STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING _____ B. WING _____	C 09/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess one of three sampled residents (Resident #2) as having behaviors on the Minimum Data Set assessment. The findings included:	F 278	F 278 Accuracy of Resident Assessment For Resident #2, the assessment with the Assessment Reference Date 9/17/14 was modified on 10/10/14 by the Minimum Data Set Coordinator to reflect the	10/30/14

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

Electronically Signed | 10/20/2014

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F 278	Continued From page 1 Resident #2 was admitted to the facility on 11/9/2012 with diagnosis including Alzheimer's disease, osteoarthritis and diabetes. Resident #2 resided on a locked Alzheimer's unit. Review of the nurse's notes dated 9/17/14 (3 p - 11 p) indicated Resident #2 was "trying to get out doors and trying to work on another resident's Geri chair." The resident stated "there is a copperhead and I don't have my knife." The as needed (PRN) Ativan was administered at 6:00 PM and 10:00 PM. The Minimum Data Set (MDS) dated 9/17/14 indicated Resident #2 was severely impaired in cognition and memory. The MDS assessed Resident #2 as having behaviors of wandering. There were no behaviors of physical or verbal inappropriate behaviors with others assessed on the MDS. Interview with the MDS nurse on 9/30/14 at 2:14 PM revealed she had not assessed Resident #2 as having behaviors other than the wandering. The MDS nurse was not aware Resident #2 had behaviors in September during the assessment timeframe for the last MDS. She had not read the nurse's note dated 9/17/14 prior to completion of the MDS.	F 278	documented behaviors. Residents currently residing in the facility that exhibit behaviors have the potential to be affected. For residents currently residing in the facility that exhibit behaviors, a review of the most recently completed Minimum Data Set Assessment was completed on or before 10/29/2014 by the Minimum Data Set Coordinator to ensure that behaviors exhibited within the assessment reference period were accurately coded on the MDS. Re-education has been conducted with the Licensed Nurse whose function is the Minimum Data Set Coordinator on or before 10/29/2014 by the Regional Case Mix Coordinator. Quality Improvement monitoring will be conducted by the MDSC/Administrative Nurse to ensure that documented behaviors within the assessment reference period have been coded accurately on the MDS. This Quality Improvement Monitoring will be completed three times per week for four weeks, then two times per week for four weeks, then weekly for four weeks. Results of the Quality Improvement Monitoring will be discussed at the monthly Quality Assurance Performance Improvement Committee Meeting for three months. The committee will recommend revisions to the plan to sustain substantial compliance.	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		10/30/14

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F 280 SS=D	Continued From page 2 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to update the care plan to include non drug interventions for behaviors prior to administering an anti-anxiety medication and identify target behaviors for one of three sampled residents receiving anti-anxiety medications. Resident #2. The findings included: Resident #2 was admitted to the facility on 11/9/2012 with diagnosis including Alzheimer's disease, osteoarthritis and diabetes. Resident #2	F 280	F 280 Revising and Updating the Resident Care Plan For Resident #2, the care plan was updated on or before 10/29/2014 by the Minimum Data Set Coordinator to reflect the resident□s behaviors. Residents currently residing in the facility have the potential to be affected. The MDSC has conducted a review of the care plans for current residents residing in the facility on or before 10/29/2014 to ensure	

