STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345237	A. BUILDING: _____ B. WING _____	6/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATIC	515 BARBOUR ROAD SMITHFIELD, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview the facility failed to care plan for the use of psychotropic medications for 2 of 4 residents reviewed for unnecessary medications (Resident #89 and Resident #5). Findings included:

1. Per the resident's medical record, Resident #89 was initially admitted into the facility on 3/31/14 with diagnoses that include dementia, anxiety, psychosis, and insomnia. Pertinent medications as per physician's orders included Klonopin 0.5 milligrams (mg) by mouth three times daily and every 12 hours as needed for anxiety (as continued upon admission on 3/31/14), Zoloft 100 mg by mouth daily (as continued upon admission on 3/31/14), Restoril 15 mg by mouth every night (as continued upon admission on 3/31/14), and Seroquel 12.5 mg by mouth twice daily (as prescribed on 5/28/14). As per the Minimum Data Set (MDS) dated 4/7/14, Resident #89 was documented as being cognitively intact.

The Resident's Care Area Assessment (CAA) dated 4/7/14 triggered for declining activities of daily living function, incontinence care, risk for falls, risk for malnutrition, risk for developing pressure ulcers, psychotropic drug use, and potential for pain.

The analysis of findings on the CAA Worksheet dated 4/9/14 identified a potential problem as the resident being at risk for side effects from psychotropic drug use; including disturbances of balance, gait, and positioning ability. The worksheet stated that psychotropic medications would be addressed in the care plan.

The resident's only care plan, dated 4/16/14, did not have any goals or approaches for the use of psychotropic medication.

The DON was interviewed on 6/25/14 at 12:23 PM. She verbalized agreement that the psychotropic medications for Resident #89 were not care planned as instructed by the CAA to do. She did not know why

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they were not care planned.

The MDS nurse #1 was interviewed on 6/25/14 at 12:33 PM. She stated that she looked through the electronic chart and said that all other residents' psychotropic medications were on the care plans except for these residents (residents #89 & #5). She did not indicate why Resident #89's care plan did not address the use of psychotropic medications.

2 Per the resident's medical record, Resident #5 was initially admitted to the facility on 9/17/12 with diagnoses that included dementia and depression for which Zoloft 100 mg by mouth every night was prescribed on 10/8/2012 by the primary care physician. The resident's cognition was assessed as severely impaired as per the Minimum Data Set dated 4/16/14.

The Care Area Assessment (CAA) as per 9/5/2013 triggered for declining visual function, declining activities of daily living function, incontinence care, risk for falls, risk for malnutrition, risk for developing pressure ulcers, and psychotropic drug use.

The analysis of findings on the CAA worksheet dated 9/5/13 identified a potential problem as the resident being at risk for side effects from Zoloft; particularly in relation to falls. The CAA worksheet stated that the use of psychotropic medications would be addressed in the care plan and would describe the impact of the problem and rational for care plan decision.

The care plans completed on 6/17/13, 9/8/2013, 12/16/13, 3/14/14, and 6/23/14 revealed no plan of care had been included to address either the areas of mood or use of psychotropic medication.

The DON was interviewed on 6/25/14 at 12:23 PM. She verbalized agreement that the psychotropic medication for Residents #5 was not care planned as instructed by the CAA to do. She stated that she did not know why they were not care planned.

The MDS nurse #1 was interviewed on 6/25/14 at 12:33 PM. She stated that she looked through the electronic chart and said that all other residents' psychotropic medications were on the care plans except for these residents (residents #89 & 5). She did not indicate why Resident #5's care plan did not address the use of psychotropic medications.