STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 06/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	523 COUNTRY CLUB DR FAYETTEVILLE, NC 28301

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interviews and record review the facility failed to notify the	F 157	1. No action is required as resident #1 is no longer in the facility. 2. Licensed nursing staff was in-serviced by the Director of Nursing and Quality Assurance RN, regarding timely physician notification of acute episodes (i.e. chest pain, anxiety), timely recording of signs and symptoms that warrant giving as needed medication and the need to document the effect of as needed medications in the clinical record. 3. The Director of Nursing, Quality Assurance RN or designee will review the 24 hour shift reports and conduct audits using the QA tool for "Acute Episodes". To ensure timely physician notification, appropriate nursing documentation and monitoring of acute episodes weekly times 4 weeks, then monthly times 3 months. 4. The facility will monitor its performance by conducting daily rounds,	6/8/11 6/18/11 7/5/11 7/5/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia Crone LNHA	Administrator	6/27/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 physician of new onset chest pain and a change in mental status for 1 of 3 sampled residents. (Resident #1) Findings include: Resident #1 was admitted to the facility on 5/4/11. The resident's diagnoses included; hip fracture, atrial fibrillation, history of TIA (transient ischemic attack) and history of DVT (deep vein thrombosis). The "Admission Nursing Assessment" form, dated 5/4/11 revealed the resident required assistance for bathing, personal hygiene, dressing and transfers. The resident was noted to be alert, oriented, friendly and cooperative. The "Initial Assessment" completed by the attending physician on 5/5/11 revealed in the resident was alert, oriented and very pleasant. She was not noted as being anxious at that time. The resident's heart rate was noted as being irregular. She had no complaints of chest pain noted. The physician progress note, dated 5/10/11, did not reveal any reports or complaints of anxiety or chest pain at that time. The "Rehabilitation Consultation Report", dated 5/11/11 did not note any anxiety or chest pain. Review of the nurse's notes from 5/4/11 to 5/10/11 revealed no concerns noted in regards to anxiety or chest pain. A nurse's note dated 5/11/11 at 10AM read in	F 157	review of the 24 hour shift reports and completion of the "Acute Episodes" audits by the Director of Nursing, Quality Assurance RN or Designee times 4 weeks then monthly times 3 months. The results of the audits will be forwarded to the Quality Assurance Committee for review and evaluation of the effectiveness of the training and compliance with standards of practice for physician notification, documentation and monitoring of acute episodes. Ongoing in-service training will continue during new hire orientation, at least two times yearly and as needed.	

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F 157	Continued From page 3	F 157		

mention the resident having any signs or symptoms of anxiety or chest pain. A second nurse's note on 5/13/11 at 9:50PM noted the resident was able to voice her concerns. There was no indication the resident had any signs or symptoms of anxiety or chest pain.

There was one nurse's note on 5/14/11. The note was timed as 1:15AM. The resident was "pleasant with staff" and able to voice her needs to the staff. She had no signs or symptoms of anxiety or chest pain.

On 5/15/11 a nurse's note, timed 1:50AM revealed resident #1 was pleasant, quiet and able to voice her needs. She had no noted concerns with anxiety or chest pain.

On 5/16/11,according to a nurse's note, the resident complained of pain in her back (per nurse #2). She became unresponsive and the facility staff initiated CPR. Resident #1 expired at a local hospital on 5/16/11.

During an interview on 6/7/11 at 1:35PM nurse #1 indicated she worked with resident #1 during the course of her stay. The nurse stated she remembered the resident having one day where she was "very fidgety and anxious." Nurse #1 recalled the resident's heart rate was elevated and she could not sit still in the chair. Nurse #1 stated she called the physician and was given a verbal order for Xanax 0.25 mg (milligrams) 1 by mouth three times a day as needed. Nurse #1 reviewed the medication administration record (MAR) for resident #1 and stated she did not give

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part, "Resident c/o (complained) chest pains to right side of chest. BP (blood pressure) 110/62, apical pulse 102. Resident c/o anxiety. Will notify PA (physician's assistant) in NAD (no acute distress)."

On 5/11/11 at 9PM a nurse's note reflected the resident complained of right side pain and was medicated with an as needed pain medication. There was no mention of anxiety or chest pain. The resident indicated the pain medication was effective.

A verbal order, dated 5/12/11, read in part, "Xanax 0.25mg (milligram) 1 po (by mouth) tid (three times daily) prn (as needed) anxiety."

There was one nurse's note on 5/12/11. The note was timed 10:20PM. There was no mention of the resident having any anxiety or chest pain at that time.

