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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on record review, Physician interview, Nurse Practitioner (NP) interview, staff interviews, and Responsible Party (RP) interview, the facility failed to notify the resident's (Resident #89) Responsible Party (RP) and the facility Physician of the resident's fall and change in condition for 1 of 4 sampled residents reviewed for change of condition. Findings included: Resident #89 was originally admitted to the facility on [DATE]; she was readmitted on [DATE]. Her diagnoses included malignant neoplasm of colon, weakness, malignant neoplasm of unspecified ovary. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #89 was cognitively intact. She was independent concerning mobility which included sitting to lying, chair/bed to chair transfer, toilet transfer, tub/shower transfer, walking 10 ft, walking 50 feet with 2 turns, and walking 150ft. She was in hospice care. Review of Resident#89's electronic medical record (EMR) listed her daughter #1 as her responsible person (RP). Review of Nurse #1's progress notes revealed on 7/14/2024 resident #89 was found lying on the floor beside her bed. She had fallen out of bed and hit her head on the trash can. She was found to have a 1/2-centimeter (cm) laceration over left eyebrow. Resident #89's family who lived locally, (daughter #2 and resident #89's son in law), came to visit her. The nursing documentation further stated resident #89 knew daughter #2 and her son in law and spoke with them at that time. (continued on next page)

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

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/23/24 12:28 PM with Nurse #1. She stated she did not witness the fall. She added resident #89 was in hospice and had a do not resuscitate order (DNR). She stated she was notified by Nurse #2 that resident fell and had a gash on her head. She stated resident #89 was placed back to bed and she was still talking at that time. Nurse #1 asked Nurse #2 if resident needed to go out. Nurse #1 stated Nurse #2 called resident #89's hospice nurse. Nurse #1 stated daughter #2 and son in law came to visit resident #89 and was informed about the fall. Nurse #1 added daughter #2 came to the nursing desk to tell them resident #89 fell asleep and they would come back another time. Nurse #1 stated the hospice nurse arrived and stated the hospice nurse called the physician and daughter #1 (RP) in North Dakota (ND) who told her she did not want resident #89 to be sent out. Nurse #1 added the next day the Nurse Practitioner (NP) came in and spoke to daughter #2 and son in law (who live locally), as well as daughter #1. The hospice supervisor was present as well. Daughter #1 living in ND was put on speaker phone and stated she did not want resident #89 sent out. An interview was conducted on 7/23/24 at 3:00pm with daughter #2 who was present after resident #89 fell . She stated she and her husband walked into resident #89's room and was told by staff resident had just fallen. She stated resident #89 responded to her. Approximately 15-20 minutes later resident #89's eyes closed, and she started snoring. She then called her brother, who lives locally and told him something wasn't right. At that point resident #89 opened her eyes, leading daughter #2 to think she was overreacting. She stated she went out to nursing desk and told them resident#89 was asleep and they would come back. She stated around 7pm her sister/resident #89's RP called her and told her the hospice nurse called her and informed her resident #89 fell and she had symptoms of a possible brain bleed. An interview was conducted on 7/23/24 at 2:41pm with resident #89's daughter #1/RP. She stated she found out about resident #89's fall and unconscious state from the Hospice Nurse the evening of 7/14/2024. Daughter #1 was not notified by the facility until the next day that resident #89 fell and was not responsive. An interview was conducted on 07/24/24 at 11:56 AM with Nurse #2. She stated she recalled resident #89 fell and hit her head. She believes she was the one who called hospice. She stated she was present when hospice came, however does not recall a phone conversation with resident #89's RP. She does recall another daughter being present. She stated resident #89 had been declining in the previous weeks. She recalled that resident #89 was alert at the time she left her shift. