STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(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 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 observation, staff interview and record review, the facility failed to maintain a medication administration error rate of less than 5% as evidenced by 4 medication errors out of 26 opportunities for 3 of 5 residents (resident #9, resident #70 and resident #151) resulting in an error rate of 15.38%. The problems included the medication dosage was not correct, the medication was administered at the wrong time and the medication was not given with food as ordered. The findings included: 1. During a medication administration observation on 1/21/2016 at 8:48 AM, nurse #1 removed medications for resident #9 from pre-packaged cards and placed medications in a dispensing cup. Included in the cup was Finasteride 5 milligrams (mg). Nurse #1 entered the resident ' s room and administered the medications to resident #9. The resident took the medications by mouth. Record review indicated a physician order on 12/24/2015 for Finasteride 1mg by mouth (PO) in the morning related to enlarged prostate without lower urinary tract symptoms. The order also indicated resident received 1 mg in the morning and had a separate order for 5mg at bedtime. Nurse #1 was interviewed on 1/21/2016 at 9:00 AM and stated she was unaware of the order for Finasteride 1mg because the electronic medication administration record (EMAR)	F 332	F332 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #9, #70 and #151. The medical provider for each resident was notified of the medication variance for resident #9, #70, and # 151 on 1/21/16. Resident #151 was administered second tablet on 1/21/16. 2. All residents receiving medication in the facility have the potential to be effected by the alleged deficient practice. Nurse #1 received education on medication management on 1/26/16. Nurse #2 is no longer employed by the facility. 3. The licensed nurse staff were re-educated started on 2/9/16 regarding standard practices associated to medication management to include how to prevent medication errors. Newly hired licensed nurses will receive the education during orientation. Any licensed nurse that did not receive the re- education will be scheduled to receive prior to working next shift. 4. The Medication Pass Worksheet will	2/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2016

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F 332	Continued From page 1 specified Finasteride 1 tab (5mg). Review of the EMAR record revealed an order for Finasteride 1 tab (5mg) po every morning. The facility Director of Nursing (DON) indicated in an interview on 1/21/2016 at 9:05 AM it was her expectation for medications to be administered per physician orders. 2. During a medication administration observation on 1/21/2016 at 11:23 AM, nurse #2 removed medications for resident #70 from pre-packaged cards and placed medications in a dispensing cup. Included in the cup were Carvedilol 6.25mg and Isosorbide Dinitrate 40mg. Nurse #2 entered the resident ' s room and administered the medications to resident #70. Resident #70 took the medications by mouth with a cup of water. Nurse #2 did not offer the resident any food when he gave her the medications. Lunch had not been served prior to resident #70 ' s medication administration, lunch trays were served at 12:40 PM. Record review indicated a physician order on 3/1/2015 for Cardvedilol 6.25mg two times a day for hypertension (high blood pressure) with food. Record review further indicated a physician order on 3/1/2015 for Isosorbide Dinitrate 40mg every 12 hours for the prevention of angina attacks (chest pain, discomfort or tightness). The scheduled times for administration were 8:00 AM and 8:00 PM. Nurse #2 was interviewed on 1/21/2015 at 11:45 AM and reported he had not noticed the order for Cardvedilol indicated to be given with food. Nurse #2 also reported he noticed the time for Isosorbide to be administered was 8:00 AM when he administered the medication to resident #70. The DON stated in an interview on 1/21/2016 at 11:55 AM her expectation for medication administration was medications to be	F 332	be used to observe 50% of license nurse staff passing medications times 1 week; then 10% of license nursing staff on a weekly basis for 4 weeks; then random observations monthly for 2 months . Observation concerns will be forwarded to the QAPI team monthly x3 months then as needed for review and changes in performance improvement as indicated.	

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F 332	Continued From page 2 administered per the physician orders. The DON also indicated her expectation was the nursing staff administer the correct dosage, at the correct time, and any specific medication instructions to be followed. 3. During a medication administration observation on 1/21/2016 at 11:34 AM, nurse #2 removed medications from pre-packaged cards and facility stock medication bottles and placed medications in a dispensing cup. Included in the cup was Cholecalciferol 1000 unit tablet. Nurse #2 entered the resident ' s room and administered the medications to resident #151. Resident #151 took the medications by mouth. Record review indicated a physician order on 5/14/2015 for Cholecalciferol 1000 units, give 2 tablets by mouth daily. Nurse #2 was interviewed on 1/21/2016 at 11:45 AM and stated he was unaware the Cholecalciferol order indicated resident #151 was to receive two tablets. The DON stated in an interview on 1/21/2016 at 11:55 AM her expectation for medication administration was medications to be administered per the physician orders. The DON also indicated her expectation was the nursing staff administer the correct dosage, at the correct time, and any specific medication instructions to be followed.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		2/16/16

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F 431	Continued From page 3 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard an expired medication in one of six medication carts observed. Findings included: On 1/22/2016 at 2:55 PM, the medication carts and medication rooms were observed. A medication cart serving 300 hall had iron supplement expired on 8/2015. On 1/22/2016 at 3:33 PM, in an interview with the	F 431	F431 1. Corrective action has been accomplished for the alleged deficient practice in regard to an expired medication in one of six medication carts observed. The six medication carts were audited for expired medications on 1/25/16.	

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F 431	Continued From page 4 Director of Nursing (DON), stated the nurses were responsible to check their medication cart daily for expired medications, and the unit managers were also responsible for checking medication carts for expired medications. The DON further stated her expectation was no expired medications on the medication carts. On 1/22/2016 at 4:40 PM, in an interview with the Assistance Director of Nursing (ADON), stated night shift nurses were responsible for checking their medication carts for expired medications daily, and unit managers were responsible for checking them monthly.	F 431	2. All residents that receive medications have the potential to be effected by the alleged deficient practice. 3. The license nursing staff began re-education 2/9/16. on medication management to include the necessity to remove expired medication before expiration. Newly hired licensed nurses will receive the education during orientation. Any licensed nurse that did not receive the re- education will be scheduled to receive prior to working their next shift. 4. The DON , Unit Managers, pharmacy technician , or nurse manager will audit each medication cart weekly times four, using the Expired Medication Audit Tool to check for expired medications, then monthly thereafter by Unit Manager or nurse manager with results forwarded to DON. All audit results will be forwarded to the QAPI for review and changes in performance improvement as indicated.	