STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345547	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN PLACE HEALTH AND REHAB, LLC	1 MARITHE COURT GREENSBORO, NC 27407

(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 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET 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, interviews with the consultant pharmacist, nurse practitioner, and facility staff, the facility failed to continue 1 medication (Rena-Vite) to 1 of 1 resident (Resident # 157) reviewed for dialysis. Findings included: A review of the Quarterly Minimum Data Set (MDS) dated 10/29/15 revealed Resident #157 was admitted to the facility on 12/23/11. Resident #157 was cognitively intact, and required extensive assistance for all activities of daily living (ADLs). Active diagnoses included end stage renal disease (ESRD) and dialysis treatment. A review of the monthly physician orders dated 7/1/15 through 7/31/15 and 8/1/15 through 8/31/15 revealed an order for Rena-Vite tab-take 1 tab by mouth (PO) every morning. A review of the physician orders dated 9/1/15 through 9/30/15, 10/1/15 through 10/31/15, and 11/1/15 through 11/19/15 revealed no physician order for Rena-Vite. No physician order was present to discontinue Rena-Vite for Resident #157. A review of the Medication Administration Records (MAR) dated 9/1/15 through 9/30/15, 10/1/15 through 10/31/15, and 11/1/15 through 11/19/15 for Resident #157 revealed no Rena-Vite was administered to Resident #157 since 8/31/15. An interview was conducted on 11/18/15 at 11:40 AM with the Nurse Practitioner (NP) and revealed she was responsible for continuing or	F 281	Submission of the response to The Statement of Deficiencies by The undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. The quotes attributed to staff members are inaccurate and/or taken out of context. Renavite was ordered for resident #157 on 11 23 2015. All residents re-admitted in the last 90 days, will have MARS audited by 12 18 2015. The nurse (or designee) will compare discharge summary orders, to pre-hospital physician□s orders. Any discrepancies noted will be clarified with MD/NP at that time and corrected. The Nurse Manager (or designee) will audit all re-admissions the following day. On the first of each month the nurse (or designee) will send the Physician's Order Sheet to dialysis in order to share any new, changed or discontinued orders. The nurse (or designee) will also send the communication sheet to dialysis with each dialysis appointment to ensure any new, changed or discontinued orders are shared.	12/18/15

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

Electronically Signed | 12/14/2015

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F 281	Continued From page 1 discontinuing medications prescribed for residents. She did not discontinue Reno-Vite for the resident (Resident #157), and stated she had no reason to discontinue the medication. She also stated most dialysis patients were prescribed Rena-Vite. On 11/18/15 at 11:40 AM, an interview was conducted with the consultant pharmacist for the facility. She stated the facility nurses, not the consulting pharmacist, was responsible for ensuring the MAR was accurate. She also stated if there is a physician or NP signature on the monthly orders she considered them accurate. She stated she reviewed monthly orders and compared them to physician orders, but did not question discrepancies because, " If a medication drops off a patient ' s list from one month to the next it is the nurses responsibility to clarify it, not mine. " She also stated she would have had no reason to discontinue Rena-Vite for the resident (Resident #157). On 11/19/15 at 8:50 AM, an interview was conducted with the Director of Nursing (DON). She stated there was no record of the resident (Resident #157) having had received Rena-Vite after 8/31/15, and there was no record the medication was discontinued. She stated the night shift nurses (11 PM- 7 AM) completed 24 hour chart checks for new or discontinued physician orders. She was not able to state which nurses completed the 24 hour chart checks for Resident #157, but all nurses were responsible to ensure the MAR was accurate for all residents. The expectation was for nursing staff to review any telephone or written orders and would make corrections as needed. Nurses were expected to check with the physician or NP if there were discrepancies or if orders needed clarification. An interview was conducted with the RN	F 281	All residents readmitted, that return to facility with discharge orders, will have a new MAR written out by the admitting nurse. The new MAR will be compared to discharge summary orders and to pre-hospital orders. Any discrepancies will be clarified with MD/NP as evidenced by a clarification order. All admitting nurses will be in-serviced on the re-admission process by the Nurse Managers or designee. The in-service will be completed by 12 14 2015. This process will be shared with any new admitting nurses upon hire. The QA committee will review the information reported and revise as necessary and implement any changes as needed.	

