DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING ______ B. WING ______	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HWY 221 RUTHERFORDTON, NC 28139

(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
F 000	INITIAL COMMENTS No deficiencies were cite as a result of the complaint investigation Event ID #QVIK11.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #99 has been assessed by the MDS Coordinators and care plan has been updated based on current assessment on October 15, 2013. Behavior monitoring was put in place by the Director of Clinical Services as of October 1, 2013. Resident #104 has had a bladder assessment which was completed by the Director of Clinical Services and the Unit Manager on October 15, 2013.	10/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bethany Bayford	Executive Director	10-17-13

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.

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This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interviews and record review, the facility failed to conduct assessments for anxious behavior and increase in frequency of incontinent episodes for 2 of 16 sampled residents (Residents #99 and #104.)

The findings included:

1. Resident #99 was admitted to the facility on 05/29/13 with diagnoses which included depression and recent surgical repair of the left femur.

Review of Resident #99's admission Minimum Data Set (MDS) dated 06/05/13 revealed an assessment of severely impaired cognition. Resident #99 did not exhibit behaviors and did not receive anti-anxiety medication according to the MDS.

Review of a telephone physician's order taken by Nurse #1 dated 06/24/13 revealed direction for Ativan 0.5 milligrams (mg.) to be administered twice daily for anxiety.

Review of the 90 day scheduled MDS dated 08/25/13 revealed Resident #99's cognition was moderately impaired. Resident #99 received an anti-anxiety medication 7 days a week.

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2. Residents that may be affected by the same deficient practice have assessments in place for psychoactive and/or incontinence management. New admissions will be assessed on admission and at 30 days by the MDS Coordinators. This will continue quarterly and with significant changes as indicated. MDS Coordinators have been educated on correct coding, staff and resident interviews and care planning by the Director of Clinical Services on September 26, 2013.

3. Facility Administrator will review assessments in the morning interdisciplinary team meeting for possible discrepancies and to insure all needed assessments are complete. Care plans will be reviewed during the morning interdisciplinary team meeting. New assessments will be reviewed in the morning clinical meeting five (5) days a week for two (2) weeks, then twice a week for, four (4) weeks. Twenty-five percent (25%) of all admission, significant change, ninety (90) day and quarterly assessments will be reviewed monthly for ten (10) months.

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F 272	Continued From page 2 During an interview with Resident #99 on 09/25/13 at 9:14 AM, Resident #99 explained he worried about his legs and the ability to return home. Interview with the MDS nurse on 9/26/13 a 11:30 AM revealed an assessment of Resident #99's anxiety and use of anti-anxiety medication was not done. The MDS nurse explained interventions would have been documented in Resident #99's care plan if anxiety had been identified as a problem. The MDS nurse could not provide a reason for the lack of an assessment. Interview with Nurse #4 on 09/26/13 at 1:51 PM revealed she communicated Resident #99's anxiety and requested medication in the communication book used by Nurse #1. Nurse #4 explained staff could calm Resident #99 with interventions of one to one conversations, offering food, pain management, and looking at magazines. Nurse #4 reported Resident #99's anxious behavior required staff interventions everyday and she thought a medication should be requested. Interview with Resident #99's physician on 09/26/13 at 1:30 PM revealed he expected the nursing staff to assess the cause of anxiety and attempt interventions before requesting a medication. Interview with the Director of Nursing on 09/26/13 at 2:21 PM revealed she expected staff to complete a documented assessment of Resident #99's anxiety. The DON reported successful interventions after the assessment would have been included in the care plan.	F 272	4. Results of the QI monitoring will be reported by the MDS Coordinators to the Quality Assurance Performance Improvement (QAPI) committee monthly for twelve (12) months for continued substantial compliance and/or revision.	

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2. Resident #104 was admitted to the facility on 06/13/13 with diagnoses which included lung cancer and depression.

Review of Resident #104's admission Minimum Data Set (MDS) dated 06/20/13 revealed an assessment of intact cognition. Resident #104 required the extensive assistance of two persons for toilet use and was occasionally incontinent of urine.

