DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345236	B. WING		C 08/06/2016
NAME OF PI	ROVIDER OR SUPPLIER	010200		STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/2016
			8	20 WELLINGTON AVENUE	
WILMING	TON HEALTH AND REHA	BILITATION CENTER	N	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
		encies cited as a result of gation survey of 8/6/2016.			
F 279 SS=D	483.20(d), 483.20(k)(COMPREHENSIVE (-	F 279		8/31/16
		e results of the assessment d revise the resident's of care.			
	plan for each residen objectives and timeta medical, nursing, and	elop a comprehensive care t that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive			
	to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's				
	by: Based on observatio interviews, the facility description of interver access site by listing fistula (a surgical inte and artery in the arm)	is not met as evidenced n, record review and staff provided an inaccurate ntions required for a dialysis interventions for a dialysis rvention connecting a vein o n the Care Plan of a d dialysis treatment through		F-279, Care Plans "Address how corrective action will accomplished for those residents found have been affected by the deficient practice o On 8-6-2016, the care plan for Resident #34 was corrected to reflect	
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
	cally Signed				08/26/2016

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.

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		E SURVEY PLETED
			A. DOILDING		с	
		345236 B. WING			/06/2016	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
WILMINGTON HEALTH AND REHABILITATION CENTER			820 WELLINGTON AVENUE			
			WILMINGTON, NC 28401			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
F 279	Continued From page	e 1	F 27	9		
	a central venous cath	neter (a catheter placed in a		accurate interventions rela	ated to his	
	• / //	er chest for one of one or dialysis (Resident #34).		dialysis access site.		
				" Address how correcti	ve action will be	
	Findings included:			accomplished for those re	sidents having	
	Resident #34 was ad	mitted to the facility on		potential to be affected by	the same	
	8/7/2010 with diagnos			deficient practice		
		ease) with hemodialysis,		o As of 8-6-2016, the D		
	Anemia, and Diabete			Nursing reviewed the care		
		Data Set (MDS) dated		current residents identified		
		Resident #34 was cognitively emodialysis for End Stage		patients, and confirmed th	e care plans	
	Renal Disease (ESR			were appropriate.		
	-	ted with the annual MDS		" Address what measu	res will be put	
		uld proceed with a Care Plan		into place or systemic cha		
	related to dialysis.			ensure that the deficient p	-	
		al medical record revealed a		occur		
	History and Physical	(H&P) dated 8/9/2010 which		o By 8-19-2016, the Dir	ector of Nursing	
		34 was admitted with a left		or designee re-educated f	acility licensed	
		access site. The H&P further		nurses on appropriatenes	•	
		34 did not have a functioning		of care plan interventions	for facility	
	A/V (arterial/venous)			dialysis patients.		
		Plan dated 6/01/2016		" Indicate how the facil		
		34 required dialysis due to				
		al was Resident #34 would vention should any signs or		monitor its performance to solutions are sustained. 1		
		ations from dialysis occur.		develop a plan for ensurin		
		luded after dialysis, check		is achieved and sustained	-	
		ite for thrill (a vibration felt on		be implemented and the c	-	
	•	the arm) and bruit (a sound		evaluated for its effectiver		
	-	pe on the dialysis fistula in		of Correction is integrated		
	the arm) twice per sh	ift on the day resident		assure system of the facili	ty.	
	returned and then da	-		o The Director of Nursi		
		ducted with Resident #34 on		will audit dialysis patient c	-	
	8/4/2016 at 11:00 AM			weekly times four weeks,		
	÷	motorized wheelchair in the		monthly times three month		
	-	esident #34 was alert and		o The Director of Nursi		
	thin white collared sh	34 was observed wearing a		findings to the Quality Ass	urance	1

