

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 Post Road Warwick, RI 02886	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41729</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice relative to following a physician's order for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing page 314 which states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.</p> <p>Record review of a community reported complaint submitted to The Rhode Island Department of Health on 5/30/2024 alleges in part, that the resident did not receive his/her medications on the second shift of 5/30/2024, as ordered.</p> <p>Record review revealed Resident ID #1 was admitted to the facility in May of 2023, with diagnoses including, but not limited to, adult failure to thrive and pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time).</p> <p>Record review of a physician's order dated 10/19/2023 states in part, Medication Administration: second nurse verification twice a day 7:00 AM-11:00 AM, 7:00 PM-11:00 PM.</p> <p>Record review of the Medication Administration Record (MAR) for June 2024 failed to reveal evidence that a second nurse verified the medication administration on 6/3, 6/4, and 6/5/2024 during the 7:00 PM-11:00 PM medication administration, as ordered.</p> <p>Record review of the MAR for May 2024 failed to reveal evidence that a second nurse verified the medication administration on 5/30/2024 during the 7:00 PM-11:00 PM medication administration, as ordered.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff A, on 6/6/2024 at approximately 11:35 AM, he acknowledged that he worked on 6/3, 6/4, and 6/5/2024. He further acknowledged that he did not verify the medication administration with a second nurse on 6/3, 6/4, and 6/5/2024, as ordered.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview with Licensed Practical Nurse, Staff B, on 6/7/2024 at approximately 10:02 AM, she acknowledged that she worked on 5/30/2024. She further acknowledged that she did not verify the medication administration with a second nurse on 5/30/2024, as ordered.</p> <p>During a surveyor interview with the Director of Nursing Services on 6/6/2024 at approximately 2:33 PM, she was unable to provide evidence the resident's medications were verified by a second nurse on the above-mentioned dates, as ordered.</p>