STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff, pharmacy, and physician interviews, the facility failed to monitor the side effects and behavior of a resident on scheduled Trazadone (antidepressant) and [MEDICATION NAME] (antianxiety) for 1 of 1 sampled resident, reviewed for [MEDICAL CONDITION] medications (Resident # 5). Findings included: Resident #5 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Documentation on the quarterly minimum data set assessment dated [DATE] revealed Resident #5 was severely cognitively impaired with no moods or behaviors in the assessment period. Documentation on the care plan, dated as last reviewed on 7/7/20, revealed a focus area for resident #5 for a behavior problem relative to yelling out loudly continuously without the ability to explain why. Interventions included monitoring/documenting side effects and effectiveness, intervening as necessary to protect the rights and safety of others, and documentation of behavior and potential causes. Documentation on the same care plan had a focus area for the resident's use of antianxiety medication relative to behavior management due to an anxiety disorder and yelling out. Interventions were to give the medication as ordered, monitor for side effects of the medication, and report to the medical doctor. Documentation on the care plan had an additional focus area for antidepressant medication relative to depression. Interventions included to give the medication as ordered, monitor/document side effects and effectiveness every shift. Documentation in the physician orders [REDACTED].#5 received the [MEDICATION NAME] 1 mg as ordered. Documentation in the physician orders [REDACTED]. Review of the MAR for March 2020 to July 30, 2020 revealed Resident #5 received the Trazadone 50 mg as ordered starting on 3/30/20. Documentation in the physician orders [REDACTED].#5 on 4/7/20. Documentation in a nurse practitioner note dated 4/8/20 revealed Resident #5 was seen for yelling out. The 4/8/20 nurse practitioner note added an order for [REDACTED].#5 received the Trazadone 25 mg as ordered starting on 4/14/20. Documentation in the nursing progress notes from January 2020 to July 30, 2020 did not reveal any behaviors or monitoring of behaviors. Documentation in physician progress notes [REDACTED]. The medication administration records from March 2020 to July 30, 2020 did not reveal any monitoring of behaviors or the side effects of [MEDICATION NAME] or Trazadone. An observation was made of Resident #5 on 7/29/20 at 9:58 AM. Resident #5 was reclining in bed hollering and yelling at a level that could be heard five doors down from her room. A nurse aide was observed to pass the room of Resident #5 but did not enter the room. An observation was made of Resident #5 on 7/29/20 from 3:55 PM to 4:55 PM. Resident #5 was reclining in bed very tearful calling out Ma Ma repeatedly at a level that could be heard five doors down from her room. Multiple staff members were observed to pass the room of Resident #5 but did not enter the room. An interview was conducted with the Director of Nursing (DON) on 7/30/20 at 8:50 AM. The DON stated that Resident #5 would holler and yell sporadically and that if it became a problem the nurses would slip notes under her door to let her know. The DON stated that nurses do monitor Resident #5 for her behaviors but that there was no specific order for them to do so. The DON revealed that the electronic medical record had a template for behavior monitoring but that it had not been used for Resident #5. The DON indicated that sometimes Resident #5 could be consoled and sometimes not. The DON acknowledged that there was no written documentation of the monitoring of the behavior of Resident #5 for the effectiveness of interventions or medications. An observation was made of Resident #5 on 7/30/20 at 9:23 AM. Resident #5 was reclining in bed tearfully crying and yelling. Resident #5 stated, I want my child to read and write. Can you teach her? I want her to be a good child. Resident #5 stopped crying after expressing her desire to the surveyor. An interview was conducted with Nurse #1 on 7/30/20 at 9:36 AM. Nurse #1 revealed that sometimes Resident #5 would calm down when she was hollering but sometimes not. Nurse #1 indicated that Resident #5 could be confused at times and other times had the ability to hold a conversation. Nurse #1 also indicated that there was a place in the electronic medical record to document a change or an increase in behaviors for residents. Nurse #1 stated that she was not assigned to care for Resident #5 very often and that there was no set nurse who cared for Resident #5 on a regular basis. An interview was conducted with NA (nurse aide) #3 on 7/30/20 at 10:53 AM. NA #3 stated she was familiar with Resident #5 and was usually assigned to the area where Resident #5 resided. NA #3 indicated that sometimes she was able to get Resident #5 to stop hollering if she attended to her immediate care needs, but that it depended on what kind of day the resident was having and if Resident #5 had her medications. NA #3 stated that if other residents were complaining about Resident #5 hollering, she would ask the nurse to see if anything could be done to help. An interview was conducted with the physician for Resident #5 on 7/30/20 at 12:10 PM. The physician stated that the nurse practitioner who initiated an order for [REDACTED].#5 and he was not made aware of any concerns recently. An interview was conducted with the pharmacy consultant for facility on 7/30/20 at 12:21 PM. The pharmacist stated that she expected the facility to monitor the behaviors and side effects of the medications for behaviors. The pharmacist stated that she looked for this monitoring and documentation in the progress notes and on the MAR. The pharmacist stated that it was unusual to give Trazadone in the morning but that she would expect for the nursing staff to document in the notes if they saw excessive drowsiness due to the medication Trazadone.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.