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 09/24/2015

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews with resident and staff, the facility failed to answer resident call bells for residents needing assistance, to maintain dignity for 3 of 4 residents (Resident # 1, Resident #53 and Resident#56) reviewed for dignity Findings Included: 1. Resident # 53 was admitted on 6/15/2014 diagnoses with a diagnoses of Parkinson's disease. The Minimum Data Set (MDS) dated July 24, 2015 indicated that Resident #53 was cognitively intact, had adequate hearing and vision, clear speech, was able to be understood and understand others. She also was incontinent of bladder and bowels. Resident # 53 required extensive assistance of one person for toileting and two people for transfer from the bed to the chair. Interview with Resident #53 on 9/22/2015 at 9:45pm, Resident # 53 stated that her call bells were not being answered in a timely manner. Resident #53 indicated on Monday night, 9/21/2015, that she put her call bell on and waited over an hour, while wet, for someone to come in	F 241	Resident concerns regarding the timeliness of staff answering call lights were addressed individually with resident #1, resident #55 and resident #53 on October 14, 2015 by the Director of Nurses. The Director of Nurses shared the facility's plan of action to ensure that call lights are answered in a timely manner with these residents on October 14, 2015. All residents in the facility have a Department Manager assigned as their "Guardian Angel." Residents are asked during the week day Guardian Angel rounds if their needs are being met and if the call lights are answered in a timely manner. Resident care and call light concerns are immediately addressed and documented as a grievance to ensure appropriate follow up.	10/22/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/2/15

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 241	Continued From page 1 and change her. Resident indicated that this was always the problem during the evening shift; the staff was very slow about answering call bells. Resident #53 indicated that " because of my Parkinson's I speak very slowly, sometimes the staff act like what I need is not important to them and this hurts my feelings". Resident # 53 stated " all I can do is lay here'. Resident # 53 indicated that staff talks disrespectful to her a lot. Resident # 53 indicated that she put her call light on 9/4/2015 and waited over 1 hour for staff to come and provide care to her and another aide come in and cut the light off but did not provide care. Resident #53 revealed that she urinates on herself a lot because it takes staff so long to help me." Resident # 53 stated " This is a problem and the Director of Nursing (DON) was aware of staff not answering the call bell. Resident #53 stated that it ' s not a good feeling when you are wet. " Resident # 53 indicated that she had completed a grievance report about the incident on the 4th of September. Resident # 53 stated that " it ' s no better. " Resident # 53 also indicated that staff do talk ugly and yell at her during care but she had not reported this. A Review of a grievance complaint report dated 9/4/2015 revealed Resident # 53 had complaints about NA (Nursing Assistant) not answering call bell. From the review of this grievance that NA was placed on another unit and consulted about prompt response to call lights and other care needs. NA was also consulted about Resident rights and dignity. And what her expectations are during working hours at the facility to ensure that continuity care was provided for her residents. On 9/22/2015 at 9:45pm an observation on of a	F 241	Facility staff have been re-educated on the expectation to answer call lights in a timely manner to ensure the residents needs are being met and that their dignity is maintained. This education was conducted by the Director of Nurses and the Staff Development Coordinator and was completed by October 21, 2015. Newly hired facility staff will be educated during their orientation on the expectation to answer call lights in a timely manner to ensure their needs are being met and that their dignity is maintained. Call light response times will be monitored by utilizing a call light audit. The audit form will be completed by the Director of Nurses or designee to ensure call lights are being answered in a timely manner. The audits will be randomly performed during all three shifts and at different times during the shifts. The response time to at least six resident call lights will be monitored with each completed audit. The audit will be completed daily (including weekends and holidays) for 3 weeks, weekly for 8 weeks and then monthly x 4 months.	

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F 241	Continued From page 2 clock was on the wall and observed to have the correct time on it. An observation of the resident ' s room on 9/22/2015: at 10:15pm the clock on the wall between the residents two TV ' s had been observed and indicated the correct time. The clock was within view of the resident ' s bed. An interview with Resident #53 on 9/22/2015 at 10:15pm indicated that that was how she knew how long it took for staff to answer her call bell and provide care for her. Resident revealed that she had waited up to one hour and a half, or longer, to be changed before, and revealed that this has been going on for months. During an interview with the Director of Nursing on 9/22/2015 at 11am revealed her expectation of staff answering call bell she stated that "call bells are No Passing Zone" She indicated that staff needs to be answering the call bell within a few minutes and that 1 hour was to long for any residents to wait to be cared for. DON stated " we still have a problems with call bells not being answered. " Interview with Nursing Aide #1 on 9/23/2015 at 4pm revealed that she been working with resident #53 for 3 months. NA # 1 stated " that I had never been ugly to this resident and denied taking a long time to answer her call light. She also indicated that she never walked in her room and cut off the light without providing care.	F 241	Any concerns identified when completing the audit will be addressed immediately. The call light audit results will be reviewed monthly for a minimum of six (6) months in the facility's QA meeting. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance and determine the need for further audits beyond six (6) months.	

