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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	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Friends Homes West of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened	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	with termination from the Medicare program if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey dates and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. F-329 It is the intent of the facility that 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 in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination 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	

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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	drugs receive gradual dose reductions, an behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Criteria 1. Corrective action to be accomplished for those resident found to have been affected by the alleged deficient practice. These actions were taken with R#2. The pharmacist reviewed the two anti-depressants for R#2 on November 11, 2013 and based on a review of R#2□s medication regimen review in the medical record, depression stable with Zyprexa and Prozac; [and] insomnia stable with Remeron and Ativan. A recommendation to the physician was generated on November 11, 2013 by the pharmacist noted R#2 was doing better with decreased crying, was out of the room more than before the use of Zyprexa. The practitioner□s notes stated the depression was stable (November 12, 2013); and did continued the use of Zyprexa with other anti-depressant medications. November 19, 2013 the practitioner noted in the review of R#2□s diagnosis of depression, sleeps well, weights stable, no further crying episode. The practitioner is monitoring the use of the medications for R#2□s depression closely and taking actions deemed appropriate to meet R#2□s medical needs. The pharmacist and the physician also reviewed the use of the psychoactive	

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medication for R#2. The pharmacists on November 11, 2013 recommended to the practitioner to consider the discontinuation of the Remeron, since the resident had been back in the facility for approximately 2 months with mood, weight and sleep documented as stable. The practitioner acted on these recommendations, as is documented by the practitioner□s note in R#2□s record change Remeron to PRN for now. That order change was carried out by the nursing staff. On November 19, 2013 the practitioner reviewed the pharmacist□s recommendation again and agreed to discontinue the Remeron. (Attachment A).

Criteria 2. Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice.
The following action was taken with residents who receive anti-psychotic and anti-depressant medications.

Nursing staff were educated on the importance of the means of completing the behavior flow sheets for residents who receive anti-depressants and anti-psychotics by the Staff Development Coordinator (SDC). The SDC will educate licensed staff on the importance and means of monitoring residents□ behaviors, needs and responses on the behavior flow sheets of the anti-depressants and anti-psychotic medication administration and documenting those resident responses as

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F 329	Continued From page 4	F 329	indicated by the residents plan of care. (Attachment B). Nursing staff have been educated to send the Medication Regimen Review form to the pharmacy for newly admitted residents with the other admission documents. These admission documents are sent prior to or within 24 hours of the admission. The admitting nurse will submit the Request for Medication Regimen Review (MRR) form to the pharmacy for a pharmacists review for newly admitted residents, (Attachment J). These requests to the pharmacy are submitted as a part of a new resident admission notification to the pharmacy. The new resident admission notification to the pharmacy includes, but is not limited to, demographic information, the physicians orders, insurance information, and other documents. The medications of residents (regardless of whether the resident is a new admission or is an existing resident) who receive anti-psychotic and or anti-depressant medications, behavioral flow sheets and notes from the practitioner are reviewed on a monthly basis by the pharmacist. The pharmacist makes recommendations of actions to consider, including but not limited to, actions such as continuing the medication as prescribed, discontinuing the medication, gradual dose reduction of the medication, or other actions or any combination of these to the prescribing practitioner based on the review. These	

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recommendations are given to the prescribing practitioner, the Medical Director and to the Director of Nursing for follow-up.

Criteria 3. Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur.

The pharmacist will make notes of the medications, request of the prescribing practitioner for clarification, review and discontinuation of these orders, as appropriate, based on that monthly review. These data will be given to the DON and/or to the prescribing practitioner for follow-up based on the recommendations and the medical care needs of the resident. (Attachment G)

The prescribing practitioner will review these data from the MRR reviews for new admissions and monthly MRR (the medications as prescribed, review of the supportive documentation) and take action based on these pharmacist□s reviews, which may include but are not limited to, continuing the medications as prescribed, discontinuing medications, gradual dose reduction of these prescribed medications or any combination of these and other actions the practitioner deems to be necessary to meet the needs of the residents.

