| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345318 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(continued on next page) |

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 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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345318 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and physician and pharmacist technician specialist interviews, the facility failed to obtain an order to flush a percutaneous intravenous central catheter (PICC) with normal saline and heparin (blood thinning agent) flushes for 1 of 1 resident (Resident #129) reviewed for intravenous (IV) antibiotics. Findings included: Resident #129 was admitted to the facility on [DATE]. Diagnoses included diabetic foot ulcer, pain, osteomyelitis (bone infection), and left toes amputations. The Minimum Data Set 5 day assessment dated [DATE] revealed Resident #129 was moderately cognitively impaired and had impairment to one side to his lower extremity. Resident #129 was assessed as having a pressure ulcer and a surgical wound and was receiving intravenous (IV) medications. A physician's order written on 11/19/25 to monitor double lumen PICC dressing to right upper extremity to ensure the dressing was clean, dry and intact every shift for infection prevention. A physician's order written on 11/19/25 for Meropenem (antibiotic) IV Solution reconstituted one gram (gm) use 100 milliliters IV every 8 hours for infection of bone and bone marrow until 12/24/25 to infuse over 30 minutes. There were no physician orders for the administration of saline or heparin flushes. Review of the Medication Administration Record for November from 11/19/25 through 11/30/25 revealed Resident #129 received the Meropenem antibiotic 3 times daily for a total of 34 doses as evidenced by a checkmark and nursing initials. Review of the Medication Administration Record for December from 12/01/25 through 12/03/25 revealed Resident #129 received the Meropenem antibiotic 3 times daily for a total of 7 doses as evidenced by a checkmark and nursing initials. A physician's order written on 11/20/25 change double lumen (two access ports) to the right upper extremity PICC line dressing and hub (access point) every day shift on Tuesday for infection prevention. A physician's order written on 11/21/25 for Vancomycin Hydrochloride (antibiotic) IV Solution 1.5 grams/250 milliliters (ml) IV in the morning for infection to bone and bone marrow until 12/24/25 to infuse minimally over 2.5 hours. There were no physician orders for the administration of saline or heparin flushes. Review of the Medication Administration Record for November from 11/19/25 through 11/30/25 revealed Resident #129 received the Vancomycin antibiotic daily for 11 days as evidenced by a checkmark and nursing initials. Review of the Medication Administration Record for December from 12/01/25 through 12/03/25 revealed Resident #129 received the Vancomycin antibiotic daily for 3 days as evidenced by a checkmark and nursing initials. An observation of Resident #129's medications with Unit Manager #1 on 12/03/25 at 11:30 AM revealed a box of prefilled 10ml saline flushes individually wrapped and labeled with Resident #129's name and a box of prefilled 5ml heparin flushes individually wrapped labeled with Resident #129's name. There were noted to be several saline and heparin flushes removed from each box. An interview with Nurse #4 on 12/03/25 at 11:23 AM revealed when she administered the Meropenem IV Antibiotic IV she would first sanitize the hub with an alcohol wipe, flush the access port with 10ml saline flush, and start the medication as ordered. She stated when the medication was completed, she would flush the catheter line with 10ml saline again and then flush with 5ml of a heparin flush. Nurse #4 confirmed there were no orders written to flush the IV catheter, but the pharmacy provided the flushes for Resident #129 so she used them. She stated the flushes were to keep the catheter line patent (unobstructed). Nurse #4 stated she should have clarified the orders with the Physician for the flushes. An interview was conducted with Nurse #6 via phone on 12/03/25 at 12:30 PM. Nurse #6 reported whenever a resident had an IV antibiotic the protocol was to flush with 10ml of normal saline, give the antibiotic, flush with 10ml saline again and then flush with 5ml of heparin. At this time, the orders were reviewed with Nurse #6 and she confirmed there were no actual orders to flush the IV catheter with saline or heparin. She stated there were available prefilled flushes labeled for Resident #129 on the medication cart and in the medication room for saline and heparin flushes and from experience she knew that the catheter line should be flushed before and after the administration of an IV antibiotic to keep the line patent. Nurse #6 stated she should have clarified with the physician and entered the