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F 241	Continued From page 3 2. Resident # 1 was admitted on 5/29/2008 with a diagnoses of Cerebral Palsy. The Minimum Data Set (MDS) dated 9/2/2015 indicated that Resident # 1 was cognitively impaired, had adequate hearing and clear speech, was able to be understood and understand others. There were behaviors exhibited and she rejected care. Resident # 1 required extensive to total assistance for all her activities of daily care, but Resident # 1 can fed herself. Resident # 1 was always incontinent of bowel and bladder. Resident # 1 sometimes used an in-and-out catheter. During an interview on 9/21/2015 at 4pm, when asked if staff treated her with dignity and respect, Resident #1 stated staff talked " ugly " to her and are very " rough " with her during care. Resident # 1 indicated that " if she rings her call bell she ' ll wait for 45 min to 1hr for staff to come in and cut it off. When they cut off the bell, they say " I will be back in a few " and " a few " ended up being another hour or so. " Resident # 1 also reported that" one NA (Nursing Assistant) told her that none of the staff members want to help me or provide care for me because of my attitude and because I was mean." Resident # 1 revealed that she was not mean and didn't have a bad attitude. Resident # 1 revealed that this made her feel really bad and hurt her feelings because she hated that she could not do anything for herself. Resident # 1 indicated that she wanted to cry sometimes because of her situation. Resident # 1 also revealed that 2nd and 3rd shifts are the worst about answering call bells. Resident # 1 indicated that she told the Director of Nursing on Monday 9/21/2015 that	F 241		

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F 241	Continued From page 4 she did not want one NA(Resident #1 named the NA and one of the Nurses(Resident #1 named the nurse) to work with her because of them being rough with her during care. Resident # 1 also stated that Nurse took over an hour or so to provide her with pain medication. Resident # 1 revealed that this happen all the time during the second shift. An observation of the resident's room on 9/22/2015 at 10pm revealed that the clock on the wall between the resident ' s TV indicated the current time. The clock was within view of the resident's bed. Resident indicated that this was how she knew how long it took staff to answer her call bell and provide care for her. Resident revealed that she had waited up to two hours or longer for someone to provide care for her and she did also state that this has been going on for months. During an interview with the Director of Nursing on 9/23/2015 at 9:30am, she indicated that Resident # 1 had informed her several times that " staff was not answering call bells in a timely manner that she was not getting the assistance for her needs. DON indicated that this was why she conducted in service training about ein answering call bell in a timely manner on 9/18/2015. Interview with Nursing Aide #1 on 9/23/2015 at 4pm revealed that she been working with resident#1 for 3 months and indicated that she answered her call bell but, resident does not want anyone to assist her with her ADL's because she indicated that she was in pain. NA # 1 revealed that she had never been ugly to this resident and denies taking a long time to answer her call light.	F 241		

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F 241	Continued From page 5 She also indicated that she never walked in her room and cut off the light without providing care for her. A review of Grievance/complaint report forms from July 2015 until present revealed concerns from 6 other residents indicated that staff are not answering the call bell in a timely manner which posed a major problem on second shift. Several of the grievance/complaint reports were on the same hall with Resident #1. During an interview with the Director of Nursing on 9/22/2015 at 11am revealed her expectation of staff answering call bell she stated that "call bells are No Passing Zone" She indicated that staff needs to be answering the call bell within a few minutes and that 1 hour was to long for any residents to wait to be cared for. DON stated " we still have a problems with call bells not being answered. " 3. Resident #55 was admitted 4/16/2015, with diagnosis of UTI, COPD. His most recent MDS assessment indicates that he is cognitively intact. He also required extensive assistance with transfers and toileting. During an interview with Resident # 55 on 9/23/2015 at 9:23 am, he was alert and oriented and able to answer questions without difficulty. He expressed that he had trouble getting staff to answer his call light on two occasions recently. He stated that he had used his call light to request a blanket. He said that staff had put him to bed and covered him with a sheet and he was cold. He asked for a blanket and timed the staff.	F 241		

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F 241	Continued From page 6 He reported that it took staff 30 minutes to bring him a blanket. He also stated that he is sure of the time because he noted the time he called and when they brought him a blanket.. He said he was cold and he has " thin blood " being 95 years old. He also stated that he had a fall recently. He said that he had called for assistance with toileting. The staff did not answer so he decided to get up on his own. He said he broke his foot in that fall. He said that he did talk to the Administrator and DON about that fall and the staff not answering the call light. He said their response was, I will talk to them. Record review showed that Resident #55 did have a fall with injury including broken toes on 8/28/2015 as he reported. During an interview with the Administrator and DON 9/23/2015 11:14 am, they both stated that they were unaware of Resident #55 ' s fall being related to staff not answering his call light.	F 241		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident's 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, record reviews, and staff	F 323	F 323 – Supervision to Prevent Accidents 1) The shower chair was immediately removed from operation.	6/22/15