The actions the prescribing practitioners took based on the pharmacist□s

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recommendations will be provided to the Director of Nursing and to the Medical Director for review and further action deemed appropriate based on that review of the practitioner□s actions in order to avoid unnecessary medications being prescribed by the practitioner.

Criteria 4. Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system.

The Director of Nursing or designee, will review 10% of residents weekly for four months to monitor:
a) new admission documents including the new admission medication regimen review, have been submitted to the pharmacy with the new admission documentation;
b) that recommendations from the pharmacy based on the new admit MRR is communicated to the practitioner for further action, as appropriate;
c) that the behaviors associated with the rationale for prescribing these medications, are documented by the licensed nursing staff;
d) that the pharmacist reviews medications monthly, makes notes of the medications, and makes appropriate recommendations to the physician based on that monthly review, which may include, but are not limited to, requests for clarification, to consider discontinuation, to consider changes to the orders, and/or to consider non-pharmaceutical approaches to address behaviors of

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F 329	Continued From page 7	F 329	residents as appropriate; and e) that the prescribing practitioner reviews these pharmacy recommendations and takes action based on these reviews. (Attachments H, I and J) These data results will be reported to the Medication Management Review of the Quality Assessment and Assurance (QA&A) Committee at its next meeting. The QA&A Committee will evaluated the effectiveness of this plan and adjust the plan, as needed, based on the results. The Director of Nursing is responsible to see that the QA&A Committee recommendations are acted upon in a timely manner. Criteria 5. Date corrective action for alleged deficient practice will be accomplished. November 29, 2013	
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 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	F 332	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Friends Homes West of the truth of the facts alleged in this statement of deficiency and	11/29/13

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F 332	Continued From page 8 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 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	F 332	plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare program if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey dates and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. F-332 It is the intent of the facility to provide medications to residents as ordered by the physician, and to not exceed an error rate of five percent or greater. Criteria 1. Corrective action to be accomplished for those resident found to have been affected by the alleged deficient practice. The Director of Nursing reviewed the medical records of resident #1 to ensure the residents did not have negative outcome related to the medications errors referenced in this report, that is, of receiving two drops of Azelastine 0.05% to	

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F 332	Continued From page 9 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	both eyes, rather than one drop as prescribed by the physician. These findings were reported to the physician on October 31, 2013 for corrective action, if any. R#1□s physician indicated that R#1 receiving 2 drops of Azelastine 0.05% rather than 1 drop of Azelastine 0.05% to both eyes was not significant with no further orders or action required. (Attachment F) As stated in the 2567 report, R#9 did not receive an incorrect dosage, the nurse discarded the syringe, obtained another syringe and administered the correct dose of Novolog insulin to R#9. Criteria 2. Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice. Residents have the potential to be affected by improper administration of medication. The nursing staff have been education that an administering nurse will have insulin syringe (after drawn-up in the syringe) checked by another licensed nurse prior to the administration of the insulin to the resident. Nurses will be or have been instructed to not squeeze the eye drop dispenser when it is inverted for administration into the resident□s eye. Licensed nurses will be or have been educated by the Staff Development Coordinator (SDC) on the importance and means of medication administration, actions to take should a medication error	

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F 332	Continued From page 10	F 332	take place and how to report medication errors properly. (Attachments K and L) Criteria 3. Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Licensed nurses will be or have been educated by the Staff Development Cordinator (SDC) on the importance and means of medication administration (including the five rights of medication administration), actions to take should a medication error take place and how to report medication errors properly. The licensed staff have been education that an administering nurse will have insulin syringe (after drawn-up in the syringe) checked by another licensed nurse staff member prior to the administration of the insulin to the resident. This check is to verify the correct dose, as prescribed, has been drawn up into the syringe. Licensed staff have been instructed to not squeeze the eye drop dispenser when it is inverted for administration into the resident□s eye, these bottles are designed to dispense one drop with gravity, and not squeezed. The Director of Nursing or designee (the Assistant Director of Nursing or Staff Development Coordinator) will evaluate the effectiveness of these educational measures through Medication	