orders in the electronic medical record. An interview was conducted with the Nurse Practitioner on 12/03/25 at 1:10 PM and revealed there should have been specific orders in place for both the saline and the heparin flushes. She stated she would enter both those orders now. The Nurse Practitioner stated the saline and heparin flushes were important because they kept the catheter line open and prevented blockages. The NP stated having the orders on the eMAR ensured the flushes were being administered. An interview was conducted with Nurse #3 via phone on 12/03/25 at 5:21 PM. Nurse #3 reported that when she hung the IV antibiotics for administration she always used the SASH |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345318 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, Nurse Practitioner, and Wound Physician interviews, the facility failed to provide treatment for surgical wound as specified in the hospital discharge summary (Resident #48) and failed to offload a neck/shoulder contracture as ordered (Resident #6). This was for 2 of 3 residents reviewed for skin integrity (Resident #48 and Resident #6). Findings included:<br><br>1) Review of the hospital discharge summary orders dated 11/18/25 revealed Resident #48 was status post (recent past event) a left total hip replacement with surgical incision to left hip. The physician order sheet indicated Per facility guidelines Aquacel protocol, change every 5-7 days or as needed. Aquacel is wound care dressing that absorbs and locks in drainage and bacteria.<br><br>Resident #48 was admitted to the facility on [DATE]. Diagnoses included osteoarthritis of hip and left hip replacement.<br><br>The Minimum Data Set admission assessment dated [DATE] revealed Resident #48 was moderately cognitively impaired and was assessed as having a surgical wound.<br><br>A nurse's note written on 11/18/25 by Nurse #7 revealed, Aquacel dressing in place, resident admitted this shift.<br><br>A physician's order written on 11/18/25 directed nursing staff to monitor surgical incision to left hip for signs and symptoms of infection every shift for prevention. Document findings in nurses note.<br><br>A physician's order written on 11/18/25 revealed cleanse surgical incision to left hip with normal saline solution (NSS), pat dry with gauze and cover with a clean dry dressing.<br><br>There were no orders transcribed into the list of physician's orders to apply or change an Aquacel dressing in 5-7 days or as needed.<br><br>An interview was conducted with Unit Manager #1 on 12/03/25 at 1:00 PM. Unit Manager #1 revealed she was the admitting nurse, and she did not see the wound order on the discharge instructions. She stated she only saw one page of the discharge summary orders from the hospital and an FL2 form (a medical form that lists physicians' recommended care needs and medications). She stated on the FL2 form it was noted on the first page Resident #48 had a surgical incision to left hip. She stated since she did not see any other orders for his surgical hip wound, she implemented an order after discussing with the Nurse Practitioner to cleanse with NSS, pat dry and cover with clean dry dressing daily. Unit Manager #1 stated it was not until 12/01/25 that she realized from the Wound Treatment Nurse that she overlooked the discharge wound orders to change Aquacel dressing to left hip in 5-7 days or as needed. She stated the order for changing the Aquacel never made it to the Treatment Administration Record (TAR) because she overlooked it. She stated she would have expected the floor nurses to question the current order when they noticed the Aquacel dressing in place and not just signed the TAR and put in a nursing note. The nurses should have clarified the order with the physician.<br><br>(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<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #48's care plan dated 11/18/25 revealed a plan of care was in place for actual impairment to skin integrity of left hip, left ankle, right ankle and venous insufficiency with a goal that resident would not have any complications related to surgical incision of left hip through the review date. Interventions included keep skin clean and dry. Use lotion on dry skin. Do not apply on surgical incision and monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, and signs and symptoms of infection to physician.<br><br>An interview was conducted with Resident #48 on 12/01/25 at 3:08 PM. Resident #48 stated he had just a had hip replacement and he had staples to his left hip with a dressing. Resident #48 stated none of the nurses changed the dressing to his hip since he was admitted .<br><br>The November 2025 Treatment Administration Record (TAR) revealed an order to cleanse surgical incision to left hip with NSS, pat dry with gauze, and cover with a clean dry dressing every day shift.