STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345180	A. BUILDING _____ B. WING _____	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY PINES RETIREMENT COMM	1000 WESLEY PINES RD LUMBERTON, NC 28358

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an individualized care plan to address a resident at high risk for developing pressure ulcers for 1 of 1 residents reviewed for pressure ulcers (resident #71) and failed to develop a care plan for a resident receiving an anti-depressant medication (resident #12). The findings include: Ex. #1 Resident #71 was admitted to the facility on admitted on 8/19/13 with diagnoses including	F 279	F279 Prior to survey, facility staff had discovered that Resident #71□s initial care plan did not address his being at high risk for developing pressure ulcers. At that point in time, a MDS and care plan was written and implemented that included approaches designed to heal the pressure ulcers that had developed and address the Resident□s high risk for developing pressure ulcers. Resident #71 was being given appropriate care at the time of survey. During survey, Resident #12 was found to	12/3/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/02/2013

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F 279	Continued From page 1 Status Post Hip Fracture, Alzheimer's Dementia and Anemia. Review of the most recent Minimum Data Set (MDS) Assessment dated 8/26/13 identified the resident as cognitively impaired, having no pressure ulcers, at risk for pressure ulcers, needing extensive assistance with bed mobility and having no bed or chair pressure relieving devices. Review of the initial plan of care dated 8/19/13 there was nothing checked or written in the area of pressure ulcer/skin at risk area. During an interview with the Director of Nursing on 11/6/13 at 8:30AM she stated that the initial care plan should have addressed the resident's high risk of pressure ulcers and interventions should have been put into place related to this risk. Ex. #2 Resident #12 was re-admitted to the facility on 7/19/13 with diagnosis including Coronary Artery Disease, Degenerative Joint Disease and Anemia. Review of the Physician's order dated 7/19/13 documented the resident was ordered Zoloft, an anti-depressant medication to be given daily. Review of the care plans identified there was not a care plan in place for Resident #12 for anti-depressant use. During an interview with the Director of Nursing on 11/6/13 at 8:30AM she stated that the resident should have been care planned for her anti-depressant use.	F 279	have an anti-depressant prescribed with no diagnosis and no care planned approaches to monitor the effects of the anti-depressant medication. Upon learning this, a facility nurse contacted the attending physician and was given a diagnosis for the prescribed anti-depressant. Additionally, a facility MDS nurse added an approach to the Resident□s care plan to address the use of anti-depressant medication and implemented a behavior monitoring form in the Resident□s chart. The MDS nurses reviewed the care plans of all Residents that had been recently admitted and had not yet been fully assessed by the care plan nurses. The nurse management team has reviewed each Residents□ MARs and medical records to ensure that every medication has a proper diagnosis. Any medications found to not have an appropriate diagnosis resulted in a call to the attending physician to either discontinue the medication or give a proper diagnosis. The admissions coordinator has been instructed to insist upon a diagnosis for each medication from the physician writing the admitting orders. In the event that the admitting physician does not give a diagnosis for each medication, the nurse management team will contact the Resident□s attending physician to obtain a diagnosis or an order to discontinue the medication. The MDS nurses have reviewed the care plans of every resident receiving anti-depressant medication to ensure the use is care planned and the Resident□s	

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F 279	Continued From page 2	F 279	behavior is being monitored to help determine the efficacy of the medication. In-service education will be provided for all nurses on the following issues: 1. If a nurse calls a physician to give a report of any Resident□s condition, the nurse is responsible for obtaining a proper diagnosis for any medication the doctor orders. 2. The importance of the initial care plan addressing all risk factors. 3. The importance of properly assessing each Resident while performing a medication pass and comparing observed needs/risk factors with what has been written on the care plan. Any suspected issues have to be reported to the nurse management team. No one can assume that someone else has recognized a potential issue; each nurse is responsible for communicating with the team. The administrator will draft a letter to be sent to all attending physicians informing them of the facility having received a citation for a medication not having a proper diagnosis. The letter will also inform the attending physicians that federal regulations require that each medication prescribed have an appropriate diagnosis given at the time the medication is ordered. In the event that a hospital doctor or a previous attending physician wrote an order for a medication and did not include a diagnosis, it is the new attending doctors□ responsibility to assess the Resident and either give a diagnosis or discontinue the medication.	