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F 280	Continued From page 3 resided on a locked Alzheimer's unit. Physician orders dated 3/25/14 included use of Ativan 1 milligram (mg) to be administered under the tongue (sublingual) every two hours as needed for agitation. Review of the August 2014 Medication Administration Record (MAR) revealed the PRN (as needed) Ativan .5 ml (1 mg) had been administered eleven times. On 8/11/14 Ativan was administered three times in a 24 hour period for a total dose of 3 mg. On 8/21/14 Ativan was administered four times in a 24 hour period for a total dose of 4mg of Ativan. The reason the medication was administered was documented as agitation. Review of the nurse's notes dated 8/11/14 at 10:00 PM revealed Resident #2 was " moving furniture, trying to leave facility, trying to start fights with other residents - pushing -scratching-scratching- squeezing arms and hands of staff when re-directing him. Ativan PRN given with no effect until later in evening after 9:45 PM. Resident now resting in room. Resident constantly being re-directed & (and) re-educated, with little to no effect ... " Review of the nurse's notes dated 8/21/14 at 1:45 PM revealed Resident #2 was confused and received PRN Ativan 2 times that shift (7AM to 3 PM). Resident #2 was described as "agitated/anxious ... " with no other behaviors documented. The nurse's note dated " (3p -11p) indicated Resident #2 was up trying to walk and "staggering" at 5:00 PM. The staff was unable to keep the resident seated. " After supper resident hitting on PT (physical therapy) staff & pushing	F 280	that residents exhibiting behaviors have these behaviors documented on the care plan. Re-education has been provided to the Interdisciplinary Team including the MDSC by the Regional Case Mix Coordinator on or before 10/29/2014 regarding updating resident care plans to include resident behaviors. Quality improvement monitoring will be conducted by the MDSC for (5) resident care plans three times per week for four weeks , then two times per week for four weeks, then weekly for four weeks to ensure that residents exhibiting behaviors have their behaviors documented on the care plan. Results of the Quality Improvement monitoring will be discussed by the Quality Assurance Performance Improvement Committee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The QAPI committee will discuss any necessary revisions to the plan to sustain substantial compliance.	

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F 280	Continued From page 4	F 280		

other residents. PRN ativan given. " (No time of administration of the Ativan was documented in the nurse ' s note) The documentation continued with Resident #2 was squeezing staff hands and agitation was noted. He refused to have a finger stick blood sugar checked, was redirected and allowed staff to check his blood sugar. Documentation continued with "PRN Ativan given, resident squeezing hands and fingers of staff members. " (No time of administration of the Ativan was documented in the nurse's note.) The second entry for 8/21/14 for the 3p - 11p shift included 8:30 PM Resident #2 was swinging at staff.

The Minimum Data Set (MDS) dated 9/17/14 indicated Resident #2 was severely impaired in cognition and memory. The MDS assessed Resident #2 as having behaviors of wandering. There were no behaviors of physical or verbal inappropriate behaviors with others assessed on the MDS.

The updated care plan as of 9/17/14 included problems of wandering/elopement risk, episodes of voiding in the floor in the locked unit, at risk for developing drug related side effects due to receiving an antidepressant and an anti anxiety medication and currently resides in a locked unit. Resident enjoys music, exercises, outings, food, TV and helping others. The approaches for staff included document any wandering behaviors each shift, resident resided in a locked unit, assist him with toileting and redirect the resident when attempting to void in the floor, document any behaviors, observe the resident for side effects from medication and notify the physician, encourage resident to attend activities, observe resident during activities and monitor attendance.

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F 280	Continued From page 5 Review of the nurse ' s notes dated 9/17/14 (3 p - 11 p) indicated Resident #2 was "trying to get out doors and trying to work on another resident's Geri chair." The resident stated "there is a copperhead and I don't have my knife." The PRN Ativan was administered at 6:00 PM and 10:00 PM. Interview with the MDS nurse on 9/30/14 at 2:14 PM revealed she had not care planned target behaviors for use of the Ativan. There had been a care plan in place prior to the 9/17/14 update for a "history" of behaviors. Further interview revealed she had discontinued that care plan. The MDS nurse was not aware Resident #2 had behaviors in September during the assessment timeframe for the last MDS.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide thickened liquids as ordered by the physician for one of one sampled resident on thickened liquids. Resident #2	F 309	F 309(D) Resident # 2 was provided with Nectar Thickened Liquids on 9/30/2014 by the Certified Nurse□s Assistant. The resident was assessed by the Licensed Nurse and	10/30/14