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F 323	Continued From page 7 interviews, the facility failed to follow the Manufacturer's Safety/Maintenance Information for the shower chair commode resulting in the accident of 1 of 4 sampled residents reviewed for accidents. Resident#103. Findings included: The facility's "Operation Instructions for the Shower Chair Commode Models (dated 9/1/10)" included: "Precautions: exaggerated user movement in any direction or sitting on the edge of the seat may cause the chair to tip. Safety/Maintenance Information: make certain chair is assembled according to enclosed instructions. Check pipe and fittings for hairline fractures monthly. Check all junctures monthly to make certain the pipe and fittings do not pull apart." Resident #103 was admitted to the facility on 5/21/15 with diagnoses which included: diabetes mellitus, peripheral vascular disease, glaucoma, dementia, mood disorder, and major depression. Review of the invoices, indicated a shower chair was delivered to the facility on 8/7/15. Review of the most recent MDS (Minimum Data Set) dated 8/21/15 indicated Resident #103 had severely impaired cognition; required assistance with bathing; had functional limitations of bilateral lower extremities; and had no falls since her admission. The assessment also revealed the resident weighed 104.5 pounds and was 47 inches tall. The Care Plan included the resident was at risk for falls due to her bilateral above the	F 323	2) All other facility shower chairs were inspected by the facility Maintenance Director. This inspection included ensuring junctures are secure and pipes are free from hairline cracks or fractures. 3) Education will be provided to the facility Maintenance Department by the facility Administrator. Education will include ensuring shower chairs are inspected monthly. Inspection should include ensuring junctures are secure and pipes are free from hairline cracks/fractures. Per shower chair manufacturer guidelines the following was added to the facility "Shower Chair Audit": Monthly inspection of shower chair to ensure shower chair junctures are secure and pipes are free from hairline cracks/fractures.	

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F 323	Continued From page 8 knee amputations, limited mobility/weakness and glaucoma. One of the interventions in the resident's Care Plan indicated the staff were to keep the resident ' s environment clear and safe. Review of the facility's Shower Chair Audit for September 2015 included as areas of inspection: manufacturer name; color; weight limit; condition of pad; condition of wheels; condition of arm rails; condition of brakes; inspected by; and, date of inspection. There were no areas of inspection which included the Manufacturer's Safety/Maintenance Information concerning checking the junctures monthly to make certain the pipe and fittings do not pull apart. On 9/24/15 at 11:10am, several nursing staff were observed running toward the community shower which was located directly across from the nurse ' s station. Resident #103 was observed lying on her back on the floor in the doorway of the community shower. The lower part of the resident ' s body was still positioned in the seat of the chair with the front legs of the chair in the air. NA#1 (Nursing Assistant) was observed in the shower room bending towards the resident who was lying on the floor, face-up in a supine position. The resident was alert, verbal, and complained of back pain. The DON (Director of Nursing) was immediately notified and upon her arrival at the scene, she began assessing resident for injuries and neurological checks were started on the resident. The DON revealed that she would be sending the resident to the ER emergency room for evaluation due to resident hit her head on the floor and was complaining of pain in her back. Resident #103's physician and family were notified. Emergency Medical Transportation arrived at 11:30am and the	F 323	4) An inspection of all facility shower chairs utilizing the facility "Shower Chair Audit" will be performed by the Maintenance Director or Maintenance Assistant monthly. Inspections will involve ensuring junctures are secure and pipes are free from hairline cracks or fractures. Maintenance Director or Maintenance Assistant will review shower chair inspections with the facility Safety Committee and Quality Assurance Committee monthly for a minimum of three (3) months. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance.	

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F 323	Continued From page 9 resident was transported to the hospital. During an interview on 9/24/15 at 11:43am, NA#1 revealed that while escorting Resident #103 to the shower room, she turned the shower chair and propelled the resident into the shower room backwards over the hump in the flooring at the threshold of the shower room. NA#1 revealed that the back of the shower chair came off and the resident fell backwards onto the floor in the shower room. NA#1 stated that the resident did not hit her head, but the resident informed her that her back hurt. NA#1 revealed she was trained to assist residents in the shower chair through the doorway of the shower room by turning the shower chair backwards and pulling chair over the hump in the floor at the threshold. During an interview on 9/24/15 at 1:10pm the DON indicated that the shower chair was approximately one month old and there had never been any problems with the shower chair falling apart. During an interview on 9/24/15 at 1:52pm, the Administrator revealed that the shower chair was delivered to the facility, fully assembled, without instructions. He also revealed that during the facility's monthly Safety Meetings, the general conditions of the shower chairs were checked and both shower chairs were last checked on 9/3/15 by the facility's Human Resource Coordinator/Safety Team Member. He further stated that upon inspection of the shower chair after the accident/incident, he felt the accident was the result of equipment failure because there was no functional purpose for the back of the shower chair to be removed; and, there were no missing screws or parts on the shower chair.	F 323		

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F 323	Continued From page 10 On 9/24/15 at 3:03pm, the DON indicated the nursing assistants had been instructed to pull residents backwards in the shower chairs through the shower rooms' thresholds because of the slight incline/ramps in the doorways the shower rooms. She revealed that the incident was an accident because the nursing assistant followed the facility's protocol. During an interview on 9/24/15 at 3:25pm, the Maintenance Supervisor revealed the shower chairs were inspected monthly by himself or his assistant, but not documented. He also revealed that the shower chair involved in the accident was delivered to the facility already assembled approximately three to six months ago and stated that the shower chair was sturdy and intact. On 9/24/15 at 3:45pm, the DON revealed that the resident had just returned from being evaluated at the hospital and the resident had no injuries as a result of the accident in the shower chair.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 25 opportunities for 2 of 6 residents (Resident #25	F 332	Resident #25's Pancreaze DR administration time was changed on October 1, 2015. The order now instructs the nurse to administer the medication with meals.	10/22/15

