list of level II PASRR residents. He stated he had to look in the chart to verify PASRR status. He indicated the facility may need a new system to track PASRR level II residents.<br><br>An interview was conducted on 2/17/16 at 3:17 | F 278 | | |

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| F 278 | Continued From page 2<br>PM with MDS Coordinator #1. She stated she was responsible for answering question A1500 on the MDS for Resident #159. She stated she obtained the information on level II PASRRs from the assigned SW. She indicated SW #1 was assigned to Resident #159. She stated she was unable to recall if she asked SW #1 to verify Resident #159's PASRR level II status prior to completing his 12/4/15 annual MDS. The PASRR level II for Resident #159 was reviewed with MDS Coordinator #1. The annual MDS dated 12/4/15 for Resident #159 was reviewed with MDS Coordinator #1. She revealed the MDS was coded incorrectly and should have indicated that Resident #159 was a level II PASRR. | F 278 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | | 3/18/16 |

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| F 280 | Continued From page 3 | F 280 | | |

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and record review the facility failed to review and revise the care plan for vision to indicate the discontinued use of eyeglasses for one of two residents (Resident #48) reviewed for vision. The findings included:

Resident #48 was admitted to the facility on 4/20/15 with multiple diagnoses that included heart disease. His quarterly Minimum Data Set (MDS) assessment dated 1/9/16 indicated he was cognitively intact, had impaired vision, and was not wearing corrective lenses.

Resident #48 was care planned for visual sensory/perceptual alteration. The problem onset date was indicated as 4/20/15 with the most recent review date of 1/26/16. The interventions included: ensure eyeglasses were appropriate strength/type for resident's needs, ensure eyeglasses were in place and worn by resident during waking hours, and ensure assistance was provided to resident to maintain cleanliness of eyeglasses.

An observation of Resident #48 was conducted on 2/18/16 at 9:44 AM. Resident #48 was in his room, laying on his bed with the television turned on. Resident #48 was awake and was not wearing eyeglasses.

An interview was conducted with Resident #48 on 2/18/16 at 9:45 AM. He stated he used to have eyeglasses, but they broke a year or two ago and he had not gotten a new pair. He indicated he

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| F 280 | Continued From page 4<br>had difficulty seeing things that were close up. Resident #48 revealed he was not able to read due to his impaired eyesight. He stated he missed reading. He indicated he was interested in getting new glasses and seeing an eye doctor. He stated he had not informed staff of this information.<br><br>An interview was conducted with Nurse #2 on 2/18/16 at 9:50 AM. She stated Resident #48 had not had eyeglasses. She stated she had not observed Resident #48 wearing eyeglasses. She indicated he had not complained of issues with his vision.<br><br>An interview was conducted with MDS Coordinator #3 on 2/18/16 at 10:04 AM. She stated she was responsible for completing Resident #48's care plan. The care plan related to vision for Resident #48 was reviewed with MDS Coordinator #3. She revealed the care plan was not accurate as Resident #48 was not in possession of eyeglasses. MDS Coordinator #3 reviewed her personal documentation for Resident #48. She stated her notes from Resident #48's admission indicated he had eyeglasses, but the eyeglasses were at his home. She stated she thought the eyeglasses were going to be brought into the facility by a family or friend. She revealed the eyeglasses were never brought to the facility for Resident #48. She stated she should have revised the care plan. | F 280 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of | F 282 | | 3/18/16 |

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| F 282 | Continued From page 5<br>care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, and record review, the facility failed to follow the care plan interventions for vision for one of two residents (Resident #48) reviewed for vision and for dialysis for one of one residents (Resident #35) reviewed for dialysis. The findings included:<br><br>1. Resident #48 was admitted to the facility on 4/20/15 with multiple diagnoses that included heart disease. His quarterly Minimum Data Set (MDS) assessment dated 1/9/16 indicated he was cognitively intact, had impaired vision, and was not wearing corrective lenses.<br><br>Resident #48 was care planned for visual sensory/perceptual alteration. The problem onset date was indicated as 4/20/15 with the most recent review date of 1/26/16. The interventions included: ensure eyeglasses were appropriate strength/type for resident's needs, ensure eyeglasses were in place and worn by resident during waking hours, and ensure assistance was provided to resident to maintain cleanliness of eyeglasses.<br><br>An observation of Resident #48 was conducted on 2/18/16 at 9:44 AM. Resident #48 was in his room, laying on his bed with the television turned on. Resident #48 was awake and was not wearing eyeglasses.<br><br>An interview was conducted with Resident #48 on 2/18/16 at 9:45 AM. He stated he used to have | F 282 | | |