Facility ID: 923408

If continuation sheet Page 2 of 11

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI	E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					С
	345236		B. WING	08/06/201	
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
WILMINGTON HEALTH AND REHABILITATION CENTER				820 WELLINGTON AVENUE	
	ION HEALTH AND REH			WILMINGTON, NC 28401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPL
F 279	Continued From pag	e 2	F 27	9	
		t was visible on his left upper		o If the Quality Assurance Com	mittee
		indicated the dialysis shunt		determines there are continued pro	
	site in his left lower a	rm had not been functional		after three months regarding dialys	sis
		admission in 2010. Resident		patient care plans, it will continue t	
		was completed through a		receive Director of Nursing reports	
		s left upper chest which		review them monthly until the prob	lem is
	contained two ports.	Coordinator was		resolved.	
	An interview with MD	16 at 11:25 AM and revealed			
		on for the assessments was			
		formation in the computer.			
		ated she was unaware			
	Resident #34 did not	have a dialysis fistula and			
		nt #34 received dialysis			
	-	dialysis catheter. The MDS			
		Resident #34 's Care Plan			
	•	be accurate to ensure the rmation is provided for staff.			
		or indicated the Care Plan			
		reflect Resident #34 ' s			
	dialysis site needs.				
	An interview with the	Administrator on 8/5/2016 at			
		pectations were for resident '			
	s Care Plan informat				
		Interim Director of Nursing			
		d on 8/5/2016 at 3:00 PM. er expectation was for the			
		iccurate information so			
		ire could be provided.			
F 309		ARE/SERVICES FOR	F 309	9	8/31/1
SS=D	HIGHEST WELL BEI	NG			
	Each resident must r	eceive and the facility must			
		y care and services to attain			
		est practicable physical,			
	mental, and psychos				
		comprehensive assessment			

Facility ID: 923408

If continuation sheet Page 3 of 11

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345236	B. WING			0	C 8/06/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		REET ADDRESS, CITY, STATE, ZIP CODE		
				82	0 WELLINGTON AVENUE		
WILMING	VILMINGTON HEALTH AND REHABILITATION CENTER			w	ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From page	e 3	F	309			
	by: Based on observatio	is not met as evidenced			F-309, Assessments	:U I	
review, the facility failed to assess a dialysis po- site for bleeding, signs and symptoms of infect or an intact dressing after dialysis treatments p the Physicians order and Care Plan for 1 of 1 residents reviewed for dialysis (Resident #34).		is and symptoms of infection after dialysis treatments per and Care Plan for 1 of 1			 Address how corrective action w accomplished for those residents fou have been affected by the deficient practice Beginning 8-5-2016, nurses cher 	nd to	
	Findings included: Resident #34 was ad 8/7/2010 with diagnos Stage Renal Disease	mitted to the facility on ses which included End (ESRD) with Hemodialysis			the dialysis site for Resident #34 upo return from dialysis for signs and symptoms of bleeding, infection, and intact dressing.		
	5/25/2016 indicated F intact and required he Renal Disease (ESRI	Data Set (MDS) dated Resident #34 was cognitively emodialysis for End Stage D). A Care Area			" Address how corrective action w accomplished for those residents hav potential to be affected by the same deficient practice	ring	
	indicated nursing wou related to dialysis. A review of the clinica History and Physical	ed with the annual MDS uld proceed with a Care Plan al medical record revealed a (H&P) dated 8/9/2010 which 34 was admitted with a left			 On 8-6-2016, the Director of Nur reviewed medical records of other dia patients, and confirmed that the nurs are properly checking any dialysis sit upon return from dialysis treatment. 	alysis es	
	upper chest dialysis a indicated Resident #3 A/V (arterial/venous) A review of the Care	access site. The H&P further 34 did not have a functioning dialysis fistula. Plan dated 6/01/2016			" Address what measures will be p into place or systemic changes made ensure that the deficient practice will occur	to not	
	renal failure. The goa have immediate inter symptoms of complic	34 required dialysis due to Il was Resident #34 would vention should any signs or ations from dialysis occur. Iuded after dialysis, check			 By 8-19-2016, the Director of Nu or designee re-educated facility licent nurses on checking dialysis sites post-dialysis for bleeding, signs and symptoms of infection, and intact 	-	
	resident ' s dialysis si the dialysis fistula in t heard by a stethosco	te for thrill (a vibration felt on the arm) and bruit (a sound pe on the dialysis fistula in ift on the day resident			dressing. Indicate how the facility plans to monitor its performance to make sure	that	

