STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. BUILDING ______ B. WING ______	C 12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK REHABILITATION CENTER	**3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103**

(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 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 family and staff interviews and record reviews, the facility failed to ensure a resident was free from unnecessary drugs by simultaneously administering a narcotic pain medication and two antipsychotic medications ordered on an " as needed basis " without the clinical need for these medications for one of three sampled residents (Resident #1). Findings Included:	F 329	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following	1/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/17/2016

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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Continued From page 1

Resident #1 was admitted on 12/16/15 with the diagnoses of schizophrenia, depression and peripheral neuropathy and pressure ulcer.
Review of the admission assessment dated 12/16/15, revealed she was alert with a short term memory problem and was severely impaired with cognition for decision making. She was able to understand and could make her needs understood.
Review of the physician orders dated 12/16/15, revealed
· risperidone tablet(an antipsychotic) 1 MG (milligram) Give 1 tablet by mouth as needed for Chronic Schizophrenia QD (every day) PRN (as needed).
· Haloperidol tablet 1 MG (an antipsychotic), Give 1 tablet by mouth every 6 hours as needed for Agitation.
· Norco Tablet (a narcotic pain medication containing acetaminophen and hydrocodone) 5-325 MG Give 1 tablet by mouth every 6 hours as needed for pain.
During an interview on 12/28/14 at 3:56 PM, Nurse #6 indicated Resident #1 was admitted late on 1st shift. She had no complaints of pain and was not disruptive. Nurse # 6 indicated the family requested that medications be administered for pain and to " calm her down " . Resident #1 was not symptomatic. No scheduled medication were due. She indicated that she and Nurse # 2 looked at the physician ' s orders for what was ordered for pain and agitation. She gave her risperidone 1 MG, haloperidol 1MG and Norco 1 MG. When asked why she gave the risperidone, haloperidol and the Norco she responded, she felt intimidated by the family.
During an interview 12/28/15 at 5:30 PM, Administrator indicated concern that haloperidol,

F 329

plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Resident #1 has been discharged from the facility.

What corrective action will be accomplished for those residents found to have potential to be affected by the deficient practice?

Any resident on PRN medications have the potential to be affected. Therefore, Licensed Nurses will be counseled by the Director of Nursing on completing a thorough analysis of the resident and identifying the clinical need for administering the PRN medication prior to administration. After administration of a PRN medication to a resident, the nurse should document the clinical need for administering the PRN medication in the resident medical record.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

Licensed Nurses will be educated on non-pharmacological interventions prior to

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F 329	Continued From page 2 risperidone and Norco were all given without a need and expected the nurse to involve the nurse supervisor for guidance. During an interview on 12/28/15 at 6:08 PM, Aide #1 indicated she was with Resident #1 at 3:00 PM, and made the bed and assisted her to bed. Resident #1 verbalized pain, from the pressure ulcer when she was moved. Her behavior was cooperative. During an interview on 12/29/15 at 9:14 AM, family member indicated she was present during the admission on 12/16/15 between 2:00PM and 2:30 PM. She had requested Resident #1 receive the medications that were due. She indicated Resident # 1 was not agitated or in pain. She wasn ' t aware of what medications Nurse #6 had given. During an interview on 12/29/15 at 9:25 AM, Physical Therapist indicated she had completed the physical therapy evaluation on 12/16/15 at 4:00 PM. Resident #1 was cooperative and pleasant. She had no indication of pain. She participated in the therapy evaluation. During an interview on 12/29/15 at 10:56 AM, Nurse #2 indicated she admitted Resident #1, about 2:00 PM on 12/16/15. She was mildly confused and was peasant. She was cooperative and assisted with turning during her skin assessment. She wasn ' t in pain. The family repeatedly asked for Resident #1 ' s pain and antipsychotic medications. No scheduled medications were due. Nurse #2 indicated Resident #1 wasn ' t hollering or disruptive and wasn ' t complaining of pain. When asked why both of the antipsychotic medications were given simultaneously when Resident #1 was asymptomatic, Nurse #2 indicated the family insisted, and the family was more familiar with Resident #1.	F 329	the usage of PRN medications. Licensed Nurses will be educated on communicating appropriate uses of PRN medication versus non-pharmological interventions to the Resident/Family when applicable. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of Nurses (DON) or Designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance with the use of PRN medications and the documentation of interventions performed prior to administering the PRN medications. These audits will be conducted weekly for one month, and then bi-monthly for 2 months. The DON or designee will report results of the audits to the Quality Assurance Committee who will determine the need for further monitoring beyond the three (3) months.	

