	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDI	NG		с	
		345537	B. WING			1	0/01/2015
NAME OF P	ROVIDER OR SUPPLIER	•	1				
				23	305 SILVER STREAM LANE		
SILVER S		REHABILITATION CENTER		W	VILMINGTON, NC 28401		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY		F	241			10/26/15
	The feeility much are	weeks some for residents in s					
		mote care for residents in a nvironment that maintains or					
		dent's dignity and respect in					
	full recognition of his						
	5	2					
	This REQUIREMEN	T is not met as evidenced					
		view and resident and staff			F241 Dignity and Respect of Individua	lity	
	interviews the facility	/ failed to treat residents with			For those individual residents, Residen	, Residents based on	
	dignity for six of twe	nty nine alert and oriented			#6, #9, #5, #8, #11, and #10, based on		
		#6, #9, #5, #8, #11 and #10)			resident interview a concern form has		
		call bells and not providing			been generated for each individual. Each	ch	
		ving (ADL) care. The list of			resident continues to reside at facility.		
	facility.	sidents was provided by the			Passuas all residents have the potentic	al to	
	The findings include	d:			Because all residents have the potentia be affected by the cited deficiency, a		
		d:			resident representative interviewed all		
	1. Resident #6 was a	admitted to the facility on			alert and oriented residents for any digi	nitv	
		ses of stroke and hemiplegia			issues or concerns they might have.	,	
	affecting right side.	The recent significant and					
		mum Data Set (MDS)			Based on individual resident concerns,		
		/11/15 indicated Resident #6			staff education is being provided by an		
		ct. The quarterly MDS dated			administrative nurse regarding caring for		
		esident #6 had adequate ys incontinent for bowel and			residents in a manner and environment that would maintain or enhance each	[
		v with Resident #6 on 9/30/15			resident¿s dignity and respect with reg	ard	
		d she was recording the date			to call light response and assistance wi		
		ne had to wait before staff			ADL¿s.		
	-	ell. On 9/16/15, Resident #6					
		ours, on 9/20/15, Resident #6			Measures to ensure the deficient practi	се	
		nd half hours, on 9/23/15,			will not occur include a resident intervie		
		wait for two hours. Resident			monitoring tool to ask alert and oriented	b	
		sometimes the Nurse Aid			residents how they feel they are being		
		om, turned off the call bell			treated, if they feel they are getting the		
	-	be right back but did not ours. Resident #6 indicated			assistance needed with ADL¿s and if th feel their call light is being answered	iey	
	OTHE DACK IOI (WO II				issi their san light is being allowered		

Electronically Signed

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.

10/24/2015

TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE S COMPL	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING		CONTE	
		345537	B. WING			1/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER S	TREAM HEALTH AND RE	EHABILITATION CENTER		2305 SILVER STREAM LANE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 241	Continued From page	e 1	F 24	1		
	sometimes the nurse did not clean or wipe she had appointment accident in her brief, and it was 25 minutes Resident #6 stated " dirty and filthy to sit in 2. Resident #9 was a 1/21/15, with diagnos overactive bladder ar dysfunction of bladde quarterly MDS asses indicated Resident #8 adequate vision. Res assistance for toiletin person. The MDS fur always being incontir urinary catheter. An in 9/30/15 at 9:45 AM re wait for almost seven from bowel movemer 9/28/15, she had to w staff came to clean he staff would turn off re that they would come return for hours. On the Resident #9 further in PM, she told an NA s but the NA did not co NA after 11:00 PM ch Resident #9 asked to same morning and N she would be back, b then. Resident #9 staff	aids put a new brief on and her off. Resident #6 stated on 9/23/15 and she had an she reported to her nurse is before an NA cleaned her. It makes me feel bad, it is in it until they come." dmitted to the facility on uses of hypertension, and neuromuscular rr. Review of Resident #9 's sment dated 7/31/15 9 was cognitively intact with ident #9 required extensive g with the use of one staff ther coded Resident #9 as nent of bowel and had a nterview with Resident #9 on evealed last week she had to hours to be cleaned up at after using call bell. On vait for four hours before er up. Resident #9 indicated sident's call bell, then tell her back and they would not		 timely. Additional measures include call b observations at various times acro three shift by a resident representation monitor timely call light response. Corrective actions will be monitored resident interview monitoring tool faffected individuals 3 times per we four weeks then weekly for four weeks then monthly for 3 months. Resident interview monitoring tool random alert and oriented resident times per week for four weeks then monthly months. Call light response audits will be conducted 3 times per week for 4 weeks then monthly for 4 weeks then monthly months. Call light response audits will be conducted 3 times per week for 4 weeks then months and then weekly for four weeks then months and a sneeded. 	ss all ative to ed by for eek for eeks for ts 3 n y for 3 weeks thly for will be & y s,	

