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 _____	C 07/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	1478 RIVER ROAD WINNABOW, NC 28479

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to have a medication error rate of less than 5% as evidenced by 3 errors out of 25 opportunities resulting in an error rate of 12% for 2 of 3 residents observed during a medication pass (Resident #5 and Resident #7). The findings included: The facility policy titled Six Rights of Medication Administration read: " When you are giving medication, regardless of the type of medication, you must always follow the six rights. Each time you administer a medication, you need to be sure to have the: 1. Right individual 2. Right medication 3. Right dose 4. Right time 5. Right route 6. Right documentation. " 1a. Resident #5 was admitted to the facility on 4/3/15 and re-admitted on 6/19/15. The resident had a diagnosis of Anemia. Review of the monthly physician ' s orders for July 2015 for Resident #5 revealed an order dated 6/22/15 for Ferrous Sulfate 325mg (milligrams), take 1 tablet by mouth in the morning with breakfast. Ferrous Sulfate is an enteric coated iron supplement given for anemia. According to the National Institute of Health no pill form of an iron supplement should be crushed. Review of the Medication Administration Record (MAR) for July 2015 revealed an entry for Ferrous Sulfate 325mg 1 tablet by mouth. The entry was followed by " DO NOT CRUSH. "	F 332	Effected residents medication administration records were reviewed and checked against orders to ensure that they were correct. Staff member that had the errors was individually related to specific errors made in addition to individual education related to 6 rights of medication administration and what constitutes a proper medication order. (7/16/2015) After interviewing staff member that committed errors, we believe that this was an isolated incident as she was extremely nervous as this was her first encounter with surveyors. That being said we assumed that everyone is capable of making medication errors and therefore decided to educate all staff who regularly administer or occasionally administer meds. Our pharmacy consultant will provide training for proper handling of medication orders and documentation of orders and a Pharmacy RN will provide physical demonstration. In addition, they will train the trainer (DON, ADON, SDC) and these processes will be incorporated in the new hire orientation. Specifics of the education will include	8/4/15

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

Electronically Signed | 07/28/2015

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F 332	Continued From page 1 On 7/14/15 at 8:45AM, Nurse #1 was observed to prepare medications for Resident #5. The nurse was observed to dispense one Ferrous Sulfate 325 mg tablet in a medication cup. The nurse was observed to transfer the medication to a pouch and placed in a pill crusher and crushed the medication. The nurse emptied the pouch into the medication cup and added apple sauce. The nurse was observed to enter the resident ' s room and administer the resident ' s morning medications including the Ferrous Sulfate. Nurse #1 stated in an interview on 7/14/15 at 10:55AM that Resident #5 would not take her pills whole and she just wasn ' t thinking when she crushed the Ferrous Sulfate. The Nurse stated the medication should not have been crushed because it was coated to protect the stomach. On 7/14/15, the Director of Nursing (DON) stated in an interview Resident #5 had been taking her medications crushed in applesauce. The DON stated the nurse should have requested the physician to change the order to a liquid iron supplement. 1b. Resident #5 was admitted to the facility on 4/3/15 and re-admitted on 6/19/15. The resident had a diagnosis of Diabetes Mellitus. Review of the monthly physician ' s orders for July 2015 revealed an order dated 6/22/15 to check the resident ' s finger stick blood sugar (FSBS) 3 times daily before meals and to administer Humalog insulin according to the results of the blood sugar. On 7/14/15 at 8:52AM Nurse #1 was observed to prepare and administer Resident #5 ' s morning medications. The Nurse was not observed to check a FSBS for the resident. Review of the Medication Administration Record (MAR) for July 2015 revealed an entry that read: " Humalog 100 units per ml (milliliter) vial. Check	F 332	what constitutes a proper medication order, proper D/C of order, proper rewriting of an order, proper correction or clarification of an order, documentation of medication administration (or refusal), documentation of PRN medication and physical demonstration (per checklist) of proper medication administration. Any staff who requires remediation will have individual re-education before allowed back to the floor. (8/1/2015) All new hire nurses will be required to demonstrate medication administration skills per checklist prior to administering medication without mentor nurse. All current staff will continue with medication administration education from SDC (or designee)including but not limited to biannual check of physical demonstration of medication administration using checklist and additional training as needed when an issue is identified. Any staff who does not meet requirements will be re-educated individually and required to demonstrate skills at satisfactory level. Results of medication administration demonstration will be reported at monthly QA for next three months beginning in August 2015 to ensure that training is effective and does not need to be changed.	

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F 332	Continued From page 2 FSBS 3 times daily before meals. " The entry was followed by a scale that determined how much insulin was to be given according to the FSBS. There was no documentation to show the FSBS had been checked or insulin had been given. A NA (nursing assistant) tried to feed the resident breakfast but the resident would not eat. The resident had received tube feeding during the night until 8AM that morning. Nurse #1 stated in an interview on 7/14/15 at 9:10AM the night shift did the FSBS at 6:30 in the morning. The Nurse was observed to review the MAR and stated the time had been changed to 7:30AM. The Nurse stated she had not worked on the unit in a while. The Nurse stated she had not checked the FSBS and would do it now. The Nurse was observed to check the resident ' s FSBS and stated it was 212 and administered 4u of Humalog Insulin per the scale. The physician ' s order was for a FSBS of 201-250 to administer 4 units of Humalog insulin. The Director of Nursing (DON) stated in an interview on 7/14/15 at 12:55 PM the nurse should have looked at all entries on the MAR and noticed the FSBS was to be done at 7:30AM. 2. Resident #7 was admitted to the facility on 6/12/15 and had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of the physician ' s order dated 6/12/15 revealed an order that read: Symbicort 160mg-4.5 mcg. 2 puffs inhalation qd (every day). Review of the resident ' s Medication Administration Record (MAR) for July 2015 revealed an order dated 6/12/15 for Symbicort 160/4.5 mcg (micrograms). Inhale 2 puffs by mouth daily. On 7/14/15 at 8:00AM, Nurse #1 was observed to prepare medications for Resident #7. The nurse was observed to administer pills by mouth,	F 332		

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F 332	Continued From page 3 Flonase Nasal Spray and apply an Exelon Patch to the anterior chest. The Nurse handed the resident a Symbicort 160/4.5mcg Inhaler and the resident took one puff from the inhaler and handed the inhaler to the nurse. The nurse then returned the inhaler to the medication cart. Nurse #1 stated in an interview on 7/14/15 at 820AM she was giving medications by different routes and did not notice the resident was supposed to take 2 puffs from the Symbicort Inhaler. The Nurse stated she should have taken the storage bag containing the directions for the Symbicort Inhaler into the resident ' s room with the medication. The Director of Nursing (DON) stated in an interview on 7/14/15 at 12:55PM this was part of the six rights of medication administration which was standard nursing practice. The DON stated the nurse could have taken the MAR in the room with her to administer the medications. The DON stated Nurse #1 had attended an in-service on the six rights of medication administration in April of this year.	F 332		