

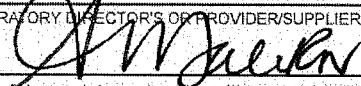
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2017
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345318 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/20/2017 |
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| NAME OF PROVIDER OR SUPPLIER BRUNSWICK COVE NURSING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 157 SS=D | <p>483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment</p> | F 157 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **NHA** (X6) DATE **8-7-2017**

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.

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| F 157 | <p>Continued From page 1 as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, physician interview and record review the facility failed to notify the physician that an antibiotic was not administered as ordered for 1 of 3 sampled residents (Resident #1).</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 06/26/17 with the diagnoses of Recurrent Urinary Tract Infections, Lewy Body Dementia with Acute Behavior Disturbance, Ushers Syndrome, Vascular Dementia, Stupor, Bilateral Hearing Loss, and Blindness.</p> <p>Review of the admission Minimum Data Set dated 07/03/17 revealed that Resident #1 was severely cognitively impaired, always incontinent of bowel and bladder and dependent for all care.</p> <p>Review of the Care Plan dated 07/09/17 for Resident #1 included a nursing diagnosis for a history of recurrent urinary tract infections. Approaches directed staff to observe for signs and symptoms of a urinary tract infection such as foul odor, increased temperature, dysuria, and frequency; and report findings to the physician.</p> | F 157 | | | |

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| F 157 | <p>Continued From page 2</p> <p>Review of the physician orders for Resident #1 dated 7/7/17 revealed an order for Ciprofloxacin 250mg twice daily for (7) days related to a urinary tract infection. The medication was circled on the Medication Administration Record (MAR) as not given on:</p> <ol style="list-style-type: none"> 1. 07/08/17 at 8:00 AM. No explanation was given on the back of the MAR. 2. 07/12/17 at 8:00 PM. No explanation was given on the back of the MAR. 3. 07/13/17 at 8:00 AM and 8:00 PM. Documentation revealed that the resident spit the medication out. <p>In an interview conducted with Nurse #1 on 7/19/17 at 11:35 AM she revealed that if a medication was not administered as ordered the nurse was to circle the dose missed and write an explanation on the back of the MAR. She also stated that the physician was to be notified when a medication was not given. She said the physician had not been notified that Resident #1 was not given (4) doses of the antibiotic Ciprofloxacin.</p> <p>In an interview with the Director of Nursing on 7/19/17 at 2:30 PM she revealed that she expected all medications to be given as ordered by the physician. She stated that if a medication was not administered as ordered she expected the nurse to notify the physician.</p> <p>In an interview with the physician on 07/20/17 at 10:00 AM he stated that if an antibiotic was not given as ordered it could allow an infection to worsen. He revealed that he had not been notified that Resident #1 had not been given the medication Ciprofloxacin as ordered. He said</p> | F 157 | | | |

Notification of Physician

F-157

Identified Problem: Nursing failed to properly notify physician of patient not taking medication as ordered.

Proposed Solution: Nursing has been re-educated on when to notify a physician related to change in patient status per nursing guidelines.

Identified Residents at Risk: The director of nursing has educated nursing staff regarding what constitutes a change in condition and notification of physician for residents.

Proposed Monitoring Tool: Assigned administrative nursing staff will monitor the MAR documentation and appropriate physician notification for all patients residing on their assigned halls. The administrative staff will utilize the station audits to monitor for proper MAR documentation and physician notification.

QAPI Integration: Administrative nursing staff (as assigned by the director of nursing) will bring their monitoring tool to each CMI/IDT meeting weekly ongoing to discuss potential improvements in the process. Administrative nursing staff (as assigned by the director of nursing) will bring their monitoring documentation to each monthly QA meeting to discuss methods of improvement for physician notification for 3 months or until desired results are achieved.

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| F 157 | Continued From page 3 that if he had known that the resident was not receiving the medication he would have changed the route to an injection or to intravenous to ensure that the medication was administered. | F 157 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; | F 329 | | |

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| F 329 | Continued From page 4 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide an antibiotic for the duration ordered by the physician for 1 of 3 sampled residents (Resident #1) resulting in the resident receiving an unnecessary medication for four days. Findings included: Resident #1 was admitted to the facility on 06/26/17 with the diagnoses of Recurrent Urinary Tract Infections, Lewy Body Dementia with Acute Behavior Disturbance, Ushers Syndrome, Vascular Dementia, Stupor, Bilateral Hearing Loss, and Blindness. Review of the admission Minimum Data Set dated 07/03/17 revealed that Resident #1 was severely cognitively impaired, always incontinent of bowel and bladder and dependent for all care. The Care Plan dated 07/09/17 for Resident #1 was reviewed with no concerns. Review of the physician orders for Resident #1 dated 7/7/17 revealed an order for Ciprofloxacin 250mg twice daily for (7) days related to a urinary tract infection. Review of the Medication Administration Record (MAR) for July 2017 revealed that Resident #1 | F 329 | | | |

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| F 329 | Continued From page 5 was administered Ciprofloxacin from 07/08/17 through 07/18/17 (eleven days). In an interview conducted with Nurse #1 on 7/19/17 at 11:35 AM she revealed that she had transcribed the order for the Ciprofloxacin. She said that a nurse on a previous shift had taken the order and that when she noticed that it had not been transcribed she did it to help the other nurse. She stated that she did not realize that it was for seven days and had not indicated a stop date on the MAR. In an interview with the Director of Nursing on 7/19/17 at 2:30 PM she revealed that she expected all medications to be given as ordered by the physician. | F 329 | | | |

Drug Regimen is Free from Unnecessary Drugs

F-329

Identified Problem: Nursing staff failed to transcribe the physician's order to include a stop date and continued to attempt to administer.

Proposed Solution: All nursing staff who administers medications was re-educated immediately regarding transcription of and administration of medications. A report was generated by the pharmacy to include all medications with stop dates to do an audit. No other errors were found.

Identified Residents at Risk: Daily, the director of nursing (or designee) will audit the physician orders and monitor for medications requiring a stop date then check for accuracy against the MAR. The pharmacy consultant will assist monthly with audits of this type ongoing.

Proposed Monitoring Tool: Daily, the director of nursing (or designee) will audit the physician orders and monitor for medications requiring a stop date then check for accuracy against the MAR. A report monthly is also generated by the pharmacy of medications with stop dates so the director of nursing (or designee) can continue to audit ongoing.

QAPI Integration: Administrative nursing staff (as assigned by the director of nursing) will bring their monitoring tool to each CMI/IDT meeting weekly ongoing to discuss potential improvements in the process. Administrative nursing staff (as assigned by the director of nursing) will bring their monitoring documentation to each monthly QA meeting to discuss methods of improvement for physician notification for 3 months or until desired results are achieved.