Facility ID: 970977

If continuation sheet Page 2 of 19

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/28/2015 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		345537	B. WING			/01/2015
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD		
SILVER S	TREAM HEALTH AND RE	EHABILITATION CENTER		2305 SILVER STREAM LANE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241	 8/26/15 with diagnose and pain. A review of record revealed a 30 9/23/15 which indicate cognitively intact and Resident #5 was code ADLs with the use of further coded Resider incontinent of bladder bowel. Resident #5 's room v 10: 15 AM, call bell w and staff entered the she would send the N resident ' s room, stat nurse and the NA carr room and NA stated s gloves. The NA came An interview with Res AM revealed she had AM. Resident #5 state come by the room an stated they would retur back and she had to v hours. Resident #5 state come by the room an stated they would retur back and she had to v hours. Resident #5 state come by the room an stated they would retur back and she had to v hours. Resident #5 state come by the room an stated they would returback and she had to v hours. Resident #8 was a 3/22/15 with diagnose and neuromuscular d review of Resident #8 assessment dated 8/2 was cognitively intact Resident #8 required 	dmitted to the facility on es of heart failure, diabetes Resident #5's medical day MDS assessment dated ed Resident #5 was had adequate vision. ed extensive assistance with two persons. The MDS nt #5 as being occasionally r and always incontinent of was observed on 9/30/15 at as flashing over the door, resident 's room and stated IA. A nurse entered the ted he would send the NA. A me back to the resident 's she would be back with e back and helped resident. sident #5 on 9/30/15 at 10:15 the call bell on since 9:30 ed the nursing staff would d turn off the call light and urn and they did not come wait for one and half to two stated " I felt bad when I	F 24			

Facility ID: 970977

If continuation sheet Page 3 of 19

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/28/2015 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345537	B. WING				C 01/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		2	305 SILVER STREAM LANE		
SILVER S		ENABILITATION CENTER		V	WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 241	incontinent of bladder with Resident #8 on 9 NA's would come by 1 light and tell her they come back and Resid for any ADLs. On 10, #8 further stated, " It really annoying." 5. Resident #11 was facility on 3/28/14 with anemia, and heart fai #11 's quarterly MDS indicated Resident #1 had adequate vision. extensive assistance person. The MDS furth being frequently incon always incontinent wi Resident #11 on 9/30 he had to wait for 30 aid to come and help bell. Resident stated wait all that time. " 6. Resident #10 was 7/6/12, with diagnose hyperlipidemia. Revie MDS assessment dat Resident #10 was con adequate vision. Res assistance for toiletin MDS further coded R occasionally incontine with Resident #10 on	esident #8 as always being r and bowel. An interview 0/30/15 at 9:30 AM, revealed the room and turn off the call would return but they did not dent #8 had to wait for hours /1/15 at 12:10 PM Resident feels like no one cares, it is originally admitted to the h diagnoses of hypertension, lure. Review of Resident assessment dated 8/20/15 11 was cognitively intact and Resident #11 required for toileting with one staff ther coded Resident #11 as ntinent of bladder and th bowel. An interview with /15 at 10:30 AM, revealed minutes or more for a nurse him after he used the call " I do not like that I have to admitted to the facility on as of hypertension, and ew of Resident #10 's annual ted 7/2/15 indicated gnitively intact and had ident #10 required extensive g with one staff person. The esident #10 as being ent of bladder. An interview 9/30/15 at 2:50 PM I bell response time would	F	241			

Facility ID: 970977

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345537	B. WING				C 01/2015
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER S	REAM HEALTH AND RE	HABILITATION CENTER			2305 SILVER STREAM LANE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	11:00 PM shift. Resid cares, they need more On 9/30/15 at 11:36 A stated, she typically here to the hall but four NA better. NA #1 further sincontinent care with with residents who has appointments and need Interview with NA #2 of stated on her hall they NAs were assigned to help for the resident's At 11:28 AM on 10/1/ stated the facility need NA for the hall would care done, and resided were neglected. At 11:33 AM on 10/1/ stated the residents were needed more help, so would give more relied In an interview on 10/ Administrator revealed bell response time sh hours, and her expect the resident's call light actually provide the a NAs to work together.	 a long time during 3:00 - ent #10 stated "No one e staff and help." AM, in an interview NA #1 had 13-14 assigned re were three NAs assigned as for that hall would be stated she could get to her the residents but had trouble ad to go for dialysis or other eded to get cleaned up. on 9/30/15 at 11:45 AM, y had 47 residents and three o the hall but needed more is care. 15, in an interview, NA #3 ded more staff, one more be better to get resident 's ents would not feel like they 15, in an interview, NA #4 vere more dependent and o one more NA on the hall f. '1/15 at 1:00 PM, the d her expectation for call ould not be 30 minutes or tation was for NAs to leave 	F	241			
F 280	483.20(d)(3), 483.10(F	280			10/26/15

