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	345318	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	1478 RIVER ROAD WINNABOW, NC 28479

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E 000	Initial Comments An unannounced recertification/complaint investigation survey was conducted on 12/08/19 through 12/12/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# QJJ711.	E 000		
F 000	INITIAL COMMENTS A recertificantion/complaint survey was conducted on 12/08/19 through 12/12/19. 2 of 9 complaint allegations were substantiated without deficiency.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to complete a significant change in status assessment for 1 of 7 residents (Resident #56) whose Minimum Data Set (MDS) assessments had been reviewed for Activities of Daily Living (ADLs). Findings included:	F 637	The significant change assessment for Resident #56 was completed 12/11/2019. MDS and IDT Team pulled a copy of the ADL change analysis report to conduct an audit of Residents who may require a significant change. As a result of the audit, there were no other Residents who	12/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/30/2019

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F 637	Continued From page 1 Resident #56 had been admitted on 8/8/19. Her diagnoses included schizophrenia, diabetes and hypertension. Resident #56's Admission MDS assessment dated 8/21/19 indicated she had been independent with all activities of daily living and occasionally incontinent of urine. Resident #56 had been discharged to the hospital on 10/19/19 and readmitted to the facility on 10/29/19. Resident #56's quarterly MDS assessment dated 11/5/19 indicated she required extensive assistance with bed mobility, toileting, hygiene, and dressing and required total assistance with bathing. Also noted she was frequently incontinent of bowel. On 12/8/19 at Resident #56 was observed sitting in her wheelchair in her room, leaning to her right side, feeding herself lunch with encouragement and cues provided by a family member. Observed dozing off when not spoken to. On 12/09/19 at 11:27 AM an interview with Nurse #2 was conducted. The nurse stated she regularly cared for Resident #56. She further stated when Resident #56 had first been admitted, she had been able to do most anything independently. Since Resident #56's hospitalization, her level of functioning had decreased, she required assistance with most of her ADLs and was not back to where she had been. On 12/11/19 at 3:11 PM an interview with Nurse Aid (NA) #3 was conducted. The NA stated when Resident #56 was first admitted, she had only	F 637	the team felt required a significant change to their MDS/ Care plan. MDS nurses reviewed the requirements for significant change assessments and assisted the SDC to educate the staff nurses per the RAI manual. This same MDS and IDT team (consisting of but not limited to Administrator, DON, ADON, MDS, SDC, Social worker, Therapy, Dietary, etc.) will pull the ADL change analysis report weekly for review. Any change that meets the criteria for a Significant change assessment will be assessed within the required timeframe. The results of the weekly reviews will be discussed monthly for 3 months at the QAPI meeting.	

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F 637	Continued From page 2 required minimal assistance. Resident #56 had been hospitalized and since returning, some days she required total care and other days only required assistance. An interview with MDS nurse #1 was conducted on 12/11/19 at 3:57 PM. The nurse stated a quarterly MDS assessment had been completed upon Resident #56's return from the hospital. She further explained she had been waiting to see if Resident #56 would return to her baseline and had 14 days to determine if there was a change. The nurse stated Resident #56 had not returned to her baseline and a Significant Change in Status Assessment (SCSA) should have been completed. She further explained she had missed going back and reevaluating Resident #56. On 12/11/19 at 4:41 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it would be her expectation that a change in status assessment be completed when changes in a resident's condition is identified.	F 637		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment correctly for 5 of 24 residents (Resident #49, #50, #56, #63, and #72) whose MDS assessments were reviewed. Findings included:	F 641	MDS nurses were educated if catheter is in use during the look back period, it will be coded on the assessment even if it was discontinued during ARD. Resident #56's assessment was modified and corrected to reflect same on 12/11/2019	12/27/19

