STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345474	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES WEST	6100 W FRIENDLY AVENUE GREENSBORO, NC 27410

(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 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, staff, nurse practitioner, and pharmacy consultant interviews the facility failed to address the use of 2 antidepressant medications (Prozac and Remeron). The facility also failed to consistently monitor targeted behaviors associated for the use of an antipsychotic drug. This was evident in for 1 of 5 sampled residents reviewed for unnecessary drugs (Resident #2).	F 329		11/29/13

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

Electronically Signed | 11/22/2013

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F 329	Continued From page 1 Findings included: Resident #2 experienced multiple admissions to the facility (most recent on 8/12/13, 9/19/13 and 9/23/13) with diagnoses which included depressive disorder, CVA (cerebrovascular accident) and dementia. Review of the September 23, 2013, October 2013 and November 2013 physician orders sheet (POS) revealed in part: Prozac 40 mg by mouth (po) every day. Remeron 7.5 po at bedtime. This represented Resident #2 was prescribed two medications for depression. Review of the significant change Minimum Data Set (MDS) assessment dated 9/30/13 revealed the resident had short term memory loss, " feeling down " , depressed or hopeless, trouble concentrating for 2-6 days with no behavior problems. Review of the care plan dated 10/7/13 revealed in part that the resident received antidepressant medications due to ongoing chronic disease conditions resulting in fatigue weariness and lack of energy. The approaches included monitoring the resident's mood and response to medication. Review of the documentation used for monitoring behaviors during the months of August 2013 and September 2013 revealed only initials of the staff for the all shifts. There was no behavior issues addressed. Review of the documentation used for monitoring behaviors for October 2013 revealed a line was drawn across the page with no documentation or initials of staff. Interview on 11/1/13 at 1:30 PM with the Director of Nurses (DON) indicated that the nurses would only	F 329		

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F 329	Continued From page 2 document if the behaviors existed. There was no comment the line drawn across the page. A review of the current nurse practitioner (NP) progress notes dated 9/27/13,10/1/13, and 10/11/13 revealed there was no documentation found to indicate why the resident was receiving 2 antidepressants. On 11/1/13 at 1:30 PM interviews with the DON, NP and consultant pharmacist and a review of Resident #1's thinned medical record was conducted. There was no documentation or information the facility could provide from the thinned record or interview to show why the resident was on 2 antidepressants. The pharmacist indicated the Remeron was ordered as a carry over from the hospitalization of 9/23/13. Neither the DON or NP could explain why Resident #1 was receiving two antidepressant medications except that the resident had orders from the hospital for Remeron. Further interview with the consultant pharmacist revealed she believed the resident may have been ordered Remeron for sleep. Interview on 11/1/13 at 12 noon with Nurse#2 and NA#1 revealed they had not witnessed any behavior problems. Both indicated that the resident wants to make her own decisions and be independent even though she required assistance. Interview on 11/1/13 at 12:05 Nurse#3 revealed she had not observed any behavior problems.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332		11/29/13

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F 332	Continued From page 3	F 332		

medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate of 5% or greater as evidenced by two (2) medication errors out of thirty (30) opportunities for errors, resulting in a medication error rate of 6.66% for 2 of 5 residents observed during medication pass. (Residents #9 and #1)
Findings included: .

1. Resident #9 was admitted to the facility on 8/29/2013 with cumulative diagnoses which included Crohn's disease managed with steroid therapy.

Review of the physician's orders for October 2013 revealed Novolog 3 units (U) subcutaneous (sq) to be administered before each meal for Capillary blood glucose level (CBG) for more then 150 milligram per deciliter (mg/dl). Novolog is a fast-acting form of insulin.

On10/30/13 at 4:27 PM, Nurse #1 was observed during the medication pass. Nurse#1 obtained the CBG and the result was 335 mg/dl. Nurse #1 prepared Novolog 5 U into a syringe to be administered to Resident # 9 until the surveyor inquired about the dose of insulin and a bubble in the syringe. Nurse#1 acknowledged that she had too much insulin in the syringe, noticed the bubble and stated she needed to start over. The syringe with the Novolog was destroyed. Nurse#1 obtained another syringe and

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F 332	Continued From page 4 administered the correct dose of Novolog insulin 3 U sq. 2. Resident #1 was admitted to the facility on 10/3/13 with cumulative diagnoses which included hypertension. Review of the physician's orders dated October 3, 2013 revealed Azelastine 0.05% HCL (hydrochloride) ophthalmic (eye) 1 drop in both eyes twice a day. Azelastine drops are used for treating itchy eyes or relieve eye inflammation associated with allergies. On 10/31/13 at 8:45 AM, Nurse #2 was observed during the medication pass. Nurse# 2 administered Azelastine 0.05% 2 drops in both eyes. Interview on 10/31/13 at 9:15 am with Nurse #2 revealed that once in a while the medication just continues to drip when administering the eye drops. Nurse #2 indicated sometimes it happens (referring to the continued flow of drops and knew that the resident should get 1 drop in each eye. Nurse #2 indicated that he never reported his concern of too much medication dispensing from the eye drop bottle to the charge nurse, administration or pharmacist. An attempt to interview Resident #1 was unsuccessful. Interview on 11/1/13 at 5:30 pm with Director of Nurses revealed her expectations for the nurse was to have the nurse contact her or the pharmacy.	F 332		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		11/29/13

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F 428 SS=D	Continued From page 5 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, nurse practitioner, consultant pharmacist and staff interviews, the consultant pharmacist failed to alert the physician and the facility of the use of two (2) antidepressants. This was evident in 1 of 5 sampled residents reviewed for unnecessary medications. (Resident#2) Findings included: Resident #2 experienced multiple admissions to the facility (most recent on 8/12/13, 9/19/13 and 9/23/13) with diagnoses which included depressive disorder, CVA (cerebrovascular accident) and dementia. Review of the September 23, 2013, October 2013 and November 2013 physician orders sheet (POS) revealed in part: Prozac 40 mg by mouth (po) every day. Remeron 7.5 po at bedtime. This represented Resident #2 was prescribed two medications for depression.	F 428		

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F 428	Continued From page 6 Review of the documentation used for monitoring behaviors during the months of August 2013 and September 2013 revealed only initials of the staff for the all shifts. There was no behavior issues addressed. Review of the documentation used for monitoring behaviors for October 2013 revealed a line was drawn across the page with no documentation or initials of staff. Interview on 11/1/13 at 1:30 PM with the Director of Nurses (DON) indicated that the nurses would only document if the behaviors existed. Interview on 11/1/13 at 12 noon with Nurse#2 and NA#1 revealed they had not witnessed any behavior problems. Both indicated that the resident wants to make her own decisions and be independent even though she required assistance. Interview on 11/1/13 at 12:05 Nurse#3 revealed she had not observed any behavior problems. Review of the Medication Regimen Reviews (MRR) dated 10/11/13 indicated " Follow Remeron-need " but did not address the use 2 antidepressants. On 11/1/13 at 1:30 PM interviews with the DON, nurse practitioner and consultant pharmacist was conducted. The pharmacist indicated Remeron was ordered as a carry over from the hospitalization of 9/23/13. The nurse practitioner and DON did not comment on why the resident was on 2 antidepressants.	F 428		