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F 281	Continued From page 2 Supervisor on 11/19/15 at 9:25 AM and revealed there was no indication Resident #157 had received the prescribed Rena-Vite since 8/31/15. She also stated there was no order to discontinue the medication, and it appeared the orders had not been continued from one month to the next (September, October, and November). An interview was conducted with the supplying pharmacy manager on 11/19/15 at 10:05 AM. He stated, " We send out the monthly MAR for each resident at the end of the month. So the September MAR arrives at the end of August, the October MAR arrives at the facility at the end of September, and so on. The nurses review the pre-printed MARs for errors, new or discontinued medications and then make corrections. Then they send the MAR back to us, we review the changes, call the facility to verify discontinued medications are really discontinued and send the MAR back. I don ' t see a discontinue order for the Rena-Vite. "	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff and resident interview the facility failed to maintain the environment free of the possibility	F 323	Submission of the response to The Statement of Deficiencies by The undersigned does not constitute an	12/18/15

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F 323	Continued From page 3 of accidents for 1 of 3 residents reviewed for accidents (Resident #7). Findings included: Resident #7 was admitted to the facility on 09/09/09 with diagnoses including hemiplegia, mental disorder, and contractures on her right ankle and right hand. The Minimum Data Set dated 10/27/15 indicated that the resident was cognitively intact and had contractures on the upper and lower right sided extremities. Resident #7 was care planned on 5/15/15 for "impaired mobility and requires extensive assist for transfers, bed mobility, and toileting...right hemiplegia with contractures to right upper extremity/right lower extremity, wears splints daily....Restorative for range of motion exercises and splint placement...." Measures instructed to staff for this topic on the care plan included "get resident out of bed as tolerated - supervise/assist resident with turning and repositioning when in bed/chair, use wheelchair for locomotion, wear right ankle/right wrist splints as indicated." A review of the medical record indicated that neither Occupational Therapy, Physical Therapy (PT), nor Restorative Nursing had recently worked with the resident's ankle contracture. The medical record indicated that physician-initiated treatment orders instructed nursing to splint the resident's hand daily and check the underlying skin daily. There were no mention of any monitoring or assessment to be done to the contracted right foot. The resident was observed to be self-propelling in the hallways on 11/16/15 at 11:05 AM with her right foot resting on a cushion on the foot rest.	F 323	admission that the deficiencies existed, that they were cited correctly, or that any correction is required. The quotes attributed to staff members are inaccurate and/or taken out of context. Resident #7 utilized a Thera-band with a positioning device for her right lower extremity. The Thera-band was removed on 11 19 2015 from the positioning device and the positioning device with Velcro straps was applied. An audit of all residents with positioning devices was completed 12 14 2015. No other resident was identified to have been affected. The MAR will reflect those who have positioning devices. The nurse(or designee) will use the "Hey Therapy" form to communicate with the therapy department that a positioning device screen is required or has been refused or needs re-evaluation. CNAs/Restorative staff will report any concerns regarding skin integrity, circulation, sensation and movement to the charge nurse Q shift. The nurse will assess and document any concerns regarding a positioning device with straps and relay any concerns to the NP/MD. Therapy staff will use the "Hey Nursing" form to communicate any new or changed orders regarding the positioning device. Any changes to the orders or the device or concerns will be reflected on the 24Hour Report. The charge nurse will check the MAR and ensure the positioning device has been observed Q shift while in use. The RN Managers or designee will observe the MAR daily x2 weeks, then every other day	

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F 323	Continued From page 4 The foot was socked and tied to the cushion/foot rest with a yellow therapy/exercise band. The band was bound around the foot rest, holding the cushion and the resident's right foot to the oot rest. The resident did not appear to be in discomfort however the band was noted to be wound tightly around the foot. Notes generated from PT on 11/24/14 did state "poor positioning of the right foot in the wheelchair...patient is unable to safely prop right foot on the leg rest without increasing risk of increasing discomfort of right ankle." However, those PT notes did not authorize the use of a yellow therapy/exercise band to tie the resident's foot onto the foot rest. Nurse #2 was interviewed on 11/18/2015 at 11:35 AM. She stated "Yes, the foot is supposed to be under the yellow band; band sits on the resident's ankle. The purpose of the band is to keep her foot on the rest. The nursing staff puts the band on the resident when they get her us in the mornings; without it her foot would drag. I have not ever seen her get her foot out of it. She asks for assistance if she needs it repositioned." When further questioned about the use, Nurse #1 stated "No one (ex. Physical or Occupational therapy, or provider) had taught us to do it this way, it is just what we staff feel is best for the resident because she will yell out "Help, help!" if her foot slips off the foot rest. Other than the routine weekly skin checks, we (staff) do not monitor or assess the foot to make sure that the skin underneath is okay or that there is not too much pressure from the band. I have never given thought to what would happen if the resident tried to get out of the wheelchair by herself but her foot was tied with the band. I don't	F 323	x2 weeks, then weekly x 2 weeks. All Nursing, Therapy and Restorative staff were in-serviced by SDC by 12 17 2015 about positioning devices and how to monitor skin integrity, circulation, sensation and movement. All Nursing, Therapy and Restorative staff were in-serviced on how to communicate the need for a screen for a positioning device. Therapy staff were in-serviced about how to communicate when a positioning device is refused or modified. The QA Nurse or designee will conduct random audits monthly on those with positioning devices to ensure monitoring continues. The QA Nurse or RN Manager will bring to monthly QA meeting. The QA committee with review for revision and implement any changes as needed.	

