STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345571	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification and complaint investigation survey was conducted from 04/08/24 through 04/11/24. The facility was found in compliance with CFR 483.73 Emergency Preparedness. Event ID #KNP611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/08/24 through 04/11/24. Event ID #KNP611. The following complaint intakes were investigated: NC00213104 and NC00206244. 1 of the 2 complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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); (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 (D) A decision to transfer or discharge the	F 580		5/1/24

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

Electronically Signed | 04/26/2024

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner, Physician, Responsible Party, and staff interviews, the facility failed to notify the responsible party of a change in medication for 1 of 1 residents (Resident #85). Findings included:	F 580	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is	

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F 580	Continued From page 2 Resident #85 was admitted to the facility on 07/10/23. Diagnoses included, in part, fracture of left femur, presence of left artificial hip joint, fall, and epilepsy. The Minimum Data Set admission assessment dated 07/17/23 revealed Resident #85 was moderately cognitively impaired and was coded as receiving scheduled pain medication and as needed pain medication. Resident #85's pain was assessed and noted to be frequent with difficulty sleeping at night and limited day to day activities. Pain described at severe. Resident #85 was coded as having major surgery prior to admission and required active skilled nursing care due to recent surgery. Resident #85 received 2 days of opioid medication during this assessment period. A review of the physician orders revealed Keppra (medication to treat seizures) 500 milligrams (mg) twice daily written on 07/10/23, Tramadol (an opioid pain medication) 50 mg one tablet every 6 hours as needed for pain written on 07/10/25 and discontinued on 07/25/23, Acetaminophen (pain relieving medication) 325 mg give 2 tablets every 6 hours as needed for pain written on 7/10/23 and changed to every 6 hours scheduled on 07/25/23. A review of a nursing progress note written on 07/25/23 at 7:25 AM written by Nurse #1 revealed nurse spoke with resident's responsible party (RP) in facility. RP expressed some concerns regarding orders she was not aware about. Writer apologized that RP was not notified and explained that in the future she would be notified of any new orders. A review of a provider note written by the previous	F 580	prepared/or executed solely because it is required by provisions of federal and state law. 1. Interventions for affected resident: The responsible party for the affected resident was notified of new order on 8/6/2024. The resident experienced no adverse effects. 2. Interventions for residents identified as having potential to be affected: All residents receiving new orders have the potential to be affected by the alleged deficient practice. The Director of Nursing or Designee audited all current residents receiving new orders to ensure that responsible parties have been properly notified. (See Exhibit One) This was completed on 4/26/2024. 3. Systemic Changes: On 4/25/2024 the Director of Nursing or Designee began education of all full time, part time and as needed licensed staff regarding the notification of responsible parties when new orders are issued. (See Exhibit Two) The Director of Nursing will ensure that any licensed staff who do not complete the in-service training by 5/1/24 will not be allowed to work until education is completed. 4. Quality Assurance Plan: The Director of Nursing or Designee will	

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F 580	Continued From page 3 Nurse Practitioner (NP) on 07/25/23 at 8:58 AM revealed, in part, reviewed resident's medications. Resident had a past medical history of subarachnoid hemorrhage (bleeding in the brain) from 04/19/23 with hospitalization, history of seizures, Dementia, and frequent falls. Current medications included Keppra (antiseizure medication) 500 mg twice daily, Tramadol 50 mg every 6 hours as needed for pain, Acetaminophen 650 mg every 6 hours as needed for pain. Current rehabilitation for left hip fracture surgery on 07/06/23. Tramadol and Keppra together have risk of lowering seizure threshold, increasing dizziness, drowsiness, confusion and decreasing motor coordination. Will discontinue Tramadol for these risks. The following medication changes have been ordered: discontinue Tramadol, change Acetaminophen 650 mg from every 6 hours as needed to three times daily for pain, and consider Oxycodone 2.5 mg three times daily as needed for pain if needed. Discussed plan with physician. Review of new physician orders written on 08/02/23 revealed an order for Oxycodone (an opioid pain medication) 5 mg give 0.5 mg tablet 4 times a day for pain. This order was discontinued on 08/07/23. A review of the medication administration record (MAR) revealed Resident #85 received Oxycodone 2.5 mg from 08/03/23 through 08/06/23 at a total of 14 doses. The MAR revealed the order was discontinued on 08/07/23. A nursing progress note written on 08/07/2023 at 12:56 PM revealed, in part, Nurse #1 spoke with RP regarding her concerns. Nurse discussed pain medication and told the RP that she would look	F 580	complete weekly audits to monitor for compliance in the notification of responsible parties when new orders are issued. (See Exhibit Three) These audits will be completed weekly x 4 weeks, then 2 x per month x 1 month, then monthly x 2 months and as needed thereafter. Compliance and effectiveness of the auditing program will be reviewed at the monthly Quality Assurance Performance Improvement meeting.	