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F 332	Continued From page 11 and Resident #129) observed during medication pass, resulting in a medication error rate of 8%. The findings included: 1) A review of Resident #25 ' s September 2015 physician ' s medication orders included a current order for Pancreaze DR to be given as one capsule by mouth with meals. The Pancreaze DR was scheduled for administration three times daily at 8:00 AM, 12:00 PM, and 5:00 PM. LS On 9/23/15 at 4:34 PM, Nurse #7 was observed as she prepared and administered medications to Resident #25. The administered medications included one Pancreaze Delayed Release (DR) capsule containing 10,500 units of lipase, 25,000 units protease, and 43,750 units of amylase. Pancreaze DR is a medication which contains a combination of digestive enzymes which act locally in the small intestine to aid in the digestion of fats, protein, and starches. Pancreaze DR is used to replace these enzymes when the body does not have enough of its own. Product information from the manufacturer indicated because of the local action of this medication, Pancreaze DR should be taken with meals or snacks. A snack was not given to the resident at the time of the medication administration. An interview was conducted on 9/23/2015 at 5:47 PM with Nurse #7. During the interview, Nurse #7 reviewed Resident #25 ' s Medication Administration Record (MAR), along with the physician ' s order to give Pancreaze DR with meals. Upon inquiry regarding the timing of the medication given in relation to meals, the nurse stated that in the past, the resident had refused to take a snack at the time of the medication pass.	F 332	Nursing management completed an audit of all resident medication administeration times on 10/5/15. Orders for medications to be given with food or meals were clarified and rewritten to coincide with the facility's meal times. The Staff Development Coordinator will educate the nurses on the importance of following the manufacturer's guidelines when administering medications by October 17, 2015. Newly hired nurses will receive this information during their orientation. It will also be included on the Licensed Nurses Orientation Competency Checklist. The Director of Nurses or designee will complete a Medication Admin Audit Report on those residents who have specific guidelines or times of administration every day for one month, 3 times a week for 3 months and monthly x three months to ensure these medications are administered timely per the product guidelines and manufacturer's instructions. Any identified concerns will immediately be addressed and corrected.	

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F 332	Continued From page 12 When asked if the medication had been given with the evening meal in the past as specified by the physician ' s order, Nurse #7 stated, " the trays (supper) are coming. " On 9/23/15 at 5:58 PM, an observation was made of Resident #25 in the facility ' s Dining Room. At that time, the resident was observed to have taken approximately two bites of the food served with his evening meal. Upon inquiry, the resident stated he had just received his meal tray. When asked, Resident #25 reported he had not experienced any gastrointestinal discomfort although he was aware that he received medication for this. A review of the meal intake record for Resident #25 revealed the resident consumed 51-75% of his evening meal on 9/23/15. An interview was conducted on 9/24/15 at 9:14 AM with the facility ' s Director of Nursing (DON). During the interview, the DON indicated the administration time of the Pancreaze DR medication for Resident #25 probably needed to be changed to better correspond with his mealtime schedule. A telephone interview was conducted on 9/24/2015 at 11:16 AM with the facility ' s consultant pharmacist. During the interview, the administration time observed on 9/23/15 for Resident #25 ' s Pancreaze DR relative to the scheduled evening meal service was discussed. The pharmacist reported, in general, she/he expected a medication ordered with a meal to be administered with the first bite of the meal or within one hour after the meal was consumed.	F 332	The 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. The Staff Development Coordinator completed a G-Tube medication pass skills check with Nurse #7 on October 14, 2015 to ensure knowledge of the correct policy and competency of the procedure. The Consultant Pharmacist completed an inservice reviewing G-tube medication administration with licensed nurses on October 15, 2015. Nurses will be required to complete a G-tube medication pass skills check with a member of Nursing management by October 20, 2015. Newly hired nurses will also be required to complete this skills check during their orientation period, prior to being assigned to a medication cart. The skills check instructs the nurse to follow the physician's order or the facility's policy for administering "Medication via Gastrostomy Tube." These instructions include: Verify the physician's orders and gather equipment at bedside.	