Facility ID: 970977

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 10/28/2015 1 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION		(X3) DATE	
		345537	B. WING			(10/	C 01/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
		HABILITATION CENTER		2305 SILVER STREAM LANE			
SILVER S		HABILITATION CENTER		WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
F 280 SS=D	PARTICIPATE PLANN The resident has the incompetent or otherwincapacitated under th participate in planning changes in care and th A comprehensive care within 7 days after the comprehensive assess interdisciplinary team physician, a registere for the resident, and of disciplines as determinand, to the extent pra the resident, the resid- legal representative; a	NING CARE-REVISE CP right, unless adjudged vise found to be ne laws of the State, to g care and treatment or reatment. e plan must be developed	F	280			
	by: Based on observation interviews, the facility for one of seventeen plans (Resident #1). Resident #1 was adm of stroke with some p diabetes and depress The quarterly Minimu 7/14/15 noted Reside impaired and needed	m Data Set (MDS) dated		F280 Right to Participate Plar Care-Revise CP For individual resident #1 the o has been reviewed and update his current level of assistance with meals. Because all residents have the be affected by the cited praction residents care plans have bee and updated as needed for cu of assistance needed for meal Measures to ensure communi- resident changes needing to b	care plan ed to refle needed e potentia ce, all en reviewe rrent leve ls. cation of	l to ed I	

Facility ID: 970977

	S FOR MEDICARE &					<u>38-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURV COMPLETE	
					с	
		345537	B. WING		10/01/2	015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SILVER ST	REAM HEALTH AND RI	EHABILITATION CENTER		2305 SILVER STREAM LANE		
				WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH(CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) /PLETIO DATE
F 280	Continued From page	e 6	F 28	0		
	assistance means the	e resident is highly involved		on resident care plan to the MDS		
	in the activity and the	e staff is providing guidance.		department will be review of the 2		
	A list of residents wh	o needed feeding assistance		report sheets and any new orders member of the MDS department		
		vealed Resident #1 was on		addition to IDT morning meeting		
	this list.			discussion.		
	The error plan dated	2/24/4E poted a factor of an		Corrective measures will be mon		
	Activities of Daily Livi	3/31/15 noted a focus of an ing (ADL) self-care		through audits performed by the l supervisor weekly for 4 weeks the		
		The goal was that Resident		2 weeks for 4 weeks then monthl		
		e current level of functioning		months. The monitoring results v		
	-	ew date. The interventions ere the resident is able to		brought to the Quality Assurance Performance Improvement month		
	feed self with set up.			meeting for further review, analyst corrective action and recommend	is,	
		erved being fed by staff on nd again on 10/1/15 at 8:30		as needed.		
		AM in an interview, the MDS				
		esident #1 was feeding				
		hen the MDS was updated. by the Nurse Assistant (NA)				
	was reviewed for July	and noted Resident #1 was				
	feeding himself. The					
		Resident #1 was being fed. r said " we missed that, we				
	need to look at him a					
	On 10/1/15 at 12:50 l	PM in an interview, the				
		he expectation was the care				
E 240		ted in a timely manner.	F 31	2	10/0	26/15
	483.25(a)(3) ADL CA DEPENDENT RESID		F 31	Z	10/2	0/15
		able to carry out activities of				
	daily living receives the maintain good nutrition	he necessary services to				