Review of Resident #104's 90 day MDS assessment dated 09/10/13 revealed an assessment of intact cognition. Resident #104 was always incontinent of urine and required the extensive assistance of two persons for toilet use.

Review of Resident #104's care plan reviewed on 09/10/13 revealed Resident #104 required staff assistance with toileting and incontinent care. The information Resident #104 would "use the bedpan at times" was included on the care plan.

Interview with Resident #104 on 09/25/13 at 10:05 AM revealed she called staff after she urinated in disposable briefs. Resident #104 explained she feared the mechanical lift transfer to a commode. Resident #104 reported staff did not offer a bedpan regularly and her urge to urinate required a rapid response so she called staff when she needed a change. Resident #104 explained she would prefer to use the bedpan and wear regular underwear. Resident #104 explained she self limited her fluids during the day so her changes would be minimal.

Interview with the Minimum Data Set (MDS) Nurse on 09/25/13 at 4:10 PM revealed Resident

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F 272	Continued From page 4 #104 refused to use the commode and chose to use briefs for urine containment. The MDS nurse explained she did not conduct an assessment when the frequency of incontinent episodes increased to always incontinent of urine. The MDS nurse reported the DON would be responsible for assessments related to urinary incontinency. Interview with the Director of Nursing (DON) on 09/26/13 at 9:05 AM revealed Resident #104 was always incontinent of urine upon admission according to the initial nursing assessment dated 06/13/13 so an assessment was not completed. The DON reported an assessment should be done since a change in incontinent episodes occurred.	F 272		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide measures to prevent the decline of urinary incontinent episodes for 1 of 3 sampled	F 315	1. Resident #104 has been assessed for changes in bladder habits/continence by the Director of Clinical Services and the Unit Manager on October 15, 2013. Findings have been addressed and care planned as of October 15, 2013 by the MDS Coordinators. 2. Residents with the potential for change in bladder and bowel incontinence have been assessed between the dates of October 1, 2013 and October 15, 2013 by the Director of Clinical Services and the Unit Managers. Bowel and Bladder programs to improve continence were put in place and	10/15/13

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residents who experienced an increase of incontinent episodes (Resident #104).

The findings included:

Resident #104 was admitted to the facility on 06/13/13 with diagnoses which included lung cancer and depression.

Review of Resident #104's admission Minimum Data Set (MDS) dated 06/20/13 revealed an assessment of intact cognition. Resident #104 required the extensive assistance of two persons for toilet use and was occasionally incontinent of urine.

Review of Resident #104's 90 day MDS assessment dated 09/10/13 revealed an assessment of intact cognition. Resident #104 was always incontinent of urine and required the extensive assistance of two persons for toilet use.

Review of Resident #104's care plan reviewed on 09/10/13 revealed Resident #104 required staff assistance with toileting and incontinent care. The information Resident #104 would "use the bedpan at times" was included on the care plan.

Interview with Resident #104 on 09/25/13 at 10:05 AM revealed she called staff after she urinated in disposable briefs. Resident #104 explained she feared the mechanical lift transfer to a commode. Resident #104 reported staff did not offer a bedpan regularly and her urge to urinate required a rapid response so she called staff when she needed a change. Resident #104 explained she would prefer to use the bedpan and wear regular underwear. Resident #104 explained she self limited her fluids during the

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care planned by October 15, 2013 by the Unit Managers and MD Coordinators. MDS Coordinators have been educated on addressing changes by the Director of Clinical Services on September 26, 2013. MDS Coordinators will report any changes in the morning interdisciplinary team meeting. This will be an ongoing part of the morning interdisciplinary team meeting.