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| F 282 | Continued From page 6<br>eyeglasses, but they broke a year or two ago and he had not gotten a new pair. He indicated he had difficulty seeing things that are close up. Resident #48 revealed he was not able to read due to his impaired eyesight. He stated he missed reading. He indicated he was interested in getting new glasses and seeing an eye doctor. He stated he had not informed staff of this information.<br><br>An interview was conducted with Nurse #2 on 2/18/16 at 9:50 AM. She stated Resident #48 did not have eyeglasses. She stated she had not observed Resident #48 wearing eyeglasses. She indicated he did not complain of issues with his vision.<br><br>An interview was conducted with MDS Coordinator #3 on 2/18/16 at 10:04 AM. She stated she was responsible for completing Resident #48's care plan. The care plan related to vision for Resident #48 was reviewed with MDS Coordinator #3. The care plan indicated Resident #48 had eyeglasses. She revealed the care plan was not being followed as Resident #48 was not in possession of eyeglasses. MDS Coordinator #3 reviewed her personal documentation for Resident #48. She stated her notes from Resident #48's admission indicated he had eyeglasses, but the eyeglasses were at his home. She indicated she thought the eyeglasses were going to be brought into the facility by a family or friend. She stated when Resident #48 initially came to the facility it was for short term care. She revealed when he changed to long term care she had not followed up on whether Resident #48 had obtained his eyeglasses from his home. She stated she was going to follow up with Resident #48 to determine if he wanted | F 282 | | |

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| F 282 | Continued From page 7<br>eyeglasses.<br><br>An interview was conducted with MDS Coordinator #2 on 2/18/16 at 2:35 PM. She stated she spoke with Resident #48 and he indicated he wanted eyeglasses. She stated a pair of reading glasses were given to Resident #48 to try on. She revealed Resident #48 reported he was able to read with the eyeglasses on. She stated a personal pair of reading glasses were going to be obtained for Resident #48. She additionally stated he was scheduled to be seen for an optometry visit.<br><br>2. Resident #35 was initially admitted to the facility on 5/6/05 and readmitted on 5/7/11 with multiple diagnoses that included end stage renal disease.<br><br>Resident #35 was care planned for dialysis. The most recent review date was a quarterly review on 1/26/16. The interventions included the monitoring of weight as ordered by the physician.<br><br>A physician's order dated 1/29/16 indicated Resident #35's weight was to be obtained weekly.<br><br>The weight records for Resident #35 were reviewed. There was one weight obtained after the 1/29/16 physician's order. The weight was obtained on 2/14/16. There was no documentation of a weight being obtained for Resident #35 from 1/29/16 through 2/13/16.<br><br>An interview was conducted with the Dietary Manager (DM) on 2/19/16 at 11:02 AM. The weight record for Resident #35 was reviewed with the DM. The physician's order from 1/29/16 that indicated a weight was to be obtained weekly for | F 282 | | |

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| F 282 | Continued From page 8<br>Resident #35 was reviewed with the DM. He stated he was unaware of the order. He stated he had just began working in this position on 2/5/16. He revealed that during the transition period between the previous DM and himself there had been some things that were missed. He stated they were in the process of implementing new procedures to address weight monitoring. | F 282 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility failed to rinse soap from the resident ' s skin after bathing and failed to change the bath cloth and water after washing the resident ' s perineal area for 1 of 1 residents (Resident #145) whose bed bath was observed.<br>Findings included:<br>Resident #145 was readmitted to the facility on 10/25/16 with diagnoses of stroke and hypertension.<br>The Admission Minimum Data Set (MDS), dated 12/22/15, indicated Resident #145 was coded as having short and long term memory impairment and severely impaired cognitive skills for daily decision making. The resident was identified as requiring extensive assistance for all aspects of daily care. | F 312 | | 3/18/16 |