<br><br>On 11/18/25, Nurse #7 signed off the treatment as evidenced by a check mark and her initials. A nurse's note written on 11/18/25 by Nurse #7 read Aquacel dressing in place, resident admitted this shift.<br><br>An interview was conducted with Nurse #7 via phone on 12/03/25 at 7:25 PM. Nurse #7 stated she worked on 11/18/25 and was assigned to Resident #48. She stated if there was a checkmark with her initials on the TAR then it meant she signed it off, but it must have been in error because she did not follow the order to cleanse with NSS. Nurse #7 stated Resident #48 was noted to have an Aquacel dressing in place and nurses do not usually remove the Aquacel dressings because it had to be done by the surgeon. Nurse #7 stated she should have clarified the treatment order when she noticed the Aquacel dressing. She stated the Aquacel dressing was intact and did not have any drainage noted on the outside.<br><br>From 11/19/25 through 11/23/25 Nurse #5 signed off the treatment with a #9 (a key code that meant to see nurse's notes). Nurse's notes written on 11/19/25 through 11/23/25 referenced Aquacel in place.<br><br>An interview was conducted with Nurse #5 via phone on 12/03/25 at 8:32 PM. Nurse #5 I think this is supposed to be #5 stated she looked at the discharge summary and did not see any orders to remove the Aquacel dressing on Resident #48. She stated she knew with Aquacel dressings, nurses are supposed to keep them in place for a certain amount of time. She stated she worked from 11/19/25 through 11/23/25 and she did not follow the order that was in place to cleanse with NSS because the Aquacel was in place and that was confusing to her. She stated she should have clarified the order on 11/19/25 and not just kept putting in a note that the Aquacel was in place. Nurse #5 stated she discussed the treatment orders with the Wound Treatment Nurse at some point (she could not recall which day), and the WTN was going to clarify the order. Nurse #5 stated she should have followed up after she let the WTN know about the order and the Aquacel dressing being in place.<br><br>On 11/24/25, the Wound Treatment Nurse signed off the treatment with a #9. A nurse's note written on 11/24/25 by the Wound Treatment Nurse read Aquacel in place.<br><br>There was no documentation on 11/25/25 or 11/26/25.<br><br>(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<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/27/25, Nurse #8 signed off the treatment as evidenced by a checkmark and her initials. An interview was attempted with Nurse #8 via phone on 12/04/25 at 10:00 AM. Nurse #8 did not return call.<br><br>On 11/28/25 and 11/30/25, Nurse #10 signed off the treatment with a #9. A nurse's note written on 11/28/25 by Nurse #10 read Aquacel to left hip in place no drainage noted. A nurse's note written on 11/30/25 by Nurse #10 read Aquacel in place.<br><br>An interview was conducted with Nurse #10 via phone on 12/04/25 at 10:18 AM. Nurse #10 stated she recalled an order being in place for Resident #48 to cleanse his surgical hip wound with normal saline. She stated she observed that Resident #48 had an Aquacel dressing and was not certain if it was supposed to be removed because there were no orders to remove it. Nurse #10 stated she texted the on-call Nurse who was the Director of Nursing (DON) on 11/28/25 about the order and the DON reached out to the Wound Treatment Nurse who said to leave the Aquacel dressing in place until the Wound Treatment Nurse returned on Monday (12/01/25). Nurse #10 stated she thought the Wound Treatment Nurse would know best about the order and that was why she called the DON to reach out to her to see what she wanted to do instead of notifying the physician and getting clarification orders. Nurse #10 stated the Aquacel dressing was intact and there was no drainage or seepage, so she left it alone.<br><br>On 11/29/25 Nurse #11 signed off the treatment as evidenced by a checkmark and her initials. An interview was attempted with Nurse #11 via phone on 12/04/25 at 10:00 AM. Nurse #11 did not return the call.<br><br>The December 2025 TAR revealed an order to cleanse surgical incision to left hip with NSS, pat dry with gauze, and cover with a clean dry dressing every day shift. There was no documentation on 12/01/25 and 12/02/25.