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F 641	Continued From page 3 1. Resident #56 had been admitted on 8/8/19. Her diagnoses included schizophrenia, diabetes and hypertension. Resident #56 had been discharged to the hospital on 10/19/19 and readmitted to the facility on 10/29/19. Nursing documentation dated 10/29/19 at6:16 PM indicated Resident #56 had been readmitted from the hospital with an indwelling urinary catheter. Facility documentation dated 10/31/19 at 5:09 PM indicated the urinary catheter had been discontinued. Resident #56's quarterly MDS assessment dated 11/5/19 indicated she was occasionally incontinent of urine. Use of an indwelling urinary catheter was not indicated. An interview with MDS nurse #1 was conducted on 12/11/19 at 3:57 PM. The nurse stated upon Resident #56's return from the hospital, she had completed as quarterly MDS assessment. She stated the indwelling urinary catheter had no supporting documentation and it had been removed. She further stated the use of the catheter should have been counted on the MDS because one had been used during part of the look-back time. On 12/11/19 at 4:41 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it would be her expectation that the MDS be coded correctly and include information regarding indwelling urinary catheters.	F 641	by the MDS coordinator. Resident #49's assessment was corrected to reflect accurate coding of pressure ulcers/ injury. Resident # 63's assessment was modified and corrected 12/11/2019. Resident #72's assessment was modified and corrected to reflect accurate weight measurement12/11/2019. Resident #50's assessment was modified and corrected to reflect proper coding related to pharmacological classification 12/11/2019. MDS nurses will continue to review section M for accuracy with oversight of the ADON before closing and submitting assessments. An audit was completed 12/27/2019 of all Resident charts for proper PASSR information and coding. Education was provided per the RAI manual to the MDS nurses, Social worker and DON/ ADON regarding accurate PASSR information collection and coding. Prior to completion and submission of comprehensive assessments, SW and MDS nurses will complete a double check with the oversight of the ADON to ensure accuracy of PASSR information, pharmacological coding, pressure ulcers/ injuries, and utilization of weight history. These reviews of information will be discussed weekly at the IDT/ Case mix meeting ongoing as well as at the monthly QAPI meeting x3 months.	

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F 641	Continued From page 4	F 641		

2. Resident #49 had been admitted on 10/25/19. Her diagnoses included hypertension, diabetes and dementia.

Nursing documentation dated 10/25/19 indicated Resident had been admitted with three pressure areas to her buttocks; one Stage II, one Stage I, and one other pressure area not staged.

Resident #49's Admission MDS assessment dated 10/31/19 did not indicate Resident #49 had a pressure ulcer/injury but noted she had one Stage I and two Stage II pressure ulcers/injury that had been present upon admission.

On 12/11/19 at 3:57 PM an interview with MDS Nurse #1 was conducted. The nurse stated the MDS had been coded incorrectly and should have been marked that a pressure ulcer/injury had been present.

On 12/11/19 at 4:41 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it would be her expectation that the MDS be coded correctly and include information regarding pressure ulcers.

3. Resident #63 had been readmitted on 7/26/19. His diagnoses included post-traumatic stress disorder (PTSD), depression, psychotic disorder and seizures.

Review of the North Carolina Medicaid Uniform Screening Tool (NCMUST) indicated Resident #63 had been determined as a PASRR (Preadmission Screening and Resident Review) Level II (identified as having a mental illness or intellectual disability) with a start date of 7/15/19, with no expiration date, and related to mental

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F 641	Continued From page 5	F 641		

illness.

Resident #63's admission MDS assessment dated 8/2/19 indicated he was not currently considered a PASRR Level II resident. His diagnoses included PTSD, depression, psychotic disorder and seizures.

An interview with the Social Worker (SW) was conducted on 12/9/19 at 10:49 AM. The SW stated resident #63 had been determined a PASRR Level II with no expiration for this determination due to his mental illness. The SW further explained that the MDS coordinator had access to the PASRR information.

On 12/11/19 at 3:57 PM an interview with MDS Nurse #1 was conducted. The nurse stated she usually checked the PASRR information when completing the MDS assessments and had missed marking this on Resident #63's assessment.

On 12/11/19 at 4:41 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it would be her expectation that the MDS be coded correctly and include information PASRR.

4. Resident #72 was admitted to the facility on 10/26/18. The resident's documented diagnoses included adult failure to thrive, abnormal weight loss, severe protein-calorie malnutrition, anorexia, and cachexia (a wasting syndrome involving weight and muscle loss). Findings included:

Resident #72's Weight Summary documented the

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resident weighed 105.4 pounds on 04/03/19, 87 pounds on 09/11/19, and 78.4 pounds on 10/16/19. (The resident experienced a 27 pound or 25.6%weight loss between 04/03/19 and 10/16/19. There resident experienced a 8.6 pound or 9.9% weight loss between 09/11/19 and 10/16/19).

Resident #72's 11/08/19 quarterly minimum data set (MDS) documented in section K that her weight was stable with no significant weight loss of 5% or greater in the last month or with no significant weight loss of 10% or greater in the last six months.