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F 279	Continued From page 3	F 279	Henceforth, all new admission charts will be reviewed in the next ITM (interdisciplinary team meeting) meeting held every weekday morning. The team will ensure that each medication has a diagnosis and that all risk factors are being addressed in the initial care plan. Any deficiencies will be addressed immediately. These reviews will become a routine part of our ITM agenda. Any nurse found to accept an order for a medication without a diagnosis will be re-educated/re-trained to the importance and necessity of each medication having a proper diagnosis. In the event of any nurse making this same mistake more than once, the facility□s progressive disciplinary policy will be implemented and could result in termination. Audit sheets will be completed for every new admission chart review for three weeks, then once per week for three months, and once per quarter thereafter. These audit sheets will become a part of the facility□s QAPI records.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		12/3/13

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F 314	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to initiate interventions to prevent the development of pressure ulcers in 1 of 1 sampled resident at high risk for developing pressure ulcers (Resident #71). The findings include: Resident #71 was admitted to the facility on admitted on 8/19/13 with diagnoses including Status Post Hip Fracture, Alzheimer's Dementia and Anemia. Review of the initial care plan dated 8/19/13 identified Resident #71 as having a fractured right hip, having an indwelling urinary catheter, as a fall risk, at risk for dehydration, at risk for a urinary tract infection, having a decline in walking, toileting, bed mobility, transferring and range of motion and having a surgical incision. The area for documentation of pressure ulcer was blank; none of the preventative interventions were checked. Review of the Initial Nursing Assessment dated 8/19/13 documented that Resident #71 had short and long term memory problems, was severely impaired cognitively in making decisions, and had an indwelling urinary catheter for retention, required total assistance for bed mobility, transferring, ambulation and toileting. Resident #71 scored a 15 on the Braden Scale risk assessment tool for skin breakdown (15-18 being at high risk, mobility being scored at very limited). He had a surgical incision to the right hip and had no pressure ulcers. Review of the side rail	F 314	F314 Prior to survey, facility staff had discovered that Resident #71□s initial care plan did not address his being at high risk for developing pressure ulcers. At that point in time, a MDS and care plan was written and implemented that included approaches designed to heal the pressure ulcers that had developed and address the Resident□s high risk for developing pressure ulcers. Resident #71 was being given appropriate care at the time of survey. A root cause analysis revealed that others whose care was being directed by an initial care plan completed at the time of admission could possibly be affected as we determined that the root cause of the problem was an inadequate initial care plan. Therefore a nurse audited the medical record of every Resident who had been recently admitted and was still being served by the initial care plan. None of these Residents were found to have risk factors that were not being addressed with proper care planned approaches. On 11/19/13 and 11/20/13 all nurses attended an in-service training/retraining regarding: " Training on completion of the initial nursing assessment and initial care plan " Where the initial care plan and initial nursing assessment forms will be found, along with a sample initial care plan and nursing assessment " How to view any Resident□s completed care plan via the computer	

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F 314	Continued From page 5 assessment portion of the assessment identified Resident #71 as immobile in bed. Review of the most recent Minimum Data Set (MDS) Assessment dated 8/26/13 identified the resident as cognitively impaired, having no pressure ulcers, at risk for developing pressure ulcer, needing extensive assistance with bed mobility, having range of motion impairment to one side of his lower extremities and having no bed or chair pressure relieving devices. Review of the Care Area Assessment Summary dated 8/26/13 triggered in the area of Pressure Ulcers related to decreased bed mobility. Review of the Nursing Progress Note dated 8/29/13 read in part, " areas to bilateral heels appears to be SDTI (suspected deep tissue injury). " Area on the right heel was 5 centimeters x 6 centimeters and the left heel was 4 centimeters x 2.5 centimeters. The area was not opened but dark maroon in color and boggy to touch. The feet were placed on elevators with feet clear of the mattress. Review of a revised Care Plan dated 8/29/13 read in part, " Problem - SDTI bilateral heels; Goals - Area to heels will heal x 30 days; Approaches - Pressure relieving device while in bed, encourage reposition often, monitor and report changes as needed and treatment per orders. " Physician ' s orders dated 8/29/13 included elevating the feet to reduce pressure, foam boots to feet while in bed, Skin Prep bilaterally to heels and right great toe. Review of Significant Change MDS dated 9/2/13	F 314	terminal at the nurses desks " Original care plans are found in the Residents charts and all nurses are expected to read the care plans and then sign them for all Residents in their care " All nurses are expected to be constantly assessing each Resident as they encounter them, searching for any need or risk factor that is not being addressed, and communicating any findings to the nursing team. Each nurse has the responsibility to implement any approaches needed and either amend the care plan themselves or go directly to the MDS nurse and ask her to amend the care plan. All care plan amendments will be communicated to all nursing staff via the 24 hour report book and via notes left on the Residents MARs to alert the on-coming nurse of a change. The nursing administrative staff reviewed the initial nursing assessment forms and the initial care plan forms. The assessment forms were found to have some unnecessary questions, which were deleted. The assessment forms and initial care plan forms were found to not be in sync, so the assessment form was rearranged to flow with the care plan form, thereby decreasing the possibility of confusion for the nurse completing the forms. All initial care plans will be reviewed in the next ITM meeting held every weekday morning. Any initial care plan found to be deficient will be corrected immediately. The nurse that had completed the care plan will receive additional training. Any nurse responsible for 3 deficient care	