<br><br>An interview was conducted with the Wound Treatment Nurse on 12/03/25 at 11:00 AM. She stated she received a call from the Director of Nursing (DON) on Friday 11/28/25. She stated the DON stated a nurse (Nurse #10) was questioning that there was an order in place to change the dressing daily, but there was an Aquacel dressing in place and asked the Wound Treatment Nurse for clarification. The WTN stated she told the DON that she would look at the orders on Monday 12/01/25 when she returned and for Nurse #10 to record #9 and document the Aquacel was dry and intact. The Wound Treatment Nurse stated on 11/24/25, she recalled the wound treatment order to cleanse with normal saline and cover with dry dressing and remembered thinking to herself she needed to clarify that order because Resident #48 had an Aquacel dressing in place. The Wound Treatment Nurse stated she meant to clarify the order before she left for the holiday and got distracted and that was why there was no documentation in the treatment record for 11/25/25 and 11/26/25. The WTN stated when she came back on 12/01/25, she looked at the discharge summary orders and saw the Aquacel dressing order to change every 5 to 7 days. The Wound Treatment Nurse stated she called the Wound Physician and told him that Resident #48 had a follow up orthopedic appointment on 12/03/25 and that the facility did not have Aquacel in the building; but there was an order to change it every 5 – 7 days per protocol. The Wound Treatment Nurse stated the Wound Physician said to leave the dressing place (Aquacel). The Wound Treatment Nurse stated when she reviewed the orders on 12/01/25 she realized the order to change the Aquacel dressing to the left hip was not transcribed on 11/18/25. The Wound Treatment Nurse stated the Aquacel dressing should have been ordered and should have been changed between 11/23/25 and 11/25/25.<br><br>(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<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Director of Nursing (DON) on 12/04/25 at 8:50 AM revealed she recalled the day that Nurse #10 reached out to her because she was the Nurse on call that day. The DON stated she sent a text message to the Wound Treatment Nurse on 11/28/25 and told her that Nurse #10 was questioning what to do about the Aquacel dressing and the new dressing order. The DON stated the Wound Treatment stated to put #9 on the TAR and document that the dressing was dry and intact and she would look at it when she got back. The DON stated the order should have been clarified when it was first observed on 11/18/25 that he had an Aquacel dressing. She stated according to the discharge summary orders that were overlooked, the Aquacel dressing should have been removed between the fifth day which would have been 11/23/25 and the seventh day which would have been 11/25/25.<br><br>An interview was conducted with the Nurse Practitioner on 12/03/25 at 2:00 PM. The Nurse Practitioner stated she did not recall discussing the order Unit Manager #1 put in place to cleanse the wound with normal saline, but she could have. She stated she would have expected the nurses to get clarification regarding the Aquacel dressing and when to remove it. She stated she discharged the resident on 12/02/25 and saw the Aquacel dressing in place. It was intact and she did not remove it. She stated she did not observe any drainage on the dressing.<br><br>An interview was conducted with Wound Physician on 12/04/25 at 11:50 PM. The Wound Physician stated the Aquacel dressing can be removed by the nurses at the facility and should have been according to the discharge summary orders by 11/25/25. He stated the Aquacel dressing helps to absorb fluid and that was why it does not get changed for about five to seven days in the case of any post-operative drainage.<br><br>2). Resident #6 was initially admitted to the facility on [DATE] with the last readmission on [DATE]. His diagnoses included rheumatoid arthritis of multiple sites, type 2 diabetes and cellulitis.<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 was cognitively intact. He was dependent with personal hygiene, bathing/showers, and dressing upper and lower body and required partial to moderate assistance with rolling left and right in bed.<br><br>A physician order dated 11/26/25 indicated please offload left neck/shoulder contracture, keep left neck fold clean and dry every 8 hours.<br><br>A Nurse Practitioner (NP) progress note dated 11/26/25 indicated the chief complaint for the visit was altered mental status and confusion. The note also indicated that the left neck and shoulder was red, moist, and macerated. The NP had discussed with staff strategies to offload contractures and keep crevices clean and dry as possible. The note indicated it was ok to apply interdry (moisture wicking fabric) to left neck skin fold for moisture wicking properties.<br><br>The NP order dated 11/26/25 indicated please offload left neck/shoulder contracture, keep left neck fold clean and dry every 8 hours (6:00 AM, 2:00 PM and 10:00 PM).<br><br>A review of Resident #6's Treatment Administration Record (TAR) for December 2025 revealed Nurse #2 had not initialed as completed offloading Resident #6's left neck/shoulder contracture at 6:00 AM on 12/3/25 as ordered.