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/24/24 at 2:29 PM with the Hospice Nurse. She stated the facility called her about resident #89's fall. She arrived at the facility between 5:30-6:00pm on 7/14/2024 and spoke to Nurse #2 who told her resident #89 had a small cut on her forehead and was talking since the last report. The hospice nurse stated she walked into resident #89's room, found her lying in bed asleep and snoring. She attempted to wake her, performed a sternal rub, and got no response. She checked her pupils which were pin-point and fixed. She stated she then went down to the nurse's station and called resident #89's RP to inform her what happened. The RP told the Hospice Nurse the facility hadn't contacted her yet about it. The Hospice Nurse and resident #89's RP discussed the options of sending her to the hospital or keeping her at the facility and keeping her comfortable; the RP told the Hospice Nurse not to send resident #89 out, to just keep her comfortable. After leaving the facility, the hospice nurse stated resident #89's RP called her back and told her she was concerned after speaking to a male nurse, that resident would not be made comfortable/monitored for seizures/get the care she needed. The Hospice Nurse stated she told the RP she would stay the night with her and returned to the facility around 9:30pm. The Hospice Nurse stated she stayed with resident and received updated pain medication orders from as needed to every 2 hours after speaking with her hospice physician. The Hospice Nurse stated she did not notice any seizure activity. Review of the Nurse Practitioner's progress note dated 7/15/2024 revealed she was not made aware of this resident #89's condition until she came in to do rounds. The NP's progress note indicated she had a detailed conversation with resident #89's son, Hospice Nurse, and her RP (via telephone) at which time resident #89's RP wanted her to have comfort measures only. The NP's progress note included that the facility staff/hospice team were made aware of the importance of contacting teamhealth whenever there is a change and or a need to speak to a provider regarding her care. During an interview on 7/24/24 at 10:41AM with the facility Nurse Practitioner she indicated resident #89's RP did not want her sent out. She added she would expect to be notified of any changes in status. An interview was conducted with the facility physician on 7/24/24 at 11:33 AM, who stated per review of NP's progress note dated 7/15/24, she was not notified of resident #89's fall until 7/15/24. He further added that his review of on call records for his practice revealed no notations of any incoming calls from facility on 7/14/2024-7/15/2024. Although he was not on call on 7/14/2024, he would expect the facility to contact the on-call provider for changes in a resident's condition.

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services for 2 of 3 (Resident #112 and Resident #115) residents reviewed for beneficiary protection review. The findings included: 1. Resident #112 was admitted to the facility on [DATE] and admitted to Medicare Part A services. Resident #112's admission Minimum Data Set assessment dated [DATE] revealed the resident had moderate cognitive impairment. Resident #112's Medicare Part A skilled services ended on 4/30/24 and he remained in the facility. Review of Resident #112's medical records revealed a NOMNC (Notice of Medicare Non-Coverage) was signed on 4/26/24. Record review revealed no SNF ABN was provided to the resident. An interview was conducted with Resident #112 on 7/25/24 at 12:05 PM and he stated he could not recall signing or receiving any forms when his Medicare Part A skilled services ended. An interview was conducted with the facility Social Worker on 7/23/24 at 11:51AM who stated he did not complete the SNF ABN form when Resident #112 remained in the facility. He stated he was unaware the SNF ABN form was necessary when a resident remained in the facility after Medicare Part A skilled services ended. An interview was conducted with the facility Administrator on 7/25/24 at 12:15 PM who stated she was unaware the SNF ABN form was necessary when a resident remained in the facility after Medicare Part A skilled services ended. 2. Resident #115 was admitted to the facility on [DATE] and admitted to Medicare Part A skilled services. Resident #115's admission Minimum Data Set assessment dated [DATE] revealed the resident hadsevere cognitive impairment. Resident #115's Medicare Part A skilled services ended on 2/9/24 and he remained in the facility. Review of Resident #115's medical records revealed a NOMNC was signed by the resident on 2/6/24. Record review revealed no SNF ABN was provided to the resident. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the facility Social Worker on 7/23/24 at 11:51AM who stated he did not complete the SNF ABN form when Resident #115 remained in the facility. He stated he was unaware the SNF ABN form was necessary when a resident remained in the facility after Medicare Part A skilled services ended. An interview was conducted with the facility Administrator on 7/25/24 at 12:15 PM who stated she was unaware the SNF ABN form was necessary when a resident remained in the facility after Medicare Part A skilled services ended.