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| F 312 | Continued From page 9<br>The care plan, reviewed on 12/22/15, indicated Resident #145 was at risk for skin breakdown. Interventions to prevent skin breakdown included frequent incontinent checks.<br>A telephone conversation was held with the resident ' s family member on 2/17/16 at 2:58 PM. She stated on 11/8/15 she and other family members visited Resident #145. Upon entering the room, she found the resident with dried feces on her body and the bed and dried feces under her fingernails. The family member stated she reported this to a staff member, but was unable to recall the staff member ' s name. During Christmas, family members visited again and found the resident in the same condition.<br>On 2/18/16 at 9:15 AM, an observation was completed of Resident #145 receiving her morning bath. When Nursing Assistant (NA) #6 pulled the sheets back, feces was visible on the outside portion of Resident #145 ' s brief. Her left hand was covered with a brown substance and a brown/black matter were under all her fingernails. The NA stated she had arrived for work at 7:00 AM, but had not checked Resident #145 for incontinence. The NA added the resident had a habit of digging into her brief and smearing feces on her brief; adding this behavior had been going on for a while. The NA soaped up the washcloth and washed the resident ' s face, arms, hands and fingers with a body wash that required rinsing per bottle instructions. A brown substance was observed on the wash cloth after the NA washed the resident ' s hands. She placed the wash cloth back into the basin. The NA did not rinse the resident ' s skin after washing, leaving white soap residue and soap bubbles on the resident ' s skin. NA #6 wiped the resident ' s skin dry with a towel. The NA continued using the same wash cloth and the same water to wash the other side of the | F 312 | | |

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| F 312 | Continued From page 10<br>resident ' s body, leaving soap residue and bubbles and wiping her skin dry with a towel. When the NA turned Resident #145 on her side, she used disposable wipes to remove the bulk of the feces, getting feces on her gloves. She used another wipe to clean her gloves. The NA continued to use the same gloves and wash cloth to wash the resident ' s lower extremities.<br>An interview was held with NA #6 on 2/18/16 at 2:29 PM. She remembered not rinsing the soap off Resident #145 ' s skin and drying her skin with the towel. The NA stated wiping and drying the soap from the resident ' s skin with a towel dried the resident ' s skin. Additionally, she remembered continuing to bathe the resident with the same gloves after wiping the stool from her gloves. NA #6 was unable to give a reason why she had not rinsed the resident and why she had not changed her soiled gloves.<br>Nurse #4 was interviewed on 2/18/16 at 2:52 PM. The nurse stated after cleaning feces from the resident ' s perineal area, the NA would be expected to change gloves and wash hands before continuing the bath.<br>MDS Coordinator #2 was interviewed on 2/18/16 at 3:40 PM. She stated she had previously been the facility ' s staff development coordinator. The MDS added staff were taught and expected to wash their hands between caring for residents, when their hands were soiled and after removing gloves. She stated NA #6 should have changed her gloves when they were visibly soiled and should not have completed perineal care without changing the bath water. She added rinsing the resident ' s skin was important to keep the skin from drying.<br>The Director of Nursing was interviewed on 2/19/16 at 10:57 AM. She stated she would have expected the NA to rinse the soap off the | F 312 | | |

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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) COMPLETION DATE |
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| F 312 | Continued From page 11<br>resident's skin prior to drying and to change the soiled gloves and water prior to continuing the resident ' s bath. | F 312 | | |
| F 371 SS=F | 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to air dry tray pans prior to stacking them in storage, failed to clean kitchen fixtures and equipment, failed to sanitize meal carts which had previously been in resident care areas, failed to discard abraded soup/cereal bowls, and failed to label and date food items in storage areas. Findings included:<br><br>1. During initial tour of the kitchen, beginning at 4:08 PM on 02/15/16, 6 of 9 tray pans which were stacked on top of one another on a storage rack had moisture trapped inside of them.<br><br>During a follow-up tour of the kitchen, beginning at 11:08 AM on 02/18/16, 1 of 8 tray pans which was stacked on top of other tray pans in storage had moisture trapped inside of it. | F 371 | | 3/16/16 |