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F 580	Continued From page 4	F 580		

into her concerns.

A late entry nursing note written by Nurse #2 on 08/18/23 at 3:23 PM revealed, in part, that this nurse and Nurse #1 spoke to RP on 08/18/23 as a follow up call. Nurse #2 explained that after following up on why changes to resident's medication of oxycodone had been changed the following occurred: 1) Resident was given Tramadol by NP #1. NP #1 reviewed medications for resident's pain with the physician. Discussed seizure threshold of medications. Resident currently on Keppra so Tramadol was discontinued due to lowering seizure threshold on 07/25/23. Oxycodone 2.5 mg 4 times daily scheduled was ordered and nursing was to notify RP of changes. 3) Resident received Oxycodone 2.5mg from 08/03/23 through 08/06/23 for a total of 14 doses. 4) Nurse #2 discussed education was given to staff on notification communication.

A phone interview with the Responsible Party on 04/09/24 at 11:59 AM revealed she was not notified the facility had ordered the Tramadol for Resident #85 until it was discontinued nor was she made aware that Oxycodone was started as a new order. The RP stated she was visiting the resident on 08/06/24 and observed the nurse administering the Oxycodone and questioned when the resident started receiving that medication.

Interview with Nurse #2 on 04/10/24 at 1:50 PM revealed she recalled Resident #85 and remembered writing the note regarding the Tramadol and the Oxycodone orders. Nurse #2 stated normally whenever the NP put a new order in place, the NP would notify the family. She stated she did not know what happened and why

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F 580	Continued From page 5	F 580		

the NP did not notify the family, but that it then initiated the facility to do a complete in-service with all nursing staff to make sure any new changes or orders were being communicated to the family by the nurse.

A phone interview with Nurse #1 on 04/10/24 at 2:10 PM revealed she recalled the day the RP was inquiring about the Oxycodone and she stated she did not notify the family regarding the change of medication with the Tramadol or the Oxycodone because she thought the NP was notifying the family.

An interview with the Physician on 04/10/24 at 4:10 PM revealed she would have expected the nursing staff to notify the family of the medication changes. The Physician stated notifying the family was not the sole responsibility of the NP when she initiated an order, but she knew that the NP would notify family at times. The Physician stated communication of who notified the family should be documented at the time of the notification to avoid confusion.

A phone interview was conducted with the previous Nurse Practitioner (NP #1) on 04/11/24 at 5:10 PM. NP #1 stated she was not responsible for notifying the families of any medication changes. She stated it was the nursing staff's responsibility.

An interview with the Director of Nursing on 04/11/24 at 5:30 PM revealed the expectation was that the nursing staff was to notify the RP of any medication changes. He stated after this incident occurred he did a full in service with all nursing staff to ensure they understood it was their responsibility to notify the family and

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F 580	Continued From page 6 document the notification in a nursing note. He did not complete a full plan of correction.	F 580		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		5/1/24

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F 758	Continued From page 7	F 758		

are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, Physician Assistant and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication (a medication that affects brain activities associated with mental processes and behavior) was limited to 14 days or document the continued use with a rationale and duration for 1 of 5 residents (Resident #10) reviewed for unnecessary medications.

Findings included:

Resident #10 was admitted to the facility on 03/12/24. Diagnoses included, in part, fracture of left humerus, metabolic encephalopathy, Parkinson's, and anxiety.

A review of the physician orders written on 03/12/24 revealed an order for Alprazolam 0.5 milligrams (mg) one tablet every 8 hours as needed for anxiety. There was no stop date indicated on this order.

The Minimum Data Set admission assessment

This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared/or executed solely because it is required by provisions of federal and state law.

1. Interventions for affected resident:

The PRN psychotropic medication order for the affected resident was amended on 4/12/2024. The resident experienced no adverse effects.