3. All new admissions and readmissions will be evaluated for incontinence and the potential need for bowel and bladder program by Restorative Nursing/Director of Clinical Services. Residents that possess the ability for improvement will be evaluated quarterly and with reported changes by floor nursing staff. The Director of Clinical Services/Unit Manager will maintain a log of assessments with results to ensure new admissions have been evaluated and a bladder and bowel program initiated, as appropriate. Changes in assessments and/or initiation of a bowel/bladder program will be reported by the Director of Clinical Services/Unit Manager in the daily Monday thru Friday morning

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F 315	Continued From page 6 day so her changes would be minimal. Interview with Nurse Aide #1 (NA) on 09/25/13 at 11:13 AM revealed Resident #104 called for staff assistance when incontinence care was required. NA #1 explained Resident #104 did not use the bedpan. Interview with NA #2 on 09/25/13 at 2:45 PM revealed Resident #104 would call when a brief required changing. NA #2 explained she relied on Resident #104 to let her know when she needed care. Interview with Nurse #3 on 09/25/13 at 3:55 PM revealed Resident #104 did not like to use a bedside commode so briefs were used. Nurse #3 reported Resident #104 was incontinent of urine. Interview with the Minimum Data Set (MDS) Nurse on 09/25/13 at 4:10 PM revealed Resident #104 refused to use the commode and chose to use briefs for urine containment. Interview with the Director of Nursing (DON) on 09/26/13 at 9:05 AM revealed she expected staff to offer the bedpan to Resident #104 on an established toileting schedule.	F 315	interdisciplinary team meeting. Changes in assessments for residents will be tracked by the MDS Coordinators daily Monday thru Friday in the morning interdisciplinary team meeting. 4. The results of the QI monitoring will be reported by the MDS Coordinators to the Quality Assurance Performance Improvement (QAPI) Committee monthly for twelve (12) months for continued substantial compliance and/or revision.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325	1. Resident #83 has been on weekly weights since September 26, 2013. Resident #83 has supplements in place as of September 26, 2013. The Registered Dietician (RD) and MD reviewed weights and medical record on September 26, 2013.	10/15/13

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F 325	Continued From page 7 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nutritional interventions for 1 of 3 residents reviewed for weight loss. (Resident #83). The findings included: Resident #83 was admitted to the facility 03/13/13 with diagnoses which included Alzheimer's disease and gall bladder stones. A review was conducted of a Dietary Progress Note dated 03/15/13 and signed by the Dietary Manager (DM). The note specified a physician's order was written and received on this date to change Resident #83's diet to regular mechanical soft with ground meat. The latest Minimum Data Set (MDS), a quarterly dated 06/19/13 indicated Resident #3 was severely cognitively impaired, makes self understood, and rarely understands others. The MDS specified the resident required extensive staff assistance with dressing and hygiene and supervision by facility staff with eating. A review of Resident #83's monthly weights revealed on 04/03/13 the weight was 127.1 pounds. The recorded weight for 07/05/13 was 131.9 pounds and on 08/02/13 the recorded weight was 128.7. On 09/03/13 the recorded	F 325	2. Residents identified with unexpected weight loss not related to diagnosis and medication use will be reviewed weekly in the Facility Weight Meeting. Monthly weights will be available for review by the Director of Clinical Services and Dietary Manager by the 5th day of each month. Residents with significant changes will be placed on weekly weights by the Dietary Manager and/or DCS, will be provided fortified foods as applicable. The Residents will be placed on the referral log for the Registered Dietitian and the Physician to review. These residents' care plans will be updated during the weekly Facility Weight Meeting. 3. Weekly and Monthly weights will be brought to the morning interdisciplinary team meeting for six (6) weeks by the Dietary manager. New admissions will be placed on weekly weights for four (4) weeks by the Director of Clinical Services/Unit Manager and reviewed at the weekly Facility Weight Meeting. Meal Averages alerts will be printed and reviewed for residents with meal consumption of <=25%. Weekly weights and Meal Averages will be maintained by the Director of Clinical Service/Nurse Manager for tracking and trending for identified weight loss and reported once a week for twelve (12)	

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weight was 121.5 pounds.

A review of Resident #83's monthly physician orders dated 09/01/13 through 09/30/13 revealed the diet order remained regular mechanical soft with ground meat. The orders did not contain any instructions for nutritional supplements. The physician telephone orders from 09/03/13 were reviewed. No telephone orders were found regarding addition of nutritional supplements.

A review of a Nutritional Monitoring Flow Sheet dated 09/03/13 listed Resident #83 as experiencing significant weight loss. The last column on the sheet was identified as "R. D. Initials when follow-up complete". There were no Registered Dietician's (RD) initials indicating Resident #83 had been assessed by the RD. Other residents on the flow sheet that were identified with significant weight loss contained the RD's initials with a date "9/18" written by them.

