STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	**413 WINECOFF SCHOOL ROAD CONCORD, NC 28027**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 3/5/15. Event ID# J0JE11.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility failed to provide toileting assistance for a resident capable of using the bathroom for one of five sampled residents. Resident #186. The findings included: Resident #186 was admitted to the facility on 12/13/14 with diagnosis of a fracture femur, diabetes and difficulty in walking. The Minimum Data Set (MDS) dated 12/20/14 indicated Resident #186 had long term memory intact and mild impairment with short term memory with a BIMs score of 12. The MDS assessed this resident with bowel and bladder incontinence as "always incontinent." Review of the care plan dated 1/11/15 indicated a problem of being at risk for urinary tract infections (UTI's). The care plan listed interventions that included staff were to to monitor for signs and symptoms of UTI's, keep the call bell in reach, encourage the resident to seek assistance for	F 241	1. Corrective action accomplished for those residents to have been affected by the deficient practice; A. Resident #186 is now being provided toileting assistance upon request. Additionally, Resident #186 call light is being answered in a timely manner. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by; A. Delivery of services will be monitored by management completing rounds throughout facility to assure care delivered is appropriate and timely. Rounds will be completed daily by Director of Nursing, Nursing Supervisors, Unit Coordinator and Administrator. Completion of rounds will be shared responsibility of above management associates. B. Facility will complete Quality Assurance observations of response time to call lights within facility daily times 60	4/2/15

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

Electronically Signed | 03/25/2015

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F 241	Continued From page 1 transfers, monitor for incontinence on care rounds and as needed (prn). The care plan indicated a problem the resident required extensive assist to toilet and was dependent on staff for activity of daily living (ADLs) secondary to a right femur fracture. Review of a physical therapy (PT) note of 2/10/15 "patient requested to go to the bathroom. PT assisted with 1-2 contact guard to stand, use grab bar and pivot to toilet. Patient requested assistance with hygiene and clothing management. PT note dated 2/6/15 indicated the patient was requesting to use the toilet. Minimum assistance for sit to stand at the grab bar in the bathroom was provided, with 2 maximum assist to complete the pivot." Review of the occupational therapy (OT) note of 2/10/15 indicated Resident #186 performed stand pivot transfer with rolling walker from arm chair to wheelchair with contact guard assistance. Patient required moderate to maximum assistance for clothing management. OT note dated 2/16/15 indicated Resident #186 completed toileting with contact guard and visual cue's for transfer. Resident #186 required set up for hygiene and minimum to moderate assistance for clothing management. Interview with Resident #186 on 3/3/15 at 1:43 PM revealed one day last week, she had to go to the bathroom and waited over an hour. Further interview revealed she knew how long she had waited by the clock on the wall in front of the resident. Resident #186 further explained some girls act like they don't want to help you. They (aides) turn the button off, tell her to give them 5	F 241	days (6 per day), then weekly times four weeks (6 per week), then monthly (6 per month) to assure compliance with state/federal regulations. Observations will be completed by Unit Coordinator□s, Nursing Supervisor□s, Director of Nursing, Director of Social Services and Administrator. Outcome of observations will be documented on Quality Assurance Monitoring Tool for Call Lights. C. Facility will complete interviews with our residents regarding dignity daily (6 per day) times 60 days then weekly (6 per week) times four weeks then monthly (6 per month) to assure compliance with state/federal regulations. Interviews will be completed by Director of Social Services, Director of Nursing, Unit Coordinators, Nursing Supervisors and Administrator. Outcome of interviews will be documented on Resident Dignity Interview form. 3. Measures/Systematic changes put in place to ensure that the deficient practice does not recur; A. Delivery of services will be monitored by management completing rounds throughout facility to assure care delivered is appropriate and timely. Rounds will be completed daily by Director of Nursing, Nursing Supervisors, Unit Coordinator and Administrator. Completion of rounds will be shared responsibility of above management associates. B. Facility will complete Quality Assurance observations of response time to call lights within facility daily times 60 days (6 per day), then weekly times four	