Review of the MAR (medication administration record) for resident #1 revealed no entries for the as needed Xanax being administered. The nurse's medication notes on the backside of the MAR had no entries for the as needed Xanax being administered.

The "Controlled Drug Record" for resident #1's as needed Xanax revealed the evening shift nurse (nurse #2) received 30 (0.25mg) tablets on 5/12/11. The record revealed nurse #1 gave the resident one Xanax (0.25mg) on 5/13/11 at 8AM.

On 5/13/11 a nurse's note, timed 3:24PM did not

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F 157	Continued From page 5 therapy that day. The resident did not complain of chest pain during her therapy. During an interview on 6/8/11 at 9:32AM the speech therapist (ST) indicated resident #1 was drowsy during her initial assessment on 5/12/11. On 5/13/11 the ST noted an increase in the resident's drowsiness. A family member had informed the ST the resident had received a Xanax the morning of 5/13/11. An interview was conducted on 6/8/11 at 10:17AM with nurse #1, nurse #2 and the director of nursing (DON). Nurse #1 had reviewed the controlled drug record for the resident. Nurse #1 stated she did not remember giving the resident the Xanax. She did not recall having a conversation with therapy in regards to giving the Xanax. Nurse #1 did recall having a discussion with a family member in regards to obtaining an order for the Xanax on 5/12/11, but she did not recall telling the family member the resident received any Xanax. Nurse #1 could not provide a reason why the administration of the Xanax was not noted on the MAR. She could not explain why there was no nurse's note to provide a reason (i.e. symptoms) for the administration of the Xanax. Nurse #1 stated she would have only given the medication if there was a reason. However, the nurse could not provide or remember the symptoms the resident was having on 5/13/11 that warranted the resident receiving Xanax. Nurse #1 indicated the resident had complained of chest pain and anxiety on 5/11/11. Per nurse #1 the physician was made aware of the resident's complaint of chest pain and anxiety on 5/12/11 and the physician ordered the Xanax at that time. Nurse #1 stated she should have	F 157		

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F 157	Continued From page 4 any of the Xanax. The nurse stated the resident was tired most of the time but easily arousable and could hold a simple conversation of few words. Nurse #1 did work with the resident on 5/16/11. She did not recall the resident having any complaints of chest pain during the dayshift. During an interview on 6/7/11 at 4:24PM nurse #2 indicated she worked with resident #1 (evenings) during her stay at the facility. Nurse #2 stated resident #1 was "never" anxious when she worked with her. Nurse #2 did not give the resident any Xanax. The nurse indicated she observed the resident to be lethargic one time and it was later in the evening and the nurse was able to arouse the resident and the resident acknowledged the nurse. Physical therapy assistant (PTA) #1 was interviewed on 6/8/11 at 9:32AM. The PTA stated resident #1 was "very drowsy" and "very out of it" on 5/13/11. She had alot of trouble keeping the resident awake and alert. The resident allowed the PTA to do passive range of motion which was different from the prior sessions. PTA #1 indicated the resident was so drowsy her dentures kept falling out of her mouth. The PTA stated "it was not a very good session." The PTA stated the resident's session only lasted about 15-20 minutes that day. PTA #1 stated prior to that day the resident was not as drowsy but she still needed encouragement to complete the therapy tasks. The PTA indicated she spoke to the resident's nurse on 5/13/11 (nurse #1) and was informed the resident had received a Xanax. PTA #1 also worked with the resident on 5/16/11. She stated the resident was "sluggish" during her	F 157		

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F 157	Continued From page 6 written a follow up note in regards to the chest pain and anxiety. To the best of her knowledge the resident did not complain of anymore chest pain or anxiety on her shift. Nurse #1 could not recall why the physician was not notified immediately of the new onset chest pain. Nurse #2 indicated on 5/11/11 the resident complained of right side pain but not chest pain. The nurse gave the resident her as needed pain medication. On 5/16/11 nurse #2 stated the resident complained of back pain before she became unresponsive. Nurse #2 indicated she questioned the resident whether or not she had any chest pain and the resident stated no it was only back pain. During an interview on 6/8/11 at 11:07AM, the physician indicated she had examined the resident two times during her stay at the facility. The physician stated she spoke at length with the resident's husband and the resident in regards to the resident's health condition. The physician indicated if she remembered correctly she ordered the Xanax because the resident had complained of being anxious. The physician indicated if the resident had used the Xanax more than a couple of times then she would discuss with the resident and the staff if the resident needed to use the medication on a long term basis. The physician would want to be informed about how the resident was tolerating the medication. If the resident was lethargic or there was an increase in drowsiness the physician expected to be notified as she would consider that a change in mental status. The physician stated she would expect to be notified right away of a resident having chest pain. She stated she would want to send the resident out to the	F 157		