<br><br>(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<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 12/3/25 at 12:30 PM with Nurse #1, Resident #6 was observed in bed with no offloading or moisture wicking fabric to the left neck/shoulder. Redness was noted to the left neck area. Nurse #1 stated that she had not looked earlier during her shift which started at 7:00 AM to see if there was anything in place to offload the left neck/shoulder contracture. She stated that the neck was supposed to be offloaded with a rolled washcloth and an interdry or an abdominal pad (highly absorbent and cushioning dressing) to wick away the moisture. Nurse #1 indicated she should have checked Resident #6's neck earlier during her shift to ensure the night shift nurse had placed something to offload Resident #6's left neck/shoulder contracture. Nurse #1 further stated that Resident #6's neck area had not gotten worse from her previous observation of the area on 12/2/25.<br><br>An interview was conducted on 12/3/25 at 2:11 PM with the nurse (Nurse #2) who was assigned to care for Resident #6 on 12/2/25 at 7:00 PM to 12/3/25 at 7:00 AM. Nurse #2 stated she could not recall if Resident #6 had a rolled towel or anything in place for offloading. She further stated that she had administered all of Resident #6's medications during her shift, the Resident was not in pain, and that she could not recall placing anything to offload Resident #6's left neck/shoulder contracture. Nurse #2 stated that she had reviewed the TARs, and she could not tell how she missed the order at 6:00 AM.<br><br>During an interview on 12/3/25 at 1:29 PM with the Nurse Practitioner (NP), she indicated that she had given an order to offload Resident #6's left neck/shoulder contracture after she noted Resident #6's left neck area was red, moist and macerated on 11/26/25. The NP verbalized she had told nursing staff that they should roll a towel and put it between the left ear and shoulder and that they could apply interdry to wick away the moisture and prevent further skin breakdown. The NP indicated she expected nurses to follow provider orders and if the area was not off loaded as ordered it could lead to further skin breakdown, infection and sepsis.<br><br>During an interview on 12/4/25 at 8:55 AM with the Director of Nursing (DON), she stated nursing staff should have offloaded Resident #6's left neck/shoulder contracture as ordered or seek further clarification from the provider if they had any questions.<br><br>During an interview on 12/4/25 at 10:02 AM with the Administrator, he stated that he expected nursing staff to follow physician orders. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345318 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(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<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff and Wound Physician interviews, the facility failed to follow a physician order for a wound treatment for 1 of 3 residents (Resident #16) observed for pressure ulcers.Findings included: Resident #16 was admitted to the facility on [DATE]. Diagnoses included quadriplegia, wedge compression fracture of third thoracic vertebra and chronic pain. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #16's cognition was intact. He had impairments on both sides to upper and lower extremities and was coded as having a stage 3 pressure ulcer and one unstageable ulcer (deep tissue injury) not present on admission during this assessment. Review of Resident #16's care plan updated on 11/14/25 revealed a plan of care was in place for actual impairments to skin integrity related to quadriplegia with a goal that wounds will show improvement by the next review date. Interventions included in part, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to physician and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Review of the physician orders revealed the following orders were in place for wound care: o Cleanse left outer ankle with normal saline, pat dry, apply calcium alginate (highly absorbent bandage ideal for controlling bleeding and lifts dead tissue from the wound) to wound bed, cover with clean dry dressing every day shift every Tuesday, Thursday, Saturday for stage 3 pressure ulcer written on 11/24/25.o Cleanse left outer knee with normal saline, pat dry, apply petroleum (non-adherent dressing to keep wounds moist, prevent sticking and offer a barrier) gauze to wound bed, cover with clean dry dressing every day shift every Tuesday, Thursday, Saturday for abrasion written on 11/24/25.o Cleanse right inner foot with normal saline, pat dry, apply petroleum gauze to wound bed, cover with clean dry dressing every day shift every Tuesday, Thursday, Saturday for deep tissue injury (DTI) written on 11/25/25. An observation of wound care was conducted on 12/03/25 at 1:50 PM with the Wound Treatment Nurse (WTN). During the wound care observation of the lower extremities the Wound Treatment Nurse removed a dated dressing initialed by Nurse #3 on 12/02/25 to Resident #16's right ankle and left ankle. The WTN stated there was supposed to be a dressing to right inner foot and pointed to the DTI noted just under the great toe. She stated the wound on the