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F 241	Continued From page 2 minutes, and then 30 minutes later you don't see them. Resident #186 explained "sometimes, I just go ahead and pee in the bed." She also explained when she had entered the facility, she had not been able to walk due to a broken leg. But now with help of one staff she can get in the bathroom. Resident #186 was asked if she was aware when she needed to use the toilet, and she replied "yes." Interview on 03/04/2015 at 4:32 PM with aide #1 on 3-11 revealed the resident knew when she had to go to the bathroom. She wears a disposable brief per her choice. Aide #1 explained Resident #186 was usually "dry" during the day and she may have an incontinent episode when in the bed.	F 241	weeks (6 per week), then monthly (6 per month) to assure compliance with state/federal regulations. Observations will be completed by Unit Coordinator□s, Nursing Supervisor□s, Director of Nursing, Director of Social Services and Administrator. Outcome of observations will be documented on Quality Assurance Monitoring Tool for Call Lights. C. Facility will complete interviews with our residents regarding dignity daily (6 per day) times 60 days then weekly (6 per week) times four weeks then monthly (6 per month) to assure compliance with state/federal regulations. Interviews will be completed by Director of Social Services, Director of Nursing, Unit Coordinators, Nursing Supervisors and Administrator. Outcome of interviews will be documented on Resident Dignity Interview form. D. All Staff will receive training on or before April 2, 2015 on the following topics: >Residents□ dignity and respect in full recognition of his or her individuality. >Responding to call lights in a timely manner. Training will be completed by Staff Development Coordinator. All new hires will receive training during orientation. E. Any associates identified to be non-compliant with dignity concerns for our residents or not responding to call lights in a timely manner will receive disciplinary action. 4. Monitoring of corrective action to ensure the deficient practice will not recur; A. Report of monitoring of delivery of services, findings of Resident interviews	

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F 241	Continued From page 3	F 241	and Quality Assurance completed on response time to call lights will be reported to the facility Quality Assurance Committee monthly times 3 to review for continued intervention or amendment of plan. In the event corrections are needed a plan will be developed, implemented and evaluated for its effectiveness.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to complete a significant change Minimum Data Set (MDS) for 1 of 1 (Resident #19) reviewed for hospice services. Findings Included: Resident #19 was admitted to facility on 4/1/14 with cumulative diagnoses of dysphagia, lack of	F 274	1. Corrective action accomplished for those residents to have been affected by the deficient practice; A. A Significant change Minimum Data Set (MDS) was completed for Resident #19 on 3-20-2015. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by;	4/2/15

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F 274	Continued From page 4 coordination, difficulty in walking, osteoporosis, dementia with behavior disturbances, Alzheimer ' s, hyperlipidemia and depressive disorder. The most recent Minimum Data Set (MDS) dated 11/24/14 which was a quarterly assessment indicated Resident #19 was not cognitively intact and required extensive assistance to total dependence for activities of daily living (ADL ' s). A review of Resident# 19 ' s care plan originally dated 4/14/14 with an updated date of 12/10/14 indicated Resident #19 was to receive hospice services. A review of the Hospice and Palliative Care Facility Care Plan revealed hospice services began for Resident #19 on 12/9/14. A record review was conducted to include Resident #19 ' s physician orders. Further review revealed a telephone physician order dated 12/8/14 in which Hospice was ordered to be consulted on Resident #19. Continued review revealed a telephone physician order on 12/10/14 in which Hospice was ordered to begin following Resident #19. Record review of Hospice provider notes indicated on 12/9/14 at 2:30 PM, Hospice met with resident and 2 family members to present Hospice care and services. Consents were signed. Continued review of Hospice notes indicated Hospice continued to visit and provide services until present day. An interview was conducted with the MDS (Nurse #2) on 3/5/15 at 10:34 AM. The MDS nurse stated that a significant change was not completed when Resident #19 began on Hospice	F 274	A. Facility will complete 100% record review of residents currently residing at our facility to determine if a major decline or improvement in the resident□s status has occurred. If a major decline or improvement is identified a significant change Minimum Data Set (MDS) will be completed. B. Facility will complete random record reviews (10 per day) times 2 months then 10 per week times 2 months to determine if a major decline or improvement in the resident status has occurred. If major decline or improvement is identified a significant change Minimum Data Set (MDS) will be completed. All residents receiving hospice services will be included in random record reviews. All record reviews will be completed by interdisciplinary team including Director of Nursing. C. Outcome of record reviews will be documented on Resident Review Audit Tool. 3. Measures/Systematic changes put in place to ensure that the deficient practice does not recur; A. Facility will complete 100% record review of residents currently residing at our facility to determine if a major decline or improvement in the resident□s status has occurred. If a major decline or improvement is identified a significant change Minimum Data Set (MDS) will be completed. B. Facility will complete random record reviews (10 per day) times 2 months then 10 per week times 2 months to determine	