Facility ID: 923408

If continuation sheet Page 4 of 11

STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED	
					С	
		345236	B. WING		08/06/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER WILMINGTON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING				820 WELLINGTON AVENUE 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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET	
F 309	dated August 1 throw an order to check the Wednesday and Frida signs and symptoms tissue and intact dress An interview was con 8/4/2016 at 11:00 AM observed sitting in a main dining room. Re oriented. Resident #34 thin white collared sh with a dressing intact chest. Resident #34 is site in his left lower a since prior to facility a #34 reported dialysis dialysis catheter in hi contained two ports. dialysis nurses clean on his left upper chess on it after every dialy stated the facility nurs site when he returned the nursing staff had when he returned fro An interview was con (Resident #34 's prin 8:30 AM. Nurse #2 in Resident #34 was ch reported it was on the Administration Recor	ily. ionthly Physician 's orders gh August 31 2016 revealed dialysis site every Monday, ay post dialysis or bleeding, of infection, surrounding using. ducted with Resident #34 on 1. Resident #34 was motorized wheelchair in the esident #34 was alert and 44 was observed wearing a irt and a dialysis catheter was visible on his left upper ndicated the dialysis shunt rm had not been functional admission in 2010. Resident was completed through a s left upper chest which Resident #34 reported the ed the dialysis catheter site at and put a clean dressing sis treatment. Resident #34 sing staff did not assess the d from dialysis and indicated never asked to see the site m dialysis. ducted with nurse #2 hary nurse) on 8/5/2016 at dicated the dialysis site for ecked every day. Nurse # 2 e Electronic Medication d (EMAR) to check the site.	F 3(errection an must e action he Plan quality signee ecords h eport ting. mittee oblems sis to and to	
	#34 reported dialysis dialysis catheter in hi contained two ports. I dialysis nurses clean on his left upper chess on it after every dialys stated the facility nurs site when he returned the nursing staff had when he returned fro An interview was con (Resident #34 's prin 8:30 AM. Nurse #2 in Resident #34 was ch reported it was on the Administration Recor Nurse # 2 reviewed th Administration Recor the order to check the since it was not on th the site was not docu	was completed through a s left upper chest which Resident #34 reported the ed the dialysis catheter site st and put a clean dressing sis treatment. Resident #34 sing staff did not assess the d from dialysis and indicated never asked to see the site m dialysis. ducted with nurse #2 nary nurse) on 8/5/2016 at dicated the dialysis site for ecked every day. Nurse # 2 e Electronic Medication		patient care plans, it will continue to receive Director of Nursing reports review them monthly until the prob	to and to	

Facility ID: 923408

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 09/13/201 DRM APPROVE
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
		345236	B. WING			C 08/06/2016	
NAME OF P	ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CIT		EET ADDRESS, CITY, STATE, ZIP CODE				
				820 \	WELLINGTON AVENUE		
WILMINGTON HEALTH AND REHABILITATION CENTER			WIL	MINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	notes. Nurse #2 repo be missed at times at busy the day had bee #34 was alert and ori report any issues with An interview was con 8/5/2016 at 10:10 AM administered the med daily. MA #1 indicated responsible for assess because assessment of practice. MA #1 indi- returned from dialysis and went straight to t #1 reported after lund returned to his room would administer his #1 reported she had assess Resident #34 Another interview wa	rted the assessments may nd would depend on how en. Nurse #2 stated Resident ented and should be able to in the dialysis site. ducted with MA #1 on 1. MA #1 reported she dications to Resident #34 d the nursing staff was asments of the residents as were not within her scope dicated Resident #34 usually as treatments by 12:30 PM he dining room for lunch. MA ch Resident #34 usually to rest for a while and she medications at that time. MA not witnessed a nurse ' s dialysis site. s conducted with Resident		309			
	his room resting in be he returned from diali- to the dining room for after lunch he went to brought his medicatio Nurse #2 entered his administration of medi assess his dialysis si Nurse #2 stated the ri checking the dialysis An interview was con Administrator on 8/5/2 Administrator reporte Physician 's orders to assessments to be co An interview was con Interim Director of Nu	dications and requested to te. Resident #34 reported nursing staff would be site every day. ducted with the facility 2016 at 2:50 PM. The d his expectation was for o be followed and resident					

