

MHH0190-POC-9.1.22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20040012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER BRYNN MARR HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE JACKSONVILLE, NC 28546		
(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) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on September 1, 2022. One complaint was unsubstantiated (intake #NC00191932), and one complaint was substantiated (intake #NC00191720). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>This facility is licensed for 18 and currently has a census of 17. The survey sample consisted of an audit of 1 current client.</p>	V 000			
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p>	V 118			

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

9PVX11

If continuation sheet 1 of 4

Allie Hein, RN 9-15-22

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V 118	<p>Continued From page 1</p> <p>(C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician affecting 1 of 1 client audited (client #1). The findings are:</p> <p>Review on 8/31/22 and 9/1/22 of client #1's record revealed: -15 year old female admitted 1/24/22. -Diagnoses included disruptive mood dysregulation disorder, and impulse disorder, unspecified.</p> <p>Review on 9/1/22 of client #1's physician orders and physician progress notes between 6/30/22 and 8/25/22 revealed: -Medication orders were listed under "Treatment" on each physician progress note listing each medication order to be continued, discontinued, or changed. -Progress notes were electronically signed by the physician. -Progress note dated 6/30/22 read, "Increase Topamax Tablet, 100 MG (milligrams), 1 tablet at bedtime..." (mood; off label used for obesity)</p>	V 118	<p>Education provided to the Medical Director by the Pharmacy Director on how to identify alerts in the electronic medical record patient profile prior to any medications scheduled to automatically stop that require reorder. The Medical Director can then determine if medication orders are to be renewed or discontinued. The Medical Director will check for these alerts when signing medication orders daily in the electronic medical record.</p>	9/8/22

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V 118	<p>Continued From page 2</p> <p>-Progress notes dated 7/7/22, 7/14/22, 8/18/22, and 8/25/22 read, "Continue Topamax Tablet, 100 MG, 1 tablet at bedtime..."</p> <p>-Progress note dated 6/30/22 read, "Increase Abilify Tablet, 20 MG, 1 tablet at bedtime..." (antipsychotic medicine; lability)</p> <p>-Progress notes dated 7/7/22/22 and 7/14/22 read, "Continue Abilify Tablet, 20 MG, 1 tablet at bedtime..."</p> <p>-There was no order to discontinue Topamax 100 mg at bedtime documented on the physician progress notes or physician order forms.</p> <p>-Verbal order dated 7/14/22 on a physician order form to discontinue Topamax 50 mg and Abilify 15 mg at bedtime.</p> <p>-Verbal order dated 7/14/22 on a physician order form to administer Topamax 100 mg and Abilify 20 mg at bedtime.</p> <p>Review on 8/31/22 and 9/1/22 of client #1's July 2022 and August 2022 MARs revealed:</p> <p>-Client #1 continued to receive Topamax 50 mg and Ability 15 mg until 7/14/22 when the dosages were increased to 100 mg and 20 mg respectively.</p> <p>-Topamax 100 mg had not been documented as administered from 8/14/22 - 8/31/22.</p> <p>Interview on 9/1/22 Nurse Manager #1 and Nurse Manager #2 stated:</p> <p>-The facility had not considered the physician progress notes to include orders.</p> <p>-There was no process in place to reconcile the orders documented on the physician progress notes and the medication orders that were being followed.</p> <p>-The Topamax had an "auto stop" in the pharmacy system for 8/14/22; therefore, the medication had been discontinued.</p> <p>-There was no process in place to consult with</p>	V 118	<p>Pharmacy Policy PHRM-II-001 Automatic Stop Orders was reviewed by the Pharmacist, [REDACTED], Medical Director, and Director of Risk Management & Performance Improvement. No revisions necessary.</p> <p>The physician will communicate any medication changes to the unit nurse or enter orders directly into the electronic medical record following weekly face-to-face encounters with the patient.</p> <p>As a second level check, training for all PRTF Registered Nurses will be provided by the Nurse Manager on identifying 72 hour medication alerts in the electronic medical record patient profile so the physician can be contacted to verify orders. This will prevent medications from automatically stopping. This will be added to the PRTF 24 hour chart check completed by overnight RNs, and monitored by Nurse leaders. RNs will sign acknowledgement they have been trained and will abide by protocol in place.</p> <p>The phrase "<i>not intended for medication order transcription</i>" to be added to PRTF physician progress notes by the Medical Director.</p>	9/8/22	9/8/22
				9/30/22	10/31/22

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V 118	Continued From page 3 the physician before a medication was discontinued based on the "auto stop" feature. -Client #1's behaviors were improving.	V 118			



192 Village Drive • Jacksonville, NC 28546 • P: 910-577-1400 • F: 910-577-2760 • www.brynnmarr.org

September 15, 2022

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: Complaint Survey completed September 1, 2022
Brynn Marr Hospital, 192 Village Drive, Jacksonville, NC 28546
MHL# MHH0190
Intake #NC00191720

To Whom It May Concern:

Enclosed you will find Brynn Marr Hospital's original Plan of Correction in response to the complaint survey conducted at our facility completed September 1, 2022. Please contact me directly at (910) 577-2710 with any questions.

Sincerely,


Allison Harris, MSW

Director of Risk Management & Performance Improvement
allison.harris@uhsinc.com