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F 274	Continued From page 5 services in December 2014. An Interview was conducted with (Nurse #1) on 3/5/15 at 3:10 PM. Nurse #1, stated that Hospice was started in December for resident #19. She further stated that the Hospice providers come and see Resident #19 week. An Interview was conducted with Director of Nursing (DON) on 3/5/15 at 3:23 PM. During this interview, the DON stated she expected staff to have completed the significant change assessment when Resident #19 was started on Hospice services.	F 274	if a major decline or improvement in the resident status has occurred. If major decline or improvement is identified a significant change Minimum Data Set (MDS) will be completed. All residents receiving hospice services will be included in random record reviews. All record reviews will be completed by interdisciplinary team including Director of Nursing. C. Outcome of record reviews will be documented on Resident Review Audit Tool. D. All Staff who complete Minimum Data Set (MDS) will receive additional training on the following topic on or before April 2, 2015. >Comprehensive Assessment after significant change/ completion of significant change when residents condition has major decline or improvement in the resident□s status that will not normally resolve itself without further intervention by staff. Training will be completed by Corporate Consultant for Minimum Data Set (MDS). All new hires will receive training during orientation. 4. Monitoring of corrective action to ensure the deficient practice will not recur; A. Report of record reviews will be reported to the facility Quality Assurance Committee monthly times 4 to review for continued intervention or amendment of plan. In the event corrections are needed a plan will be developed, implemented and evaluated for its effectiveness.	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		4/2/15

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F 281 SS=D	Continued From page 6 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to obtain a lab test for D-Dimer lab (blood test to help check for blood clotting problems) per physicians order for 1 of 1 resident (Resident #183) with orders for D-Dimer test. The findings included: Resident #187 was admitted to the facility on 1/31/15 with diagnosis of dementia, depression and deep vein thrombosis. The Minimum Data Set (MDS) with an assessment reference date of 2/7/15 revealed that Resident #187 required limited assistance for dressing, toileting, bathing and transfers. Resident #187 had lower extremity impairment on both sides, balance and walking was unsteady and he was cognitively intact. The care plan dated 2/26/15 indicated a problem for status post CVA and is on an anticoagulant and is at risk for bruising and bleeding. A review of the physician order sheet for February 2015 revealed Resident #187 was prescribed Coumadin (anti-coagulant) for diagnosis of clot prophylaxis. The nurse practitioner progress note dated 2/23/15 indicated that Resident #187 requested a visit because of right knee pain. He has a history of deep vein thrombosis on left leg. His right knee has some swelling. He has no calf pain, erythema or calf swelling on right. The progress note further indicated that pulses are palpable and comparable. He states his knee pain " feels like	F 281	1. Corrective action accomplished for those residents to have been affected by the deficient practice; A. D-Dimer (lab test) per physician order has been completed on 3-4-2015. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by; A. Facility will complete audit of all physician orders daily times 60 days then weekly times 4 to assure professional standards of quality is met. Audits will be completed by Unit Coordinator□s, Nursing Supervisor□s and/or Director of Nursing. Outcome of audits will be documented on Physician order□s Audit Tool. 3. Measures/Systematic changes put in place to ensure that the deficient practice does not recur; A. Facility will complete audit of all physician orders daily times 60 days then weekly times 4 to assure professional standards of quality is met. Audits will be completed by Unit Coordinator□s, Nursing Supervisor□s and/or Director of Nursing. Outcome of audits will be documented on Physician order□s Audit Tool. B. All licensed nursing staff will receive training on the following topic; >Professional Standards of Practice/Carrying out physician orders in a	

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F 281	Continued From page 7 he has a blood clot " . He is on Coumadin. A review of the physician telephone order dated 2/23/15 revealed an order for x-ray - right knee, 2 views and D-Dimer today, Tylenol 500 mg three times a day for pain. The nurses note dated 2/23/15 at 3:15 PM written by nurse #3 indicated a new order for x-ray right knee, 2 views, Tylenol 500 mg three times a day for pain, orders were noted and faxed and responsible party notified. A review of lab results on 3/4/15 at 4:00 PM revealed x-ray results of right knee on 2/23/15 and D-Dimer results could not be located. During an interview with nurse #3 on 3/4/15 at 4:11PM who signed off the order for the knee x-ray and D-Dimer indicated that the D-Dimer lab was not obtained on 2/23/15, she did not do a lab requisition form because she thought that D-Dimer was part of the x-ray. An interview with the director of nurses on 3/5/15 at 2:20 PM revealed that each morning new orders are checked by unit managers to ensure they are carried out and transcribed correctly and this order was missed.	F 281	timely manner. >Interpretation of physician orders. Training will be completed on or before April 2, 2015 by Staff Development Coordinator. All new hires will receive training during orientation. 4. Monitoring of corrective action to ensure the deficient practice will not recur; A. Report of audit findings will be reported to the Quality Assurance Committee monthly times 3 to review for continued intervention or amendment of plan. In the event corrections are needed a plan will be developed, implemented and evaluated for its effectiveness.	
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	F 329		4/2/15