2. Interventions for residents identified as having potential to be affected:

All residents with PRN psychotropic medication orders have the potential to be

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F 758	Continued From page 8 dated 03/19/24 revealed Resident #10 was cognitively impaired and exhibited hallucinations and refusal of care. Resident #10 received antianxiety, antidepressants, anticoagulant (blood thinner) and opioids during this assessment. Review of the Pharmacy Consultants medication regimen review dated 03/13/24 indicated, in part, "PRN psychotropic medications are limited to 14 days. If you would like to extend Alprazolam 0.5 mg one tablet every 8 hours PRN for anxiety past 14 days, please document a rationale and indicate a duration." This was reviewed and signed by the Physician Assistant dated 03/14/24 with a rationale stating, "working to wean off Alprazolam and hopefully will only need this one 14 dose package." Review of March 2024 Medication Administration Record revealed Resident #10 received Alprazolam 0.5 milligrams daily from 03/16/24 through 03/31/24. Review of the April 2024 Medication Administration Record revealed Resident #10 received Alprazolam 0.5 milligrams daily from 04/01/24 through 04/10/24. An interview with the Physician Assistant on 04/11/24 at 4:15 PM revealed when she reviewed this recommendation from the pharmacist, she did not include the end date along with her rationale and should have. The Physician Assistant added, when the nurse's put orders in for a PRN psychotropic medication, they should be putting an end date. She stated nursing did not make her aware that she was taking this regularly and she would reevaluate to see if the resident needed this medication scheduled	F 758	affected by the alleged deficient practice. All residents with PRN psychotropic medication orders were audited by the Director of Nursing or Designee to ensure stop 14-day stop dates are in place. (See Exhibit Four) This was completed on 4/24/2024. 3. Systemic Changes: On 4/25/2024 the Director of Nursing or Designee began education of full time, part time and as needed licensed staff; as well as the attending physician and physician extenders on the requirement of a 14-day stop date for all PRN psychotropic medication orders. (See Exhibit Five) The Director of Nursing will ensure that any licensed staff who do not complete the in-service training by 5/1/2024 will not be allowed to work until education is completed. 4. Quality Assurance Plan: The Director of Nursing or Designee will complete weekly audits to monitor for compliance in the implementing 14-day stop dates on PRN psychotropic medication orders. (See Exhibit Six) These audits will be completed weekly x 4 weeks, then 2 x per month x 1 month, then monthly x 2 months and as needed thereafter. Compliance and effectiveness of the auditing program will be reviewed at the monthly Quality Assurance Performance Improvement meeting.	

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F 758	Continued From page 9 instead of as needed. An interview was conducted with Nurse #3 on 04/11/24 at 4:20 PM. Nurse #3 reported anytime a resident was on a PRN psychotropic medication it should have a stop date at 14 days. She stated she entered the order as it was listed on the hospital discharge summary and she forgot to the put the 14 day stop date on the order. An interview with the Director of Nursing (DON) on 04/11/24 at 5:30 PM revealed he would have expected the PRN stop date to be applied. The DON stated the monthly Pharmacy medication recommendations regarding as needed orders with stop dates were given directly to the Physician or the Physician Assistant for review. Once the Physician reviewed and signed the recommendation, he would implement the order. The DON stated his nursing staff were aware of the regulation to have a stop date for as needed psychotropic medications and should have identified this when transcribing the order and during their medication pass.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and the Physician Assistant interviews the facility failed to administer an as needed antihypertensive medication as prescribed by the physician for blood pressure greater than 150/90 millimeters of mercury (mm Hg) resulting in 3 missed doses.	F 760	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	5/1/24

