

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2012
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573	
(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 record review and staff interviews, the facility failed to notify the designated legal	F 157	F157 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #1 discharged from the facility on 08/17/12, and is no longer a resident of the facility. For those residents having the potential to be affected by the same alleged deficient practice, all licensed nurses have received inservice education on the facility's policy and the regulatory expectation that residents and/or their legal surrogate/responsible person is to be notified in the event of a Medication Error, including the erroneous administration of a drug. To ensure compliance, the Director of Nursing shall review all Medication Error reports to ensure the affected resident's or their legal surrogate/responsible party is notified of the error. Such review shall include a review of the affected resident's medical record to ensure such documentation is included by the practitioner responsible for the error, or the practitioner who discovers the error has been made. The Director of Nursing shall present the findings and subsequent plan of correction for this alleged deficient practice to the facility's Quality Assurance Committee. Furthermore, the Director of Nursing shall report to the Committee any identified discrepancies no less than monthly for three months, and quarterly thereafter.	10/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jim O. Strickland, Administrator* TITLE _____ (X6) DATE 10/19/12

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 representative that a medication error occurred for 1 of 3 sampled residents (Resident #1). Findings included: A review of the facility's policy for incident reporting revised August 2007 read in part, "Notify the family and/or responsible party of incidents/accidents for which a report has been made." Resident #1 was admitted into the facility on 1/6/12. Diagnoses included Dementia. The MDS completed on 8/17/12 indicated Resident #1 mental status was moderately impaired. A review of the initial admission history and assessment form dated 1/16/12 listed ativan as an allergy. A review of the face sheet dated 1/23/12 listed ativan as an allergy. A review of the medication administration record (MAR) dated 4/1/12 at 7:00 am, revealed Resident #1 was administered ativan 0.5 milligrams (mg) by mouth for agitation, signed by Nurse #1 with effective results. Listed on the same MAR was a documented allergy to ativan. A review of the nurses notes dated 4/1/12 at 4:00 pm revealed a family member was present by the bedside of Resident #1. The nurse's note did not indicate the family was notified that ativan 0.5 mg was administered in error. A review of the medication error report acknowledged that a medication error occurred	F 157			

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F 157	Continued From page 2 on 4/1/12 at 7:00 am by Nurse #1, in that ativan 0.5 mg was administered by mouth to Resident #1 with no ill effect. The medication error was documented as discovered on 4/11/12 by the Director of Nursing (DON). The designated legal representative was not documented as notified. In an interview attempted on 10/2/12 at 11:38 am, Nurse #1 phone message stated, "No longer in service." In an interview on 10/2/12 at 12:30 pm, the designated legal representative listed on the medical record face sheet stated she was not notified by the facility of a medication error occurrence. In an interview on 10/2/12 at 1:23 pm, the secondary contact legal representative listed on the medical record face sheet stated he was not notified by the facility of a medication error occurrence. In an interview on 10/2/12 at 1:35 pm, the physician stated she expected the designated legal representative to have been notified of the medication error. In an interview on 10/5/12 5:00 pm, the DON indicated she expected the family to have been notified of any medication changes and clarified any questionable medication allergies, with the designated legal representative/physician.	F 157			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280			

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F 280	Continued From page 3 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 record review and staff interviews, the facility failed to update/revise the care plan for 1 of 3 sampled residents who had repeated falls (Resident #1). Findings included: Resident #1 was admitted into the facility on 1/6/12. Diagnoses included Dementia and Cerebrovascular Accident (Stroke) with Left side weakness. The discharge Minimum Data Set (MDS) completed on 8/17/12 indicated Resident #1 mental status was moderately impaired. Functional status was indicated as required extensive assistance with bed mobility, transfer, walking in room/corridor, toilet use, and personal	F 280	F280 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #1 discharged from the facility on 8/17/12, and is no longer a resident of the facility. For those residents having the potential to be affected by the same alleged deficient practice, the MDS Coordinator has reviewed all Care Plans for residents who have care plans for falls to ensure the care planning interventions/approaches are updated for each fall. To complete the task, the MDS Coordinator shall reconcile the Care Plans for all residents currently care planned for falls against the facility's incident (falls) log for the most recent 3 months. Any resident's Care Plan found to be lacking an update related to the interventions subsequent to a fall, shall be updated to include the new interventions. Additionally, the MDS Coordinator was inserviced on the importance of updating resident's care plans by revising any interventions/approaches related to falls weekly. The MDS Coordinator shall present the findings and subsequent plan of correction for this alleged deficient practice to the facility's Quality Assurance Committee. Furthermore, the MDS Coordinator shall report to the Committee any identified discrepancies no less than monthly for three months, and quarterly thereafter.	10/26/12	

