STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	**1478 River Road , Winnabow, North Carolina, 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
F0000	INITIAL COMMENTS The surveyor entered the facility on 2/17/26 survey to conduct a complaint investigation. The survey team was onsite 2/17/26 through 2/19/26. Additional information was obtained offsite on 2/20/26. Therefore, the exit date was 2/20/26. Event ID #1E42E011 The following intakes were investigated: 274419 and 2742511. 1 of the 2 complaint allegations resulted in deficiency.	F0000		03/06/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the staff, Consultant Pharmacist, Nurse Practitioner (NP), and Medical Director, the facility failed to prevent a significant medication error when Nurse #1 administered Resident #2 Haldol (an antipsychotic medication used to treat severe behavioral issues) IM (intramuscular) (delivered via injection) 20 milligrams (mg) instead of the ordered 2 mg. This deficient practice affected 1 of 3 residents reviewed for significant medication errors. The findings included: Hospital records indicated Resident #2 had been admitted from 2/3/26 through 2/9/26 for hip pain following a fall. His principal discharge diagnosis was failure to thrive in an adult. The hospital records also indicated he had active problems that included recurrent falls, severe protein-calorie malnutrition, benign paroxysmal positional vertigo (dizziness) and Parkinson's disease. Resident #2 was discharged from the hospital with recommendations to continue the	F0760	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/10/26 Resident #2 received an incorrect dose of Haldol intramuscular (IM) when nurse#1 received an emergent verbal order from nurse practitioner (NP) to administer 2 milligrams (mg) of Haldol intramuscularly (IM). Nurse #1 administered 20 mg Haldol IM resulting in a medication administration error. This was recognized by the administering nurse #1 shortly after medication administration. NP assessed resident #2 heart and lungs post medication administration with no adverse effects noted. Resident #2 was sent to Emergency Room for further evaluation/ monitoring per NP order for further respiratory and cardiac assessment. According to hospital records for resident #2, no adverse cardiac or respiratory effects from the Haldol dosage was noted/observed during hospitalization. Resident #2 discharged home post hospital stay. The root cause of this medication error was determined to be during the verbal order process. Nurse #1 did not verbalize the order back to the NP for dose verification prior to administration of medication. Nurse #1 was provided 1:1 education regarding verbal order receipt and dose confirmation by the Director of Nursing (DON) on 2/11/2026. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	03/12/2026

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 reverse for further 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.