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| F 371 | Continued From page 12<br>At 4:22 PM on 02/18/16 the dietary manager (DM) stated tray pans were supposed to be air dried before stacking them on top of one another on final storage shelving. He reported if the pans were wet when they were stacked there was the chance the trapped moisture could support the growth of bacteria and lead to the development of foodborne illness.<br><br>At 4:34 PM on 02/18/16 a dietary employee stated tray pans were supposed to be spread out on a drying rack and completely air dried before being transferred and stacked on final storage racks. He reported trapped moisture could lead to the development of harmful bacteria.<br><br>2. During initial tour of the kitchen, beginning at 4:08 PM on 02/15/16, two fluorescent light panels above the steam table were contaminated with dust and dried food. In addition, the doors and handles to the reach-in freezer were dirty and had dried food on them.<br><br>At 9:28 AM on 02/18/16 the same two fluorescent light panels above the steam table were still contaminated with dust and dried food, and the doors and handles to the reach-in freezer were dirty and had dried food on them.<br><br>At 4:22 PM on 02/18/16 the dietary manager (DM) stated there was a cleaning schedule in place when he arrived at the facility a couple of weeks ago. However, he reported he was not sure how often the dietary staff was supposed to clean doors/handles to storage units. He also commented he thought maintenance would probably be responsible for cleaning light fixtures and vents. According to the DM, dirty kitchen fixtures and equipment could lead to | F 371 | | |

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| F 371 | Continued From page 13<br>cross-contamination of foods.<br><br>At 4:34 PM on 02/18/16 a dietary employee stated the dietary staff was supposed to wipe down and disinfect kitchen surfaces, including fixtures and equipment, nightly. He also reported the dietary staff covered a broom and cleaned lighting fixtures as needed when food was not being prepared.<br><br>3. At 9:20 AM and 9:30 AM on 02/18/16 meal carts which were emptied from the breakfast meal were taken outside and hosed down with water. When the carts were returned to the kitchen they still had dried food on them. At this time dietary staff reported the hosing down of the meal carts with water was all that was done to them between meals.<br><br>At 4:22 PM on 02/18/16 the dietary manager (DM) stated since the meal carts had been in dining rooms and resident hallways they should be sanitized in order to avoid the chance of cross-contamination and the development of foodborne illness.<br><br>At 4:34 PM on 02/18/16 a dietary employee stated dietary staff should wipe down the meal carts with a bleach solution after being hosed off between meals. He reported this was the best way to sanitize them and make sure bacteria did not contaminate food and the hands of staff distributing the food.<br><br>4. During an examination of kitchenware, beginning at 11:08 AM on 02/18/16, 15 of 27 (55.6%) plastic soup/cereal bowls were abraded inside. | F 371 | | |

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| F 371 | Continued From page 14<br>At 4:22 PM on 02/18/16 the dietary manager (DM) stated the dietary staff should have disposed of the abraded bowls because the abrasions made it more difficult to kill bacteria that could be harbored there. He reported new bowls should replace those that were damaged.<br><br>At 4:34 PM on 02/18/16 a dietary employee stated damaged kitchenware, such as the abraded bowls, should be pulled and taken to the DM for inspections so he could count and reorder those that needed replacing.<br><br>5. During initial tour of the kitchen, beginning at 4:08 PM on 02/15/16, packaging and food items which were opened in the dry storage room were found without labels and dates. A 5-pound box of biscuit mix, a bag of cake mix, a 16-ounce bag of marshmallows, two bags of flour tortillas, a bag of lasagna noodles, and a bag of spaghetti noodles were opened but without labels and dates. In the walk-in refrigerator a gallon container of slaw dressing, a bag of boiled eggs, a 5-pound bag of shredded mozzarella cheese, and two packages of cheese slices which were opened were without labels and dates. A tray pan containing scrambled egg and sausage and leftover cooked ham in the walk-in refrigerator had no labels and dates on them. Boxes in the walk-in refrigerator containing thawing pork, ground beed, and chicken had no dates on them indicating when they were pulled from the freezer and the thawing process began. In the walk-in freezer repackaged ham, two bags of cookie dough, and a bag of chicken which were opened were without labels and dates.<br><br>At 9:50 AM on 02/18/16 hamburger, turkey, and ham which were thawing in the walk-in | F 371 | | |