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F 280	Continued From page 4 hygiene. Falls was documented as occurred since the prior assessment with two or more falls that resulted in injury (not major), and two falls that resulted in no injury. The quarterly MDS completed on 6/14/12, balance was documented as not steady and only able to stabilize with human assistance with moving from a seated to standing position, walking, turning around, moving on/off the toilet, and surface to surface transfer. Range of motion to the upper/lower extremities was impaired on one side. A review of the care plan with a problem onset date of 1/13/12 stated, "At risk for injury from falls, history of fall at home prior to hospitalization. Has left side weakness from previous cerebrovascular accident. Scores as a risk for falls using facility risk assessment tool." A review of the incident/accident report dated 2/11/12 documented at 8:30 am, "Resident states the wet floor sign was falling to floor and she was trying to catch the sign and fell out of the chair." The care plan revealed no updates until 3/4/12 which indicated "Toileting schedule while awake. Assist to toilet every two hours." A review of the incident/accident report dated 4/8/12 documented at 1:50 pm, "Resident noted in room #__ on knees with trunk laying across the bed with wheelchair behind and locked. "The care plan revealed no updates until 5/25/12 which indicated "Remind to always call for help prior to getting up, occupational therapy per physician orders." A review of the incident/accident report dated 5/4/12 documented at 3:45 pm, "Resident	F 280			

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F 280	<p>Continued From page 5</p> <p>observed lying on her back on the floor mat beside her bed." The care plan revealed no updates until 5/25/12 which indicated "Remind to always call for help prior to getting up, occupational therapy per physician orders."</p> <p>A review of the incident/accident report dated 6/25/12 documented at 4:00 am, "Resident observed lying on bathroom floor on left side of body. 5 centimeter (cm) x 4 cm hematoma to left side of forehead." The care plan revealed no updates.</p> <p>A review of the incident/accident report dated 7/30/12 documented at 6:55 pm, "Resident observed on floor mat, resident stated she was sitting on the side of the bed and slid off." The care plan revealed no updates.</p> <p>A review of the incident/accident report dated 8/9/12 documented at 9:04 pm, "Resident observed on bathroom floor sitting on her bottom with legs straight out. Skin tear 1 cm x 0.5 cm noted to left pinky." The care plan revealed no updates.</p> <p>In an interview on 9/28/12 at 4:29 am, the administrator stated she expected any needed changes in fall interventions to be reflected in the care plan.</p> <p>In an interview on 9/28/12 at 6:58 am, the MDS nurse indicated the facility procedure was not to update or revise the care plan with interventions after each fall. The MDS nurse concluded that it was an oversight the care plan was not updated or revised, to include interventions related to falls on 6/25/12, 7/30/12, and 8/9/12.</p>	F 280			