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F 314	Continued From page 6 identified the resident as having 3 unstageable pressure ulcers and receiving ulcer care and having a pressure relieving device to the bed. Review of the Occupational therapy Assistant weekly progress note dated 9/3/13 documentation showed that Resident #71 had bilateral black/necrotic tissue on his heels and a thera-boot had been ordered. Physician ' s orders dated 9/4/12 included an air flow mattress to the bed and placed on the bed 9/4/13. Physician ' s orders dated 9/5/13 included Zinc 220milligrams for 3 months by mouth everyday, Ensure one can three times a day with meals and Vitamin C 500milligrams by mouth twice daily for 3 months. Review of the revised Care Plan dated 9/18/13 identified the resident at risk for skin breakdown related to extensive assist needed with bed mobility, incontinent of bowel, and having 3 suspected deep tissue injuries (one on each heel and one on his right great toe) and redness to groin area. Interventions included to encourage good nutrition, treatment as ordered, apply creams and ointments as ordered, specialty air mattress as ordered, skin assessment weekly and as needed, prompt incontinent care every 2-3 hrs and as needed, foam boots to bilateral heels to be worn when in bed and elevating feet as needed. Review of laboratory results of 8/19/13 identified Resident #71 ' s Albumin level at 2.4 (low), Hemoglobin was 8.9 (low) and his Hematocrit	F 314	plans will be deemed incompetent and will no longer be allowed to complete care plans. Audit sheets will be completed for every new admission chart review for three weeks, then once per week for three months, and once per quarter thereafter. These audit sheets will become a part of the facility□s QAPI records.	

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F 314	Continued From page 7 was 26.0 (low). Observations of the resident on 11/4/13 through 11/6/13 revealed he was using a specialty air flow mattress to his bed. He wore foam boots and had padding on his wheelchair foot rest when out of bed. During an interview with the Director of Nursing on 11/5/13 at 4:00PM she stated that the facility should have put interventions into place related to the residents Dementia and immobility on admission to prevent the pressure ulcers. During an interview with the Assistant Director of Nursing on 11/6/13 at 2:15PM he stated that the initial care plan should have addressed the resident ' s immobility and Alzheimer ' s Dementia in relation to the high risk of developing pressure ulcers and had interventions in place. During an interview with the Treatment Nurse on 11/6/13 at 2:30PM she stated that on 10/16/13 the left heel ulcer had resolved. The right heel was improving measuring 2.5 centimeters x 3 centimeters. The right great toe was improving measuring 0.8 centimeters x 0.5 centimeters. She further stated that the right heel and right great toe were still black in color, had no drainage or odor and there was no pain associated with the areas. She stated the resident is on a specialty mattress and wears foam boots. She stated when the resident was admitted he stayed in whatever position he was placed because he was immobile in the bed.	F 314		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		12/3/13