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F 157	Continued From page 7 hospital for evaluation. The physician did not remember being informed the resident had chest pain.	F 157		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide adequate indications for use and ongoing monitoring for 1 of 3 residents receiving a benzodiazepine medication (Xanax).	F 329	1. No action is required for this resident. 6/8/11 2. The Director of Nursing and Quality Assurance RN in-serviced the licensed nursing staff on how to appropriately document the indications for use and the monitoring of as needed medications. 6/25/11 3. The Director of Nursing and Quality Assurance RN and designee conducted audits of the Medication Administration Records and residents clinical records for appropriate documentation following the administration of as needed medication weekly times 3 weeks. 7/5/11 4. The facility will monitor its performance by continuing to conduct Medication Administration Records audits and chart reviews monthly times 3 months through the Quality Assurance Committee. Nursing staff will continue to be in-serviced to provide adequate 7/5/11	

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F 329	Continued From page 8 (Resident #1) Findings include: Resident #1 was admitted to the facility on 5/4/11. The resident's diagnoses included; hip fracture, atrial fibrillation, history of TIA (transient ischemic attack) and history of DVT (deep vein thrombosis). The "Admission Nursing Assessment" form, dated 5/4/11 revealed the resident required assistance for bathing, personal hygiene, dressing and transfers. The resident was noted to be alert, oriented, friendly and cooperative. She was continent of bowel and bladder. Resident #1's admission care plan, dated 5/5/11, did not include a care plan for behavioral symptoms. The "Initial Assessment" completed by the attending physician on 5/5/11 revealed in the resident was alert, oriented and very pleasant. She was not noted as being anxious at that time. The physician progress note, dated 5/10/11, did not reveal any reports or complaints of anxiety at that time. The "Rehabilitation Consultation Report", dated 5/11/11 did not note any anxiety under the psychiatric review of systems section. Review of the nurse's notes from 5/4/11 to 5/10/11 revealed no concerns noted in regards to anxiety.	F 329	documentation for the indications for use and appropriate monitoring documentation in the clinical record of as needed medications. In-service training will continue to be held for new hire employees at orientation, at least 2 times yearly and as needed.	

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F 329	Continued From page 9 A nurse's note dated 5/11/11 at 10AM read in part, "Resident c/o (complained) chest pains to right side of chest. BP (blood pressure) 110/62, apical pulse 102. Resident c/o anxiety. Will notify PA (physician's assistant) in NAD (no acute distress)." On 5/11/11 at 9PM a nurse's note reflected the resident complained of right side pain and was medicated with an as needed pain medication. There was no mention of anxiety. The resident indicated the pain medication was effective. A verbal order, dated 5/12/11, read in part, "Xanax 0.25mg (milligram) 1 po (by mouth) tid (three times daily) prn (as needed) anxiety." There was one nurse's note on 5/12/11. The note was timed 10:20PM. There was no mention of the resident having any anxiety at that time. Review of the MAR (medication administration record) for resident #1 revealed no entries for the as needed Xanax being administered. The nurse's medication notes on the backside of the MAR had no entries for the as needed Xanax being administered. The "Controlled Drug Record" for resident #1's as needed Xanax revealed the evening shift nurse (nurse #2) received 30 (0.25mg) tablets on 5/12/11. The record revealed nurse #1 gave the resident one Xanax (0.25mg) on 5/13/11 at 8AM.	F 329		

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F 329	Continued From page 10 On 5/13/11 a nurse's note, timed 3:24PM did not mention the resident having any signs or symptoms of anxiety. A second nurse's note on 5/13/11 at 9:50PM noted the resident was able to voice her concerns. The resident was incontinent of bowel and bladder. There was no indication the resident had any signs or symptoms of anxiety. There was one nurse's note on 5/14/11. The note was timed as 1:15AM. The resident was "pleasant with staff" and able to voice her needs to the staff. She had no signs or symptoms of anxiety. On 5/15/11 a nurse's note, timed 1:50AM revealed resident #1 was pleasant, quiet and able to voice her needs. She had no noted concerns with anxiety. Review of the resident's "Behavior Tracking Log" from 5/4/11 to 5/16/11 revealed no entries in the mood or behavior section. On 5/16/11, the resident complained of pain in her back (per nurse #2). She became unresponsive and the facility staff initiated CPR. Resident #1 expired at a local hospital on 5/16/11. The "Medication Disposition Form", dated 5/16/11 noted 29 Xanax (0.25mg) were returned to the pharmacy for resident #1. During an interview on 6/7/11 at 1:35PM nurse #1 indicated she worked with resident #1 during the course of her stay. The nurse stated she	F 329		