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F 323	<p>Continued From page 7</p> <p>stabilize with human assistance with moving from a seated to standing position, walking, turning around, moving on/off the toilet, and surface to surface transfer. Range of motion to the upper/lower extremities was impaired on one side.</p> <p>A review of the care plan with a problem onset date of 1/13/12 stated, "At risk for injury from falls, history of fall at home prior to hospitalization. Has left side weakness from previous cerebrovascular accident. Scores as a risk for falls using facility risk assessment tool." Interventions for physical safety while in the wheelchair included keep call bell in within reach and encourage to call for assistance, chair alarm while in chair, ensure nonskid foot wear is on prior to all transfers/ambulation, provide assistance with all transfers, toilet scheduling while awake, assist to toilet every two hours, hipsters on at all times, and remind to always call for help prior to getting up.</p> <p>A review of the fall risk assessment tool dated 1/6/12 (scored 60), 3/30/12 (scored 90), and 6/14/12 (scored 90) identified Resident #1 at high risk for falls. A score of greater than or equal to 51 was considered to be a high risk for falls.</p> <p>A review of the physical therapy (PT) discharge summaries documented PT services were rendered on 2/6/12 - 2/28/12 for muscle weakness, and abnormality of gait; 3/5/12 - 4/3/12 for muscle weakness, and 4/7/12 - 4/22/12 for muscle weakness. The discharge summary was electronically signed on 4/26/12, and indicated Resident #1 had reached her maximum potential. There were no other PT services</p>	F 323	<p>F323 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).</p> <p>Resident #1 discharged from the facility on 8/17/12, and is no longer a resident of the facility.</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, the MDS Coordinator, Director of Nursing and/or Rehab Director have reviewed all residents assessed as being "high risk for falls" pursuant to the resident's most recent Falls Risk Assessment. To complete the task, residents assessed as being high risk shall be reviewed to ensure the current interventions to prevent accidents/incidents are effective and/or are the least restrictive interventions/device possible.</p> <p>The Director of Nursing shall present the findings and subsequent plan of correction for this alleged deficient practice to the facility's Quality Assurance Committee. Furthermore, the MDS Coordinator and/or Director of Nursing shall review all residents assessed as being "high risk" for falls weekly for 4 weeks, monthly for three months, and quarterly thereafter to ensure the current interventions to prevent accidents/incidents are effective and/or are the least restrictive interventions/device possible.</p>	10/26/12	

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F 323	Continued From page 7 stabilize with human assistance with moving from a seated to standing position, walking, turning around, moving on/off the toilet, and surface to surface transfer. Range of motion to the upper/lower extremities was impaired on one side. A review of the care plan with a problem onset date of 1/13/12 stated, "At risk for injury from falls, history of fall at home prior to hospitalization. Has left side weakness from previous cerebrovascular accident. Scores as a risk for falls using facility risk assessment tool." Interventions for physical safety while in the wheelchair included keep call bell in within reach and encourage to call for assistance, chair alarm while in chair, ensure nonskid foot wear is on prior to all transfers/ambulation, provide assistance with all transfers, toilet scheduling while awake, assist to toilet every two hours, hipsters on at all times, and remind to always call for help prior to getting up. A review of the fall risk assessment tool dated 1/6/12 (scored 60), 3/30/12 (scored 90), and 6/14/12 (scored 90) identified Resident #1 at high risk for falls. A score of greater than or equal to 51 was considered to be a high risk for falls. A review of the physical therapy (PT) discharge summaries documented PT services were rendered on 2/6/12 - 2/28/12 for muscle weakness, and abnormality of gait; 3/5/12 - 4/3/12 for muscle weakness, and 4/7/12 - 4/22/12 for muscle weakness. The discharge summary was electronically signed on 4/26/12, and indicated Resident #1 had reached her maximum potential. There were no other PT services	F 323			

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F 323	Continued From page 8 documented after 4/26/12.	F 323			
	<p>A review of the occupational therapy (OT) discharge summaries documented occupational therapy (OT) services were rendered on 2/8/12 - 2/27/12 for muscle weakness; 3/8/12 - 4/14/12 for muscle weakness; 4/7/12 - 4/20/12 for muscle weakness, and 6/22/12 - 7/19/12 for muscle weakness. The discharge summary was electronically signed on 7/19/12 and countersigned on 7/20/12. The discharged summary indicated Resident #1 had reached her maximum potential. There were no other OT services documented after 7/19/12.</p> <p>A review of the incident/accident report dated 2/11/12 documented, "At 8:30 am, Resident states the wet floor sign was falling to floor and she was trying to catch the sign and fell out of the chair. Denies complaint of pain or hitting head." The cause of the fall per the facility investigation summary confirmed "Resident reached for object while in wheel chair." Measures to prevent reoccurrence included "Educate resident on asking for assistance, and continue to monitor."</p> <p>A review of the incident/accident report dated 4/8/12 documented, "At 1:50 pm, Chair alarm sounding, noted resident in room # ___ on knees with trunk laying across the bed with wheelchair behind and locked." The cause of the fall per the facility investigation summary confirmed "Resident being noncompliant with asking staff for assistance." Measures to prevent reoccurrence included "Reorient to use of call bell and room, maintain resident in high traffic area during wake hours, continue chair alarm and toileting schedule."</p>				