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F 329	Continued From page 8 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 interviews and pharmacy interview the facility failed to complete a monitoring assessment for abnormal involuntary movements for one of three sampled residents on antipsychotics. Resident # 188. The findings included: Resident #188 was admitted to the facility on 8/6/2014 with diagnosis including stroke, depression and anxiety. Record review revealed an order for Haldol (antipsychotic) dated 11/7/2014 1 milligram (mg) intramuscular (IM) to be given every four hours as needed for behavior that was a danger to self and others. Review of the November Medication Administration Record (MAR) revealed the Haldol 1 mg IM had been administered four times. Review of the December MAR revealed the	F 329	1. Corrective action accomplished for those residents to have been affected by the deficient practice; A. Resident #188 now has a Abnormal Involuntary Movement Scale (AIMS) that was completed on 3-5-2015. B. Resident #188 is no longer receiving haldol as of 3-6-2014. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by; A. Facility will complete 100% audit of all resident□s currently receiving antipsychotic drug therapy to verify that Abnormal Involuntary Movement Scale (AIMS) was completed. B. Facility will complete Random Audits off all residents currently receiving Antipsychotic drug therapy monthly times 2 months (15 per month) then weekly times 4 weeks (3 per week) to verify that Abnormal Involuntary Movement Scale	

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F 329	Continued From page 9 Haldol 1 mg IM had been administered five times. Review of the January MAR revealed the Haldol had been administered four times. Review of a Quarterly Minimum Data Set (MDS) dated 1/15/15 indicated Resident #188 had mild impairment with memory, had no behaviors, had depressed mood, was not able to walk, required extensive assistance with activities of daily living and was always incontinent of bowel and bladder. The MDS indicated Resident #188 had received an antipsychotic medication. The care plan updated on 1/27/15 included a problem of psychotropic medications were used for anxiety, depression and behaviors of " danger to self and others. Resident #188 would put himself on the floor from the bed and chair causing possible injury, hit his fist against the padded wall and had attention seeking behaviors. Interventions included were for staff to redirect the resident as able, provide psychiatric services, monitor and report signs and symptoms of depression, encourage out of room activities, and medication review by pharmacy. Interview with nurse #1 on 03/04/20 at 15 9:50 AM revealed Resident #188 can escalate in minutes. The nurses document behaviors on a behavior flow sheet and in the nurses ' notes. A telephone order dated 2/25/15 for Clarification revealed Haloperidol (Haldol) 0.5mg orally twice a day as needed was for a diagnosis of psychosis with increase in unsafe behaviors, falls Record review revealed no Abnormal Involuntary Movement Scale (AIMS) was located in Resident	F 329	(AIMS) was completed. Audits will be completed by Director of Nursing. Outcome of audits will be documented on Antipsychotic Audit Tool. C. Facility will complete audit daily times 60 days then weekly times 4 weeks of all physician orders to verify Abnormal Involuntary Movement Scale (AIMS) was completed for residents with new order for antipsychotic medication. Audits will be completed by Unit Coordinator□s, Nursing Supervisor□s, and/or Director of Nursing. Outcome of Audits will be documented on Antipsychotic Audit Tool. 3. Measures/Systematic changes put in place to ensure that the deficient practice does not recur; A. Facility will complete 100% audit of all resident□s currently receiving antipsychotic drug therapy to verify that Abnormal Involuntary Movement Scale (AIMS) was completed. B. Facility will complete Random Audits off all residents currently receiving Antipsychotic drug therapy monthly times 2 months (15 per month) then weekly times 4 weeks (3 per week) to verify that Abnormal Involuntary Movement Scale (AIMS) was completed. Audits will be completed by Director of Nursing. Outcome of audits will be documented on Antipsychotic Audit Tool. C. Facility will complete audit daily times 60 days then weekly times 4 weeks of all physician orders to verify Abnormal Involuntary Movement Scale (AIMS) was completed for residents with new order for antipsychotic medication. Audits will be completed by Unit Coordinator□s, Nursing	