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F 309	Continued From page 6 The findings included: Resident #2 was admitted to the facility on 11/9/2012 with diagnosis including Alzheimer ' s disease. Review of a Speech Therapy discharge summary dated 3/3/2014 indicated Resident #2 had a modified barium swallow study performed on 2/18/14. The swallow study results showed aspiration when swallowing thin liquids. The discharge summary documentation indicated Resident #2 tolerated nectar thickened liquids well. The caregivers (nursing staff) had received instructions on thickening liquids to the appropriate consistency for the patient. The Minimum Data Set (MDS) dated 9/17/14 indicated Resident #2 was severely impaired in cognition and memory. The MDS assessed Resident #2 as requiring limited physical assistance of one staff for eating. The updated care plan as of 9/17/14 included a problem of a " history of refusing thickened liquids " with approaches including " approach resident in calm and reassuring manner, if resident refuses care, re-approach resident at a later time and document any refusals noted. " A problem of " nutritional risk " included approaches to provide nectar thick liquids, set up meal trays for the resident and assist as needed in completing meals. Review of the September physician ' s monthly orders revealed a diet order for nectar thickened liquids. Resident #2 was observed at 12:10 PM on	F 309	there was no adverse effect to the resident. Residents residing in the facility with physician□s orders for thickened liquids have the potential to be affected. A review of residents in the facility with physician□s orders for thickened liquids was completed by the Director of Clinical Services/Administrative Nurses on or before 10/30/2014 to ensure accuracy of physician□s orders for thickened liquids. Observations by designated department managers were conducted on room rounds on or before 10/30/2014 to ensure that residents with orders for thickened liquids have thickened liquids available in their room. A review of tray tickets was conducted on or before10/30/2014 to ensure that residents with orders for thickened liquids had the appropriate order on the tray ticket. An observation of liquids provided at mealtimes has been conducted on or before 10/30/2014 by the Dietary Manager/Administrative Nurse to ensure that liquids provided were consistent with what was documented on the tray ticket. Thickened Liquids are also available in the nourishment kitchens for nursing staff to have available to provide to residents as indicated. Re-education has been provided by the Director of Clinical Services/Administrative Nurses to the nursing staff on or before 10/30/2014 regarding providing residents with sufficient fluid intake to maintain proper hydration and health. Education also	

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F 309	Continued From page 7 9/30/14 drinking coffee in a cup that had not been thickened to nectar consistency. Resident #2 was observed to cough after taking sips of coffee that was not thickened. Interview with aide #1 on 9/30/14 at 12:12 PM revealed Resident #2 had received regular coffee. She further explained the staff gave him " one cup " due to refusals of thickened coffee. Aide #1 indicated this was the usual practice of providing one cup of coffee, not thickened, at meals. Interview with DON on 9/30/14 at 12:14 PM she would expect the resident to receive thickened liquids. She would check with Speech Therapy to see if he was allowed thin coffee. Further interview indicated she would expect an order for the resident to receive regular (thin) coffee if it was OK. Interview with nurse#1on 9/30/14 at 12:17 PM revealed Resident #2 had thick liquids in the refrigerator. He received thick liquids on his tray. The coffee was the only thin liquid he received. She gave no explanation as to why staff gave coffee as a thin liquid. She explained she gave his medications with a nutritional supplement. Observations on 9/3014 at 12:25 PM revealed Resident #2 received nectar thickened liquids on his tray. He ate independently and had no further coughing episodes. Observations on 9/30/14 at 12:55 PM revealed Resident #2 drank thickened tea when prompted by the surveyor and drank the thickened tea independently one time without prompting.	F 309	included provision of fluids to residents between meals including residents with physician□s orders for thickened liquids. Other systemic changes include provision of a Hydration cart to come out three times per day between meals to include thickened liquids and to be offered to residents by nursing staff to begin on or before 10/30/2014. Observations will be conducted by the Director of Clinical Services /Executive Director/Administrative Nurses 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 months to ensure that residents are offered fluids/liquids between meals to include residents with orders for thickened liquids. Other systemic changes include coolers to be placed at the bedside of residents with physician□s orders for thickened liquids containing the appropriate physicians ordered liquid consistency to ensure that residents requiring thickened liquids have liquids available to them. Residents residing on Hickory Hall will be provided liquids per physician□s ordered consistency between meals. Designated department managers will conduct room rounds three times per week for four weeks, then two times per week for four weeks, then weekly for 4 months to ensure that the liquid consistency provided is the appropriate physician□s ordered consistency. Results of the reviews and observations will be discussed by the Director of Clinical Services/Administrative Nurse/Dietary Manager monthly at the	