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F 332	Continued From page 13 2) A review of the facility ' s policy, " Medication via Gastrostomy Tube " (Revised 2/19/11) included the following statement: " 15) Do NOT mix medications. Administer each medication separately. " Resident #129 was admitted to the facility on 5/29/15 with a cumulative diagnoses which included gastrostomy (a surgical opening into the stomach whereby a feeding tube may be inserted and used for feeding) and a history of multiple infections. On 9/23/15 at 4:47 PM, Nurse #7 was observed as she prepared medications and a tube feeding formula (one-240 milliliter (ml) can of Glucerna 1.5) for administration to Resident #129. The medications pulled for administration included one capsule of Align (a probiotic formulation); and, one-5 milligram (mg) isosorbide dinitrate tablet (a medication typically used for the management of angina or chest pain). The nurse was observed as she opened the Align capsule and placed the contents into a medication cup; she then placed the isosorbide dinitrate tablet in the same medication cup. Nurse #7 put the two medications into a plastic sleeve and crushed the medications together. The crushed medications were poured back into the med cup and approximately 10 milliliters (ml) of water were added to the cup. The two crushed medications were administered together to Resident #129 ' s via his gastrostomy tube at 5:07 PM. A review of Resident #129 ' s September 2015 Order Summary Report included an order which read, in part: " Flush tube with ...5 cc (ml water) between each med. "	F 332	Wash hands Verify correct medication by checking label three times If medication is in tablet form: crosscheck with "Do not crush" list" Crush tablets Verify resident's identity, provide privacy Explain procedure Elevate head of bed to Fowler's position Put on gloves Check dressing around tube and assess skin Stop enteral pump if applicable Remove dressing and plug at the tip of tube. Attach syringe or funnel to tip Release clamp and inject about 20-30cc of air to check for patency while listening for swooshing sound with stethoscope over epigastic area Do NOT mix medications: Administer each medication separately Mix crushed tablets with diluent or open end of capsule and pour into liquid. Pour liquid into diluent. Mix well Attach syringe, without piston, to end of feeding tube and open clamp Flush tube with at least 30ml of water Deliver medication slowly and steadily Pour up to 30ml diluted medication into syringe barrel Hold feeding tube at a slight angle and add more medication before syringe empties to prevent air from entering stomach Monitor resident's reaction throughout instillation and stop procedure if signs of discomfort are noted Flush tube by adding 30-50 ml of water Repeat above steps for each medication administered. Tighten clamp, cover end of tube or reconnect to administeration set as indicated Remove gloves Wash hands Keep head of bed elevated for 30-60 minutes after procedure	

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F 332	Continued From page 14 During an interview with Nurse #7 on 9/23/15 at 5:47 PM, the nurse acknowledged all medications administered via a gastrostomy tube needed to be separated and the tube flushed with water in between the administration of each medication. Nurse #7 stated she did not recall whether or not she separated the contents of the Align probiotic capsule from the crushed isosorbide dinitrate tablet. An interview was conducted with the facility's Staff Development Coordinator (SDC) on 9/24/15 at 8:18 AM. During the interview, the SDC indicated the expectation would be for all medications to be given individually, one at a time. She also stated it was the facility's policy that 5 cc (ml) plain water should be used to flush the gastrostomy tubing between each medication given through a gastrostomy tube. An interview was conducted on 9/24/15 at 9:14 AM with the facility's Director of Nursing (DON). The 9/23/15 observation of medication administration to Resident #129 via his gastrostomy tube was discussed. During the interview, the DON stated she would have expected the nurse to separate the medications and give them individually via the gastrostomy tube. A telephone interview was conducted on 9/24/2015 at 11:16 AM with the facility's consultant pharmacist. During the interview, the 9/23/15 observation made of medication administration via a gastrostomy tube was discussed. The pharmacist stated that unless there was a physician's order indicating otherwise, medications needed to be given separately. She also reported the gastrostomy	F 332	The Director of Nurses or a designee, will perform G-tube medication pass audits on all three shifts to ensure continued compliance. Audits will be completed two times a week for four weeks, one time a week for four weeks and monthly for three months. The audits will be reviewed monthly at the facility's 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.	

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F 332	Continued From page 15 tube should be flushed with water in between the administration of each of the medications.	F 332		
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 observations, record review and staff interview, the facility failed to follow established procedures for the consistent and accurate documentation of the administration of controlled medications on the Medication Administration Records and Controlled Drug Records for 2 of 5 residents (Resident #74, and #92) reviewed for unnecessary medications. The findings included: 1) A review of the facility's policy, "Med Pass with Medication Cart" (Reviewed 5/19/15) included a section outlining "Procedures" which read, in part: 15. "Document administration on the medication	F 514	Residents #74 and #92's Controlled Drug Records and MARs have been reconciled and accurately document the controlled medications being removed from the medication card as well as administered to the residents. Nursing management completed a facility wide audit on October 5, 2015 of the Controlled Drug Records and the actual MARs of the residents receiving those controlled medications to ensure accuracy and consistency between the two documents. Licensed nurses were re-educated on the correct procedure for administering and documenting controlled medications on October 8, 2015 by the Director of Nurses. Each Controlled Drug Record is now reconciled with the resident's MAR during every shift to shift nursing report/narcotic count. The oncoming nurse must verify and initial in the	10/22/15