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| F 371 | Continued From page 15<br>refrigerator had no "pull dates" on them to indicate when the thawing process had begun.<br><br>At 4:22 PM on 02/18/16 the dietary manager (DM) stated he preferred meats to be thawed in the walk-in refrigerator. He commented he did not realize these meats should be labeled and dated when they were pulled from the freezer and thawing began in the walk-in refrigerator. The DM reported he did not like to use meats which had been thawed for more than three days.<br><br>At 4:34 PM on 02/18/16 a dietary employee stated the dietary staff tried to only pull the amount of frozen meats that would be needed for one meal, and thawed them in the walk-in refrigerator as opposed to thawing them under running water as directed by the previous DM. He reported he was unsure why there were no "pull dates" on the thawing meats found in the walk-in refrigerator on 02/15/16 and 02/18/16 because the staff had utilized "pull dates" in the past. | F 371 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, | F 441 | | 3/18/16 |

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| F 441 | Continued From page 16<br>should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to change gloves and wash hands between resident care for 1 of 1 observation of passing meal trays (Resident #106), 1 of 1 observation of staff passing ice (Residents #111,132,55,and 171) and 1 of 1 observation made during the provision of care (Resident #145).<br>Findings included:<br>1. On 2/15/16 at 5:30 PM, Nursing Assistant (NA) #7 was observed passing a dinner tray to Resident #106. Upon entering the room, the NA placed the dinner tray on the over bed table. The | F 441 | | |

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| F 441 | Continued From page 17 | F 441 | | |

NA put on gloves, removed the urinal that was sitting on the over bed table, emptied the urinal, removed his gloves, and without washing his hands, placed the dinner tray in front of Resident #106 for his meal. Without washing his hands prior to leaving Resident #106 ' s room, NA #7 continued passing dinner trays to other residents.
At 5:40 PM on 2/15/16, NA #7 was interviewed. He stated he was taught to wash his hands after removing gloves, after providing care and between dirty and clean tasks, such as emptying an urinal and delivering meal trays. The NA acknowledged he had not washed his hands after he had emptied the urinal and prior to passing dinner trays to Resident #106 and the other residents on the hall. The NA stated he was so focused on the task of passing dinner trays that he had forgotten to wash his hands.
Minimum Data Set (MDS) Nurse #2 was interviewed on 2/18/16 at 3:40 PM. MDS nurse #2 stated she had been the previous staff development coordinator for the facility and would have expected NA #7 to wash his hands after removal of the gloves after handling the urinal.
An interview was held with the Director of Nursing (DON) on 2/19/16 at 10:42 AM. She stated the expectation was for staff to wash their hands when the hands were visibly soiled, before and after resident care and after removing gloves. The DON added she would have expected NA #7 to either wash his hands or use sanitizer after emptying an urinal and before continuing to pass meal trays.
2. On 2/17/16 at 3:45 PM, NA #8 entered the room of Resident #111 with a pair of gloves on her hands delivering ice and water. The NA picked up the resident's pitcher and gave the resident a sip of water touching the resident ' s shoulder. With the same gloves on, NA #8

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| F 441 | Continued From page 18<br>continued to pass water to Resident 132 and Resident #147, again touching the residents ' over bed table and water pitcher. NA #8 then proceeded to Resident #55 ' s room and delivered water and ice, using the same pair of gloves. NA #8 was then called to assist with repositioning Resident #171. NA #8 pulled the gloves off and without washing her hands put on more gloves and assisted with Resident #171 ' s repositioning.<br>An interview was held with the NA #8 on 2/17/16 at 4:10 PM. She stated she was taught to wash her hands before and after providing resident care. NA #8 stated she had also been taught not to wear gloves from room to room, but added she was only passing ice and not providing care. She acknowledged that touching resident's personal items and then going to another resident's room could potentially transfer germs. The NA acknowledged she had not washed her hands between resident care and after removing her gloves. She stated she had forgotten.<br>Minimum Data Set (MDS) Nurse #2 was interviewed on 2/18/16 at 3:40 PM. MDS nurse #2 stated she had been the previous staff development coordinator for the facility and stated NA #8 should not have gone from room to room touching residents and their personal belongings using the same gloves.<br>An interview was held with the Director of Nursing (DON) on 2/19/16 at 10:42 AM. She stated the expectation was for staff to wash their hands when the hands were visibly soiled, before and after resident care and after removing gloves. The DON added she would have expected NA #8 to wash her hands before going from room to room passing ice and touching residents and their belongings.<br>3. An observation was made of Resident #145 | F 441 | | |

