STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345571	A. BUILDING _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY CREEK HEALTH CENTER	740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403

(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
E 000	Initial Comments An unannounced Recertification survey was conducted from 12/19/22 through 12/22/22. The facility was found to be in compliance with the requirement of CFR. 483.73 Emergency Preparedness. Event ID # T5UZ11.	E 000		
F 000	INITIAL COMMENTS An unannounced annual Recertification and complaint investigation was completed at this facility from 12/19/22 through 12/22/22. Event ID# T5UZ11. 1 of 1 complaint allegation was unsubstantiated. NC00194812.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		1/31/23

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

Electronically Signed | 01/15/2023

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F 761	Continued From page 1 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, manufacturer's instructions, staff interviews and Consultant Pharmacist interviews, the facility failed to store an unopened bottle of eye drops in the refrigerator specified by the manufacturer's instructions for 1 of 3 medication carts and failed to record an opened date on two opened bottles of eye drops for 1 of 3 medications carts observed for medication storage. Findings included: 1. During an observation with Nurse #1 on medication cart #1 on 12/20/22 at 9:30 AM an unopened bottle of Travoprost Solution 0.004% eye drops was not refrigerated as indicated on the manufacturer's instructions which stated, "store unopened bottle in refrigerator, once opened store at room temperature and discard remaining amount not used after 6 weeks." An interview was conducted with Nurse #1 on 12/20/22 at 9:38 AM. Nurse #1 confirmed the label indicated the unopened eye drop solution should be refrigerated. Nurse #1 reported she did not know the eye drop solution was supposed to be refrigerated until it was opened. A phone interview was conducted with the Consultant Pharmacist on 12/22/22 at 10:55 AM. The Consultant Pharmacist stated the manufacturer's instructions should always be followed to ensure the medication maintains its efficacy.	F 761	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1. Interventions for affected resident: No residents were affected by the alleged deficient practice. The Director of Nursing immediately removed and discarded the undated and unrefrigerated eye drops. There were no adverse effects from the undated and unrefrigerated eye drops. 2. Interventions for residents identified as having potential to be affected: All residents receiving eye drops have the potential to be affected. On 1/12/2023 the Director of Nursing audited all medication carts to ensure that eye drops were dated and stored according to manufacturers instructions. (See Exhibit One) 3. Systemic Changes:	

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F 761	Continued From page 2 An interview was conducted with the Director of Nursing (DON) on 12/22/22 at 3:00 PM. The DON reported she expected her nursing staff to be following the manufacturer's instructions and labels as it pertained to medications. 2. During an observation with Nurse #1 on medication cart #1 on 12/20/22 at 9:30 AM revealed 2 bottles of Latanoprost Solution 0.005% eye drops were noted to be opened with no opened date indicated. Review of the manufacturer's instructions revealed "store unopened bottle in refrigerator, once opened store at room temperature and discard remaining amount not used after 6 weeks." An interview with Nurse #1 revealed after opening the Latanoprost bottles, they should have been labeled with the date they were opened. Nurse #1 added, she did not know the eye drops were only good for 6 weeks after opening. A phone interview was conducted with the Consultant Pharmacist on 12/22/22 at 10:55 AM. The Consultant Pharmacist stated the manufacturer's instructions should always be followed to ensure the medication maintains its efficacy. The Pharmacist added, the medication should be discarded after 6 weeks from opening and without the date recorded when it was opened, staff would not know when to discard the medication. An interview was conducted with the Director of Nursing (DON) on 12/22/22 at 3:00 PM. The DON reported she expected her nursing staff to	F 761	On 1/11/2023 the Director of Nursing began education of all full time, part time, and as needed licensed staff on proper labeling and storage of eye drops. (See Exhibit Two) The Director of Nursing will ensure that any licensed staff who do not complete the in-service training by 1/25/2023 will not be allowed to work until the education is completed. 4. Quality Assurance Plan: The Director of Nursing or Designee will complete weekly audits to monitor for compliance in the proper labeling and storage of eye drops. (See Exhibit Three) These audits will be completed weekly x 4 weeks, then 2x per month x 1 month, then monthly x 2 months and as needed thereafter. Compliance and effectiveness of the auditing program will be reviewed at the monthly Quality Assurance Performance Improvement meeting.	