right ankle had resolved a couple of weeks ago and she was not made aware that it had reopened. The WTN stated there was no treatment ordered for the right ankle and she did not know why Nurse #3 had a dressing on it or why Nurse #3 did not let her know it had reopened. The WTN removed the dressing to the right ankle and noted it was petroleum gauze in place. The wound on the right ankle was noted to be bleeding when she removed the dressing. The WTN stated when the wound was previously present to the right ankle, she used calcium alginate for the treatment to aid in drying the wound up. She stated she would not have put petroleum on it as that would keep it moist. She stated the treatment that was on there was the petroleum and that dressing should have been on the DTI not the right ankle. The WTN stated she would be reviewing the reopened area with the wound physician on 12/04/25. The Wound Treatment Nurse added that Nurse #3 was doing the wound care on 12/02/25 to help out the WTN, and when the WTN provided care on Resident #16 on 12/01/25 the right ankle pressure ulcer was still resolved. A phone interview was conducted with Nurse #3 on 12/03/25 at 5:21 PM who completed the wound treatments for this resident on 12/02/25 to help out the WTN. Nurse #3 stated when she did wound care, she followed the physician orders and brought in all the necessary supplies to do the wound care. She stated she thought there was an order for the right ankle and put a dressing on it. She stated the wound was open and bleeding. At this time, the orders were reviewed with Nurse #3 and there was no order to apply a petroleum dressing to the right ankle. Nurse #3 stated she put the wrong dressing on the wrong area and confirmed she should have put the dressing on the right inner foot not the ankle. An interview with the Director of Nursing (DON) on 12/04/25 at 8:50 AM revealed her expectation of wound care was that any time a floor nurse identified a new wound on a resident, they should notify the physician or nurse practitioner and the Wound Treatment Nurse for a treatment order. The DON also stated she would expect her nursing staff to ensure they are following the prescribed orders when applying dressings to wounds. A follow up interview was conducted with the Wound Treatment Nurse on 12/04/25 at 9:30 AM. The WTN stated there was no note put in the binder notifying her regarding the new pressure ulcer to the right ankle. She stated the binder was new and was just implemented because it was determined through the interdisciplinary team that the facility had |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345318 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident, staff and Nurse Practitioner (NP) interviews, the facility failed to provide supervision and ensure a smoking apron was worn for 1 of 1 resident identified as requiring supervision with smoking reviewed for smoking (Resident #99).Resident #99 was admitted into the facility on 9/30/20 with diagnoses of nontraumatic subdural hemorrhage (bleeding between the brain and its tough outer covering), syncope (a temporary loss of consciousness) and collapse (fall). A diagnosis of narcolepsy (a chronic condition where the brain cannot regulate sleep-wake cycles, causing overwhelming daytime sleepiness and sudden sleep during activities) was added on 12/9/22.Resident #99's quarterly Minimum Data Set, dated [DATE] revealed she was cognitively intact and had no impairment of her upper extremities. A review of Resident #99's smoking assessment dated [DATE], completed by the Social Service Assistant, determined Resident #99 was safe to smoke without supervision.A review of Resident #99's nursing progress note documented by Nurse #13 on 7/21/25 revealed the resident reported to her the fire from her cigarette fell onto her shirt and pants, and she went down the hallway with her clothes burning, and she was able to put it out with a cup water. A hole was noted on the bottom on her shirt along with the front of her pants. The resident denied any pain or discomfort. A complete body audit was completed and no burns or injuries were noted.Nurse #13 was not interviewed during the survey as she was no longer employed by the facility, and no contact information was available.A further review of Resident #99's medical record indicated a body audit conducted on 7/21/25 after the incident by Nurse #13 revealed no injury to Resident #99.A review of Resident #99's smoking assessment dated [DATE], completed by the Social Service Assistant, determined Resident #99 required supervision and a smoke apron related to recent burn marks on clothing. An interview conducted on 12/2/25 at 1:35 PM with the Social Service Assistant indicated that she completed the smoking assessment for Resident #99 on 7/21/25 and Resident #99 was determined to be a supervised smoker. She further indicated that she told the Social Service Worker the outcome of