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F 309	Continued From page 8 Interview with the therapy manager on 9/30/14 at 2:40 PM revealed Resident #2 was not currently on caseload for speech therapy. Further interview revealed he was not aware of any changes for the resident since the last therapy notes. The therapy manager expected Resident #2 would receive nectar thick liquids. As far as he knew, there were no changes in the resident ' s ability to swallow liquids. The nursing staff had asked for a recent speech evaluation.	F 309	Quality Assurance Performance Improvement Committee Meeting for six months. The Quality Assurance Performance Improvement Committee will recommend revisions to the plan to sustain substantial compliance.	
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.	F 329		10/30/14

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F 329	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement non drug interventions for behaviors prior to administering an anti-anxiety medication and attempt a dose reduction for one of three sampled residents receiving anti-anxiety medications. Resident #2. The findings included: Resident #2 was admitted to the facility on 11/9/2012 with diagnosis including Alzheimer's disease, osteoarthritis and diabetes. Resident #2 resided on a locked Alzheimer's unit. Physician orders dated 3/25/14 included use of Ativan 1 milligram (mg) to be administered under the tongue (sublingual) every two hours as needed for agitation. Review of the August 2014 Medication Administration Record (MAR) revealed the PRN (as needed) Ativan .5 ml (1 mg) had been administered eleven times. On 8/11/14 Ativan was administered three times in a 24 hour period for a total dose of 3 mg. On 8/21/14 Ativan was administered four times in a 24 hour period for a total dose of 4 mg of Ativan. The reason the medication was administered was documented as agitation. Review of the nurse's notes dated 8/11/14 at 10:00 PM revealed Resident #2 was "moving furniture, trying to leave facility, trying to start fights with other residents - pushing -scratching-scratching- squeezing arms and	F 329	F 329 Un-necessary Medications For Resident #2, the pharmacy has conducted a medication regimen review on or before 10/29/2014. Resident #2 was seen by the NP on 10/1/14 for Medication Review and adjustment of Psychotropic Medications. Residents residing in the facility have the potential to be affected. A pharmacy representative has conducted a medication regimen review for residents currently residing in the facility on or before 10/29/2014. Re-education has been provided to currently employed Licensed Nurses by the Director of Clinical Services/Administrative Nurse regarding the regulation for un-necessary medications, documentation of effectiveness of medications, and utilization of non-pharmacological interventions prior to administration of prn anxiolytic medications. Quality Improvement monitoring will be conducted via the Director of Clinical Services/Administrative Nurse to ensure that non-pharmacological interventions have been attempted and that rationale for use and effectiveness of the prn medication are documented on the Medication Administration Record. The QI monitoring will be conducted by the	

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F 329	Continued From page 10 hands of staff when re-directing him. Ativan PRN given with no effect until later in evening after 9:45 PM. Resident now resting in room. Resident constantly being re-directed & (and) re-educated, with little to no effect ... " Review of the nurse's notes dated 8/21/14 at 1:45 PM revealed Resident #2 was confused and received PRN Ativan 2 times that shift (7AM to 3 PM). Resident #2 was described as "agitated/anxious ... " with no other behaviors documented. The nurse's note dated (3p -11p) indicated Resident #2 was up trying to walk and "staggering" at 5:00 PM. The staff was unable to keep the resident seated. "After supper resident hitting on PT (physical therapy) staff & pushing other residents. PRN ativan given." (No time of administration of the Ativan was documented in the nurse's note) The documentation continued with Resident #2 was squeezing staff hands and agitation was noted. He refused to have a finger stick blood sugar checked, was redirected and allowed staff to check his blood sugar. Documentation continued with " PRN Ativan given, resident squeezing hands and fingers of staff members." (No time of administration of the Ativan was documented in the nurse's note.) The second entry for 8/21/14 for the 3p - 11p shift included 8:30 PM Resident #2 was swinging at staff. There were no documented non drug interventions attempted on the 7AM to 3 PM shift. There were no documented non drug interventions attempted prior to the after supper incident or the second administration of the Ativan. According to the MAR, Ativan had been given four times on this date and there was no documentation related to a fourth administration of the medication.	F 329	Director of Clinical Services/Administrative Nurse (3) times per week for (4) weeks, then (2) times per week for (4) weeks, then weekly for (4) weeks. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance.	