Facility ID: 970977

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/28/2 FORM APPRO OMB NO. 0938-0		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345537	B. WING		10/01/2015		
NAME OF PI	ROVIDER OR SUPPLIER	•	- - [STREET ADDRESS, CITY, STATE, ZIP CODE	· ·		
				2305 SILVER STREAM LANE			
SILVER S	FREAM HEALTH AND RE	EHABILITATION CENTER		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET		
F 312	Continued From page and oral hygiene.	e 7	F 31	2			
	by: Based on observation interviews and record provide incontinent ca twenty nine residents extensive to total ass Living (ADL) care (Ref Findings included: 1. Resident #6 was a diagnoses of stroke a right side. The quarter (MDS) dated 7/21/15 always incontinent for MDS noted Resident The change of therap noted the resident to needed extensive ass physical assistance of On 9/30/2015 at 10:4 whether she was just movement, she had to change her. Resident wait times in her phon she had to wait for gr changed by staff on 0 09/23/2015. Resident 9/24/2015 the call be (NA) came into the ro and said " I'l II be bar hours. Resident #6 s	A review, the facility failed to are or toileting for six of interviewed that needed istance for Activities of Daily esidents #5,6,7,8,9,10). dmitted 4/14/2015 with and hemiplegia affecting the erly Minimum Data Set noted Resident #6 to be r bowel and bladder. The #6 had adequate vision. by MDS dated 8/11/2015 be intact for cognition and sistance for all ADLs with the of one person for toileting 0 AM, Resident #6 stated		F312 ADL Care Provided For Der Residents For those individual residents, Residents#5, #6, #7, #8, #9, and concern form has been generated each individual based on resident interview. Each resident continue reside at the facility. Because all residents have the po be affected by the cited deficiency resident representative interviewe alert and oriented residents for an toileting issues or concerns they thave. Based on individual resident cond staff education is being provided administrative nurse regarding ca residents who is unable to carry of activities of daily living receives the necessary services to maintain po hygiene with regard to call light re- and assistance with ADL2s. Measures to ensure the deficient will not occur include a resident in monitoring tool to ask alert and our residents how they feel they are be treated, if they feel they are gettin assistance needed with ADL2s and feel their call light is being answe timely. Call bell observations across all t shifts at various times by a resider representative to monitor timely of	#10, a d for t es to btential to y, a ed all ny might cerns, by an uring for but ne ersonal esponse practice nterview riented being ng the nd if they red		

Facility ID: 970977

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B) ´c	OMPLETED
			5.14/11/0			С
		345537	B. WING			10/01/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER ST	REAM HEALTH AND RE	EHABILITATION CENTER		2305 SILVER STREAM LANE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 312	Continued From page	2 8	F 31	2		
	about having to wait a concern form. Reside to lay in stool and wa she felt " dirty, filthy ' A review of the concern written and signed by stated that Resident # waiting 3+ hours for the The Administrator have on a separate sheet of to the concern form. On 10/1/15 at 12:50 F Administrator stated as problem at times, and into the concern filed Administrator stated the problem of not having provide care and was On 9/30/2015 at 11:4 made of incontinent of was provided with cleat technique. On 9/30/2015 at 11:5 conducted with NA #2 Resident #6 on a reging Resident #6 was dep #2 further stated she sufficient nursing ass the resident population noted there were a to resided on the 300 have	and the PA had filed a ent #6 stated when she had it for someone to clean her, ' such a bad feeling. ern form revealed it was the PA on 9/25/2015 and #6 had stated she had been he call bell to be answered. d NAs write their statements of paper, which was attached PM, in an interview, the she did have a staffing d she stated the investigation by the PA was ongoing. The that she was working on the g enough NAs available to a looking for staff to hire. 5 AM an observation was care for Resident #6. Care can and appropriate 5 AM, an interview was 2 who provided care to ular basis. NA #2 stated that endent on staff for care. NA did not believe there were istants available to care for on on the 300 hall. NA #2 tal of 47 residents that all and it was difficult to get pleted on time when there		 response. Corrective actions will be mon resident interview monitoring t affected residents 3 times per weeks then weekly for 4 week monthly for 3 months. Resident interview monitoring completed on random alert an residents 3 times per week for then weekly for 4 weeks then 3 months. Call bell observation will be co across all three shifts at variou times per week for 4 weeks th for 4 weeks then monthly for 3 The monitoring results will be the Quality Assurance & Perfor Improvement monthly meeting review, analysis, corrective ac recommendations as needed. 	ool for week for 4 s then tool will be d oriented 4 weeks monthly for mpleted us times 3 en weekly months. brought to rmance for further	
	were only three NAs of On 10/1/15 at 12:50 F	-				