the assessments, who then informed the department heads. The Social Service Assistant stated that the smoking assessments were done quarterly and as needed.An interview conducted on 12/2/25 at 1:45 PM with the Social Service Worker revealed on 7/21/25 he had given Resident #99 a smoking apron, however, Resident #99 refused to wear it, and he had informed the department heads of the change in Resident #99's smoking status. He further stated with the incident on 7/21/25 and Resident #99's diagnosis of narcolepsy she should remain a supervised smoker.An observation with the Social Service Worker on 12/2/25 at 1:55 PM revealed Resident #99's smoking apron was located in a dresser drawer in her room.Resident #99's comprehensive care plan indicated a focus problem, revised on 7/21/25, of Resident #99 being a supervised smoker and to was to wear a smoking apron.Review of Resident #99's medical record from 7/22/25 to 12/2/25 revealed there were no documented incidents of burn marks on the resident's clothing as result of smoking or other smoking related injuries.An observation conducted on 12/2/25 at 9:19 AM of Resident #99 smoking revealed she was able to get outside to smoke independently and was not supervised by a facility staff member and was not wearing the smoking apron. There were no burn marks noted on the residents clothing and observations were made of her using a lighter to light her cigarette and the use of the appropriate fireproof receptacle to put her cigarette ashes in and extinguish her cigarette. An observation conducted on 12/2/25 at 10:05 AM of Resident #99 smoking revealed she was able to get outside to smoke independently and was not supervised by a facility staff member and was not wearing the smoking apron. There were no burn marks noted on the residents clothing and observations were made of her using a lighter to light her cigarette and the use of the appropriate fireproof receptacle to put her cigarette ashes in and extinguish her cigarette.An interview conducted on 12/2/25 at 12:55 PM with Resident #99 revealed that she went out to smoke whenever she wanted and had her own cigarettes and lighter that she kept in her room. She further revealed that no one had to watch her smoke and she did not wear an apron because she had never burnt herself. Resident #99 indicated that the facility had given her a apron to wear when she smoked but she does not wear it and it was in her dresser drawer.An interview conducted on 12/2/25 at 1:05 PM with Nurse Aide #1, assigned to Resident #99, indicated that Resident #99 was an independent smoker. Nurse Assistant #1 further indicated that she always asked the nurse if a resident required supervision when they smoked if she did not know. Nurse Aide #1 stated that any resident who smoked and was not supervised was allowed to have their cigarettes and lighter with them and could go outside to smoke anytime they wanted. An interview conducted |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345318 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff and Nurse Practitioner interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 4 residents reviewed for respiratory care (Resident #72). The findings included:Resident #72 was admitted to the facility on [DATE]. His diagnoses included hypertension, and chronic obstructive pulmonary disease (COPD).A physician order dated 2/22/24 indicated administer oxygen via nasal cannula at 2 liters per minute continuously.Resident #72's care plan had a care focus area initiated on 2/24/24 that indicated Resident #72 was at risk for shortness of breath related to COPD and chronic respiratory failure. Interventions included administering oxygen via nasal cannula as ordered.A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 was severely cognitively impaired. His diagnoses included chronic obstructive pulmonary disease. He was coded for shortness of breath or trouble breathing with exertion and when lying flat.During observation on 12/2/25 at 11:06 AM Resident #72 was observed with the oxygen nasal cannula in place. Resident #72's oxygen regulator on the concentrator was set at 3 liters per minute when viewed horizontally at eye level. During observation on 12/3/25 at 12:19 PM Resident #72 was observed with the oxygen nasal cannula in place. Resident #72's oxygen regulator on the concentrator was set at 3 liters per minute when viewed horizontally at eye level. Resident #72's oxygen regulator was verified with Nurse #1 to be set at 3 liters per minute. An interview was conducted on 12/3/25 at 12:20 PM with Nurse #1 who was assigned to care for Resident #72 on 12/2/25 and 12/3/25 during the day shift (7:00 AM - 7:00 PM). Nurse #1 stated Resident #72 had a physician order for oxygen at 2 liters per minute via nasal cannula. She further explained she would normally check the setting on the oxygen concentrator when she went to the room, but she had not checked it earlier