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

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F0760 SS = D	Continued from page 1 following psychotropic medications (medications that alter a person's brain chemistry to modify a person's mood, thoughts, perceptions and behaviors): clozapine (antipsychotic medication that can be used off-label to treat severe behavioral issues) 12.5 mg twice a day for psychosis in Parkinson's disease, clonazepam (antianxiety medication) 0.5 mg at bedtime as needed for anxiety, and Remeron (antidepressant medication) 30 mg at bedtime. Resident #2 was admitted to the facility on 2/9/26 with diagnoses which included Parkinson's Disease, adult failure to thrive, severe protein-calorie malnutrition, benign paroxysmal vertigo, history of falling, depression and cognitive communication deficit. Physician orders for Resident #2 on admission (2/9/26) included the following psychotropic medications: clozapine 6.25 mg in the morning for psychosis in Parkinson's disease, clozapine 12.5 mg at bedtime for psychosis in Parkinson's disease, clonazepam 0.5 mg every 24 hours as needed for anxiety, and Remeron 30 mg at bedtime for depression. A Progress Note written by Nurse #2 on 2/10/26 at 11:32 AM indicated at 10:50 AM Resident #2 was observed walking to the bathroom on his own when staff tried to help and the resident got aggressive. Nurse #2 wrote that the resident punched her in the stomach and punched Nurse #3 in the stomach twice. The NP was made aware and gave orders to administer 2 mg Haldol IM every 8 hours as needed (prn) for agitation, fighting, and restlessness. An interview was conducted with Nurse #2 on 2/19/26 at 10:41 AM. Nurse #2 confirmed she worked on 2/10/26 and was assigned to care for Resident #2 that day. She indicated at approximately 11:00 AM that morning she and Nurse #3 assisted Resident #2 to the bathroom. She stated as they were assisting the resident, he "head-butted" Nurse #3 in the chest and slapped Nurse #3 on her buttocks. Nurse #2 stated his behavior escalated and became violent. She stated they were unable to redirect him. She indicated she spoke with the NP, who was present at the facility, and made her aware of the resident's behaviors. The NP gave a verbal order for Haldol 2 mg IM. Nurse #2 stated before she left the nurses' station to obtain the medication from the emergency medication supply, she returned to Resident #2's room to reassess him. She stated the	F0760	Continued from page 1 Residents residing in the facility have the potential to be affected by identified deficiency. An audit of resident medication orders for errors/dose discrepancy was completed by the Nurse Educator on 2/11/26 with no further issues noted. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 2/10/2026 the Nurse Educator initiated education with staff and contract nurses regarding verbal order transcription on read back safety process 100% of the staff and contract nurses were educated by 2/13/2026. Any new or prn/contract nurses were educated by phone or verbally prior to working by the nurse educator or designee. Education provided by the Nurse Educator for licensed nursing staff regarding emergency verbal medication orders requiring second nurse verification of correct dosage prior to administration. Emergency verbal orders requiring utilization of in-house medication dispense machine will be written on a physician's order sheet and dosage confirmed by a second nurse prior to administration. Second nurse will co-sign on physicians' order sheet. This process was effective 3/12/2026. Education of 100% of providers, staff and contract nurses was completed in person or via phone 3/12/2026. New and/or as needed (PRN) licensed nursing staff to include contract nurses will receive education in person or via phone by Nurse educator or designee prior to working in facility. Director of Nursing and/or designee will review new orders daily to identify emergency verbal medication orders requiring utilization of in-house medication dispense machine and verify two nurses validated correct dosage prior to administration of medication. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. Director of Nursing and/or designee will maintain a log of identified emergency verbal medication orders to include validation of two nurse verification of dosage prior to administration of medication. A tool was created (Emergency Verbal medication order Audit Tool) to allow comparison of previous day orders and any Emergent physician order sheets for accuracy. This daily monitoring will remain in place x 30 days and will be extended should further deficient practice be identified.	

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F0760 SS = D	Continued from page 2 resident's behavior had continued to escalate. Nurse #2 reported the NP then asked if she wanted another nurse to retrieve the medication, and she agreed. A Progress Note written by Nurse #1 on 2/10/26 at 12:30 PM indicated she received a verbal order from the NP for IM Haldol immediately related to verbal and physical aggression towards staff. The note indicated she administered a 20 mg IM dose instead of the 2 mg dose that was ordered. The provider was made aware immediately and the resident was sent out to Emergency Department (ED) for evaluation. An interview was conducted with Nurse #1 on 2/17/26 at 2:35 PM. Nurse #1 stated she was a Unit Manager and had worked on 2/10/26. She indicated the NP came to the nurse's station and informed her the nurses needed assistance. A verbal order was given for Haldol IM and she went to obtain the medication from the emergency medication supply. Nurse #1 explained that the order for the Haldol was not yet written, and she could not recall if the NP told her how much Haldol was to be given; yet for some reason, 20 mg "stuck in her head." She stated she did not think to repeat the order back to the NP before she went to obtain the medication. She stated the only form of Haldol located in the emergency medication supply was vials that contained 5 mg/milliliter (ml). She stated there were 4 vials of Haldol 5 mg/ml in the emergency medication supply, and she took all 4 vials and then went to the supply room to get a needle and syringe. She indicated she administered 20 mg of Haldol IM to Resident #2. Nurse #1 stated the resident did not react to the injection. Nurse #1 indicated that she went to nurse's station and informed Nurse #2 and the NP that she administered 20 mg of Haldol to Resident #2. Nurse #1 stated that no one questioned her when she said 20 mg. Nurse #1 stated she went to a different nurse's station to complete paperwork she had been working on when she noticed the NP had left the written Haldol order there on her computer for her (Nurse #1) to enter it into the medical record. She explained that as she entered the order and got to the part where she had to enter the equation of what was on hand into the order, she said that was when it "clicked" that she had administered 20 mg instead of 2 mg. Nurse #1 stated she immediately went to Nurse #2 and informed her of the medication error, instructed Nurse #2 to monitor the resident for lethargy, and then went to inform the NP of the error. She stated the NP gave her orders to send the resident out to the hospital for cardiac monitoring. Nurse #1 stated Emergency Medical Services (EMS) arrived within	F0760	Continued from page 2 This corrective action plan was presented in 2/17/2026 QAPI meeting by the Director of Nursing. Results of daily monitoring will continue to be reported to the facility's monthly QAPI committee by the Director of Nursing/or designee until further recommendation by QAPI committee. This corrective action plan will be completed on 3/12/2026.	

