STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on site complaint investigation survey was conducted on 10/13/21. One of the 6 complaint allegations was substantiated resulting in deficiency. Event ID# LGIE11	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to treat a pressure ulcer by not completing a daily dressing change as ordered by the Physician for 1 of 2 residents observed for pressure ulcers. (Resident #1) Findings included: Resident #1 was admitted to the facility on 08/16/21. Diagnoses included, in part, a left fractured femur, peripheral vascular disease, and protein calorie malnutrition. The Minimum Data Set (an admission	F 686	Preparation and submission of this plan of correction does not constitute an admission of or an agreement with. It is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1.) Corrective action for affected resident. There was no harm to Resident #1 as a result of dressing not being changed. The Director of Nursing and or, designee will perform a skin audit of all current	11/10/21

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

Electronically Signed | 11/03/2021

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F 686	Continued From page 1 assessment) dated 08/22/21 revealed Resident #1 was severely cognitively impaired and was not assessed at this time as having a pressure ulcer but was assessed as having a surgical wound and moisture associated skin damage. Resident #1 had a pressure reducing mattress to her bed and pressure reducing pad to her chair. On 09/09/21 a VOHRA (facility wound consultant) consult was ordered for an unstageable pressure ulcer to the left heel. A review of Resident #1 ' s care plan initiated on 08/17/21 and updated on 09/10/21 included a plan of care for impaired skin integrity to left hip surgical incision, multiple venous (vascular) stasis wounds to bilateral extremities and left great toe and a pressure ulcer to the left heel. Interventions included, in part, to administer treatments as ordered and assess and document the status of the area. A physician ' s order written on 09/11/21 for Resident #1 ' s left heel was to cleanse with normal saline, apply calcium alginate to open area, and apply skin prep to eschar area and wrap with gauze. A review of the consult assessment by VOHRA on 09/13/21 confirmed the wound to the left heel ulcer measuring 1.7 X 2.4 X 0.1 was vascular (related to poor blood flow) and the order was changed to Santyl ointment (a debriding agent which removed damaged tissues from a wound) 250 units per gram to left heel topically (on top of skin) and cover with clean dry dressing daily. A physician order written on 09/14/21 for the left heel vascular ulcer included to cleanse area with	F 686	residents to ensure there are no new issues present. No new areas were identified as a result of this audit. This audit was completed on 10/27/2021 2.) How will the facility identify other like residents. All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing, and or designee will perform an audit of all current residents requiring dressing changes to ensure they are dated properly. This audit was completed on 10/27/2021 3.) What will be done to prevent reoccurrence. The Director of Nursing and or, designee will educate licensed nurses and certified nursing assistants on basic skin care. Licensed nurses were educated on following physician orders and ensuring dressing are dated appropriately. The education was completed on 10/19/2021. Licensed nurses and certified nursing assistants who have not received the education will not take an assignment until they receive the education from the Director of Nursing and or designee. Any agency nurses/certified nursing assistants and newly hired licensed staff will receive the education during orientation by the Director of Nursing and or designee. 4.) How will the facility monitor and maintain ongoing compliance. The	

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F 686	Continued From page 2 normal saline, apply Santyl ointment 250 units per gram to left heel topically every day for wound care and cover with a clean dry dressing. A VOHRA wound assessment was completed on 09/20/21 and now indicated the wound to the left heel was a pressure ulcer (deep tissue injury) measuring 2.5 X 3.5 X 0.1. A VOHRA wound assessment on 09/27/21 for the left heel pressure ulcer deep tissue injury measuring 2.2 X 2.5 X 0.1 indicated the wound was improving and to continue with cleansing area with normal saline, apply Santyl ointment and cover with clean dry dressing. A VOHRA wound assessment on 10/11/21 revealed the wound was a stage 4 pressure ulcer to the left heel measuring 1.8 X 1.8 X 0.1 and improving. The treatment was changed to cleanse with normal saline, apply Santyl ointment and calcium alginate, and cover with a clean dry dressing every day. A Physician order written on 10/11/21 revealed an order to cleanse left heel pressure ulcer with normal saline, apply Santyl 250 units per gram and calcium alginate, cover with a clean dry dressing every day. An observation of wound care to Resident #1 ' s left heel was conducted with Nurse #1 on 10/13/21 at 1:50 PM. Nurse #1 proceeded to change the dressing to the left heel for Resident #1 and removed the nonskid sock from her left foot. The current dressing was in tact and dated 10/11/21 with Nurse #1 ' s initials. The measurements were recorded as 1.8 X 1.8 X 0.1.	F 686	Director of Nursing and or designee will monitor all treatments completed to ensure the appropriate date is present. Director of Nursing and or designee will perform audits 5x a week for 3 weeks, then 2x a week for 3 weeks, then weekly for 3 weeks. Results of the audit will be reviewed monthly for 4 months by the Quality Assessment Process Improvement Committee for recommendations and or additional audits	