that morning when she was in Resident #72's room.Attempts to interview the nurse who was assigned to care for Resident #72 on night shift 12/2/25 at 7:00 PM to 12/3/25 at 7:00 AM were unsuccessful. An interview was conducted on 12/3/25 at 1:29 PM with the Nurse Practitioner (NP). She stated she expected nurses to ensure oxygen was set at the ordered rate and if they needed to titrate the oxygen rate, she expected nurses to call the provider to request adjustment to the oxygen rate.An interview was conducted on 12/3/25 at 4:17 PM with the Director of Nursing (DON). She stated Nurse #1 should have verified that Resident #72's oxygen regulator was set at the physician ordered rate. The DON explained she expected nursing staff to follow physician orders and to request an updated order if there was a need to titrate the oxygen. She stated nurses should verify oxygen rates when they assumed the residents' care and throughout their shift.During an interview on 12/4/25 at 10:02 AM with the Administrator, he stated he expected nurses to monitor the oxygen setting to ensure that it was set at the provider ordered rate. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345318 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Cove Nursing Center | 1478 River Road<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, record review, and staff interviews, the facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident (Resident #105) with a pressure ulcer wound when the Wound Treatment Nurse was providing resident care without wearing the required personal protective equipment (PPE) for 1 of 4 staff observed for infection control. Findings included: The facility policy dated 07/26/22 titled, Enhanced Barrier Precautions an infection control intervention designed to reduce the transmission of multi-drug resistant organisms. It employs targeted personal protective equipment (PPE) use during high contact resident activities to include, in part, dressing, bathing, providing hygiene, changing linens or briefs. High contact residents included, in part, wound care; any skin opening requiring a dressing, and enteral feeding tubes. An observation of Resident #105's doorway to her room revealed a small magnetic banner at the entrance of the resident's room on the door frame that had the letters EPB with the letters A (a bed) and B (b bed) the letter B was circled. There was no visible personal protective equipment (gowns, gloves) noted in Resident #105's room and there was no signage posted in the room to indicate what healthcare personnel must apply during high contact resident care activities. An observation of wound care was conducted on 12/03/25 with the Wound Treatment Nurse at 1:17 PM. The Wound Treatment Nurse entered Resident 105's room and proceeded to inform the resident she was going to do her pressure ulcer dressing change. The Wound Treatment Nurse washed her hands and applied gloves, but she did not put on a protective gown. The Wound Treatment Nurse removed the existing dressing on Resident #105. She then removed her gloves, applied hand sanitizer and reapplied clean gloves, but she did not put on a protective gown. She cleansed the wound and applied the physician ordered treatment. An interview with the Wound Treatment Nurse on 12/03/25 at 1:38 PM revealed she realized halfway through that she forgot to put on a gown while doing her pressure ulcer treatment. The Wound Treatment Nurse stated on the rehabilitation hall where Resident #105 resided, the PPE was kept on top of the resident closets, and the signage should have been posted on the outside of the resident's bathroom door. She stated if she had seen the signage out in the open, it would have helped her to remember to apply the PPE. The Wound Treatment Nurse stated the residents' rooms should have the Enhanced Barrier Precaution signage hanging in the resident's room as well as having the magnetic banner on the door frame, but she did not know why there was no signage in Resident #105's room. The Wound Treatment Nurse stated that the signage indicated that staff should wear gloves and gowns for high contact resident care which included wound care that required a dressing, but the magnetic banner only indicated there was EBP in the room and which bed (as indicated by a circle around the letter). An interview with the Director of Nursing (DON) on 10/02/25 at 3:30 PM revealed she would have expected the staff member to apply the appropriate PPE to include a gown whenever she was providing care to a resident with an open wound. She stated the Enhanced Barrier Precaution policy was in place to protect other residents and staff members from infection and that more education needed to be given to the staff. The DON added that on the Rehabilitation Hall the gowns were put on top of the resident's closet and there should have been signage on the bathroom door as well as the magnetic banner on the entrance door. |