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of medication, dental and continence for 4 of 30 residents whose MDS assessments were reviewed (Resident # 283, Resident #99, Resident #76 and Resident #115). Findings included: 1. Resident # 283 was admitted on [DATE] with diagnosis which included major depressive disorder. Review of Resident #283's physician orders revealed an order dated 12/19/23 for Aripiprazole 5 milligrams (mg). Give 1 tablet by mouth every 12 hours related to major depressive disorder. Review of Resident #283's December 2023 electronic Medication Administration Record revealed resident received Aripiprazole 5 mg 1 tablet every 12 hours related to major depressive disorder. Review of Resident #283's admission Minimum Data Set (MDS) dated [DATE] revealed resident was cognitively intact and had no behaviors. The MDS indicated Resident #283 received an antipsychotic medication, an antidepressant and anticoagulant. The antipsychotic medication review was coded as no antipsychotic medication was not received since admission. An interview was conducted with MDS Coordinator #1 on 7/25/24 at 10:15 AM. MDS Coordinator #1 stated it was an error that the antipsychotic medication was not coded on the MDS assessment. An interview was conducted on 7/25/24 at 3:15 PM with the Director of Nursing (DON). The DON revealed that she expected that the MDS assessments would be completed accurately. 2. Resident # 99 was admitted to the facility on [DATE] with medical diagnosis which included: diabetes, stroke and peripheral vascular disease. Review of Resident #99's significant change Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact and had no broken natural teeth. An interview and observation were conducted with Resident #99 on 7/22/24 at 11:51 AM. Observation revealed Resident #99 had multiple broken upper teeth. Resident #99 stated her cardiologist advised she was not a candidate for dental procedures. An interview was conducted with MDS Coordinator #1 on 7/25/24 at 10:15 AM. MDS Coordinator #1 stated Resident #99's MDS assessment was miscoded when the dental section indicated resident did not have any dental issues. MDS Coordinator #1 stated the MDS assessments should be accurate and include the resident's current condition. An interview was conducted with the DON on 7/25/24 at 3:15 PM. The DON revealed that she expected that the MDS assessments would be completed accurately. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #76 was admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease and failure to thrive. Review of Resident #76's electronic health record revealed a progress note dated 6/27/24 at 9:00 PM which indicated the resident was alert, required minimal assistance with care and was continent of bowel and bladder. Review of Resident #76's annual Minimum Data Set (MDS) assessment dated [DATE] indicated resident was always continent of bladder and occasionally incontinent of bowel. An interview was conducted with Resident #76 on 7/22/24 at 1:15 PM. Resident #76 stated she was able to take herself to the bathroom and was continent of bowel and bladder. An interview was conducted with the MDS Coordinator #1 on 7/25/24 at 10:15 AM. MDS Coordinator #1 indicated it was human error that bowel and bladder was miscoded on Resident #76's annual MDS assessment dated [DATE]. An interview was conducted with the DON on 7/25/24 at 3:15 PM. The DON stated she expected that the MDS assessments would be completed accurately. 39731 4. Resident #115 was admitted to the facility on [DATE] with diagnoses that included depression, dementia and agitation. A review of the physician's orders revealed Resident #115 received olanzapine (an antipsychotic medication) 10 mg at bedtime since 3/11/24 for delusions. Resident #115's most recent Minimum Data Set (MDS) assessment dated [DATE], a quarterly assessment revealed Resident #115 was assessed as having severe cognitive impairment. He received antipsychotic and antianxiety medication during the lookback period. The assessment was further coded as antipsychotics not being received on the question related to gradual dosage reduction of antipsychotic medication. During an interview with MDS Coordinator #1 on 7/24/24 at 4:12 PM she stated Resident #115 received antipsychotic medication during the lookback period and the assessment question regarding a gradual dose reduction was coded incorrectly. An interview was conducted with the DON on 7/25/24 at 3:15 PM. The DON stated she expected that the MDS assessments would be completed accurately.