An observation of Resident #83 being served lunch was conducted on 09/25/13 at 12:14 PM. The resident was served lunch in the dining room. The lunch tray consisted of ground ham, garlic potatoes, green beans, iced tea, and a cookie. Facility staff set up the tray for the resident who did not require assistance with eating. The resident was observed eating approximately 30% of the meal. Staff was observed encouraging Resident #83 to eat more and asking if the resident would prefer any other foods. The resident refused to eat more or to request any food substitutions.

An interview was conducted with Nursing Assistant (NA) #6 on 9/26/13 at 8:00 AM. NA #6

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weeks in the morning interdisciplinary team meeting for any further interventions.

4. Results of the QI monitoring will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for twelve (12) months by the Dietary Manager for continued substantial compliance and/or revision.

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stated she was part of the facility's weight team. She described her job was to obtain residents' weights both monthly and weekly as needed. She stated she gave a copy of the weights obtained to the Director of Nursing (DON), Dietary Manager (DM), and the Administrator.

An interview was conducted with NA #5 on 09/26/13 at 8:12 AM. NA #5 stated she was part of the facility's weight team. NA #5 stated she had helped with Resident #83's weight on 09/03/13. She remembered obtaining a weight of 121.5 pounds that was below the resident's previous weight and reporting the low weight to the resident's nurse. NA #5 stated the nurse asked for Resident #83 to be reweighed. NA #5 stated the same weight of 121.5 pounds was obtained when the resident was reweighed.

An interview was conducted with the DM on 09/26/13 at 10:03 AM. The DM described the facility weight committee consisted of herself, Social Worker, Activities Director, DON, MDS Coordinator, and Administrator. She stated the weight team met weekly. The DM stated she received a report of weights obtained from the weight team and calculated the percentage of weight loss or gain. She confirmed on 09/03/13 she found Resident #83 had a significant weight loss of 5.597% in one month. The DM added she placed Resident #83's name on the Nutritional Monitoring Glow Sheet for the RD to assess on her next facility visit. The DM explained the resident was discussed in the next facility weight meeting. The DM explained the facility had recently gone with a new company to manage the kitchen. She stated the new company also provided a RD consultant that visited the facility periodically. The DM stated she provided the RD

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with a list of residents with nutritional needs including significant weight loss. The DM explained before the new company, she would notify the resident's nurse when she found significant weight loss. The nurse would in turn notify the physician to obtain an order for initiation of a nutritional supplement and the resident would be assessed by the RD on her next visit to the facility.

An interview was conducted with the consulting RD on 09/26/13 at 10:46 AM. The RD reviewed the Nutritional Monitoring Flow Sheet. She confirmed she did not assess Resident #83 on her last visit to the facility which was 09/18/13. She stated she knew she would be back in the facility on 09/26/13 and the facility had weekly weight meeting to review weight loss. The RD explained she was not only the venue to order nutritional supplements for the residents.

An interview was conducted with the DON and MDS Coordinator on 09/26/13 at 10:58 AM. The MDS Coordinator stated Resident #83 was reviewed at the last weight meeting which was on 09/20/13. She stated the weight committee agreed the resident would be seen by the RD on her next facility visit. The DON stated Resident #83 had recently had problems with nausea related to dizziness. The DON acknowledged nausea would contribute to weight loss and require weight monitoring. The DON also acknowledged Resident #83's weight loss should have been addressed when it was discovered.

F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from

F 329 — 1. Resident #99 has been assessed for anxiety by the Director of Clinical Services and the Unit Manager with interventions in place to — 10/15/13

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unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident, staff and physician interviews, and record review, the facility failed to implement interventions prior to administration of an anti-anxiety medication (Ativan) for 1 of 3 sampled residents who received psychoactive medications (Resident #99).

The findings included:

Resident #99 was admitted to the facility on 05/29/13 with diagnoses which included

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relieve anxiety, including medication management as of October 10, 2013. Interventions have been care planned as of October 10, 2013.