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F 323	Continued From page 9	F 323			
	<p>A review of the nurse's note dated 4/8/12 at 1:50 pm revealed Resident #1 stated to Nurse #1 that she was trying to go to bed.</p> <p>A review of the psychiatry evaluation dated 5/16/12 revealed Resident #1 had mild dementia, history of falls, and jumped up without waiting for help from the wheelchair without assistance. The evaluation concluded "Evidence of mild short-term memory loss. Encouraged to ask for assistance when she wants to get up."</p> <p>A review of the incident/accident report dated 5/24/12 documented, "At 12:50 pm, Resident observed sitting on the fall mat in front of air conditioner unit. Resident stated she slipped out of wheel chair when she rolled over fall mat. No complaint of pain or discomfort. No injuries noted." The cause of the fall per the facility investigation summary confirmed "Fall mat was on floor, resident was trying to propel self over fall mat, wheel chair couldn't roll over fall mat." Measures to prevent reoccurrence included "Make sure fall mat is off floor if resident is not in bed."</p> <p>A review of the incident/accident report dated 7/30/12 documented, "At 6:55 pm, resident was observed on floor mat. Resident stated she had gotten out of wheelchair and was sitting on the side of the bed and she slid off. Denies pain, no treatment required." The cause of the fall per the facility investigation summary confirmed "Resident was sitting on the side of the bed and slid down onto the floor mat." Measures to prevent reoccurrence included "Continue with bed/chair alarm, toileting schedule, low bed with</p>				

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F 323	Continued From page 10 fall mat, and will place hipsters."	F 323			
	<p>In an interview on 9/27/12 at 3:50 pm, Nurse #2 stated when Resident #1 resided at the facility she could not say the interventions that were in place prevented Resident #1 from falling out of the wheelchair. Nurse #2 added the interventions that were in place focused to alert the staff when Resident #1 attempted to get up unassisted. Nurse #2 concluded interventions at times was unsuccessful due to Resident #1 was observed already on the floor, by the time staff observed Resident #1.</p> <p>In an interview on 9/27/12 at 6:27 pm, the Rehab Director (RD) stated Resident #1 had a specialized wheelchair designed to provide support and maintain a neutral posture alignment and maintained safety. When questioned regarding Resident #1 continued falls from the specialized wheelchair what other interventions could have been attempted, the RD added based on her professional experience as a occupational therapy assistant/rehab manager, a lab buddy may have provided a calmness and safety awareness for Resident #1 by decreasing anxiety and agitation, therefore, provided support and safety. The RD concluded such an intervention was never attempted due to there was no received order request from the nursing department for a trial to evaluate the benefits or risks of use.</p> <p>In an interview on 9/27/12 at 6:30 pm, the DON stated she did not feel that recommending a lap buddy or self release belt to be assessed by therapy was appropriate for Resident #1, due to such interventions may have increased the risk</p>				

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NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573		
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F 323	Continued From page 11 for injury, nor did Resident #1 have a medical symptom or diagnoses to justify use. In an interview on 9/27/12 at 6:40 pm with the RD accompanied by the DON, the RD stated "Devices such as a lap buddy if recommended by the nursing department per physician order for trial, has the potential to provide a calmness to the resident and decrease anxiety/agitation, thus decreasing the desire to stand up unassisted." In an interview on 9/28/12 at 6:20 am, nursing assistant (NA) #1 indicated Resident #1 gait was unsteady, weak, and required constant reminders when in the wheelchair not to stand up unassisted. In an interview on 9/28/12 at 6:37 am, NA #2 stated Resident #1 mobility status was weak and that when the chair/bed alarm sounded she would have to track the alarm, due to repeated attempts to stand up unassisted. NA #2 concluded Resident #1 required stand by assistance to maintain a safe balance. In an interview on 9/28/12 at 7:25 am, NA #3 indicated Resident #1 was not safe to walk alone. NA #3 described Resident #1 mobility status as "Wobbly and unsteady." On 9/28/12 at 7:30 am, when requested from the DON and rehab director a wheelchair for observation same as Resident #1 had while at the facility, no wheelchair was provided for physical observation. In an interview on 9/30/12 at 8:13 am, Nurse #3 described Resident #1 mobility status as weak on	F 323			