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		STRUCTION	(X3) DATE	O. 0938-039 E SURVEY PLETED	
		345236	B. WING			C 08/06/2016		
	ROVIDER OR SUPPLIER	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 820 WELLINGTON AVENUE WILMINGTON, NC 28401				00/2010	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309 F 312	access sites daily bu dialysis treatments d which could occur.	sess dialysis resident ' s t especially on the days of ue to the complications NRE PROVIDED FOR	F				8/31/16	
SS=D	A resident who is una daily living receives t	able to carry out activities of he necessary services to on, grooming, and personal						
	by: Based on observation interview and record provide nail care for of for Activities of Daily #96). Findings included: Resident #96 was add brain cancer, edemat failure and history of The admission 5 day dated 6/299/2016 no cognitively intact and assistance for all Acti with the physical ass persons. Resident #95 supervision after his Resident #96 was tof with assistance of on Resident #96 did not	review, the facility failed to one of 40 residents reviewed Living (ADL) care (Resident Imitted with diagnoses of , encephalopathy, kidney colon cancer. Minimum Data Set (MDS) ted Resident #96 to be needed extensive ivities of Daily Living (ADLs),		" ac ha pr o pr ind ac pc de o fa pr " int er	-312, ADL - nail care Address how corrective action w complished for those residents fou ave been affected by the deficient actice On 8-6-2016, a registered nurse ovided nail care for Resident #96 to clude trimming and cleaning fingerr Address how corrective action w complished for those residents hav otential to be affected by the same eficient practice By 8-8-2016, nursing staff check cility residents and confirmed that oper nail care has been given. Address what measures will be p to place or systemic changes made usure that the deficient practice will cour By 8-19-2016, the Director of Nu	nd to phails. ill be ring ed put eto not		