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F 332	Continued From page 11	F 332	Administration Observation using the CMS tool (CMS-20056) of the licensed nursing staff. The DON or designee will observe 1 medication pass with 2 licensed staff per week for a period of 1 month with education and/or disciplinary actions taken with those staff based on those results. The observations will continue for four months. These observations will continue for three more months, in the following manner, if the education provided has the expected results, although the DON will increase the observations based on the results of each observation. The plan for months two, three and four is 1 observation every week with 1 licensed staff the second month, 1 observation every other week with 2 licensed staff the third month, and 1 observation with 2 licensed staff the fourth month with education and/or corrective disciplinary action taken based on these observations. Criteria 4. Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. Data obtained from these medication administration observations will be analyzed by the SDC, DON and/or Pharmacist consultant for patterns, trends and/or further educational opportunities, including analysis based on the phase of the error (error by the prescriber, the nurse transcribing the physician□s order to the pharmacy, the dispensing pharmacy, or by the nurse administering	

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F 332	Continued From page 12	F 332	the medication) and report these trends, education and disciplinary action taken to the Medication Management Committee of the Quality Assessment and Assurance (QA&A) Committee at its next meeting. The QA&A Committee will evaluate the effectiveness of the plan and adjust the plan, as needed, based on trends identified in the audits. The Administrator is responsible to see that the QA&A recommendations are acted upon in a timely manner. Criteria 5. Date corrective action for alleged deficient practice will be accomplished. November 29, 2013	
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, nurse practitioner, consultant pharmacist and staff interviews, the consultant pharmacist failed to alert the physician	F 428	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Friends	11/29/13

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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 428	Continued From page 13 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. 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	F 428	Homes West of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare program if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey dates and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. F428 It is the intent of the facility to have the drug regimen of each resident 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. Criteria 1. Corrective action to be accomplished for those resident found to have been affected by the alleged deficient practice. These actions were taken with R#2.	

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F 428	Continued From page 14 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	The pharmacist reviewed the two anti-depressants October 11, and again on November 11, 2013. R#2'□s practitioner reviewed R#2'□s medical record on November 12, 2013 and November 19, 2012. The pharmacists recommended discontinuation of Remeron also noting that continued use of Zyprexa was beneficial for R#2 as documented by the decrease in R#2'□s crying and R#2'□s coming out of the room (November 11, 2013). The practitioner on November 12, 2013 changed the Remeron frequency to every night PRN and noted that R#2□'s crying episodes were better [less frequent]. November 19, 2013 the practitioner discontinued the Remeron medication as recommended by the pharmacist on November 11, 2013 and noted that R#2 sleeps well, weights are stable, no further crying with Prozac [and] Zyprexa in R#2□'s medical record. (Please refer to the Attachment A, Parts 1-2.) Criteria 2. Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice. The pharmacist will conduct a review of residents who are prescribed mood altering medications, including anti-psychotics and anti-depressant medications and present this review to the physician prescribing and to the Director	

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F 428	Continued From page 15	F 428		

of Nursing for review every month. (Please refer to the Attachment G.)

Criteria 3. Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur.

On a monthly basis, the pharmacist will make notes of the medication regimen for residents, including anti-depressant and anti-psychotic as well as other medications, request of the physician for clarification, review and discontinuation of these orders, as appropriate, based on that monthly review. These data will be given to the DON and/or to the physician for follow-up based on the recommendations and the medical care needs of the resident.

Criteria 4. Facility□'s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system.

The Director of Nursing or designee, will review 10% of residents monthly for three months in order to monitor the pharmaceutical regimen review is completed at least monthly and is documented in the medical record of the resident. (Please refer to the Attachment H, Parts 1-5 and Attachment I, Parts 1-3.)

These data results will be reported to the Quality Assessment and Assurance (QA&A) Committee at its next meeting as

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F 428	Continued From page 16	F 428	trends and actions. The QA&A Committee will evaluated the effectiveness of this plan and adjust the plan, as needed, based on the results. The Director of Nursing is responsible to see that the QA&A recommendations are acted upon in a timely manner. Criteria 5. Date corrective action for alleged deficient practice will be accomplished. November 29, 2013	