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| F 441 | Continued From page 19<br>receiving morning care from NA #6 on 2/18/16 at 9:15 AM. The resident ' s hands were covered with a brown, dried material. The NA used the wash cloth to clean the resident ' s hands and then continued washing the resident with the same cloth. While providing incontinent care, NA #6 used disposable wipes to remove the bulk of the resident ' s bowel movement. Feces was observed on the NA ' s gloves. NA #6 used disposable wipes to remove the feces from the gloves she wore and then continued the bath using the same gloves.<br>An interview was held with NA #6 on 2/18/16 at 2:29 PM. The NA stated she remembered she continued to bathe Resident #145 after wiping the feces from her gloves with a disposable wipe. She was unable to give a reason why. She stated the danger of continuing to work with feces on her gloves could be infection.<br>Minimum Data Set (MDS) Nurse #2 was interviewed on 2/18/16 at 3:40 PM. MDS nurse #2 stated she had been the previous staff development coordinator for the facility and would have expected NA #6 to remove the visibly soiled gloves and wash her hands prior to completion of Resident #145 ' s bath.<br>An interview was held with the Director of Nursing (DON) on 2/19/16 at 10:42 AM. She stated the expectation was for staff to wash their hands when the hands were visibly soiled, before and after resident care and after removing gloves. The DON added she would have NA #6 to change her gloves and wash her hands when she noticed the gloves were visibly soiled and before continuing the resident ' s bath. | F 441 | | |
| F 520 SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS | F 520 | | 3/18/16 |

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| F 520 | Continued From page 20<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. .<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to providing assistance with ADLs (activities of daily living) which resulted in a repeat citation at F312. The re-citing of F312 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: | F 520 | | |

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| F 520 | Continued From page 21<br>This tag is cross-referenced to:<br><br>F312: Failure to provide assistance with ADLs: Based on observation, staff interviews, and record review the facility failed to rinse 1 of 1 sampled residents (Resident #145) reviewed for personal hygiene.<br><br>Review of the facility's survey history revealed F312 was cited during a 04/30/15 annual recertification survey, and was re-cited during the current 02/19/16 annual recertification survey.<br><br>At 5:00 PM on 02/19/16 the administrator stated on 04/30/15 the facility was cited for a facial hair issue. He reported the facility corrected the problem. However, he stated the F312 citation this year involved failure to rinse a resident during a bath. Even though he received a citation in 2015 and 2016 at F312; he explained the deficient practice was not really the same, failure to remove a white facial hair in 2015 and failure to rinse a resident in 2016. | F 520 | | |

F 278 483.20 ASSESSMENT
ACCURACY/ COORDINATION

Address how corrective action will be accomplished for those residents found to have been affected by the deficiency

**Assessment for this resident was modified to correct PASSR to level II. Assessment was resubmitted with correct information.**

Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice

**An audit of all PASSRs will be conducted by SW to ensure accuracy. Required modifications, if any, will be reported to the Administrator immediately then reviewed with MDS nurses to be modified and resubmitted. A list of all level II PASSRs will be generated as a result of the audit.**

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur

**The level II PASSAR list will be compiled and maintained SW. SW will advise MDS nurse of PASSR level at time of admission, annual and quarterly assessments as well as significant changes.**

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance program of the facility

**Audits of new admissions will include PASSR level to ensure accuracy at admission. Results of audits as well as list of level II PASSRs will be reported at QA monthly for 3 months.**

Include dates when corrective action will be completed.

**Completion Date: Friday, March 11, 2016**

Revised
3/22/2016

# ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

2/15/2016
Date

Signature of Authorized Official

Zachary B. Miller
Name and Title of Authorized Official (please print or type)

Brunswick Cove Living Center, LLC
Name of Healthcare Facility Receiving/Requesting Funding

1478 River Rd SE
Street Address

Winnabow, NC 28479
City, State, Zip Code

Please mail form to:
U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

Form HHS-690
1/09