Facility ID: 970977

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	· · /	E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED	
		345537	B. WING		1	C)/01/2015	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		0/01/2015	
SILVER S	FREAM HEALTH AND RE	EHABILITATION CENTER		305 SILVER STREAM LANE /ILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 312	Administrator stated s problem at times. The she was working on t enough NAs available looking for staff to him 2. Resident #9 was a diagnoses of overactineuromuscular dysfu quarterly MDS dated #9 was cognitively intextensive assistance assistance of one per Resident #9 was cod incontinent of bowel a catheter. On 9/30/15 at 9:45 Al #9 stated last week, a she waited 7 hours to movement. Resident waited 4 hours for sta #9 indicated that staff when the call bell was they would be back, thours. In an interview Resident #9 noted sh of having to wait on th the Administrator, but Resident #9 had told PM, she needed to bo not come back. Resident shift changed her. Du	she did have a staffing e Administrator stated that he problem of not having e to provide care and was e. dmitted 1/21/2015 with ive bladder and nction of bladder. The 7/31/2015 noted Resident cact and needed for toileting with the physical rson. The MDS further noted ed as being always	F 312				

Facility ID: 970977

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C MAME OF PROVIDER OR SUPPLIER 345537 STREET ADDRESS, CITY, STATE, ZIP CODE 10/01/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
A. BUILDING C 345537 B. WING C 10/01/2019 NAME OF PROVIDER OR SUPPLIER SILVER STREAM HEALTH AND REHABILITATION CENTER	STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(X3) DATE	SURVEY
345537 B. WING 10/01/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE SILVER STREAM HEALTH AND REHABILITATION CENTER 2305 SILVER STREAM LANE 2305 SILVER STREAM LANE	AND PLAN OF (CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SILVER STREAM HEALTH AND REHABILITATION CENTER 2305 SILVER STREAM LANE			345537	B. WING				-
SILVER STREAM HEALTH AND REHABILITATION CENTER	NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	SILVER ST	REAM HEALTH AND RE	EHABILITATION CENTER					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (xet) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	CORRECTIVE ACTION SHOULD BE CO EFERENCED TO THE APPROPRIATE	
F 312 Continued From page 10 F 312 On 10/1/2015 at 11:55 AM, NA #4, who worked on the facility 's 200 hail where Resident #9 resided, stated she felt the facility was short staffed. NA #4 said '1 have told the Director of Nursing and she has said they are trying '. F 312 On 10/1/15 at 12:50 PM, in an interview, the Administrator stated she did have a staffing problem at times, and she knew about the second shift NA #5 not changing Resident #9. The Administrator stated that she way working on the problem at times, and she knew about the second shift NA #5 not changing Resident #9. Staffing sheets for 9/30/2015 and 10/1/2015 were reviewed and revealed there were 3 NAs schedued for the 200 hall and 300 hall for both days. The 200 hall for the 3:00 PM to 11:00 PM shift only had 2 NAs for the entire shift and 1 NA working from 7:00 PM to 11:00 PM. 3. Resident #5 was admitted 8/26/2015 with diagnoses of diabetes, heart failure, pain, and edema. The 30 day Minimum Data Set (MDS) dated 9/23/2015 noted the resident to be cognitively intact and needed extensive assistance for all ADLs, with the physical assistance for wing adequate vision without corrective lenses. An observation was made of Resident #5 's room on 9/30/2015 at 10:15 AM. The call bell outside the room was flashing and the bell was sounding. A staff member entered the room and left the door ajar, then came to the door and looked back and bod the resident that she would find the		On 10/1/2015 at 11:52 on the facility's 200 f resided, stated she fe staffed. NA #4 said " Nursing and she has On 10/1/15 at 12:50 F Administrator stated s problem at times, and second shift NA #5 nd The Administrator state the problem of not hat to provide care and w Staffing sheets for 9/3 reviewed and reveale scheduled for the 200 days. The 200 hall for shift only had 2 NAs f working from 7:00 PM 3. Resident #5 was ad diagnoses of diabetes edema. The 30 day M dated 9/23/2015 note cognitively intact and assistance for all ADL assistance of two pers Resident #5 to be occ urine and always cont was also coded as hat without corrective lens An observation was m on 9/30/2015 at 10:15 the room was flashing A staff member enters	5 AM, NA #4, who worked hall where Resident #9 eff the facility was short I have told the Director of said they are trying " . PM, in an interview, the she did have a staffing d she knew about the ot changing Resident #9. ted that she was working on ving enough NAs available vas looking for staff to hire. 30/2015 and 10/1/2015 were ed there were 3 NAs 0 hall and 300 hall for both r the 3:00 PM to 11:00 PM for the entire shift and 1 NA 4 to 11:00 PM. dmitted 8/26/2015 with s, heart failure, pain, and dinimum Data Set (MDS) d the resident to be needed extensive .s, with the physical sons. The MDS noted casionally incontinent of tinent of bowel. Resident #5 aving adequate vision ses. made of Resident #5 ' s room 5 AM. The call bell outside g and the bell was sounding. ed the room and left the to the door and looked back	F	312			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345537	B. WING				C 101/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SILVER S	TREAM HEALTH AND RE	EHABILITATION CENTER			2305 SILVER STREAM LANE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 312	resident 's Nurse Ass the room Resident #5 the call bell on at 9:30 resident made this sta the room and asked if saw the call light on. I had to go to the bathr that he would find her NA #6 did come into t get gloves because th empty, and she would this happens all the tii hours in the past. Res so bad when she had and assisted Residen she stated " This is a On 9/30/2015 at 11:11 care on the 300 hall for she feels there is usu care to the residents of stated she had been I Resident #5 needed a morning of 9/30/2015 On 9/30/2015 at 11:44 stated there was a sta When informed as to Resident #5 's room, that the first staff men assisted Resident #5 Administrator indicate additional staff. 