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F 323	Continued From page 5	F 323		

really know when this practice started but it is just something that we have been doing and it's been working."

Resident #7 was interviewed on 11/18/2015 at 11:40 AM. The foot was in the footrest, but the band was under her foot. The resident confirmed that staff typically positioned the band over her foot to keep it in the footrest. She indicated that although she had not minded this practice of binding her foot, the band sometimes hurts because it is tight around and under her foot.

The PT staff was interviewed on 11/18/2015 at 11:46 AM. They stated that Resident #7 is not currently on their case load so they do not position her in the wheelchair or monitor her foot. The PT aide confirmed that she did not know that the practice of binding Resident #7's foot to the foot rest with a yellow therapy/exercise band was being done at the facility. "PT had recommended for her to use a specialized cushion with safe, soft Velcro straps that attached to her wheelchair and went across her foot in the past. I don't think using a staff-invented device of binding her foot to keep it in place is safe practice."

Resident #7's foot was observed with Nurse #2 on 11/18/2015 at 12:27 PM. No injuries or redness was noted on the right foot.

The Therapy Director was interviewed on 11/19/2015 at 11:13 AM. At this time, Resident #7 was observed sitting in her wheelchair with the yellow strap cut off of the foot rest and hanging loosely on the foot rest cushion. The Therapy Director stated "I don't know who cut this strap off and left it hanging on the footrest like this. The resident was authorized by PT on 10/14/15 to

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F 323	Continued From page 6	F 323		

use a Velcro strap to keep her foot in the foot rest. It was determined to be safe for her; we never authorized the use of a yellow therapy to keep her footrest in place and certainly not to keep her foot in place on the foot rest. Per our assessments, we know that she is capable of holding on to things and pulling herself up." The Therapy Director refused to comment but did nod her head in agreement when asked if the band across Resident #7's foot could cause her to fall if she attempted to stand up and if the use of a tightly bound therapy band could result in increased pressure across her foot. She further nodded in agreement that the device was considered unsafe/dangerous because it was being done without consent, assessment, and adequate monitoring.

The Director of Orthopedic Rehab and Physical Therapist was interviewed on 11/19/15 at 12:17 PM. He stated "I am aware that the practice is being done by whomever the resident asks to place the band over her foot, because (Resident #7) has asked me to do it as well. The band should be loose enough to be positioned widely across her foot to allow her to move around but I don't think anyone is assigned to make sure that it is. She is a hard patient because she refuses braces and orthopedic consults. In my opinion, this banding is better for her then her foot falling off the foot rest and breaking off because of the chronically tight tone of her leg. I am not aware of how tight the band is because I don't monitor her." He provided documentation from PT: 12/3/14 - "patient and PT had discussion about having a cushion built brace for her right ankle, patient refused to have any stating that she would not wear it, she's contended with her foot in the wheelchair attachment provided by PT (the Velcro

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F 323	Continued From page 7 strapping device)." The Rehabilitation Interdisciplinary Note dated 4/24/15 was also provided by the Director of Othropedic Rehab. It stated "patient still able to propel wheelchair in facility, patient now uses a different leg rest on right lower extremity (than what was originally recommended by therapy. Patient however stated that it's fine, instructed patient that if she experiences difficulty on RLE to let therapy know." The facility was unable to provide documentation confirming that Resident #7 had appropriate assessments done for the use of the yellow therapy/exercise band. The facility did not have documentation that any sort of education was done to Resident #7 on the risks of banding an extremity, or education to staff on how to safely and appropriately apply the band device. The facility did not have any documentation on any consent obtained from Resident #7 or any recommendations/orders from therapy/provider to authorize the use of the banding device. The facility did not have any documentation of any monitoring to ensure that the device did not result in harm or discomfort to the resident. The nurse consultant was interviewed on 11/19/2015 at 1:04 PM. She stated "We do not know how this banding process got started or who gave Resident #7 the band initially....We just asked maintenance to see if we can find or make an alternative device to keep her foot in place."	F 323		
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	F 329		12/18/15