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F0760 SS = D	Continued from page 3 15 minutes and took the resident to the hospital. During an interview with Nurse #2 on 2/19/26 at 10:41 AM she stated that she was at the nurses' station on 2/10/26 when Nurse #1 came to inform her and the NP that she had made a medication error and administered 20 mg of Haldol instead of 2 mg to Resident #2. Nurse #2 stated she attempted to assess the resident and obtain vital signs. She explained that she placed a blood pressure cuff on the resident's arm; however, she could not obtain a reading because he would not remain still. Nurse #2 stated she notified the NP and Nurse #1, and the decision was made to call EMS and transfer the resident to the ED. Nurse #2 stated later that day the hospital contacted the facility and reported Resident #2 was stable and remained mildly agitated. An interview was conducted with the NP on 2/18/26 at 11:18 AM. She stated on 2/10/26 she observed Resident #2 kicking, punching, scratching, and grabbing at staff and observed as staff tried redirecting him with methods such as providing him an activity, offering him food and drink, and toileting; however, these methods did not help him and his behaviors continued to escalate. She further explained Resident #2 had just been admitted to the facility the day before and prior to this episode, these behaviors had never been witnessed. The NP reported that the resident's hospital paperwork indicated he had a history of delirium (sudden, temporary, and fluctuating state of severe confusion and reduced awareness), so it was expected that he would have some behaviors transitioning to the facility. The NP stated she reviewed Resident #2's medical record for any medication allergies and then made the decision to write an order for Haldol 2 mg IM. She stated she gave Nurse #1 a verbal order for the medication first and then wrote the order. The NP stated she clearly recalled that she instructed Nurse #1 to administer Haldol 2 mg IM injection. She reported she told Nurse #1 that she would write the order and leave it there for her to enter it into the medical record later. The NP stated Nurse #1 left to get the medication out of the emergency medication supply and she (the NP) wrote the order and then left to continue rounding on other residents. The NP indicated that shortly after, Nurse #1 came to her and informed her that she had administered 20 mg of Haldol to Resident #1 instead of 2 mg of Haldol. She explained that Haldol could cause over-sedation which then could lead to cardiac symptoms such as heart arrhythmias (abnormal heart rhythm) and respiratory depression (a dangerous condition where breathing becomes too slow or shallow,	F0760		

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F0760 SS = D	Continued from page 4 causing carbon dioxide to build up in the blood) and that at higher doses could increase these risks. She further explained that due to that reason, she instructed Nurse #1 to transfer Resident #2 to the ED for evaluation and monitoring. She reported that she observed Resident #2 prior to his ED transfer sitting in his wheelchair at the nurses' station and that he did not exhibit any signs or symptoms of acute distress. She said at that point, the resident was awake, alert, sitting calmly, and was not displaying any behaviors. The NP stated she assessed the resident and that his heart and lungs were within normal limits and he appeared stable. Resident #2's Admission History and Physical completed by the Medical Director, dated 2/10/26, indicated the hospital discharge summary for the resident's stay prior to admission indicated he had significant hallucinations. The Medical Director's assessment included psychosis related to Parkinson's disease. The resident was admitted on clozapine. Resident #2 was noted to require close monitoring and psychiatric follow-up due to his diagnosis and medication regimen. The Medical Director documented that after evaluating the resident at the facility that day (2/10/26), he received a call from the facility reporting a medication error. The NP had ordered Haldol 2 mg IM, however, Resident #2 received 20 mg and was transferred to the ED for monitoring. The hospital record indicated on 2/10/26 Resident #2 presented to the hospital due to agitation and aggressive behavior at the facility. The resident had been discharged from the hospital to the facility the day before (2/9/26) for physical debility related to Parkinson's disease. After admission to the facility, he developed worsening paranoia and aggressive behaviors, including attempts of physical assault. Facility staff administered 20 mg of Haldol IM in error when a lower dose had been intended. Resident #2's heart was a normal rate and rhythm, he was able to protect his airway, laboratory studies were appropriate, and electrocardiogram (EKG) showed no arrhythmias. The resident remained paranoid and suspicious of others and the hospital admitted him for further evaluation and monitoring. The Hospitalist (physician in charge of Resident #2's care) consulted with Resident #2's neurologist who provided recommendations for low dose Seroquel or low dose Risperdal (both antipsychotic medications) should they require additional medications to treat his paranoia, psychosis and delusions (firm, fixed, and false beliefs	F0760		

