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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075375 | A. Building<br>B. Wing | 02/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bride Brook Rehabilitation & Nursing Center | 23 Liberty Way<br>Niantic, CT 06357 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for pain management, the facility failed to ensure a complete and accurate medical record regarding physician notification with a change in status. The findings include:<br><br>Resident #1's diagnoses included fracture of the shaft of the left femur (straight part of the thigh bone running from below the hip to the knee) and age-related osteoporosis (weak and brittle bones).<br><br>The Resident Care Plan (RCP) dated 12/4/24 identified that Resident #1 had acute pain with interventions that included for staff to notify the physician if interventions are unsuccessful, or if the current complaint is a significant change from the resident's past experience of pain.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of nine (9) indicative of moderately impaired cognition and required substantial assistance for showering and was dependent on staff for bed mobility and transfers.<br><br>A physician's order dated 12/3/24 directed to administer Oxycodone ( a narcotic pain medication) 5 milligrams (mg) by mouth every four (4) hours as needed for pain.<br><br>A physician's order dated 12/6/24 directed to administer Acetaminophen ( over the counter pain medication) 1000 milligrams (mg) by mouth three times a day for pain.<br><br>Review of the Medication Administration Record (MAR) for December 2024 identified that Resident #1 was administered the Oxycodone 5 mg on 12/4/24 at 9:32 PM for a reported pain level of four (4) out of ten (10), on 12/9/24 at 10:12 AM for a reported pain level of five (5) out of ten (10), on 12/10/24 at 2:10 AM for a reported pain level of six (6) out of ten (10), on 12/10/24 at 4:12 PM for a reported pain level of seven (7) out of ten (10), on 12/10/24 at 9:57 PM for a reported pain level of eight (8) out of ten (10), on 12/11/24 at 4:43 AM for a reported pain level of nine (9) out of ten (10) and on 12/11/24 at 10:00 AM for a reported pain level of eight (8) out of ten (10). All the aforementioned pain levels had follow up documentation that the pain was relieved. The MAR further identified that the Oxycodone 5 mg was ineffective at controlling the resident's pain on 12/10/24 at 4:12 PM, on 12/11/24 at 4:43 AM and on 12/11/24 at 10:00 AM.<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 |
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| NAME OF PROVIDER OR SUPPLIER Bride Brook Rehabilitation & Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 23 Liberty Way Niantic, CT 06357 | |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A nurse's follow-up note written by LPN #1 and dated 12/10/24 at 9:57 PM (5-hours and 45-minutes after the administration) identified that the 4:12 PM Oxycodone 5 mg dose was ineffective with a follow-up pain level of seven (7) out of ten (10).<br><br>A nurse's follow-up note written by RN #5 and dated 12/11/24 at 7:29 AM (2-hours and 46-minutes after the administration) identified that the 4:43 AM dose of Oxycodone 5 mg was ineffective with a follow-up pain level of eight (8) out of ten (10).<br><br>A nurse's note written by RN #5 and dated 12/11/24 at 11:05 AM (1-hour and 5-minutes after the administration) identified that the 10:00 AM dose of Oxycodone 5 mg was ineffective with a follow-up pain level of eight (8) out of ten (10).<br><br>Review of nurse's notes identified that the provider wasn't notified of Resident #1's unrelieved pain on 12/10/24 at 4:12 PM that was unrelieved by the Oxycodone 5 mg until 12/11/24 at 12:55 PM.<br><br>A Change in Condition assessment dated [DATE] at 12:55 PM identified that Resident #1 was noted with constant pain with minimal relief from the as needed Oxycodone and scheduled Acetaminophen. New orders were obtained to send the resident out for to the hospital for an x-ray and/or CT scan (detailed cross-sectional x-ray images of a specified body part) for comparison to the previous imaging.<br><br>Interview with MD #1 on 2/5/25 at 12:49 PM identified that although he was unsure of the time, the facility notified him on 12/10/24 that Resident #1 was having increasing pain that was unrelieved by the as needed Oxycodone 5 mg. He reported that since the resident also had scheduled Acetaminophen three times daily and the Oxycodone 5 mg was available to be given every four (4) hours, he addressed the pain management the next day on 12/11/24, and increased the Oxycodone to 10 mg.<br><br>Interview with the DNS on 2/5/25 at 1:08 PM identified that the provider should have been notified as soon as it was identified that the Oxycodone 5 mg was ineffective. She stated she reached out to RN #6 (Nursing Supervisor) who reported to her that she reached out to MD #1 and he identified that he'd address the change the following day, but stated her expectation was that all change in conditions and provider notifications be documented in the clinical record timely, and she was unsure why there was no documentation in the record when the change was identified. Further, she reported that the facility has a paper 'Change in Condition' provider communication book and stated she would check the book to see if there were any entries notating that the provider was notified.<br><br>Interview with LPN #1 (evening nurse on 12/10/24) on 2/5/25 at 2:24 PM identified that she could not recall any details regarding the incident but reported that if a resident had pain that was unrelieved by pain medication or other interventions, she would have notified the Nursing Supervisor when she identified the change. Additionally, she identified that nursing should be following up on a resident's pain within an hour of medication administration and documenting the follow-up pain level, stating she was unsure when she followed-up or why the documentation from the 4:12 PM administration was over five (5) hours later.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with RN #5 on 2/5/25 at 3:24 PM identified that although she could not recall the time, and did not do an assessment, she reported that she notified MD #1 on 12/10/24 when she was notified by LPN #1 that Resident #1's pain medication was ineffective. She identified that MD #1 is cautious with narcotic medications and stated he would address Resident #1's pain management the next day, stating he did not give any orders or offer any alternatives until the resident was seen. RN #5 reported that she communicated with LPN #1 that MD #1 stated he would see the resident the next day, identifying that LPN #1 should have documented the change and the provider notification.<br><br>Although attempted, an interview with RN #4 was not obtained.<br><br>Review of the Documentation in the Medical Record policy (undated) directed, in part, that each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations and services provided in the resident's medical record in accordance with state law and facility policy and the documentation shall be completed in a timely manner. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or response to care. |