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F 329	Continued From page 8 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow orders to change a routine allergy medication to an 'as needed' status as written on the pharmacy recommendation form by the provider for 1 of 5 residents reviewed for unnecessary medications (Resident #42). Findings included: Resident #42 was admitted to the facility on 05/15/14 with diagnoses that included allergic rhinitis for which she had been prescribed Claritin 10 mg by mouth daily.	F 329	Submission of the response to The Statement of Deficiencies by The undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. The quotes attributed to staff members are inaccurate and/or taken out of context. Resident #42 medication was clarified 11 19 2015 with NP and order remained unchanged. The RN Managers(or designee) will audit all re-admissions the following day. All	

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F 329	Continued From page 9 The Minimum Data Set dated 10/07/15 indicated that the resident was cognitively intact. However the resident was not available for an interview during the time of the survey. The nurses' notes were reviewed and did not indicate any issues with either the allergic rhinitis or with the prescribed Claritin. A pharmacy recommendations dated 10/06/15 prompted the provider to consider changing the Claritin from a daily scheduled medication to an 'as needed' medication based on symptoms. The prescriber had checked the "agree" box on the pharmacist-generated recommendation form and had signed and dated at the bottom of the form on 10/13/15, indicating that the form now became an authentic prescriber's order. A review of the Medication Administration Record (MAR) showed that for the dates after 10/13/15, and until 11/20/15 (the date of medication review), the Claritin continued to be administered as a daily scheduled medication. There was no indication on the MAR that the order was changed to an 'as needed' status during this time. Nurse #1 was interviewed on 11/19/15 at 11:25 AM. She indicated that she had continued to give the Claritin as a scheduled daily medication. Upon showing her the recommendation form, she stated "I was not aware that the pharmacy had made that recommendation and was not aware that the provider had changed the order to an 'as needed' status because I never saw this recommendation form. Recommendation forms are usually set aside for the nurses to review, then given to the providers, and then returned to	F 329	re-admssions will require a hand written MAR. It will be checked by a second nurse. The RN Manager (or designee) will audit the documentation the following day after each re-admission that has discharge orders. The DON or Designee audited the pharmacy recommendations generated in the last three months on 12 11 2015 and confirmed that all accepted recommendations have been implemented. The nurse will send the Physician's Order Sheet to dialysis on a monthly basis. The nurse or (designee)will send the Communication sheet to dialysis with each scheduled appointment. A copy of all future consultant pharmacist recommendations will be made before distributing nursing recommendations to the nursing supervisor, and physician□s recommendations to physicians or nurse practitioners. The DON or designee will place copies in a note book. At the end of each month the DON or designee will review the original consultant pharmacist report to confirm that all recommendations have been acted upon and implemented. Any recommendations that are noted to be not acted upon will be corrected at that time and noted on the audit tool. The DON or designee will track any recommendations not acted upon and take to QA/QI Committee monthly. The QA Committee will review for revision	

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F 329	Continued From page 10 the nurses to again review and insert into the medical record. Because I was not aware that this recommendations was ever made, the form must have been generated, signed by the provider, and put into the medical record prior to a nurse reviewing it; otherwise it would have been changed on the MAR and proper steps would have been followed." The Director of Nursing was interviewed on 11/19/2015 at 12:20 PM. She stated "I would expect nursing to follow up on pharmacy recommendations."	F 329	and implement as needed.	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		12/18/15