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F 760	Continued From page 10 This occurred for 1 of 1 resident (Resident # 7) reviewed for medication administration. Findings included. Resident #7 was admitted to the facility on 03/21/24 with diagnoses including hypertension. The Minimum Data Set (MDS) admission assessment dated 03/28/24 revealed Resident #7 was cognitively intact. She had no rejection of care. A care plan dated 03/21/24 for Resident #7 revealed to administer antihypertensive medications as ordered. A physicians order dated 03/22/24 for Resident #7 revealed Clonidine (antihypertensive) oral tablet 0.1 milligram. Give 1 tablet by mouth every 24 hours as needed for hypertension. Give if systolic blood pressure is greater than 150 mm Hg and diastolic blood pressure is greater than 90 mm Hg. Review of the progress notes for Resident #7 from 03/21/24 through 03/31/24 revealed a blood pressure reading recorded on 03/23/24 at 9:33 AM of 168/98 mm Hg. The progress note revealed no documentation that Clonidine 0.1 mg as needed for blood pressure greater than 150/90 was administered to Resident #7. Review of the Medication Administration Record (MAR) dated March 2024 for Resident #7 revealed Clonidine 0.1 mg as needed for blood pressure greater than 150/90 mm Hg was not administered to Resident #7 on 03/23/24.	F 760	conclusions set forth in the statement of deficiencies. The plan of correction is prepared/or executed solely because it is required by provisions of federal and state law. 1. Interventions for affected resident: The physician of the affected resident was notified. The resident was assessed by the physician and was noted to be at baseline and vitals were stable. Resident orders were reviewed and the order was clarified. The resident has since been discharged. 2. Interventions for residents identified as having potential to be affected: All residents with a PRN blood pressure medication with parameters have the potential to be affected by the alleged deficient practice. The Director of Nursing or Designee audited all residents with a PRN blood pressure medication with parameters to ensure medications are administered according to physician□s orders (See Exhibit Seven) This was completed on 4/24/2024. 3. Systemic Changes: On 4/25/2024 the Director of Nursing or Designee began education of all full time, part time and as needed licensed staff on administration of medication for PRN blood pressure medications with parameters. (See Exhibit Eight) The Director of Nursing will ensure that any	

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F 760	Continued From page 11 Further review of the Medication Administration Record (MAR) dated March 2024 for Resident #7 revealed blood pressure readings less than 150/90 and the as needed Clonidine 0.1 mg was not needed and was not administered. Review of the Medication Administration Record (MAR) dated April 2024 for Resident #7 revealed blood pressure readings greater than 150/90 on the following dates: 04/01/24 the blood pressure reading was 179/98 mm Hg. 04/09/24 the blood pressure reading was 155/95 mm Hg. Review of the Medication Administration Record (MAR) dated April 2024 for Resident #7 revealed no documentation that Clonidine 0.1mg as needed for blood pressure greater than 150/90 mm Hg was administered to Resident #7 on 04/01/24 or 04/09/24. Review of the progress notes for Resident #7 from 04/01/24 through 04/09/24 revealed no documentation that Clonidine 0.1 mg was administered. During an interview on 04/11/24 at 6:10 PM the Physician Assistant stated Resident #7 had orders for scheduled Clonidine 0.1 mg daily and an as needed dose was ordered to be given once every 24 hours if her blood pressure was greater than 150/90 mm Hg. She indicated Resident #7 should have received the as needed dose on the days her blood pressure was elevated above 150/90 mm Hg. She stated she evaluated Resident #7 today and she was at her baseline and her vital signs were stable. She stated	F 760	licensed staff who do not complete the in-service training by 5/1/2024 will not be allowed to work until education is completed. 4. Quality Assurance Plan: The Director of Nursing or Designee will complete weekly audits to monitor for compliance in administration of PRN blood pressure medications with parameters. (See Exhibit Nine) These audits will be completed weekly x 4 weeks, then 2 x per month x 1 month, then monthly x 2 months and as needed thereafter. Compliance and effectiveness of the auditing program will be reviewed at the monthly Quality Assurance Performance Improvement meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345571	A. BUILDING _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 12	F 760		

Resident #7 did not have any adverse effects by not receiving the 3 missed doses of the medication.

During an interview on 04/11/24 at 6:35 PM Nurse #7 stated he was the assigned Nurse for Resident #7 on 04/01/24. He stated he did not give the as needed dose of Clonidine to Resident #7 because he gave the 9:00 AM scheduled dose and didn't want to give her 2 doses. He indicated he was uncertain of when exactly the blood pressure reading was taken on 04/01/24. He indicated with an elevated blood pressure of 179/98 he should have clarified the order with the physician.

During an interview on 04/11/24 at 7:33 PM Nurse #4 stated the vital signs recorded on 04/09/24 for Resident #7 were taken by another staff member. She stated when she documented the blood pressure reading of 155/95 for Resident #7, she did not think to look at her medications to detrmine if any as needed medications for increased blood pressure should be given. She stated she did not administer as needed Clonidine to Resident #7 on 04/09/24.

Nurse #8 who was assigned to Resident #7 on 03/23/24 when the blood pressure reading was 168/98 was not available for an interview.

During an interview on 04/11/24 at 6:47 PM the Director of Nursing stated Resident #7 should have received the Clonidine 0.1 mg as needed for increased blood pressure when the blood pressure was greater than 150/90 mm Hg. He stated that did not occur and education would be provided.