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F 761	Continued From page 3 be following the manufacturer's instructions and labels as it pertained to medications.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired food items stored for use in the walk-in refrigerator. This practice had the potential to affect the foods served to the residents. The findings included: Initial observation of the kitchen walk-in refrigerator occurred on 12/19/2022 at 10:15 AM with the Director of Dining Services and revealed a plastic container of mandarin oranges with a	F 812	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.	1/31/23

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F 812	Continued From page 4 discard date of 12/14/2022. A follow-up observation of the kitchen walk-in refrigerator on 12/21/2022 at 11:25 AM revealed a plastic container of yellow sliced cheese with a discard date of 12/19/2022 and a plastic container of chocolate mousse with a discard date of 12/19/2022. An interview with the Chef was completed on 12/21/2022 at 11:25 AM. The Chef stated that the expired food items observed on 12/19/22 and 12/21/2022 should have been discarded. He further stated that all the Dining Services staff were responsible for removing expired food items from the walk-in refrigerator. An interview with the Administrator occurred on 12/21/2022 at 3:45 AM. The Administrator stated that she expected the Dining Services staff to follow safe food handling practices when labeling and storing food items.	F 812	1. Interventions for affected resident: No residents were affected by the alleged deficient practice. The expired cheese, chocolate mousse and mandarin oranges were immediately removed and discarded by the Director of Dining Services. 2. Interventions for residents identified as having potential to be affected: All residents have the potential to be affected. On 1/12/2023 the Director of Dining Services audited the walk-in refrigerator to ensure all expired items were discarded.(See Exhibit Four) 3. Systemic Changes: On 1/12/2023 the Director of Dining Services began education of all full time, part time, and as needed food service staff on discarding expired items timely. (See Exhibit Five) The Director of Dining Services will ensure that any of the above food service staff who do not complete the in-service training by 1/25/2023 will not be allowed to work until the education is completed. 4. Quality Assurance Plan: The Director of Dining Services or Designee will complete weekly audits to monitor for compliance in the discarding of expired items timely. (See Exhibit Six) These audits will be completed weekly x 4 weeks, then 2x per month x 1 month, then monthly x 2 months and as needed	

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F 812	Continued From page 5	F 812	thereafter. Compliance and effectiveness of the auditing program will be reviewed at the monthly Quality Assurance Performance Improvement meeting.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring,	F 867		1/31/23

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F 867	Continued From page 6	F 867		

including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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F 867	Continued From page 7 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F 867		

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F 867	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 10/8/2021. This was for 1 deficiency cited in the area of Food and Nutrition Services (F812). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F 812: Based on observations and staff interviews the facility failed to remove expired food items stored for use in the walk-in refrigerator. This practice had the potential to affect the foods served to the residents. During the recertification and complaint survey completed 10/8/2021 the facility failed to maintain safe food temperatures for potentially hazardous foods. Hot foods should be maintained at a temperature of 135 degrees or higher and cold foods should be maintained at a temperature of 41 degrees or lower. A telephone interview was completed with the Administrator on 12/22/2022 at 09:31 AM. The Administrator stated that she didn't think the facility's QA program for the kitchen had failed. She further stated that the facility was previously cited for failing to maintain safe food	F 867	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1) Interventions for affected resident: No residents were affected by the alleged deficient practice. The Director of Dining Services discarded the yellow cheese, container of mandarin oranges and chocolate mousse. 2) Interventions for residents as having potential to be affected: A Quality Assurance Performance Improvement meeting was held on 1/13/2023 to discuss the process for ensuring accurate auditing and use of the Quality Assurance Tool regarding expired food items in the walk-in refrigerator. (See Exhibit Seven) 3) Systemic Changes: On 1/13/23 the Director of Dining Services was re-educated by the Administrator on the Quality Assurance Performance Improvement process and the Quality	

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F 867	Continued From page 9 temperatures and that was not an issue during the current survey. The Administrator indicated that the facility would focus on developing a QA specific for safe food handling and storage practices.	F 867	Assurance Tool for auditing the walk-in refrigerator for expired food items. (See Exhibit Eight) 4) Quality Assurance Plan: The Director of Dining Services and the Administrator will perform audits on the walk-in refrigerator for expired food items process weekly x 4 weeks, then 2x per month x 1 month, then monthly x 2 months. (See Exhibit Nine) A Quality Assurance Performance Improvement meeting will be held weekly x 4 weeks, then monthly to review and discuss the facility adherence to and accuracy of the Quality Assurance tool and monitoring process. (See Exhibit Ten)	