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record reviews, observation, resident and staff interviews the facility failed to develop a comprehensive person-centered care plan for the focus areas of antidepressant and antiplatelet medications, continence and indwelling catheter for 3 of 30 residents (Resident #76, Resident #99 and Resident #283) reviewed for comprehensive care plans. Findings included: 1.Resident #76 was admitted to the facility on [DATE] with diagnoses of depression, anxiety and insomnia. Review of Resident #76's electronic health record revealed a progress note dated 6/27/24 at 9:00 PM which indicated resident was alert and required minimal assistance with care. Resident #76 was continent of bowel and bladder and was non ambulatory. Review of Resident #76's annual Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact, was always continent of bladder and occasionally incontinent of bowel. The MDS indicated Resident #76 received antianxiety, antidepressant, antibiotic, opioid, and antiplatelet medications. The Care Area Assessment (CAA) for psychotropic medication dated 6/28/24 indicated to proceed to the care plan to address psychotropic medication use. Review of Resident #76's care plan last updated on 6/28/24 revealed a focus area of occasional bladder incontinence and at risk for skin breakdown. Resident #76's care plan did not include a focus area of antidepressant or antiplatelet medication use. Review of Resident #76's July 2024 electronic Medication Administration Record revealed electronically signed entries for duloxetine (an antidepressant medication) 60 milligram (mg) once per day, doxepin (an antidepressant medication) 50 mg 2 capsules at bedtime for insomnia, and aspirin 81 mg once per day. An interview was conducted with Resident #76 on 7/22/24 at 1:15 PM. Resident #76 stated she was able to take herself to the bathroom and was continent of bowel and bladder. An interview was conducted on 7/25/24 at 10:15 AM with MDS Coordinator #1. MDS Coordinator #1 stated care plans should be accurate and reflect the resident's current condition. MDS Coordinator #1 stated medications including antidepressants and antiplatelet medications should be included in the care plan. MDS Coordinator #1 verified Resident #76 received antidepressants and antiplatelet medications and should have been included in the resident's care plan. MDS Coordinator #1 further indicated Resident #76's care plan did not accurately reflect resident's continence and toileting ability (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 7/25/24 at 3:15 PM with the Director of Nursing (DON). The DON stated she expected the care plans would be person centered and accurately reflect the resident's condition including medications and continence. 2. Resident #99 was admitted to the facility on [DATE] with diagnoses of stroke and peripheral vascular disease. Review of Resident #99's significant change Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact, was frequently incontinent of bladder and always incontinent of bowel. Resident #99 was coded as having received antiplatelet and anticoagulant medications. The Care Area Assessment (CAA) for incontinence dated 5/20/24 indicated to proceed to the care plan to address bladder and bowel incontinence. Review of Resident #99's most recent care plan dated 5/20/24 revealed a focus area of incontinence of bladder. Interventions included notifying nursing if incontinent during activities and clean peri area with each incontinence episode. Resident #99's care plan did not include incontinence of bowel, constipation or medications received for constipation. Resident #99's care plan did not include a focus area of antiplatelet medication use. Review of Resident #99's July 2024 electronic Medication Administration Record revealed electronically signed entries for: aspirin 81 mg one time per day for prevention, clopidogrel bisulfate 75 mg one time per day related to history of transient ischemic attack and cerebral infarct, polyethylene glycol 17 gram (gm) once per day for constipation, senna glycoside 8.6 mg give 2 tablets at bedtime for constipation. An interview and observation were conducted with Resident #99 on 7/22/24 at 11:51 AM. Resident #99 stated she had incontinence of bowel and bladder, required incontinence care with thorough cleansing of her peri area and had areas of skin breakdown. Observation indicated Resident #99 had a small bruise on her hand. Resident #99 stated she received blood thinning medication and bruised easily. An interview was conducted with MDS Coordinator #1 on 7/25/24 at 10:15 AM. MDS Coordinator #1 stated the care plans were to be accurate and include the resident's current condition. MDS Coordinator #1 stated Resident #99's care plan should have included bowel incontinence and medications. An interview was conducted on 7/25/24 at 3:15 PM with the DON. The DON stated she expected the care plans would be person centered and accurately reflect the resident's condition including incontinence and medications. 