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F 323	Continued From page 12 one side (could not recall which side) and unsteady.	F 323	F329 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to use non pharmacological strategies for a behavior, and identify/clarify a documented allergy to ativan that resulted in administration of the medication to 1 of 3	F 329	Resident #1 discharged from the facility on 8/17/12, and is no longer a resident of the facility. For those residents having the potential to be affected by the same alleged deficient practice, all licensed nurses have been inserviced on the importance of attempting and noting the effectiveness of non-pharmacological treatments prior to using pharmacological measures to treat resident behaviors. Furthermore, all licensed nurses have received inserviced education related to the importance of verifying a resident's drug allergy(ies) prior to administering any medication(s) and the need to notify the resident and/or the resident's legal surrogate/responsible person. To ensure compliance, all orders, except orders dispensed from the facility's emergency kit, shall be reviewed by a pharmacist prior to dispensing. Those orders filled from the emergency kit shall be reviewed daily by the Director of Nursing and/or Charge Nurse/Unit Supervisor to ensure the resident does not possess an allergy to the ordered medication. The Director of Nursing shall present the findings and subsequent plan of correction for this alleged deficient practice to the facility's Quality Assurance Committee. Furthermore, the Director of Nursing and/or Charge Nurse/Unit Supervisor shall review all orders to be dispensed from the emergency kit daily for 2 weeks, weekly for one month, monthly for three months, and quarterly thereafter to ensure residents do not receive a drug to which the resident has an allergy.	10/26/12	

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F 329	Continued From page 13 sampled residents (Resident #1). Findings included: Resident #1 was admitted into the facility on 1/6/12. Diagnoses included Dementia. The admission Minimum Data Set (MDS) completed on 1/19/12 and discharge MDS dated 8/17/12 indicated there was no physical or verbal behavior problems directed toward others. The MDS listed no antianxiety or antipsychotic medications as received during the last seven days or since admission. The MDS completed on 8/17/12 indicated Resident #1 mental status was moderately impaired. The care plan dated 3/30/12 indicated the use of trazodone as a psychotropic drug for depression. The care plan did not indicate any identified behavioral concerns or approaches for behaviors on admission, nor the most recent care plan updated on 6/14/12. A review of the admission history and assessment form dated 1/16/12 listed ativan as an allergy. A review of the face sheet dated 1/23/12 listed ativan as an allergy. A review of the social services progress notes for March 2012 dated 3/8/12, 3/15/12, and 3/29/12 stated "No behaviors noted." A review of the nurses' notes for March 2012 revealed no documented behavioral concerns that Resident #1 was a physical threat to self or others. A review of the nurses note dated 4/1/12 at 7:00	F 329			

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F 329	<p>Continued From page 14</p> <p>am indicated Resident #1 kicked the wet floor sign over in an aggressive manner with her feet, due to the sign was in her way. The nurse's note concluded the physician was notified and a new order (as needed every eight hours) was received and documented. There were no documented non pharmacological interventions to calm Resident #1, after the sign was indicated as kicked aggressively.</p> <p>A review of the medication administration record (MAR) dated 4/1/12 at 7:00 am, revealed Resident #1 was administered ativan 0.5 milligrams (mg) by mouth for agitation, signed by Nurse #1 with effective results. Listed on the same MAR was a documented ativan allergy. Ativan 0.5 mg was documented as discontinued on 4/1/12 after administration.</p> <p>In an interview attempted on 10/2/12 at 11:38 am, Nurse #1 phone message stated, "No longer in service."</p> <p>In an interview on 10/2/12 at 1:35 pm, the physician stated the ativan was discontinued on 4/1/12 due to the ativan caused increased confusion for Resident #1. The physician elaborated medications to date had been evaluated by the psychiatrist and meds adjusted to improve cognitive functioning, due to documented confusion episodes. There was no mention of Resident #1 prior to kicking the wet floor sign being a physical threat to self or others. The physician concluded she expected Nurse #1 to have verified any documented allergies in the medical record, prior to administering the ativan.</p> <p>In an interview on 10/3/12 at 2:45 pm, the</p>	F 329			

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F 329	Continued From page 15 pharmacy manager (PM) stated pharmacy record indicated that ativan 0.5 mg was pulled from the emergency controlled kit on 4/1/12. The PM concluded that an allergy to ativan was documented in the system and expectation was that allergies were verified, prior to administering the medication. In an interview on 10/5/12 at 5:00 pm, the Director of Nursing indicated she expected the ativan order to have been reviewed with the physician and any documented allergies clarified.	F 329			