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F 328	Continued From page 8 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews, and review of facility policy, the facility failed to ensure proper storage of respiratory equipment for 3 of 3 residents (Resident Identifier #64, #71, #2) receiving nebulizer and CPAP treatments. The findings include: Review of the facility policy entitles Administering Medications through a Small Volume (Handheld) Nebulizer, dated 2010, Section Steps in the procedure #29 - "When equipment is completely dry, store in a plastic bag with resident's name and the date on it." Ex. 1 Resident #64 was admitted to the facility on 3/12/13 with diagnoses including Pulmonary Fibrosis. Review of the Medication Administration Record for October 2013 identified that Resident #64 receives Albuterol Sulfate P/F UD 2.5mg/3ml vial - nebulizer three times per day at 8AM, 2PM and	F 328	F328 The nursing staff immediately went to the Resident rooms listed and corrected the problem of the respiratory equipment not being stored properly. The face masks were cleaned, dried, and placed in plastic bags for storage. The current date was written on the plastic bags. Any Resident using respiratory equipment has the potential to be effected. Therefore the nursing staff did a room to room sweep to ensure that all respiratory equipment was being properly stored, correcting any deficient practice found. A master list of all Residents was made to ensure that we will be able to check every piece of equipment in use. This list became the facility□s audit list for respiratory equipment. All MD orders written will be taken to the next day□s ITM meeting for review. Any Resident receiving an order for respiratory equipment will be added to the master list. Anyone having an order discontinued will	

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F 328	Continued From page 9 8PM. (According to Lexi-Comp's Drug Reference Handbook, 12th edition, Albuterol is used as a bronchodilator in airway obstruction due to asthma or Chronic Obstructive Pulmonary Disease.) During an observation on 11/4/13 at 4:10pm the nebulizer was observed sitting on the bedside table uncovered. During an observation on 11/5/13 at 8:35am the nebulizer was observed sitting on the bedside table uncovered. During an observation on 11/6/13 at 8:45am showed the nebulizer was observed sitting on the beside table uncovered. During an interview with the Director of Nursing on 11/6/13 at 8:55am she stated that all nebulizers are to be rinsed and bagged in a zip lock bag after use. Ex #2 Resident #71 was admitted to the facility on 8/19/13 with diagnoses including Pneumonia. Review of the Medication Administration Record for the month of November 2013 documented that Resident #71 was receiving respiratory treatments via a hand-held nebulizer for the diagnosis of Pneumonia. Observations were made on 11/5/13 at 12:00PM. The nebulizer, including mask, was observed to be sitting on the nightstand uncovered. Observations were made on 11/5/13 at 4:00PM.	F 328	be stricken from the list. The MD orders will also be checked for an appropriate diagnosis. The care plan nurse(s) attending the ITM will be responsible to amend the Resident□s care plan appropriately. All nursing staff will be in serviced re: the importance and necessity of storing all respiratory equipment correctly. All Residents with respiratory equipment will be audited daily for 3 weeks to ensure the equipment is stored properly. Audits will then be performed weekly for three months and thereafter will be performed quarterly as part of the facility□s QAPI program. Any deficient practice will result in responsible employees being retrained. Any employee that fails on three or more occasions to store the equipment properly will be disciplined per the facility□s progressive disciplinary policy, up to and including termination.	

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F 328	Continued From page 10	F 328		

The nebulizer was observed to be sitting on the nightstand, without a mask, with the end of the tubing uncovered.

During an interview with the DON on 11/6/13 at 8:55am she stated that all nebulizers are to be rinsed and bagged in a zip lock bag after use.

Ex. 3 Resident # 2 was admitted to the facility on 9/28/04 and readmitted on 11/1/11 with diagnosis including obstructive sleep apnea.

Review of Resident # 2 ' s clinical record documented a Physician ' s Order dated 5/2/12 to apply continuous positive airwave pressure machine (CPAP) at bedtime at 17 cm water, remove every morning.

During an observation on 11/5/13 at 9:36 AM the CPAP face mask was observed sitting on the bedside table uncovered.

During an observation on 11/5/13 at 1:50 PM the CPAP face mask was observed sitting on the bedside table uncovered.

During an observation on 11/6/13 at 8:42 AM the CPAP face mask was observed sitting on the bedside table uncovered.

During an interview with Resident #2 ' s Nurse she stated that the CPAP mask is supposed to be covered with a bag to protect the mask.

During an interview with the Director of Nursing on 11/6/13 at 9:10 AM she stated that the CPAP mask should be covered.