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F 686	Continued From page 3 An interview was conducted with Nurse #1 on 10/13/21 at 2:00 PM. Nurse #1 reported the dressing change for Resident #1 was ordered to be done daily. Nurse #1 confirmed the current dressing that was in place dated 10/11/21 were her initials and she last changed the dressing on 10/11/21 as ordered. Nurse #1 stated she was not assigned to Resident #1 on 10/12/21 and did not know why the dressing was not changed by the nurse that was assigned to her. An interview was conducted with Nurse #2 via phone on 10/13/21 at 2:22 PM. Nurse #2 confirmed that she was assigned to Resident #1 on 10/12/21 and stated she did not change the dressing as ordered to the left heel pressure ulcer because she was very busy and had passed it on to be done with Nurse #3 on the next shift. An interview was conducted with the Director of Nursing (DON) on 10/13/21 at 2:40 PM. The DON reported she spoke with Nurse #3 and Nurse #3 reported she had no knowledge of being asked to do the dressing change to Resident #1 ' s left heel on 10/12/21 when she and Nurse #2 reported off. The DON reported the treatment order was in place to monitor and assess the wound daily and Nurse #2 should have changed the dressing for Resident #1 on 10/12/21 per the physician order.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		11/10/21

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F 842	Continued From page 4	F 842		

accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 5 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility inaccurately documented on the treatment administration record that a daily pressure ulcer treatment was done. The facility indicated the treatment was done, by signing the treatment administration record, but the order had not been followed and the treatment was not done on 10/12/21 as documented for 1 of 2 residents observed for pressure ulcers. (Resident #1) Findings included: Resident #1 was admitted to the facility on 08/16/21. Diagnoses included, in part, a left fractured femur, peripheral vascular disease, and protein calorie malnutrition.	F 842	1. Corrective action for affected resident. Resident #1 was not harmed as a result of the alleged deficient practice of inaccurate documentation. The treatment was completed and appropriately documented on 10/13/2021 per the physician order. 2. How will the facility identify other like residents. The Director of Nursing and or designee will audit current residents with dressing change orders to ensure appropriate documentation was completed. This audit was completed on 10/27/2021 and no discrepancies were found. 3. What will the facility do to prevent this	

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F 842	Continued From page 6 A Physician order written on 10/11/21 revealed an order to cleanse left heel pressure ulcer with normal saline, apply Santyl 250 units per gram and calcium alginate, cover with a clean dry dressing every day. An observation of wound care to Resident #1 ' s left heel was conducted with Nurse #1 on 10/13/21 at 1:50 PM. Nurse #1 proceeded to change the dressing to the left heel for Resident #1 and removed the nonskid sock from her left foot. The current dressing was intact and dated 10/11/21 with Nurse #1 ' s initials. The measurements were recorded as 1.8 X 1.8 X 0.1 and Nurse #1 proceeded to complete the dressing change as ordered. An interview was conducted with Nurse #1 on 10/13/21 at 2:00 PM. Nurse #1 reported the dressing change for Resident #1 was ordered to be done daily. Nurse #1 confirmed the current dressing that was in place dated 10/11/21 were her initials and she last changed the dressing on 10/11/21 as ordered. Nurse #1 stated she was not assigned to Resident #1 on 10/12/21 and did not know why the dressing was not changed by the nurse that was assigned to Resident #1. An interview was conducted with Nurse #2 via phone on 10/13/21 at 2:22 PM. Nurse #2 confirmed that she was assigned to Resident #1 on 10/12/21 and stated she did not change the dressing as ordered to the left heel pressure ulcer because she was very busy and had passed it on to be done with Nurse #3 on the next shift. Nurse #2 stated she did not know why her initials were on the Treatment Administration Record (TAR) which would indicate the dressing had been done.	F 842	from reoccurring. The Director of Nursing and or designee will educate licensed staff on following physician orders as written and document appropriately with the correct date in the medical record. This education was completed on 10/19/2021. Licensed nurses and certified nursing assistants who have not received the education will not take an assignment until they receive the education from the Director of Nursing and or designee. Any agency nurses/certified nursing assistants and newly hired licensed staff will receive the education during orientation by the Director of Nursing and or designee. How will the facility monitor and maintain ongoing compliance. The Director of nursing and or designee will monitor treatments that require a dressing change to ensure the are properly dated and documented in the medical record. Director of Nursing and or designee will perform audits 5x a week for 3 weeks, then 2x a week for 3 weeks, then weekly for 3 weeks. Results of the audit will be reviewed monthly for 4 months by the Quality Assessment Process Improvement Committee for recommendations and or additional audits	

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F 842	Continued From page 7 Nurse #2 stated if she did not to the treatment she would not have signed off on it. An interview was conducted with the Director of Nursing (DON) on 10/13/21 at 3:40 PM. The DON reported she spoke with Nurse #3 and Nurse #3 reported she had no knowledge of being asked to do the dressing change to Resident #1 ' s left heel on 10/12/21 when she and Nurse #2 reported off. The DON reported the treatment order was in place to monitor and assess the wound daily and Nurse #2 should have changed the dressing for Resident #1 on 10/12/21 per the physician order.	F 842		