3. Resident #283 was admitted on [DATE] with diagnosis which included in part urinary retention. Review of Resident #283's physician orders revealed an order dated 12/26/23 for indwelling catheter to bedside drainage due to urinary retention. Review of Resident #283's admission MDS dated [DATE] revealed resident was cognitively intact, had an indwelling catheter and was always incontinent of bladder and bowel. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Area Assessment (CAA) for incontinence/catheter dated 12/26/23 was reviewed and indicated to proceed to the care plan to address use of a catheter. Review of a care plan dated 12/26/23 revealed a focus area of bowel and bladder incontinence. The goal indicated resident will remain free from skin breakdown due to incontinence and brief use. Interventions included Resident #283 used disposable briefs, cleanse peri-area after incontinence episodes, and check frequently for incontinence. Resident #283's care plan did not include a focus area of indwelling catheter. An interview was conducted with MDS Coordinator #1 on 7/25/24 at 10:15 AM. MDS Coordinator #1 stated the care plans should be accurate and include the resident's current condition. MDS Coordinator #1 indicated indwelling catheter should have been included in Resident #283's care plan. An interview was conducted on 7/25/24 at 3:15 PM with the DON. The DON stated she expected the care plans would be person centered and accurately reflect the resident's condition. The DON indicated an indwelling catheter should have been included in the care plan.

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, staff, Nurse Practitioner and Physician interviews, the facility failed to ensure a resident had an ophthalmology appointment scheduled as ordered on 1/11/24, 2/13/24 and 3/26/24 resulting in the resident not seen until 4/19/24 and failed to obtain the retinol specialist appointment recommended by the ophthalmologist for 1 of 1 resident (Resident #101) reviewed for vision. Findings included: Resident #101 was admitted on [DATE] with diagnoses which included post traumatic brain injury and Parkinson's Disease. Resident #101's electronic health record revealed a Nurse Practitioner progress note dated 1/11/24 which indicated resident had a visual disturbance and the note indicated the resident needed to see an ophthalmologist. Resident #101's electronic health record revealed a physician order entered by Nurse #8 dated 1/11/24 for ophthalmology consult for visual disturbances of the left eye with history of cataract about [AGE] years ago. An interview was conducted with Nurse #8 on 7/25/24 at 2:50 PM. Nurse #8 stated she worked at the facility through an agency. Nurse #8 stated she was not able to enter orders in the computer, did not know why the order showed that she entered it. Nurse #8 stated she did not know anything about an order for an ophthalmologist consult for Resident #101. Resident #101's electronic health record revealed a Neurology consultation note dated 2/5/24 which indicated resident complained of acute visual changes which started 4 weeks ago. The note indicated Resident #101 was very concerned about his vision and needed an ophthalmologist appointment for vision concerns. Resident #101's electronic health record revealed a 2/13/24 physician progress note which indicated a second request was made for resident to have an ophthalmology appointment. Resident #101had a new complaint of diplopia (double vision) and vision changes. Resident #101's electronic health record revealed a physician order entered by Nurse #7 dated 2/13/24 for an ophthalmology appointment due to visual changes and diplopia (double vision). Attempts were made to interview Nurse #7 via phone with messages left. No return call was received. Resident #101's electronic health record revealed a physician progress note dated 3/18/24. The physician note stated neurology requested resident to have an appointment with ophthalmology secondary to double vision to the left eye. The note further indicated on the last encounter 1 month ago, an ophthalmologist appointment was requested. Resident #101 continued to complain of left sided vision changes. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #101's electronic health record revealed a 3/26/24 Nurse Practitioner (NP) progress note which indicated an order was written once again for a referral to an ophthalmologist due to visual changes and blurred vision of the left eye. Resident #101's electronic health record revealed a physician order entered by Nurse #7 dated 3/26/24 for an ophthalmology consult for evaluation of blurred vision. Attempts were made to interview Nurse #7 via phone with messages left. No return call was received. Resident #101's electronic health record revealed a 4/19/24 ophthalmology chart note which indicated resident presented for a first eye exam. The ophthalmology chart note indicated Resident #101 had a comprehensive eye exam and presented with right eye blurriness and left eye was totally blurry. Resident #101 was unable to see out of the left eye. The note stated Resident #101 required urgent referral within 1 to 2 weeks to a retinol specialist for further assessment