2. Residents with the potential to be affected include those on antipsychotics, anxiolytics an hypnotics. Residents with the potential to be affected have had a psychoactive medication evaluation completed by the Director of Clinical Services/Unit Manager as of October 15, 2013 and behavior monitoring was put in place as of October 15, 2013 by the Director of Clinical Services/Unit Manager.

3. Staff have been educated on behavior management and documentation by the Director of Clinical Services on October 9, 2013. Evaluations will be conducted on admission, quarterly and with changes in condition by staff licensed nurses. The Director of Clinical Services/Nurse manager will review new orders for antipsychotics, anxiolytics and hypnotics on admission for need along with the implementation of non-medication interventions to decrease use of these types of medications. This audit will be

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	345464	A. BUILDING ______ B. WING ______	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HWY 221 RUTHERFORDTON, NC 28139

(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

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depression and recent surgical repair of the left femur.

Review of Resident #99's admission Minimum Data Set (MDS) dated 06/05/13 revealed an assessment of severely impaired cognition. Resident #99 did not exhibit behaviors and did not receive anti-anxiety medication according to the MDS.

Review of a telephone physician's order taken by Nurse #1 dated 06/24/13 revealed direction for Ativan 0.5 milligrams (mg.) to be administered twice daily for anxiety.

Review of Resident #99's Medication Administration Records (MAR) revealed documentation of Ativan 0.5 mg administration to Resident #99 twice daily at 9:00 AM and 9:00 PM from 06/24/13 to 09/25/13.

Review of the 90 day scheduled MDS dated 08/25/13 revealed Resident #99's cognition was moderately impaired. Resident #99 received an anti-anxiety medication 7 days a week.

During an interview with Resident #99 on 09/25/13 at 9:14 AM, Resident #99 explained he did not know the medications he received and relied on facility staff. Resident #99 reported his worries were his legs and the ability to return home. Observation during the interview revealed Resident #99 was alert and smiled.

Interview with Nurse #2 on 09/26/13 at 9:48 AM revealed Resident #99 received Ativan twice daily. Nurse #2 explained she thought Resident #99 was admitted from the hospital with an Ativan order. Nurse #2 reported Resident #99

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completed weekly for twelve (12) weeks, then monthly for nine (9) months. Psychoactive medications will be reviewed weekly in the Facility Behavior Management Meeting. This will be ongoing.

4. Results of the QI monitoring will be reported by the Director of Clinical Services at the monthly Quality Assurance Performance Improvement (QAPI) meeting.

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expressed anxiety about his progress in therapy and if discharge home was a possibility but demonstrated no anxious behaviors.

Interview with Nurse Aide (NA) #4 on 09/26/13 at 10:00 AM revealed Resident #99 expressed worry about his legs and if he could go home soon. NA #4 reported Resident #99 usually smiled and talked with staff.

Interview with Nurse #1 on 09/26/13 at 10:44 AM revealed she obtained the order for the Ativan on 06/24/13. Nurse #1 reported she asked the physician for a medication order based on a message in the physician's communication book which described Resident #99 as anxious.

Continued interview with Nurse #1 revealed she was not aware of any interventions staff implemented for Resident #99's anxious behavior before the request for the Ativan order.

Interview with Resident #99's physician on 09/26/13 at 1:30 PM revealed he expected nursing staff to attempt interventions to calm anxiety before a request for medication for Resident #99. The physician explained he would expect nursing staff to explore reasons for anxiety and implement interventions. If the interventions failed, staff would notify him and medication would be considered.

Interview with Nurse #4 on 09/26/13 at 1:51 PM revealed she communicated Resident #99's anxiety and requested medication in the communication book used by Nurse #1. Nurse #4 explained staff could calm Resident #99 with interventions of one to one conversations, offering food, pain management, and looking at

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 14 magazines. Nurse #4 reported Resident #99's anxious behavior required staff interventions everyday and she thought a medication should be requested. Interview with the Director of Nursing on 09/26/13 at 2:21 PM revealed she expected staff to implement interventions to reassure and calm residents before requesting an anti-anxiety medication. If the interventions were successful, the care plan would be updated and the staff should not request a medication order for anxiety.	F 329		