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F 425	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, interviews with the consultant pharmacist, nurse practitioner, dispensing pharmacy staff, and facility staff, the dispensing pharmacy failed to include 1 physician ordered medication (Rena-Vite) on the pre-printed monthly orders for 3 (September, October, and November) of 5 (July through November) months for 1 of 1 resident (Resident #157) sampled for dialysis. Findings included: A review of the Quarterly Minimum Data Set (MDS) dated 10/29/15 revealed Resident #157 was admitted to the facility on 12/23/11. Resident #157 was cognitively intact, and required extensive assistance for all activities of daily living (ADLs). Active diagnoses included end stage renal disease (ESRD) and dialysis treatment. A review of the physician orders dated 7/1/15 through 7/31/15 and 8/1/15 through 8/31/15 revealed an order for Rena-Vite tab-take 1 tab PO every morning. A review of the physician orders dated 9/1/15 through 9/30/15, 10/1/15 through 10/31/15, and 11/1/15 through 11/31/15 revealed there was no physician order to discontinue Rena-Vite for Resident #157. A review of the Medication Administration Records (MAR) dated 9/1/15 through 9/30/15, 10/1/15 through 10/31/15, and 11/1/15 through 11/19/15 for Resident #157 revealed no entries for the physician prescribed Rena-Vite. An interview was conducted on 11/18/15 at 11:40 AM with the Nurse Practitioner (NP) and revealed she was responsible for continuing or discontinuing medications prescribed from the hospital. She did not discontinue Rena-Vite, and stated she had no reason to discontinue the	F 425	Submission of the response to The Statement of Deficiencies by The undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. The quotes attributed to staff members are inaccurate and/or taken out of context. Renavite was ordered for resident #157 on 11 23 2015. All residents re-admitted in the last 90 days will be audited. The will be MARS audited by 12 18 2015 by comparing discharge summary orders, to pre-hospital physician□s orders. Any discrepancies noted will be clarified with MD/NP at that time and corrected. All residents readmitted (return to facility with discharge orders) will have a new MAR written out by hand the admitting nurse with each re-admission that has discharge orders. The admitting nurse will check orders and the following day the RN Manager or designee will also check the orders. The orders will be compared to the discharge summary orders and against the to pre-hospital orders. The nurse will clarify any discrepancies with MD/NP as evidenced by a clarification order. The RN Managers (or designee)will audit all re-admissions with discharge summaries the following day. The first of the month the Physician's Order Sheet will be sent to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345547	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN PLACE HEALTH AND REHAB, LLC	1 MARITHE COURT GREENSBORO, NC 27407

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F 425	Continued From page 12 medication. She also stated most dialysis patients were prescribed Rena-Vite. On 11/18/15 at 11:40 AM, an interview was conducted with the consultant pharmacist for the facility. She stated the facility nurses, not the consulting pharmacist, was responsible for ensuring the MAR was accurate. She also stated if there was a physician or NP signature on the monthly orders she considered them accurate. She stated she reviewed monthly orders and compared them to physician orders, but did not question discrepancies because, " If a medication drops off a patient ' s list from one month to the next it is the nurses responsibility to clarify it, not mine. " She also stated she would have had no reason to discontinue Rena-Vite. On 11/19/15 at 8:50 AM, an interview was conducted with the Director of Nursing (DON). She stated the night shift nurses (11 PM- 7 AM) completed 24 hour chart checks for new or discontinued physician orders and changed the MAR until the pharmacy sent a new MAR at the end of the month. She was not able to state which nurses completed the 24 hour chart checks for Resident #157, but all nurses were responsible to insure the MAR was accurate for all residents. The expectation was for nursing staff to review any telephone or written orders and then make hand written corrections as needed. Nurses were expected to check with the physician or NP if there were discrepancies or if orders needed clarification. An interview was conducted with the RN Supervisor on 11/19/15 at 9:25 AM and revealed there was no indication Resident #157 had received a multivitamin since 7/23/15, nor had she received the prescribed Rena-Vite since 8/31/15. She also stated there was no order to discontinue either medication	F 425	Dialysis to share any changed, new or discontinued orders. The communication sheet will also be shared with dialysis at each appointment. All admitting nurses will be in-serviced on the readmission process by nursing management. The in-service will be completed by 12 14 2015. This process will be given to any new admitting nurses upon hire. Audits will be done monthly to ensure ongoing compliance. The QA committee wit review for revision and implement changes as needed.	

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F 425	Continued From page 13 An interview was conducted with the supplying pharmacy manager on 11/19/15 at 10:05 AM. He stated the usual procedure for the dispensing pharmacy was to send the facility the MARs for their residents towards the end of each month. The facility reviewed them and sent them back with any corrections for new, discontinued, or changed medications. If the facility did not write any corrections there was no way for the supplying pharmacy to know if anything had changed so they would not change the MAR. If a facility sent a MAR with discontinued, new, or changed medications the supplying called the facility to verify the change was correct and generated a new MAR. The pharmacy manager stated he did not know why the Rena-Vite was omitted from the September, October, and November MARs.	F 425		