During an interview with MDS Nurse #1 on 12/11/19 at 3:49 PM she stated the weight documented in Resident #72's 11/08/19 MDS assessment was obtained on 10/16/19 so the resident experienced a significant weight loss of greater than 5% in the last month (between 09/11/19 and 10/16/19) and a significant weight loss of greater than 10% in the last six months (between 04/03/19 and 10/16/19). She reported that there was an inaccuracy in the coding of Resident #72's 11/08/19 MDS because the resident had experienced significant weight loss, and yet the assessment documented that the resident's weight was stable. She explained that her assistant completed the Resident #72's 11/08/19 assessment, and the assistant was a brand new registered nurse (RN) who was unable to attend the September 2019 MDS training for which she had been scheduled.

During an interview with the Director of Nursing (DON) on 12/11/19 at 4:41 PM she stated she expected all MDS assessments to be coded accurately.

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F 641	Continued From page 7	F 641		

5. Resident #50 was admitted to the facility on 10/26/19 with diagnoses that included heart failure (HF), transient ischemic attack (TIA), hypertension (HTN), cerebral infarction, and tachycardia.

A Physician order dated 10/27/19 for Resident #50 revealed to start Plavix 75 mg every day (QD) for heart failure to start 10/27/19 at 9:00 AM. The Medication Administration Record (MAR) for November 2019 and December 2019 documented the resident had received the medication daily during her stay at the facility.

The Minimum Data Set (MDS) admission assessment dated 11/06/19 documented in Section N0410 (E) that Resident #50 had received anticoagulants during her stay at the facility box was checked (yes) for being on an anticoagulant. Resident #50 was on Plavix (clopidogrel) 75 mg every day (QD) for heart failure. The Resident Assessment Instrument (RAI) page # 472 revealed that Plavix should not be coded as an anticoagulant in section N0410E. The RAI further stated under MDS Section N0410 (E), "Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel (Plavix) here".

In an interview conducted with the MDS nurse on

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F 641	Continued From page 8 12/11/19 at 3:30 PM she stated her assistant had not coded the MDS assessment correctly. The MDS nurse sad her assistant was new to her role at the facility, and she felt that it was an error or over sight on her assistant's part. An interview with the Director of Nursing (DON) on 12/11/19 4:40 PM she stated, even though the MDS nurse assistant had only been in the role as the MDS nurse assistant for such a short time, should have documented Plavix medication correctly in Resident #50's MDS, and did not.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		12/27/19

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F 657	Continued From page 9 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise a care plan to reflect hospice services for 1 of 1 resident (Resident #7) reviewed for hospice. Findings included: Resident #7 had been admitted on 12/28/18. Her diagnoses included femur fracture, depression, psychosis and anxiety. Hospice documentation indicated Resident #7 had elected hospice services on 8/22/19. A significant change in status assessment Minimum Data Set (MDS) dated 9/2/19 indicated Resident #7 had received hospice services. Resident #7's care plans were reviewed on 12/8/19 at 2:05 PM. The care plans did not include hospice goals or interventions or indicate she had been receiving hospice services. An interview with MDS nurse #1 was conducted on 12/11/19 at 3:57 PM. The nurse stated that care plans should be revised after MDS assessments and the hospice care plan had been missed. On 12/11/2019 at 4:41 PM an interview was conducted with the Director of Nursing (DON). The DON stated it would be her expectation for care plans to be updated after assessments and to include hospice information as necessary.	F 657	Resident #7's are plan has been updated to reflect Hospice Care services 12/11/2019. All care plans have been audited for accuracy, even those not yet entered into electronic medical records. No other inaccuracies have been found. All care plans will be reviewed no less than quarterly or at a significant change/ incident and updated as needed for each Resident per their individual needs. Interdisciplinary team has been re-educated per the regulatory requirements of individual care planning. Updated care plans will be discussed weekly at the IDT/ CMI meeting as well as monthly x 3 months at the QAPI meeting.	