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F 514	Continued From page 16 sheet or in the computer, and update the Individual Control Drug Record for Schedule II drugs." Resident #74 re-entered the facility on 6/24/15 with a cumulative diagnoses which included chronic pain. Her admission orders included 5 milligrams (mg)/ 325 mg hydrocodone/acetaminophen (a combination opioid pain medication) to be given as one tablet by mouth every six hours as needed (PRN) for pain. Hydrocodone / acetaminophen is a controlled substance medication. On 9/23/15, a review of Resident #74's Controlled Drug Record (a declining inventory record) was completed. The resident's Controlled Drug Record revealed 67 doses of 5 mg / 325 mg hydrocodone / acetaminophen (a combination opioid pain medication) were removed from the medication cart between 9/1/15 and 9/23/15 (the date of the review). One tablet of hydrocodone/acetaminophen was documented as removed from the medication cart for Resident #74 on each of the following dates/times: 9/1/15 at 8:20 AM, 2:30 PM, and 9:11 PM; 9/2/15 at 8:47 AM, 2:37 PM, and 9:00 PM; 9/3/15 at 8:30 AM, 2:45 PM, and 9:00 PM; 9/4/15 at 8:11 AM, 2:30 PM, and 9:00 PM; 9/5/15 at 8:35 AM, 2:20 PM, and 9:00 PM; 9/6/15 at 7:25 AM, 1:30 PM, and 8:09 PM; 9/7/15 at 8:00 AM, 2:45 PM, and 9:00 PM; 9/8/15 at 8:10 AM, 2:25 PM, and 9:00 PM; 9/9/15 at 8:06 AM, 2:15 PM, and 9:00 PM; 9/10/15 at 8:30 AM, 2:40 PM, and 9:00 PM; 9/11/15 at 8:30 AM, 2:30 PM, and 8:30 PM; 9/12/15 at 9:30 AM, 3:30 PM, and 10:00 PM; 9/13/15 at 9:40 AM; 3:00 PM, and 8:52 PM; 9/14/15 at 8:00 AM, 2:23 PM, and 9:35 PM;	F 514	"checked by" box on that form that every controlled medication signed out on the Controlled Drug Record during the previous shift has also been documented in the resident's MAR. Any discrepancies are to be reported to the Director of Nurses immediately. Newly hired nurses will be educated on this procedure during their facility orientation. It will also be added to the Licensed Nurses Orientation Checklist and signed off by the Staff Development Coordinator when complete. The Director of Nurses or designee will audit the Controlled Drug Records and MARs of five residents to ensure accuracy and consistency between the two documents. Audits will be completed daily for two weeks, three times a week for two weeks, two times a week for two weeks, weekly for two weeks and monthly for three months. 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	

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F 514	Continued From page 17 9/15/15 at 7:54 AM, 2:00 PM, and 9:11 PM; 9/16/15 at 7:55 AM, 2:00 PM, and 9:00 PM; 9/17/15 at 8:15 AM, 2:30 PM, and 9:00 PM; 9/18/15 at 7:39 AM, 2:00 PM, and 9:05 PM; 9/19/15 at 7:44 AM, 2:00 PM, and 9:00 PM; 9/20/15 at 7:17 AM, 1:45 PM, and 9:00 PM; 9/21/15 at 7:30 AM, 2:00 PM, and 8:20 PM; 9/22/15 at 8:00 AM, 2:30 PM, and 8:55 PM; and, 9/23/15 at 8:13 AM. Comparison of the resident ' s Controlled Drug Record with the September 2015 Medication Administration Record (MAR) revealed 15 of the 67 hydrocodone/acetaminophen tablets removed from the medication cart during the month were not noted on the MAR as having been administered to the resident. There was no documentation on the MAR to indicate hydrocodone/acetaminophen was administered to Resident #74 on the following dates/times: 9/1/15 at 2:30 PM; 9/3/15 at 8:30 AM and 2:45 PM; 9/4/15 at 2:30 PM; 9/7/15 at 8:00 AM and 2:45 PM; 9/8/15 at 2:25 PM; 9/10/15 at 9:00 PM; 9/13/15 at 3:00 PM; 9/17/15 at 8:15 AM; 9/19/15 at 9:00 PM; 9/20/15 at 1:45 PM, and 9:00 PM; 9/21/15 at 7:30 AM; and, 9/22/15 at 2:30 PM. An interview was conducted on 9/23/2015 at 2:55 PM with Nurse #1 and a follow-up interview was conducted with the nurse on 9/23/15 at 4:10 PM. Based on the Controlled Drug Record review, Nurse #1 was identified to have pulled Resident #74 ' s hydrocodone/acetaminophen from the	F 514	compliance and determine the need for ongoing audits beyond three months.	

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F 514	Continued From page 18 medication cart without documenting its administration to the resident (on the MAR) on following dates/times: 9/3/15 at 8:32 AM; 9/3/15 at 2:45 PM; 9/7/15 at 8:00 AM; 9/7/15 at 2:45 PM; 9/8/15 at 2:25 PM; 9/17/15 at 8:15 AM; and, 9/21/15 at 7:30 AM. Upon request, the nurse discussed the process employed for the administration / documentation of a PRN (as needed) controlled substance medication to a resident. Nurse #1 stated a resident would be assessed, the physician orders and dates/times of prior receipt of the medication(s) would be reviewed. The nurse indicated if deemed appropriate, the medication would be pulled from the medication cart, given to the resident, and then documented on both the Controlled Drug Record and the MAR after it had been administered. During the interview, the nurse verified her signature on the Controlled Drug Record. Nurse #1 reported she specifically recalled giving the hydrocodone / acetaminophen to Resident #74 twice on 9/21/15, but stated she may have forgotten to include documentation on the MAR. An interview was conducted on 9/23/2015 at 3:36 PM with the facility ' s Director of Nursing (DON). Upon review of Resident #74 ' s Controlled Drug/Record and MAR, the DON acknowledged there were inconsistencies between the two records. Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the resident ' s Controlled Drug Record and the MAR. The DON identified the nurses who pulled / administered the resident ' s medication on the dates/times in question by his/her	F 514		