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F0760 SS = D	Continued from page 5 that cannot be changed by evidence or reason) while he was in the hospital. Resident #2's family member had been pleased with his mobility progress while at the hospital and elected to take him home with plans for outpatient physical therapy. The resident had no outbursts while at the hospital, however his paranoid delusions persisted and the Hospitalist ordered for home Clozapine therapy, adjusted to 12.5 mg twice a day. Resident was discharged home on 2/13/26. A telephone interview was conducted with the Medical Director on 2/18/26 at 2:55 PM. The Medical Director stated that once staff identified the medication error on 2/10/26, the resident was immediately transferred to the hospital for evaluation and treatment. He explained that he was informed of the medication error on 2/10/26 by Nurse #1 after Resident #2 had already been transferred to the hospital. The Medical Director stated that due to the medication error and the potential for serious harm, sending the resident to the hospital for evaluation and monitoring was appropriate. He reported that based on the information provided to him by Nurse #1 after the medication error occurred, the resident appeared to pose a danger to himself and staff on 2/10/26. The Medical Director stated he believed the order for Haldol 2 mg IM was appropriate at that time. He reported that Haldol and other antipsychotic medications carried a risk of cardiac arrhythmias. He indicated he could not state how quickly cardiac symptoms could occur after a high dose of Haldol and indicated the question would be better addressed by the Consultant Pharmacist. During the interview, the Medical Director reviewed the hospital record for Resident #2 and stated the resident was monitored in the ED for 24 hours and did not experience cardiac arrhythmias. An interview was conducted with the facility's Consultant Pharmacist on 2/18/26 at 3:27 PM. She stated the DON informed her of the medication error for Resident #2 on 2/11/26. The Consultant Pharmacist stated that based on the reported behaviors, an order for Haldol 2 mg IM was appropriate. She explained that 2 mg IM is considered a starting dose. She stated that in an acute psychotic episode, the dose may be repeated hourly, depending on the resident's response. The Consultant Pharmacist indicated that Haldol dosing depended on the individual. She explained that common side effects of a 2 mg dose include sleepiness and a calming effect, with the goal of calming the individual without causing sleep. She further explained that the potential for adverse effects increased as the dose	F0760		

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F0760 SS = D	Continued from page 6 increased. She stated higher doses increased the risk of cardiac symptoms, including QT prolongation (an electrical abnormality seen on an EKG in which the heart muscle takes longer than normal to recharge between beats). She reported Haldol could also cause respiratory depression and coma in overdose situations. The Consultant Pharmacist stated that 20 mg was not automatically considered an overdose. She stated she reviewed the Haldol package insert and noted the maximum recommended dose listed was 30 mg. The Consultant Pharmacist stated that although 20 mg was below the listed maximum dose, it was a high dose given at one time and sending Resident #2 to the ED for monitoring was appropriate. An interview was conducted with the DON on 2/19/26 at 12:23 PM. The DON stated the medication error occurred during an incident in which the resident was combative and aggressive toward staff. The DON stated the nurse (Nurse #1) who received the order did not repeat the order back to the NP. She stated this breakdown in the process contributed to the medication error. The DON stated it was her expectation that nurses follow best practices when receiving and implementing medication orders and indicated that best practices included repeating the verbal order back to the NP. An interview with the Administrator was conducted on 2/20/26 at 9:28 AM. The Administrator stated it was his expectation the nurses follow the physician's medication orders. He stated that nurses should check and double-check orders to ensure they administer the correct medication and dose. The facility provided a corrective action plan that was not acceptable to the state survey agency.	F0760		