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F 329	Continued From page 10 #188 ' s medical record. Interview with unit manager #1 on 03/05/2015 at 10:45 AM revealed an AIMS should have been done. On 03/05/2015 at 11:13 AM an interview with the Director of Nursing indicated an AIMS for this resident was not located. Interview with the Director of Nursing on 03/05/2015 at 2:25 PM revealed the AIMS was not done. She explained the AIMS were completed on a quarterly basis. The resident was not receiving the medication until recently. For clarification the Director of Nursing was asked if the Haldol was started in November 2014, would she expect an AIMS to be done and she stated " yes. " On 03/05/2015 at 2:51 PM an interview with the Pharmacy consultant revealed the facility should have an AIMS for Resident #188. The assessment for monitoring an antipsychotic would be completed at the onset of use of the Haldol, He did not remember any recommendations for an AIMS. He further explained " If it was not there, (in the medical record) it must not have been done. " The presence of an AIMS would be something he would check during the monthly medication reviews.	F 329	Supervisor□s, and/or Director of Nursing. Outcome of Audits will be documented on Antipsychotic Audit Tool. D. All licensed nurse□s will receive training on the following topics: >Drug Regimen is free from unnecessary drugs. >Completion of Abnormal Involuntary Movement Scale (AIMS). Training will be completed by Staff Development Coordinator on or before April 2, 2015. All new hires will receive training during orientation. 4. Monitoring of corrective action to ensure the deficient practice will not recur; A. Report of audit findings will be reported to the Quality Assurance Committee monthly times 3 months to review for continued intervention or amendment of plan. In the event corrections are needed a plan will be developed, implemented and evaluated for its effectiveness.	
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.	F 428		4/2/15

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	345186	A. BUILDING _____ B. WING _____	C 03/05/2015

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FIVE OAKS MANOR	**413 WINECOFF SCHOOL ROAD CONCORD, NC 28027**

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F 428	Continued From page 11 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 interviews and pharmacy interview the facility failed to complete a monitoring assessment for abnormal involuntary movements for one of three sampled residents on antipsychotics. Resident # 188. The findings included: Resident #188 was admitted to the facility on 8/6/2014 with diagnosis including stroke, depression and anxiety. Record review revealed an order for Haldol (antipsychotic) dated 11/7/2014 1 milligram (mg) intramuscular (IM) to be given every four hours as needed for behavior that was a danger to self and others. Review of the November Medication Administration Record (MAR) revealed the Haldol 1 mg IM had been administered four times. Review of the December MAR revealed the Haldol 1 mg IM had been administered five times. Review of the January MAR revealed the Haldol had been administered four times. Review of the Consultant Pharmacist's Medication Regimen Review for December 2014 and January 2015 revealed Resident #188's	F 428	1. Corrective action accomplished for those residents to have been affected by the deficient practice; A. Resident #188 now has a Abnormal Involuntary Movement Scale (AIMS) that was completed 3-5-2015. B. Resident #188 is no longer receiving haldol as of 3-6-2015. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by; A. All resident□s drug regimen has been reviewed by a licensed pharmacist (completed on 3-19-2015) and irregularities have been reported to attending physician and Director of Nursing and these reports have been acted upon. B. Licensed pharmacist will review each resident□s drug regimen monthly and report irregularities to attending physician and Director of Nursing and reports will be acted upon in a timely manner. C. Facility will complete 100% audit of all residents currently receiving antipsychotic drug therapy to verify that Abnormal Involuntary Movement Scale (AIMS) was completed. D. Facility will complete random audits of	