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F 329	Continued From page 3 During an interview on 12/29/16 at 2:10 PM, Director of Nursing indicated her expectation was for the nurse to determine the need for an antipsychotic or pain medication.	F 329		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure medications were accurately documented to the electronic medication administration record (EMAR) for one (1) of three (3) residents reviewed for unnecessary medications. (Resident #1) Findings included: Resident #1 was admitted on 12/16/15 with the diagnoses of schizophrenia, peripheral neuropathy and pressure ulcer. Review of the admission assessment dated 12/16/15 revealed she was alert with a short term memory problem and was severely impaired with cognition for decision making. She was usually able to	F 514	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	1/22/16

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F 514	Continued From page 4 understand and was able to make her needs understood. Review of the Med Pass with Medication Cart procedure dated 05/19/2015, revealed in part, 15. Document administration on the medication sheet or in the computer, and updated the Individual Control Drug Record for Schedule II drugs. Review of the physician orders dated 12/15/15 revealed, · Risperidone tablet (an antipsychotic), 1 MG (milligram), Give 1 tablet by mouth as needed for Chronic Schizophrenia QD (every day) PRN (as needed). · Haloperidol Tablet 1 MG (an antipsychotic), Give 1 tablet by mouth every 6 hours as needed for agitation. · Norco Tablet (acetaminophen and hydrocodone used as a pain medication) 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain. Review of the facility emergency medication log for Norco 5/ 325 MG revealed one (1) tablet was dispensed on 12/16/15 at 3:45 PM for Resident #1 by Nurse #6. Review of the Emergency Medication Slips dated 12/16/15 at 3:45 PM, revealed haloperidol 1 MG 1 tablet and respiradol 0.25 MG four (4) tablets were dispensed for Resident #1 by Nurse #2. Review of the MAR for December revealed on 12/16/15, Nurse #6 and Nurse #2 failed to document on the E-MAR the administration of risperidone tablet 1 MG (milligram), haloperidol tablet 1 MG and Norco tablet 5-325 MG. During an interview on 12/28/14 at 3:56 PM, Nurse #6 indicated she had administered one (1) tablet of haloperidol 1 mg , four (4) tablets of risperidone 0.25 MG and one (1) tablet of Norco	F 514	1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 Medication Administration Record (MAR) has been reconciled and a late entry was entered on the MAR which accurately reflects the administration of Norco 5/325 mg (1) tab by mouth, Haldol 1mg (1) tablet by mouth and Risperidone 0.25mg (4 tablets) by mouth on 12/16/15 @ 3:45 pm by Nurse #2 Individual re-education was provided to Nurse #2 by the Director of Nursing on ensuring administration of medication are documented on the resident□s MAR. 2) What corrective action will be accomplished for those residents found to have potential to be affected by the deficient practice? All emergency medication slips will be reviewed for current facility residents from December 15th, 2015 □ January 15th, 2016 to ensure all medications removed and administered to a resident from the facility emergency medication supply is accurately documented on the resident MAR. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

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F 514	Continued From page 5 5-325 MG. She indicated she had forgotten to document on the EMAR. She indicated she had not written a note. During an interview 12/29/15 at 2:10 PM, Director of Nursing indicated her expectation was medications to be documented accurately on the EMAR.	F 514	Licensed Nurses will be re-educated by the Director of Nursing on the correct procedure for utilizing medications from the facility emergency medication kit and accurately documenting medications utilized on the resident MAR. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nurses or designee will audit the facility emergency medication kit and emergency medication slip(s) to ensure any medications utilized are accurately documented on the resident MAR. Audits will be completed daily for four (4) weeks, two (2) times a week for eight (8) weeks, and weekly for four (4) weeks. Audit results will be reviewed at the facility's monthly Quality Assurance meeting for a minimum of three months. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance and determine the need for ongoing audits beyond three months.	