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F 514	Continued From page 19 signature on the Controlled Drug Record. During the interview, the DON stated the Controlled Drug Record only documented the medication was pulled out of the med cart. She reported the nurse also needed to document on the MAR that the medication had been administered to the resident. The DON indicated her expectation was for both the Controlled Drug Record and the MAR to reflect the withdrawal of the medication from the med cart and the administration of this medication to the resident. When asked, the DON acknowledged she would expect documentation on the two records to be consistent with one another. An interview was conducted on 9/23/2015 at 4:05 PM with Nurse #2. Nurse #2 was identified to have pulled Resident #74 ' s hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on following dates/times: 9/1/15 at 2:30 PM; 9/10/15 at 9:00 PM; and, 9/20/15 at 1:45 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #2 stated she would assess a resident, check both the MAR and Controlled Substance Records for the dates/times the resident last received the medication, administer the medication, and then document the med administration on both the resident ' s MAR and the Controlled Substance Record. Nurse #2 stated she was, " supposed to always document in both places. " During the interview, the nurse verified her signature on the Controlled Drug Record for the dates/times in question. A telephone interview was conducted on	F 514		

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F 514	Continued From page 20 9/24/2015 at 10:39 AM with Nurse #4. Nurse #4 was identified to have pulled Resident #74 's hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on 9/13/15 at 3:00 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #4 stated the procedure was to document on the Controlled Drug Record when a medication was pulled, to give the medication, then document its administration on the resident ' s MAR. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse reported it probably occurred at a time when she got distracted after coming out of the resident ' s room. Nurse #4 indicated she would expect both the medication withdrawal from the cart and its administration to be documented on the Controlled Drug Record and the MAR. A telephone interview was conducted on 9/24/2015 at 10:45 AM with Nurse #5. Nurse #5 was identified to have pulled Resident #74 's hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on the following medication dates/times: 9/19/15 at 9:00 PM; and, 9/20/15 at 9:00 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #5 indicated the procedure included documenting on the Controlled Drug Record and MAR after a PRN controlled substance medication was given to a resident. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse stated she did not recall the	F 514		

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F 514	Continued From page 21 specific instances in question. However, Nurse #5 reported sometimes the computer "goes down or messes up" and sometimes she may get distracted or called away. Regardless, Nurse #5 indicated she would expect documentation of the controlled substance medication given to be included on both the declining inventory log and the MAR. A telephone interview was conducted on 9/24/2015 at 10:55 AM with Nurse #3. Nurse #3 was identified to have pulled Resident #74 ' s hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on 9/22/15 at 2:30 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #3 reported once a controlled substance medication was pulled for a resident she would sign it out on the book (the Controlled Drug Record), give the medication, and then record its administration on the MAR. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse indicated such a discrepancy would occur if the medication was signed out but the nurse didn't " click on it " to record the entry in the electronic MAR system. Nurse #6 was not available for an interview during the survey investigation. Nurse #6 was identified as the nurse who pulled Resident #74 ' s hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on 9/4/15 at 2:30 PM; A telephone interview was conducted on 9/24/15 at 11:16 AM with the facility ' s Consultant	F 514		

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

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F 514	Continued From page 22 Pharmacist in regards to the documentation required when a controlled substance medication was pulled from the medication cart and administered to a resident. Upon inquiry, the pharmacist stated her expectation was, " as soon as they (the nurse) punch that med out of the card (it) needs to be documented on the declining inventory log. " The pharmacist also indicated the nurse would be expected to document on the resident ' s MAR after the medication was administered to the resident, indicating the date/time the medication was given. 2) A review of the facility ' s policy, " Med Pass with Medication Cart " (reviewed 5/19/15) included a section outlining " Procedures " which read, in part: 15. " Document administration on the medication sheet or in the computer, and update the Individual Control Drug Record for Schedule II drugs. " Resident #92 was admitted to the facility on 5/8/15 with a cumulative diagnoses which included episodes of anxiety. His admission orders included 0.5 milligrams (mg) lorazepam (an antianxiety medication) given as one tablet by mouth every 4 hours as needed (PRN) for anxiety. On 9/23/15, a review of Resident #92 ' s Controlled Drug Record (a declining inventory record) from July, August and September 2015 was completed. The resident ' s Controlled Drug Record revealed 7 tablets of 0.5 mg lorazepam were removed from the medication cart between 7/1/15 and 9/23/15 (the date of the review). One tablet of lorazepam was documented as removed from the medication cart for Resident #92 on	F 514		