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F 428	Continued From page 12 record was reviewed by the pharmacy consultant. There were no recommendations for nursing to complete an Abnormal Involuntary Movement Scale (AIMS) for Resident #188. Review of a Quarterly Minimum Data Set (MDS) dated 1/15/15 indicated Resident #188 had mild impairment with memory, had no behaviors, had depressed mood, was not able to walk, required extensive assistance with activities of daily living and was always incontinent of bowel and bladder. The MDS indicated Resident #188 had received an antipsychotic medication. The care plan updated on 1/27/15 included a problem of psychotropic medications were used for anxiety, depression and behaviors of " danger to self and others. Resident #188 would put himself on the floor from the bed and chair causing possible injury, hit his fist against the padded wall and had attention seeking behaviors. Interventions included were for staff to redirect the resident as able, provide psychiatric services, monitor and report signs and symptoms of depression, encourage out of room activities, and medication review by pharmacy. Record review revealed the Abnormal Involuntary Movement Scale (AIMS) was not located in Resident #188 ' s medical record. Interview with unit manager #1 on 03/05/2015 at 10:45 AM revealed an AIMS should have been done. Interview with the Director of Nursing on 03/05/2015 at 2:25 PM revealed the AIMS was not done. She explained the AIMS were completed on a quarterly basis. The resident was	F 428	all residents currently receiving antipsychotic drug therapy monthly times 2 months (15 per month) then weekly times 4 weeks (3 per week) to verify that Abnormal Involuntary Movement Scale (AIMS) was completed. Audits will be completed by Director of Nursing. Outcome of audits will be documented on Antipsychotic Audit Tool. E. Facility will complete audit daily times 60 days then weekly times 4 weeks of all physician orders to verify Abnormal Involuntary Movement Scale (AIMS) was completed for residents with a new orders for antipsychotic medication. Audits will be completed by Unit Coordinator□s, Nursing Supervisor□s and/or Director of Nursing. Outcome of audits will be documented on Physician orders/ Antipsychotic Audit Tool. 3. Measures/Systematic changes put in place to ensure that the deficient practice does not recur; A. All resident□s drug regimen has been reviewed by a licensed pharmacist (completed on 3-19-2015) and irregularities have been reported to attending physician and Director of Nursing and these reports have been acted upon. B. Licensed pharmacist will review each resident□s drug regimen monthly and report irregularities to attending physician and Director of Nursing and reports will be acted upon in a timely manner. C. Facility will complete 100% audit of all residents currently receiving antipsychotic drug therapy to verify that Abnormal	

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F 428	Continued From page 13 not receiving the medication until recently. For clarification the Director of Nursing was asked if the Haldol was started in November 2014, would she expect an AIMS to be done and she stated " yes. " On 03/05/2015 at 2:51 PM an interview with the Pharmacy consultant revealed the facility should have an AIMS for Resident #188. The assessment for monitoring an antipsychotic would be completed at the onset of use of the Haldol, He did not remember any recommendations for an AIMS. He further explained " If it was not there, (in the medical record) it must not have been done. " The presence of an AIMS would be something he would check during the monthly medication reviews.	F 428	Involuntary Movement Scale (AIMS) was completed. D. Facility will complete random audits of all residents currently receiving antipsychotic drug therapy monthly times 2 months (15 per month) then weekly times 4 weeks (3 per week) to verify that Abnormal Involuntary Movement Scale (AIMS) was completed. Audits will be completed by Director of Nursing. Outcome of audits will be documented on Antipsychotic Audit Tool. E. Facility will complete audit daily times 60 days then weekly times 4 weeks of all physician orders to verify Abnormal Involuntary Movement Scale (AIMS) was completed for residents with a new orders for antipsychotic medication. Audits will be completed by Unit Coordinator□s, Nursing Supervisor□s and/or Director of Nursing. Outcome of audits will be documented on Physician orders/ Antipsychotic Audit Tool. F. All Licensed Nurse□s will receive training on the following topics; >Drug Regimen is free from unnecessary drugs. >Completion of Abnormal Involuntary Movement Scale (AIMS). Training will be completed by Staff Development Coordinator on or before April 2, 2015. All new hires will receive training during orientation. G. Consultant pharmacist will receive additional training on the following topics; >Drug Regimen Review, Report Irregularities to Attending Physician and Director of Nursing.	

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F 428	Continued From page 14	F 428	>Completing recommendations for Antipsychotic drug Therapy. Utilization of Abnormal Involuntary Movement Scale (AIMS). Training will be completed by Supervisor for consultant pharmacist whom is a Licensed Pharmacist. In the event a change in pharmacy consultant occurs, they will receive training during orientation. 4. Monitoring of corrective action to ensure the deficient practice will not recur; A. Report of all audit and resident□s monthly drug regimen reviews will be reported to the Quality Assurance Committee monthly to review for continued intervention or amendment of plan. In the event corrections are needed a plan will be developed, implemented and evaluated for its effectiveness.	