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F 329	Continued From page 11	F 329		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from 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 record review and staff and physician interviews, the facility failed to ensure (1) of five (5) sampled residents reviewed for unnecessary medications had a supporting diagnosis for an anti-depressant medication and failed to ensure that the anti-depressant medication use was monitored (Resident #12).	F 329	F329 A nurse promptly called the affected Resident□s attending physician and was given a diagnosis for the anti-depressant the Resident was taking. The care plan nurse promptly amended the Resident□s care plan to include behavior monitoring and placed a behavior monitoring form in the	12/3/13

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	345180	A. BUILDING _____ B. WING _____	11/06/2013

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F 329	Continued From page 12 The findings include: Resident # 12 was admitted to the facility on 3/19/13 and re-admitted on 3/27/13 and 7/19/13 with diagnoses including Coronary Artery Disease, Hypertension, Anemia, Osteoarthritis and Degenerative Joint Disease. The most recent Quarterly Minimum Data Set (MDS) Assessment dated 9/17/13 did not reflect an active diagnosis of depression under section I. Under Section D - Mood, feeling down, depressed or hopeless documented no, never. Resident #12 did not have a care plan for the use of an Anti-Depressant. Review of the Hospital Discharge summary dated 7/19/13 did not reflect a diagnosis of Depression. Review of the March, April, May, and June 2013 Medication Administration Record showed no order for or documentation that the resident was receiving the anti-depressant medication Zoloft. The resident returned from the hospital on 7/19/13 with no documentation of an order for Zoloft. Review of the Physician ' s orders dated 7/19/13 and signed by the facility physician documented an order for Zoloft 25milligrams to be given each evening. The resident did not have a diagnosis to support the indication for the use of Zoloft. Review of the Medication Administration Record dated July 2013 documented that Zoloft 25milligrams each evening was started on	F 329	Resident□s medical record. Any Resident taking anti-depressant medication has the potential to be affected. Therefore, a list of all anti-depressants being used by facility Residents was obtained from the pharmacy. Each Resident on the list was audited to ensure that a proper diagnosis was in the medical record and appropriate care planning was in place to monitor the behavior of the Resident and the effects of the medication. All Residents receiving anti-depressant drug therapy have an appropriate diagnosis in their medical record, as well as behavior monitoring in place. Going forward, we will request from the pharmacy a report listing all anti-depressant medications in use and the Residents receiving the medications. This will be our initial master list. We will review all MD orders during the ITM meeting each weekday morning and add or delete names to or from the master list as MD orders are received. In the event that a GDR has been ordered, that will be noted as well. At least one of the MDS nurses will be in attendance at each ITM meeting and will therefore be aware of the need to amend a Resident□s care plan according to the MD orders given. The MDS nurse will amend the care plan and implement a behavior monitoring form in the Resident□s chart. When the monthly pharmacy reports are received they will be compared to the master list by nursing administration to ensure that the pharmacy has added and/or deleted Residents per the MD	

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F 329	Continued From page 13 7/22/13. Review of the medical record documented one month of behavior monitoring for August 2013. The behaviors listed were Restlessness, Mood Changes and Insomnia. All days, nights and evenings were listed as 0 or unchanged. Review of the Pharmacy Progress Notes for July 2013 through October 2013 did not reflect any notes in reference to the Zoloft or recommendations for a diagnosis for the use of Zoloft. During an interview with the Assistant Director of Nursing on 11/5/13 at 2:04pm he stated that there is not a listed diagnosis for the use of the medication. During an interview with the Administrator on 11/5/13 at 4:15pm he stated that he wished that every medication on the Medication Administration Record would have a diagnosis beside it. He further stated that when the physician accepts the resident as his patient, then the physician is responsible for making sure every medication has a diagnosis. During an interview with the Director of Nursing on 11/6/13 at 8:30am she stated that it is expected that each medication in use have an appropriate diagnosis and that monitoring would be done on resident ' s requiring the use of anti-depressant medication. During an interview with the physician on 11/6/13 at 2:20pm he stated it is important to have a diagnosis for each medication the resident is receiving and have that diagnosis is on the	F 329	orders. The audit will also verify that any order for a GDR has been properly recorded by the pharmacy. The DON or her designee will perform a weekly chart audit of each Resident□s chart that has had an anti-depressant added or discontinued, or an order for a GDR within the past week. The audit will determine that the anti-depressant has an appropriate diagnosis in the chart and that appropriate care planning and behavior monitoring has been put in place or either discontinued as appropriate. These weekly audits will be performed weekly times 3 months. A monthly audit will then be implemented as an on-going part of the facility□s QAPI program. The NHA and DON review each month□s pharmacy recommendations after the MDs response has been recorded to ensure that recommendations for dose reductions and duplicate therapy have been addressed appropriately by the attending physicians. A root cause analysis will be performed on any discrepancies found while auditing to determine where the breakdown occurred. Appropriate action will be taken to correct the discrepancy and address the breakdown in the system.	

