

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/02/2024
NAME OF PROVIDER OR SUPPLIER Brunswick Pointe Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 Laurel Road Brunswick, OH 44212	
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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on record review, interview, and policy review the facility failed to ensure a safe and orderly discharge for Resident #3. The affected one resident (#3) of three residents reviewed for discharge planning. Findings include: Review of the medical record for Resident #3 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included type two diabetes, other chronic osteomyelitis, right ankle, and chronic kidney disease. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 08/17/24, revealed Resident #3 had intact cognition. Review of the discharge care plan dated 10/04/24 revealed Resident #3's plan was to discharge home. Review of the physician order dated 08/22/24 revealed an order for tirzepatide (Mounjaro) 7.5 milligrams (mg) weekly for diabetes. Review of the discharge summary dated 10/04/24 revealed Resident #3 was discharged with instructions provided and services set up. All medications were sent with the resident except Mounjaro 7.5 mg. Review of the Discharge Medication Receipt dated 10/04/24 revealed staff provided all medications except Mounjaro 7.5 mg. Interview on 11/02/24 at 9:30 A.M. with Resident #3 revealed the facility failed to supply the Mounjaro 7.5 mg injections when he discharged . Resident #3 stated he received an injection on 10/03/24 and then on 10/11/24 which was a day later than scheduled due to not having the medication. The pharmacy filled a prescription for Mounjaro 7.5 mg on 09/24/24 which included four injections. The pharmacy where he went for his medications upon discharge would not refill the medication after his discharge because the refill date was 10/24/24. After several calls to the pharmacy and insurance company, the pharmacy was able to provide the Mounjaro on 10/11/24. (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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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/02/24 at 10:15 A.M. with the Administrator and Director of Nursing revealed the nurse who discharged Resident #3 did not look in the refrigerator for any unused Mounjaro belonging to Resident #3 because he received an injection the day before he was discharged . The Administrator said the facility destroyed all medications left behind due to the facility policy. Documentation was provided and reviewed which confirmed Resident #3's Mounjaro was destroyed after his discharge from the facility. The Administrator stated that once the facility was aware of the problem, Resident #3's pharmacy was contacted regarding refilling the prescription. Interview on 11/02/24 at 10:25 A.M. with Licensed Practical Nurse (LPN) #205, the nurse who discharged Resident #3, confirmed she did look in the refrigerator for Resident #3's remaining Mounjaro injections and therefore the unused Mounjaro was not provided to Resident #3 upon Resident #3's discharge. LPN #205 did not look for the remaining doses of Mounjaro because Resident #3 received a Mounjaro injection the day before. LPN #205 stated the injections were scheduled once weekly so she figured the prescription would be filled by the resident after discharge. Interview on 11/02/24 at 11:33 A.M. with the owner of Resident #3's pharmacy revealed he did not refill the Mounjaro prior to 10/11/24 because the refill was dated 10/24/24. However, after contacting Resident #3's insurance company and the nursing home's pharmacy the pharmacist was able to override the prescription and refill the medication. Review of the facility policy titled, Discharge Process for Planned Discharges, dated 2018 revealed all medications except for controlled medications were to be provided to the resident at discharge. This deficiency represents non-compliance investigated under Complaint Number OH00158955.		