4. Resident #8 was an diagnoses of chronic and diabetes. The quarterly MDS da	sistant (NA). Upon entering is stated that she had turned 0 AM. As soon as the atement a nurse came into f he could help because he Resident #5 stated that she room. The nurse indicated r NA and he left the room. the room, stated she had to he glove box on the wall was d return. Resident #5 stated me, and she has waited 1 ½ sident #5 stated that she felt t to wait. NA #6 did return at #5. When NA #6 returned a crazy day! " 5 AM, NA #6, who provides on the 300 hall. NA #6 busy in another room when assistance during the 5 AM, the Administrator affing shortage at times. what had occurred in the Administrator stated nber in the room could have to the bathroom. The ed she was looking to hire	F	312			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED			
		345537	345537 B. WING				C / 01/2015			
NAME OF PROVIDER OR SUPPLIER				:	STREET ADDRESS, CITY, STATE, ZIP CODE					
SILVER S	TREAM HEALTH AND RE	HABILITATION 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)			IX	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 312	extensive to total assi physical assistance or noted Resident #8 was bladder and bowel. On 9/30/2015 at 9:30 must wait a long time answered for incontin hours and nights and Resident #8 also indic in and say they would back for hours. Resid ever got a bath on tim On 10/1/2015 at 12:10 she likes to have ice, #8 stated she had asl and no one brings it. I call bell was not answ frustrated and that no On 9/30/2015 at 11:30 working on the 200 ha for Resident #8, was it there was not enough indicated she could go residents but had trou had to go to dialysis of needed to get cleaned On 10/1/15 at 12:50 F Administrator stated s problem at times. The she was working on the looking for staff to hire 5. Resident #10, who 200 hall, was admitted	 stance for ADLs with the f two persons. The MDS as always incontinent for AM Resident #8 stated she for the call bell to be ent care, sometimes it was evenings were worse. Cated the NAs would come I be back, but did not come ent #8 stated that she hardly ne. D PM Resident #8 stated but rarely gets ice. Resident ked for ice so many times Resident #8 stated when the vered for a long time, she felt one cared. 6 AM NA #1, who was all and usually provided care interviewed and she stated a staff for the 200 hall. NA #1 et to her incontinent uble with the residents who or to appointments and d up. PM, in an interview, the she did have a staffing a Administrator stated that he problem of not having a to provide care and was 	F	312						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		345537	B. WING				C 01/2015			
NAME OF PROVIDER OR SUPPLIER			•		STREET ADDRESS, CITY, STATE, ZIP CODE	-				
SILVER S	TREAM HEALTH AND RE	HABILITATION 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)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ON SHOULD BE COMI HE APPROPRIATE				
F 312	annual MDS dated 7// was cognitively intact assistance for all ADL assistance of one per personal hygiene. The as always continent for ostomy. On 9/30/2015 at 2:50 when he needed assis bell response time was sometimes care was particular day that was noted the care was m PM to 11:00 PM shift. one cared. On 10/1/2015 at 11:22 provided care to Resis facility was short staff aides tried to work tog short and the resident aware and didn ' t fee that staffing had been weeks, but 4 NAs we hall) for the best care never been a time wh there had been a time NAs caring for the 20 would certainly slow t staff. On 10/1/15 at 12:50 F Administrator stated s problem at times. The she was working on the	2/2015 noted Resident #10 and needed extensive s with the physical son for toileting and e MDS coded Resident #10 or bladder and as having an PM Resident #10 stated stance to the bathroom, call as at least 30 - 40 minutes, not given and there was no s worse. Resident #10 ostly delayed on the 3:00 Resident #10 stated that no 8 AM, NA #3, who regularly dent #10, stated she felt the ed. NA #3 indicated the gether if the staffing was ts were told so they were I neglected. NA #3 indicated better over the past two re needed on the hall (200 . NA #3 noted there had en there were 4 NAs, but e when there were only 2 0 hall residents, which he call bell response by the PM, in an interview, the she did have a staffing e Administrator stated that he problem of not having e to provide care and was	F	312						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/28/2015 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	COMF	3) DATE SURVEY COMPLETED C	
	345537		B. WING _			10/01/2015		
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
SILVER ST	REAM HEALTH AND RE	EHABILITATION CENTER			05 SILVER STREAM LANE ILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	diagnoses of end stag congestive heart failu following a stroke. Th 8/3/2015 noted Resid intact and needed exid ADLs with the physica The MDS also coded occasionally incontine incontinent of bowel. On 9/30/15 at 9:12 AI she did not get her bar needed assistance to had to wait more than to be answered. Resi bothered her most wa On 9/30/2015 at 11:30 working on the 200 has stated there was not of NA #1 indicated she of residents but had trou had to go to dialysis of needed to get cleaned On 10/1/2015 at 1:00 stated her expectation should be " as needed turn the call bell off ar Administrator stated so 483.30(a) SUFFICIEN PER CARE PLANS The facility must have provide nursing and r maintain the highest p	dmitted 12/25/2011 with ge renal disease, dialysis, re, diabetes and aphasia e quarterly MDS dated ent #7 to be cognitively tensive assistance with all al assistance of one person. Resident #7 as being ent of bladder and frequently M Resident #7 stated that ath on time and that she the toilet and sometimes a 30 minutes for her call bell dent #7 stated that what as getting her bath late. 6 AM NA #1, who was all, was interviewed and she enough staff for the 200 hall. could get to her incontinent uble with the residents who or to appointments and		312			10/26/15	