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F 329	Continued From page 11	F 329		

The nurse's notes for the days/times of Ativan administration in August did not include interventions attempted prior to administration of the Ativan.

The Minimum Data Set (MDS) dated 9/17/14 indicated Resident #2 was severely impaired in cognition and memory. The MDS assessed Resident #2 as having behaviors of wandering. There were no behaviors of physical or verbal inappropriate behaviors with others assessed on the MDS.

The updated care plan as of 9/17/14 included problems of wandering/elopement risk, episodes of voiding in the floor in the locked unit, at risk for developing drug related side effects due to receiving an antidepressant and an anti anxiety medication and currently resides in a locked unit. Resident enjoys music, exercises, outings, food, TV and helping others. The approaches for staff included document any wandering behaviors each shift, resident resided in a locked unit, assist him with toileting and redirect the resident when attempting to void in the floor, document any behaviors, observe the resident for side effects from medication and notify the physician, encourage resident to attend activities, observe resident during activities and monitor attendance.

Review of the September 2014 MAR revealed PRN Ativan had been given nine times. The medication was administered on 9/3, 9/7, 9/10, 9/16, 9/17 and 9/29/14. Review of the MAR indicated the Ativan was not always effective and a second dose was then given. The MAR documentation of follow up for effectiveness of the medication was not present for each time of administration.

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	345466	A. BUILDING _____ B. WING _____	C 09/30/2014

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F 329	Continued From page 12 Review of the nurse's note dated 9/3/14 (3 p - 11 p) revealed the resident was wandering in the unit and touching other residents inappropriately. He kept asking for his wife and thought another resident was his wife. Staff attempted to redirect, but he continued to "think back on same issue." The PRN Ativan was given at 3:45 PM with effect noted. There were no nurse's notes for review for 9/7/14. Review of the nurse's notes dated 9/10/14 on the 3-11 shift revealed PRN Ativan was given at 6:15 PM (no documented behaviors) and with "no effectiveness noted." PRN Ativan was given at 10:05 PM for behavior of "almost at a running step." No documented non drug interventions had been attempted prior to administration of the Ativan. Review of the nurse's notes dated 9/16/14 (3 p - 11 p) indicated Resident #2 had received the PRN Ativan at 5:00 PM and 7:10 PM for "restlessness and agitation." Resident #2 had behaviors of "pacing in the unit" and looking for his wife, and "trying the main doors." The note did not indicate non drug interventions were attempted prior to administration of the Ativan. Review of the nurse's notes dated 9/17/14 (3 p - 11 p) indicated Resident #2 was "trying to get out doors and trying to work on another resident's Geri chair." The resident stated "there is a copperhead and I don't have my knife." The PRN Ativan was administered at 6:00 PM and 10:00 PM. The note did not indicate non drug interventions were attempted prior to administration of the Ativan.	F 329		

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F 329	Continued From page 13	F 329		

There were no nurse's notes for review for 9/29/14.

Continued observations on 9/30/14 at 10:00 AM until 12:00 PM revealed Resident #2 was asleep on the couch in a sitting position. Resident #2 remained asleep until 10:33 AM and would nap with frequent intervals of being awake until 12:00 PM. Activities were being provided during this time and he did not participate or wake up completely.

An interview was conducted on 9/30/14 at 3:30 PM with nurse # 2 who worked with Resident #2 on the evening shift. Nurse #2 explained Resident #2 was upset due to another resident getting in his space on 9/10/14. The Ativan had been given due to the resident being "upset" with the other resident. This nurse explained she did not work in the unit on a regular basis. Nurse #2 had not informed the physician of Resident #2's recent behaviors. Interventions that had been attempted with Resident #2 included sitting with the resident, offering a snack, or holding his hand. She further explained "If he does not get calmed down, he will be so agitated he would not be able to go to sleep later on in the shift." Continued interview revealed redirection with Resident #2 did not always work. Nurse #2 explained she did not document what she had tried unless it was "a big deal." Frequent behaviors Resident #2 exhibited were explained as "He will go to doors and attempt to open them, look for (name) his wife and wander."