and possible treatment. Resident #101's quarterly Minimum Data Set (MDS) dated [DATE] indicated resident was cognitively intact and had adequate vision. Resident #101's care plan last revised on 6/4/24 revealed vision was not addressed. An interview was conducted with Resident #101 on 7/22/24 at 11:50 AM. Resident #101 stated his main concern was that he needed to see a retinol specialist. Resident #101 expressed concern about his vision and the need for an appointment to find out more about what was going on with his eye. He indicated there were no changes with his daily function. An interview was conducted with the Medical Records Specialist on 7/24/24 at 4:30 PM. The Medical Records Specialist indicated she was responsible for coordinating podiatry, dental and ophthalmology visits for the facility. The Medical Records Specialist indicated typically the facility provided ophthalmology services in house but the company the facility used did not have a provider to send to the facility since August 2023. The Medical Records Specialist stated she informed the Director of Nursing that there was not an ophthalmologist available to provide services at the facility. An interview was conducted with MDS Coordinator #1 on 7/25/24 at 10:15 AM. She stated she tested his vision for the MDS assessment by having him identify objects and read a sentence. MDS Coordinator #1 stated if a resident's record had an order for a referral to see a specialist and she did not see evidence that it was done, she would discuss it with the provider and follow up with staff regarding the appointment. MDS Coordinator #1 stated she did not recall any follow up that she had completed regarding the ophthalmologist or retinol specialist appointments for Resident #101. A follow up interview with MDS Coordinator #1 was conducted on 7/25/24 at 12:05 PM. MDS Coordinator #1 stated a care plan meeting was held with Resident #101 on 6/17/24 and during the meeting, he stated he was worried about his vision. The DON attended the meeting and put in a request for the physician to discuss the results of his April ophthalmologist appointment. MDS Coordinator #1 stated Resident #101 was scheduled for a follow up appointment with the ophthalmologist on 8/7/24 at 2:30 PM. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Transportation Specialist on 7/25/24 at 2:45. The Transportation Specialist stated she was responsible for scheduling appointments after she received an appointment tracker form from the nurse with the order written by the physician or NP. After she received the form, the Transportation Specialist stated she faxed the resident's demographic records to the office and would wait a few days or weeks to call the office to see if the appointment could be scheduled. The transportation specialist was unable to provide an appointment tracker form for Resident #101 for ophthalmologist or retinol specialist appointments or records of calls that she made to obtain the appointments. The Transportation Specialist was unable to recall why there was a delay in obtaining Resident #101's ophthalmology appointment. The Transportation Specialist stated she did not know about the order for the retinol specialist consult for Resident #101. An interview was conducted with the Nurse Practitioner (NP) on 7/25/24 at 10:45 AM. The NP stated she wrote orders for appointments and there was a delay in obtaining them. The NP stated it was hard to get appointments made for residents. The NP stated it was important for Resident #101's overall care to be seen by the ophthalmologist and the retinol specialist. The NP indicated the facility should follow orders to obtain appointments. An interview was conducted with the Physician on 7/24/24 at 11:45 AM. The Physician stated he was not sure why there was a delay in obtaining appointments. The Physician indicated referrals were always a problem and obtaining appointments with specialists could be difficult. The Physician stated orders were rewritten several times for the ophthalmology appointment for Resident #101 as it was not made. The Physician stated he expected the facility should follow up to clarify if an appointment had been made by the ophthalmologist for the resident to be seen by the retinol specialist and the nursing staff should communicate the status of appointments. An interview was conducted with the Director of Nursing (DON) on 7/25/24 at 3:15 PM. The DON stated there was a system process failure with the referrals for appointments. When an order was written for a consult or an appointment, the nurse was supposed to complete an appointment tracker form and give it to the Transportation Specialist. The DON stated Nurse #7 worked as needed (PRN) and may not have been aware of the process for obtaining appointments. The DON further indicated the consult note from the ophthalmologist was scanned into the electronic record and may not have been reviewed by the NP or physician. The DON stated she expected that when a provider wrote an order for an appointment it would be obtained in a timely manner and the status of the order would be communicated to the provider.