Event ID: NW6K11

Facility ID: 923408

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ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR D PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING			· · ·	E SURVEY PLETED		
IDENTIFI	CATION NUMBER.	A. BUILDING	G		C	
	345236	B. WING			08/06/2016	
NAME OF PROVIDER OR SUPPLIER WILMINGTON HEALTH AND REHABILITATION CENTER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
		820 WELLINGTON AVENUE WILMINGTON NC 28401				
FICIENCY MUST BE PR	ECEDED BY FULL	ID PREFIX TAG		,		(X5) COMPLETION DATE
n page 7		F 3 ²	12			
				or designee re-educated facility direct care staff on proper nail care.		
ad a deficit in self his ADLs related oal was Resident i function. Included: Encourag tasks. Ensure effe rior to ADL activiti ks as needed. Bat cluded check nail ath day and as ne onurse. Provide sp nower cannot be to choose simple con hances the reside 0 AM, Resident # on each hand and en. There was dark rneath all nails on 10:00 AM an obs be bath, change m. NA #1 provide bosed body when lained what she w esident #96 would ha not clean Resider ails were observe rown matter unde 8:30 AM, Resident	-care to limited #96 will improve e active pain es. Provide hing /showering length and trim cessary. Report onge bath when olerated. Assist mfortable ent 's ability to 26 was observed all nails except both hands. ervation of ADL at #1 gave ed his brief and d privacy and she washed him. vas doing as she ooperative. NA ve a shower that tt #96 's nails.			solutions are sustained. The facility m develop a plan for ensuring that correct is achieved and sustained. The plan m be implemented and the corrective act evaluated for its effectiveness. The PL of Correction is integrated into the quation assure system of the facility. o The Director of Nursing or designed will perform random audits to ensure residents receive proper nail care week times four weeks, and then monthly time three months. o The Director of Nursing will report findings to the Quality Assurance Committee during its monthly meeting. o If the Quality Assurance Committee determines there are continued problem after three months regarding nail care, will continue to receive Director of Nursing	ust stion nust ion an lity ee kly nes kly nes it sing	
	D REHABILITATION	LIER D REHABILITATION CENTER MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) m page 7 his area went to care plan. dated 6/30/2016 noted a focus of had a deficit in self-care of his ADLs related to limited goal was Resident #96 will improve f function. ncluded: Encourage active n tasks. Ensure effective pain prior to ADL activities. Provide sks as needed. Bathing /showering ncluded check nail length and trim bath day and as necessary. Report o nurse. Provide sponge bath when hower cannot be tolerated. Assist o choose simple comfortable nhances the resident 's ability to 00 AM, Resident #96 was observed on each hand and all nails except en. There was dark brown matter erneath all nails on both hands. It 10:00 AM an observation of ADL e. Nursing Assistant #1 gave a bed bath, changed his brief and im. NA #1 provided privacy and kposed body when she washed him. plained what she was doing as she Resident #96 was cooperative. NA ident #96 would have a shower that a not clean Resident #96 's nails. nails were observed to be broken, prown matter underneath all nails. It 8:30 AM, Resident #96 was ng up in bed. Resident #96 was ng up in bed. Resident #96 was hower the	JER D REHABILITATION CENTER MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG m page 7 F 3 is area went to care plan. dated 6/30/2016 noted a focus of had a deficit in self-care of his ADLs related to limited goal was Resident #96 will improve f function. F 3 nocluded: Encourage active n tasks. Ensure effective pain prior to ADL activities. Provide sks as needed. Bathing /showering ncluded check nail length and trim bath day and as necessary. Report o nurse. Provide sponge bath when hower cannot be tolerated. Assist o choose simple comfortable nhances the resident 's ability to 00 AM, Resident #96 was observed on each hand and all nails except en. There was dark brown matter erneath all nails on both hands. tt 10:00 AM an observation of ADL e. Nursing Assistant #1 gave a bed bath, changed his brief and im. NA #1 provided privacy and cposed body when she washed him. plained what she was doing as she Resident #96 was cooperative. NA ident #96 would have a shower that it not clean Resident #96 vas roown matter underneath all nails. tt 8:30 AM, Resident #96 was rog up in bed. Resident #96 was	IER State D REHABILITATION CENTER ID MARY STATEMENT OF DEFICIENCIES ID CIERCIENCIES ID PREFIX TAG F312 ID PREFIX TAG F 312	JER STREET ADDRESS, CITY, STATE, ZIP CODE D REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE WILMINGTON, NC 28401 D MARY STATEMENT OF DEFICIENCIES FICIENCY MIST DE PRECEDED BY PLUL ORY OR LSC IDENTIFYING INFORMATION) PRETAIL TAG PRETAIL PRETAIL PRETAIL ORY OR LSC IDENTIFYING INFORMATION) PRETAIL TAG PRETAIL TAG PRETAIL ORY OR LSC IDENTIFYING INFORMATION) PRETAIL TAG PRETAIL TAG PRETAIL TAG PRETAIL TAG PRETAIL TAG PRETAIL TAG PRETAIL ORY OR LSC IDENTIFYING INFORMATION) PRETAIL TAG PRETAIL TAG PRETAIL TAG Or designee re-educated facility direct care staff on proper nail care. THO TAGE ADD AND RESIDENT PROVIDERS THE DIRECTOR MURICIPAL PROVIDERS TAG F 312 Or designee re-educated facility plans to monitor its performance to make sure is solutions are sustained. The facility matching that correct is achieved and sustained. The plan in be implemented and the corrective act evaluated for its effectiveness. The PI of Corrector IS INTRING OR designed in the Cuality ASSURANCE OR THE PRETAIL D0 AM, Resident #96 was observed on neach hand and all nails except enreant all nails on both hands.	Jer STREET ADDRESS, CITY, STATE, ZIP CODE D REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE WARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION MARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION OPT OR LSC IDENTIFYING INFORMATION PRETX MARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION OPT OR LSC IDENTIFYING INFORMATION PRETX Impage 7 Is area went to care plan. dated 6/30/2016 noted a focus of had a deficit in self-care Indicate how the facility direct care staff on proper nail care. Included: Encourage active function. Indicate how the facility direct care staff on proper nail care. Indicate how the facility direct care staff on proper nail care. Indicate how the facility direct care staff on proper nail care. Indicate how the facility direct care staff on proper nail care. Indicate how the facility direct care staff on proper nail care. Indicate how and part and trim prior to ADL activities. Provide sks as needed. Bathing /showering noluded check nail ength and trim path day and as necessary. Report nhances the resident #96 was observed on each hand and all nails except en. Three was dark brown matter ameath all nails on both hands. O The Director of Nursing will report findings to the Quality Assurance Committee during its monthly meeting. 0 If the Quality Assurance Committee determines there are are continued problems after three months regarding nail care, it will continue to receive Director of Nursing reports and to review them

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ATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATI	D. 0938-039 E SURVEY PLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING			C
		345236	B. WING	08/06/2016		
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	TON HEALTH AND REHA	BILITATION CENTER		20 WELLINGTON AVENUE VILMINGTON, 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 API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 312	Continued From page	2 8	F 312			
	morning. The nails or remained long, eight there was light brown NA #1 stated she did	of them were broken and matter underneath all nails. not know if Resident #96 vious evening. NA #1 stated				
	observed to have ligh fingernails on both ha Nursing (DON) was p believed the matter u peanut butter. The Do broken and some we expectation was the r trimmed.	resent and stated she nderneath the nails was ON noted the nails were re long. The DON stated her nails would be cleaned and				
F 431 SS=D			F 431			9/3/16
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a	loy or obtain the services of t who establishes a system and disposition of all ifficient detail to enable an n; and determines that drug and that an account of all aintained and periodically				
		y and cautionary				
		tate and Federal laws, the drugs and biologicals in				