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	-	ID HUMAN SERVICES				FORM	APPROVED	
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	0. 0938-0391 SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		C 10/01/2015		
		345537	B. WING					
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	01/2010	
					2305 SILVER STREAM LANE			
SILVER SI	LVER STREAM HEALTH AND REHABILITATION CENTER			\	WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 353	Continued From page	2 15	F	353				
	determined by resider individual plans of car	nt assessments and		000				
	 Individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. 							
	by: Based on observatio interviews and record provide sufficient staf of Daily Living (ADL) (Resident #7 and Res 6 of 8 residents (Resi incontinent care. Findings included: 1.This citation is cross Based on observation interviews and record provide incontinent ca twenty nine residents extensive to total assi Living (ADL) care (Resident)	review, the facility failed to f to give adequate Activities care for 2 of 2 residents sident #13) for bathing, and dents #5,6,7,8,9,10) for s referenced to F312 - h, staff and resident review, the facility failed to are or toileting for six of interviewed that needed istance for Activities of Daily esidents #5,6,7,8,9,10).			 F353 Sufficient 24-hr Nursing Staff per Care Plans Citation is cross referenced to F312 and F241 For those individual residents, Residents#5, #6, #7, #8, #9, #10, #11 at #13, a concern form has been generate for each individual based on resident interview and each continues to reside facility. Because all residents have the potentiate be affected by the cited deficiency, a resident representative interviewed all alert and oriented residents for any AD assistance issues or concerns they might a state of the sta	nd and ed at al to L		
	2. This citation is cross	s referenced to F241 -			have.			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	: 10/28/201 APPROVEI . 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
345537			B. WING			10/0	<i>,</i>)1/2015
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER S	REAM HEALTH AND R	EHABILITATION CENTER			305 SILVER STREAM LANE VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Continued From page	e 16	F	353			
		ew and resident and staff					
		failed to treat residents with			Based on individual resident concerns	S,	
		ty nine alert and oriented			staff education is being provided by a		
		#6, #9, #5, #8, #11 and #10)			administrative nurse regarding provid		
		call bells and not providing			nursing and related services to attain		
		ing (ADL) care. The list of sidents was provided by the			maintain the highest practicable physic mental, and psychosocial well-being of		
	facility.	sidents was provided by the			each resident, as determined by resid		
					assessment and individual plans of ca		
	Resident #16 was ad	lmitted 7/28/2015 with			with regard to call light response and		
		e Sclerosis, Urinary Tract			assistance with ADL¿s.		
		d depression. The admission					
		/IDS) dated 8/4/2015 noted			Measures to ensure the deficient prac		
	extensive assistance	ognitively intact and needed			will not occur include a resident interv monitoring tool to ask random alert ar	-	
		of one to two persons.			oriented residents how they feel they being treated, if they feel they are get	are	
	On 10/1/2015 at 9:00) AM, in an interview,			the assistance needed with ADL¿s ar	-	
		that she had attended the			they feel their call light is being answe		
	-	Resident Council meeting,			timely.		
		e facility monthly. Resident					
		or of Nursing (DON) and the			Call bell observations across all three		
		acility were also at the I6 stated that the group			shifts at various times by a resident representative to monitor timely call b	പി	
		erns regarding the facility			response.	CII	
		nd the long call bell response			Corrective actions will be monitored b	v	
		noted after the meeting there			resident interview monitoring tool for	-	
	were no changes and				affected residents 3 times per week for	or 4	
	Resident Council cor	ncerns.			weeks then weekly for 4 weeks then		
					monthly for 3 months.	l h a	
		lent Council Meeting minutes 20th, and September 17th,			Resident interview monitoring tool wil completed on random alert and orient		
		were concerns regarding			residents 3 times per week for 4 week		
	staffing at all three m				then weekly for 4 weeks then monthly 3 months.		
) AM, in an interview, the					
		she attended the September			Call bell observation will be completed		
	-	the Resident Council and			across all three shifts at various times		
	noted the DON told t	he residents there were staff			times per week for 4 weeks then wee	kly	