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on record review, observations, staff and physician interviews, the facility failed to apply signage indicating the use of oxygen outside the resident's room for 2 of 2 residents reviewed for oxygen use (Resident #11 and Resident #112). The findings included: 1. Resident #11 was admitted to the facility on [DATE] with diagnoses which included asthma. The care plan dated 6/19/24 indicated Resident #11 was using oxygen continuously at 2 LPM (liters per minutes). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #11 was cognitively intact and coded for the use of oxygen. A physician's order for Resident #11 dated 7/18/24 for 2 LPM oxygen continuous via nasal cannula and checks every shift. During an observation and interview on 7/22/24 at 10:14 am, there was no signage outside Resident #11's room indicating the use of oxygen. Resident #11 was observed not wearing her oxygen via nasal cannula at 2 LPM. The oxygen concentrator was observed on the left side of the bed in Resident #11's room. She stated she did not need oxygen. In an observation on 7/24/24 at 11:12 am, there was no signage outside Resident #11's room indicating the use of oxygen. The oxygen concentrator was observed on the left side of the bed in Resident #11's room. Resident #11 was observed not wearing her oxygen via nasal cannula at 2 LPM. During an interview with MA #2 (Medication Aide) on 7/23/24 at 2:58 pm, she stated Resident #11 was on continuous oxygen at 2 LPM. On 7/23/24 at 3:00 pm in an interview with Nurse #1, she explained she did not recognize there was no Oxygen in use, no smoking signage outside her door. She stated an Oxygen in use, no smoking signage should have been placed outside Resident #11's door when the oxygen was ordered by the physician or when nursing staff recognized the signage was not outside the door. On 7/24/24 at 2:36 pm in during an interview with the Director of Nursing, she stated nursing should have placed an Oxygen in use, no smoking sign on Resident #11's door indicating oxygen in use when the order was written by the physician. She further explained the nursing staff should have placed the Oxygen in use, no smoking sign outside Resident #11's when they placed the oxygen concentrator in her room. During an interview with the physician on 7/24/24 at 11:35 am, he stated Resident #11 had an order for continuous oxygen at 2 LPM via nasal cannula. He further stated the staff did not inform him Resident #11 was not wearing her oxygen. He indicated Resident # 11's oxygen saturation rates were within normal limits and there was no adverse outcome for Resident #11 not wearing her oxygen. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #112 was admitted to the facility on [DATE] with diagnoses which included congestive heart failure, chronic respiratory failure, interstitial pulmonary disease. A physician's order for Resident #112 dated 3/4/24 revealed 2 LPM oxygen continuous via nasal cannular and checks every shift. Review or the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #112 was cognitively intact and coded for the use of oxygen. During an observation on 7/22/24 at 11:00 am, there was no signage outside Resident #112's room indicating the use of oxygen. The oxygen concentrator was observed by the bedside in Resident #112's room. Resident #112 was observed sitting in the dining room watching television without his oxygen. In an observation on 7/23/24 at 11:00 am, there was no signage outside Resident #112's room indicating the use of oxygen. The oxygen concentrator was observed on the left side of the bed in Resident #112's room. Resident #112 was observed not wearing his oxygen. During an interview with Resident #112 on 7/23/24 at 11:09 am, stated he did take his oxygen off when he was not in his room. He liked to go to the dining room and watch television. He further stated he would wear his oxygen while he was in his room. During an interview on 7/23/24 at 3:15 pm with Nurse #5, she indicated it was the nursing staff's responsibility for placing the red oxygen signage on Resident #112's door. She further indicated she did not know why Resident #112 did not have the oxygen signage on his door. She also stated that he would take his oxygen off when he was not in his room. On 7/24/24 at 2:36 pm in during an interview with the Director of Nursing, she stated nursing should have placed an Oxygen in use, no smoking sign on Resident #112's door indicating oxygen in use when the order was written by the physician. She further explained the nursing staff should have placed the Oxygen in use, no smoking sign outside Resident #112's when they placed the oxygen concentrator in his room. During an interview with the physician on 7/24/24 at 11:35 am, he stated Resident #112 had an order for continuous oxygen at 2 LPM via nasal cannula. He indicated he was aware of Resident # 112 removing his oxygen while out of his room. He indicated his saturation rates were within normal limits and there was no adverse outcome for Resident #112 not wearing his oxygen while out of his room.