Review of the consulting pharmacist's monthly chart review notes revealed no recommendations for a dose reduction or recommendation to the

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F 329	Continued From page 14 physician for a risk verses benefit for the use of the Ativan had been requested. Interview with consulting pharmacist on 9/30/14 at 4:32 PM revealed she did not address the Ativan use in her monthly review notes. The pharmacist further explained since the resident was receiving Ativan multiple times during the month and nursing documenting it was not effective at times, she should have made a recommendation to the physician. The pharmacist indicated she would have made a recommendation to the physician for a different medication or addressed the issue.	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 observations, consulting pharmacist interview and record review the pharmacist failed to review a resident for unnecessary medication and recommend a gradual dose reduction for one of three sampled residents receiving anti anxiety medications. Resident #2.	F 428	F 428 For Resident #2, the pharmacy has conducted a medication regimen review on or before 10/29/2014. Resident #2 was seen by the NP on 10/1/14 for Medication Review and adjustment of Psychotropic	10/30/14

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F 428	Continued From page 15 The findings included: Resident #2 was admitted to the facility on 11/9/2012 with diagnosis including Alzheimer ' s disease, osteoarthritis and diabetes. Resident #2 resided on a locked Alzheimer ' s unit. Physician orders dated 3/25/14 included use of Ativan 1 milligram (mg) to be administered under the tongue (sublingual) every two hours as needed for agitation. Review of the August 2014 Medication Administration Record (MAR) revealed the PRN (as needed) Ativan .5 ml (1 mg) had been administered eleven times. On 8/11/14 Ativan was administered three times in a 24 hour period for a total dose of 3 mg. On 8/21/14 Ativan was administered four times in a 24 hour period for a total dose of 4 mg of Ativan. The reason the medication was administered was documented as agitation. Review of the September 2014 MAR revealed PRN Ativan had been given nine times. The medication was administered on 9/3, 9/7, 9/10, 9/16, 9/17 and 9/29/14. Review of the MAR indicated the Ativan was not always effective and a second dose was then given. The MAR documentation of follow up for effectiveness of the medication was not present for each time of administration. Review of the consulting pharmacist's monthly chart review notes revealed no recommendations for a dose reduction or recommendation to the physician for a risk verses benefit for the use of the Ativan had been requested.	F 428	Medications. Residents residing in the facility have the potential to be affected. A pharmacy representative has conducted a medication regimen review for residents currently residing in the facility on or before 10/29/2014. Re-education has been provided to currently employed Licensed Nurses by the Director of Clinical Services/Administrative Nurse regarding the regulation for un-necessary medications, documentation of effectiveness of medications, and utilization of non-pharmacological interventions prior to administration of prn anxiolytic medications. Quality Improvement monitoring will be conducted via the Director of Clinical Services/Administrative Nurse to ensure that non-pharmacological interventions have been attempted and that rationale for use and effectiveness of the prn medication are documented on the Medication Administration Record. The QI monitoring will be conducted by the Director of Clinical Services/Administrative Nurse (3) times per week for (4) weeks, then (2) times per week for (4) weeks, then weekly for (4) weeks. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The QAPI committee will	

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F 428	Continued From page 16 Continued observations on 9/30/14 at 10:00 AM until 12:00 PM revealed Resident #2 was asleep on the couch in a sitting position. Resident #2 remained asleep until 10:33 AM and would nap with frequent intervals of being awake until 12:00 PM. Activities were being provided during this time and he did not participate or wake up completely. Interview with consulting pharmacist on 9/30/14 at 4:32 PM revealed she did not address the Ativan use in her monthly review notes. The pharmacist further explained since the resident was receiving Ativan multiple times during the month and nursing documenting it was not effective at times, she should have made a recommendation to the physician. The pharmacist indicated she would have made a recommendation to the physician for a different medication or addressed the issue.	F 428	recommend revisions to the plan to sustain substantial compliance.	