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F 698	Continued From page 10	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to monitor a dialysis resident ' s vascular access site used for dialysis (also known as an arterial-venous (A/V) fistula) and failed to record nursing assessments of the A/V fistula cite each shift for 1 of 1 residents reviewed for dialysis (Resident #85). Findings included: Resident #85 was admitted to the facility on 03/29/18. Diagnoses included end stage renal disease and dependent on dialysis. A review of the resident ' s care plan revealed a plan of care written on 03/29/18 for dialysis related to renal dysfunction. Interventions on the care plan included, in part, to monitor the vascular access site by checking for a bruit and thrill, monitor for signs or symptoms of an infection including, color, warmth, drainage, redness or swelling and to monitor for hemorrhaging and bleeding. The Minimum Data Set quarterly assessment dated 11/20/19 revealed the resident was cognitively aware and was receiving dialysis.	F 698	Each Resident who receives dialysis services was evaluated immediately at the AV fistula/ port site. Documentation was completed per the assessments and no other complications/ inaccuracies were observed. SDC immediately began to educate nursing staff regarding assessment of Residents receiving dialysis services which was completed 12/13/2019. The electronic medical record for each Resident receiving dialysis services was updated to reflect an eMAR requirement to document the observation of AV fistulas/ ports daily every shift. All new nursing staff will receive this education at orientation. This education will also be reinforced at the monthly nurses meeting for 3 months. This documentation will be reviewed weekly by DON/ ADON, monthly by the pharmacy consultant and monthly x 3 months at the QAPI.	12/27/19

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A review of the physician orders revealed there was an order written on the hard copy of the medication administration record (MAR) for Resident #85 to dialyze every Monday, Wednesday, and Friday (MWF). There was no order noted in the hard copy (chart) or in the electronic charting to monitor the A/V fistula access site for bruit and thrill.

A record review of the July, August and September, 2019 medication administration records revealed an order for the nurse to assess left arm dialysis site every MWF status post dialysis and document the bruit and thrill. The July MAR showed 4 days out of 14 dialysis days were signed off that the assessment was completed. The August MAR showed 8 days out of 13 dialysis days that were signed off that the assessment was completed. The September MAR was incomplete. There should have been 13 dialysis days signed off that the assessment was completed. There were no orders on the October, November and December, 2019 medication administration records to assess the left upper arm A/V fistula site.

An observation of Resident #85 on 12/10/19 at 10:30 AM revealed an alert and oriented resident sitting in his room watching television. The A/V fistula vascular access site was noted to be on his left upper arm. There was no dressing in place. There was no signs or symptoms of bleeding or infection.

An interview was conducted with Resident #85 on 12/10/19 at 10:30 AM. The resident reported he had an A/V fistula access site on his left upper arm. He reported he went to dialysis out of the

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facility on Mondays, Wednesdays and Fridays. The resident was asked if the nursing staff assessed his A/V vascular access site when he returned from dialysis. The resident reported staff did not check his site. The resident reported the dialysis nurse would put a dressing on his arm after dialyzing and he usually removed the dressing. The resident reported the nurses at the facility did not remove the dressing. The resident stated he did not recall any nurse at the facility using a stethoscope to check his site before or after dialysis or on any other day. The resident stated he has had no problems with bleeding or infection to his A/V fistula access site.

An interview was conducted with Nurse #2 on 12/10/19 at 11:30 AM. Nurse #2 reported prior to Resident #85 going to dialysis she checked the resident ' s vital signs. Nurse #2 stated she checked the resident ' s A/V fistula site when the resident returned. Nurse #2 was prompted to elaborate on how she "checked" the A/V fistula. The nurse stated she checked to see if the site was bleeding and reported the resident would usually take the dressing off himself by the time she went to assess him. The nurse stated she would check for a bruit and thrill. Nurse #2 reported to check for a bruit, the nurse would palpate the A/V fistula site to feel the pulse and blood flow. (The correct way to assess the bruit was for a nurse to use a stethoscope to listen for a swoosh sound over the A/V fistula site to indicate that it was unobstructed.) Nurse #2 then stated she would check for a thrill with a stethoscope by placing the stethoscope over the A/V site and listening for a swoosh sound. (The correct way to assess a thrill would be for a nurse to palpate the vascular access to feel for a thrill or vibration to indicate arterial and venous blood

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 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	1478 RIVER ROAD WINNABOW, NC 28479

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flow). Nurse #2 stated she believed the assessments were documented in the MAR. Nurse #2 was unable to provide documentation to support the A/V fistula access site was being monitored by checking for a bruit and thrill in the electronic chart or the hard copy charts. Nurse #2 stated the nurses should be documenting that the A/V fistula access site was assessed before and after dialysis.

An interview was conducted with the Director of Nursing (DON) on 12/11/19 at 3:15 PM. The DON reported the nursing staff needed to ensure they were assessing the vascular access cite every shift every day to make sure the access was patent (unobstructed) and documenting they were able to hear a bruit and palpate a thrill by putting a (+) for positive or (-) for a negative finding in the documentation and notify the physician if there were any concerns.