If continuation sheet Page 9 of 11

					DUCTION		NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTR			TE SURVEY
		345236	B. WING				C)8/06/2016
NAME OF PI	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO		DDRESS, CITY, STATE, ZIP CODE	•			
	TON HEALTH AND REH			820 WELL	LINGTON AVENUE		
WILWING	ION REALTH AND REH	ADILITATION CENTER		WILMING	GTON, NC 28401		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	Continued From page	e 9	Í F.	131			
1 401		s under proper temperature		+31			
		only authorized personnel to					
	permanently affixed of	vide separately locked, compartments for storage of					
	Comprehensive Drug Control Act of 1976 a	d in Schedule II of the Abuse Prevention and and other drugs subject to					
	package drug distribu	the facility uses single unit ution systems in which the nimal and a missing dose can					
	by: Based on observation facility failed to remove 2 of 5 of medication of	Γ is not met as evidenced on and staff interview the ve expired medications from carts (500/600 nurses 600 hall medication aide		" acco	31, expired meds Address how corrective action omplished for those residents been affected by the deficient tice	s found to	
	Findings included:				On 8-6-2015, expired medic e removed from the med carl		
	was made of the 500 The cart was located In a medication draw of the cart was an op 10mg (a medication of an expiration date of	at 11:00 AM an observation /600 hall medication cart. beside the nurse's station. er located on the top left side used bottle of Loratadine used to treat allergies) with 07/2016. Nurse #1 observed eported the medication scarded.		acco pote defic o or he and medi	Address how corrective action omplished for those residents ntial to be affected by the satistic cient practice On 8-6-2016, the Director of er designee checked facility confirmed there were no explications Address what measures will	s having me f Nursing med carts bired	
	was made of the 500	at 11:00 AM an observation /600 hall medication cart. beside the nurse's station.		into j	place or systemic changes n ure that the deficient practice	nade to	

Facility ID: 923408

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
ND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMPLETED
		345236	B. WING		C 08/06/2016
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO	
	TON HEALTH AND REHA				
WILMING				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE E APPROPRIATE DAT
F 431	Continued From page	e 10	F 43	31	
	In a medication draws side of the cart were it Seracult Developer S blood) with expiration indicated she did not on the cart and the so discarded due to the 3) On 08/06/2016 a was made of the 600 The cart was located a medication drawer I side of the cart was a Acetaminophen 500 r resident's name hand expiration date on the Medication Aide #1 (N medications on the 60 observed the medication not know why the me and the medication sl The Director of Nursin 500/600 nursing statio observed. The medication of solution were giver indicated they would stated the carts were medications by nursin the medications and R discovered during the During an interview w at 11:30 AM the DON was for all medication	er located on the top right two 15 milliliter bottles of olution (used to detect fecal dates of 03/2016. Nurse #1 know why the solution was olution should have been expiration date. t 11:15 AM an observation hall medication aide's cart. at the end of the 600 hall. In located on the bottom left in opened bottle of mg tablets with a current I written on the bottle. The bottle was 10/2015. MA #1) was administering 00 hall on 8/6/2016 and tion. MA #1 reported he did dication was in the drawer hould have been discarded. mg (DON) was present at the on while the carts were ation bottles and the bottles in to the DON and the DON be discarded. The DON checked daily for expired ng staff and was unsure why bottles of solution were not e checks. with the DON on 08/06/2016 I reported the expectation in storage areas and e checked daily for expired		 o By 8-19-2016, the Director designee re-educated factor nurses and Medication Aids and remove from med rooms any expired medications. " Indicate how the facility monitor its performance to m solutions are sustained. The develop a plan for ensuring is achieved and sustained. The develop a plan for ensuring is achieved and sustained. The develop a plan for ensuring of Correction is integrated in assure system of the facility. o The Director of Nursing will perform inspections of m and med carts weekly times and then monthly times three ensure compliance. o The Director of Nursing findings to the Quality Assurance determines after three monthare continued problems with medications, it will continue Director of Nursing reports a them monthly until the problems with medications. 	ility licensed to check for s and carts plans to nake sure that e facility must that correction The plan must rective action ss. The Plan to the quality or designee red rooms four weeks, e months to will report ance y meeting. c Committee ns that there expired to receive and to review

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