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F 329	Continued From page 14 medical record.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Consulting Pharmacist interview and Physician interview, the facility failed to ensure that an irregularity in the medication regime was identified and reported for one (1) of five (5) residents reviewed for unnecessary medications (Resident #12). The findings include: Resident # 12 was admitted to the facility Resident was admitted on 3/19/13 and re-admitted on 3/27/13 and 7/19/13 with diagnoses including Coronary Artery Disease, Hypertension, Anemia, Osteoarthritis and Degenerative Joint Disease. The most recent Quarterly Minimum Data Set (MDS) Assessment dated 9/17/13 did not reflect an active diagnosis of Depression under section I.	F 428	F428 During survey, Resident #12 was found to have an anti-depressant prescribed with no diagnosis and no care planned approaches to monitor the effects of the anti-depressant medication. Upon learning this, a facility nurse contacted the attending physician and was given a diagnosis for the prescribed anti-depressant. The nurse management team has reviewed each Residents MARs and medical records to ensure that every medication has a proper diagnosis. Any medications found to not have an appropriate diagnosis resulted in a call to the attending physician to either discontinue the medication or give a proper diagnosis. The admissions coordinator has been instructed to insist upon a diagnosis for each medication	12/3/13

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F 428	Continued From page 15 Review of the Hospital Discharge summary dated 7/19/13 did not reflect a diagnosis of Depression. Review of the Physician's Orders for March 2013 through June 2013 and review of the Medication Adminstration Records for March 2013 through June 2013 showed no order for or documentation that the resident was receiving the anti-depressant medication Zoloft. The resident returned from the hospital on 7/19/13. The hospital discharge orders were reviewed. There was no documentation of an order for Zoloft. Review of the Physician ' s orders dated 7/19/13 and signed by the facility physician documented an order for Zoloft 25milligrams to be given each evening. The resident did not have a diagnosis to support the indication for the use of Zoloft. Review of the Medication Administration Record dated July 2013 documented that Zoloft 25milligrams each evening was started on 7/22/13. Review of the Pharmacy Progress Notes for July 2013 through October 2013 did not reflect any notes in reference to the Zoloft or recommendations for a diagnosis for the use of Zoloft. During an interview with the Assistant Director of Nursing on 11/5/13 at 2:04pm he stated that the resident has indicators for being the medication but no listed diagnosis. During an interview with the Administrator on	F 428	from the physician writing the admitting orders. In the event that the admitting physician does not give a diagnosis for each medication, the nurse management team will contact the Resident□s attending physician to obtain a diagnosis or an order to discontinue the medication. The nurse management team printed each Resident□s current MAR. As a part of the exercise stated above, the team ensured that each medication on each MAR had a diagnosis already listed, or written in. These MARs have been sent to the pharmacy with the request that they enter all the diagnosis into their database so the next month□s MARs will have a diagnosis printed by each medication. As a part of the monthly MARs review, the nursing team will ensure that henceforth, each medication has a diagnosis printed by it. The consultant Pharmacist will monitor all new orders to assure that an indication with a supporting diagnosis is documented for all medications. A consult will be generated to the attending Physician for any missing information. A quarterly compliance report will be presented to the QA committee by the consultant pharmacist.	

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F 428	Continued From page 16 11/5/13 at 4:15pm he stated that he would expect every medication on the Medication Administration Record have a diagnosis beside it. He further stated that when the physician accepts the resident as his patient, then the physician is responsible for making sure every medication has a diagnosis. During an interview with the Director of Nursing on 11/6/13 at 8:30am she stated that it is expected that each medication in use have an appropriate diagnosis. During an interview with the Pharmacy Consultant on 11/6/13 at 9:28am he stated that he believed resident #12 had initially started on the medication in May 2013 and it was discontinued and then re-started. He also stated that he believed she had a diagnosis of Depression. During an interview with the Physician on 11/6/13 at 2:20pm he stated many times the pharmacist will notice a medication without a diagnosis and will make a recommendation for a supporting diagnosis. It is important to have a diagnosis for each medication the resident is receiving and have that diagnosis on the medical record.	F 428		