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F 514	Continued From page 23 each of the following dates/times: 7/4/15 at 10:00 PM; 7/10/15 at 8:00 PM; 7/18/15 at 10:00 PM; 7/19/15 at 10:00 PM; 8/28/15 at 8:20 AM; 9/9/15 at 8:35 AM; and, 9/19/15 at 7:11 PM. Comparison of the resident ' s Controlled Drug Record with the July, August, and September 2015 Medication Administration Records (MARs) revealed 1 of the 7 lorazepam tablets removed from the medication cart during the past 3 months was not noted as having been administered to the resident. There was no documentation on the MAR to indicate lorazepam was administered to Resident #92 on 7/19/15 at 10:00 PM. An interview was conducted on 9/23/2015 at 3:36 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the resident ' s Controlled Drug Record and the MAR. The DON assisted with the identification of staff nurses ' signatures on the Controlled Drug Record. During the interview, the DON stated the Controlled Drug Record only documented the medication was pulled out of the med cart. She reported the nurse also needed to document on the MAR that the medication had been administered to the resident. The DON indicated her expectation was for both the Controlled Drug Record and the MAR to reflect the withdrawal of the medication from the med cart and the administration of this medication to the resident. When asked, the DON acknowledged she would	F 514		

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F 514	Continued From page 24 expect documentation on the two records to be consistent with one another. A telephone interview was conducted on 9/24/2015 at 10:55 AM with Nurse #3. Nurse #3 was identified to have pulled Resident #92 ' s lorazepam from the medication cart without documenting its administration to the resident (on the MAR) on 7/19/15 at 10:00 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #3 reported once a controlled substance medication was pulled for a resident she would sign it out on the book (the Controlled Drug Record), give the medication, and then record its administration on the MAR. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse indicated such a discrepancy would occur if the medication was signed out but the nurse didn't " click on it " to record the entry in the electronic MAR system. A telephone interview was conducted on 9/24/15 at 11:16 AM with the facility ' s Consultant Pharmacist in regards to the documentation required when a controlled substance medication was pulled from the medication cart and administered to a resident. Upon inquiry, the pharmacist stated her expectation was, " as soon as they (the nurse) punch that med out of the card (it) needs to be documented on the declining inventory log. " The pharmacist also indicated the nurse would be expected to document on the resident ' s MAR after the medication was administered to the resident, indicating the date/time the medication was given.	F 514		
F 520	483.75(o)(1) QAA	F 520		10/22/15

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F 520 SS=D	Continued From page 25 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put in to March 2015. This was for one recited deficiency which was originally cited in February of 2015 during a complaint survey and on the current recertification survey. The deficiency was in the area of maintain dignity for	F 520	F 520 – QA&A 1) Resident concerns regarding the timeliness of staff answering call lights were addressed individually with Resident #1, Resident #55 and Resident #53 on October 14, 2015 by the Director of Nurses. The Director of Nurses shared the facility's plan of action to ensure that call lights are answered in a timely manner with these residents on October 14, 2015. 2) All residents in the facility have a Department Manager assigned as their "Guardian Angel." Residents are asked during the week day Guardian Angel rounds if their needs are being met and if the call lights are answered in a timely manner. Resident care and call light concerns are immediately addressed and documented as a grievance to ensure appropriate follow up.	10/22/15

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F 520	Continued From page 26 residents. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 241: Dignity And Respect of Individuality: Based on record reviews, interviews with resident and staff, the facility failed to answer resident call bells for residents needing assistance, to maintain dignity for 3 of 4 residents (Resident # 1, Resident #53 and Resident #55) reviewed for dignity The facility was recited for F241 when it failed to develop and implement procedures and monitor interventions to maintain residents' dignity as it relates to answering call bells and providing assistance for independent resident. F 241 was originally cited during the February 2015 complaint survey for failed to maintain residents' dignity. During an interview with the Director of Nursing on 9/24/2015 at 3pm regarding the facility's quality assessment and assurance system. The DON indicated that the committee members consisted of the Administrator, all department heads, the pharmacist and medical director. The DON indicated that they had met monthly. The DON revealed that the department heads were responsible for the implementation and the monitoring of the action plan for that department with any concerns and/or issues in that area. When asked about call bells not being answered?	F 520	3. The Administrator will review all past facility deficiencies for past 5 years with the appropriate department manager. The facility team will review current policy and procedures to assure all policy and procedures are in action to prevent further deficient practice. 4. The Administrator will report findings from #3 above to the facility QA committee monthly for 3 months. The report will include plans that are in place to assure implemented policy and procedures are working to prevent a repeat deficiency. The committee will be involved with assessing presented plan and present recommendations and changes as necessary.	

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F 520	Continued From page 27 The DON stated " we still have a problem with call bells not being answered. "	F 520	call light 4) Call light response times will be monitored by utilizing a call light audit. The audit form will be completed by the Director of Nurses or designee to ensure call lights are being answered in a timely manner. The audits will be randomly performed during all three shifts and at different times during the shifts. The audit will be completed daily for 4 weeks, weekly for 8 weeks and then monthly for 3 months. Any concerns identified when completing the audit will be addressed immediately. The call light audit results will be reviewed monthly for a minimum of six (6) months in the facility's QA meeting. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance and determine the need for further audits beyond six (6) months.	