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review, staff interviews and Consultant Pharmacist interview the facility failed to ensure the facility staff reviewed pharmacy recommendations and documented any action taken or a rationale for no action taken on the pharmacy request for 1 of 5 residents reviewed for drug regimen review (Resident #115). The findings included: Resident #115 was admitted to the facility on [DATE] with diagnoses that included depression, dementia and agitation. A review of the physician's orders revealed Resident #115 received olanzapine (antipsychotic medication) 10 milligrams (mg) at bedtime since 3/11/24 for psychotic disturbance with mood disturbance and anxiety. A review of the electronic medical record revealed there was no AIMS (Abnormal Involuntary Movement Scale) completed. Resident #115's most recent Minimum Data Set (MDS) assessment dated [DATE], a quarterly assessment, revealed Resident #115 was assessed as having severe cognitive impairment. He received antipsychotic and antianxiety medication during the lookback period. Review of the Consultant Pharmacist's notes revealed an AIMS assessment was recommended on 3/20/24, 4/16/24, 5/22/24, and 6/17/24. There were no responses to the recommendations on the Medication Regiment Reviews. An interview on 7/25/24 at 2:03 PM with the Consultant Pharmacist revealed an AIMS assessment should have been done due to Resident #115 being placed on antipsychotic medication. An interview was conducted with the current Director of Nursing (DON) on 7/24/24 at 11:02 AM who stated the Consultant Pharmacist's recommendations should be reviewed and addressed by the DON or designee. She stated an AIMS should have been completed when the resident was placed on an antipsychotic medication and every 92 days afterwards.

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Cove Nursing Center	1478 River Road Winnabow, NC 28479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review and staff and Consulting pharmacist interviews, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) assessment for 1 of 5 residents (Resident #11) reviewed for unnecessary medications who received psychotropic medications. The findings included: Resident #115 was admitted to the facility on [DATE] with diagnoses that included psychotic disturbance with mood disturbance and anxiety. A review of the physician's orders revealed Resident #115 received olanzapine (antipsychotic medication) 10 milligrams (mg) at bedtime since 3/11/24 for delusions. A review of the electronic medical record revealed there was no AIMS completed. Resident #115's most recent Minimum Data Set (MDS) assessment dated [DATE], a quarterly assessment, revealed Resident #115 was assessed as having severe cognitive impairment. He received antipsychotic and antianxiety medication during the lookback period. Review of the Consultant Pharmacist's notes revealed an AIMS assessment was recommended on 3/20/24, 4/16/24, 5/22/24, and 6/17/24. An interview on 7/25/24 at 2:03 PM with the Consultant Pharmacist revealed an AIMS assessment should have been done due to Resident #115 being placed on antipsychotic medication. An interview was completed with the Quality Assurance Nurse on 7/24/24 at 11:07 AM who stated it must have been an oversight. She reported she was responsible for completing the AIMS when recommended by the consulting pharmacist. During an interview with the Director of Nursing on 7/24/24 at 11:02 AM she stated after reviewing Resident #115's record he had never had an AIMS assessment completed. She stated it should have been done but the computer system did not automatically trigger for nursing staff to do the assessment.