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CENTERS FOR MED	ICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/28/2015 M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
345537		B. WING			C 10/01/2015		
NAME OF PROVIDER OR SUPPLIER			•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER STREAM HEAL	TH AND RE	EHABILITATION CENTER		23	305 SILVER STREAM LANE		
				N	VILMINGTON, NC 28401		
PREFIX (EAC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353 Continued	From page	<u>-</u> 17	F	353			
that were n	ot NAs tha	at helped out doing care. The		555	for 4 weeks then monthly for 3 month	S.	
problem of provide car	Administrator stated that she was working on the problem of not having enough NAs available to provide care and was looking for staff to hire. 3. Resident #7 was admitted 12/25/2011 with diagnoses of end stage renal disease, dialysis, congestive heart failure, diabetes and aphasia following a stroke. The quarterly MDS dated 8/3/2015 noted Resident #7 to be cognitively intact and needed extensive assistance with all ADLs with the physical assistance of one person. The MDS also coded Resident #7 as being occasionally incontinent of bladder and frequently incontinent of bowel. Resident #7 was also coded for having adequate vision without corrective lenses. On 9/30/15 at 9:12 AM, in an interview, Resident #7 stated that she did not get her bath on time and it seemed to take all day to get her bath. Resident #7 stated she went to dialysis Tuesday, Thursday and Saturday but the staff could not get her bath done before she goes to dialysis. Resident #7 noted she needed assistance to the toilet and sometimes had to wait more than 30 minutes for her call bell to be answered. Resident #7 stated that what bothered her most was getting her bath late.				The monitoring results will be brought to the Quality Assurance & Performance Improvement monthly meeting for further		
diagnoses congestive following a 8/3/2015 m intact and m ADLs with The MDS a occasional incontinent for having a lenses.					review, analysis, corrective action and recommendations as needed.	ı	
#7 stated th and it seen Resident # Thursday a her bath do Resident # toilet and s minutes for #7 stated th							
working on stated ther NA #1 indic residents b	the 200 h was not ated she ut had trou dialysis o	6 AM NA #1, who was all, was interviewed and she enough staff for the 200 hall. could get to her incontinent uble with the residents who or to appointments and d up.					
4. Residen	t #13 was	admitted 7/31/2015 with					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/28/2015 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345537	B. WING				C 01/2015
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER STREAM HEALTH AND REHABILITATION CENTER					305 SILVER STREAM LANE VILMINGTON, NC 28401		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
		,			DEFICIENCY)		
F 353	slow transit constipati dated 8/10/2015 note cognitively intact and assistance for al ADL assistance of one per On 9/30/2015 at 10:3 he is supposed to get 11:00 PM shift. Resid before (9/29/2015) he be at 10:00 PM or 10 that he could not sit u shower, so he went to he knew it would not	depressive disorder and ion. The admission MDS d Resident #13 to be needed extensive s with the physical	F	353			

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