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 ______	C 10/04/2016

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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Physician Assistant (PA) interviews, the facility failed to remove a tourniquet following an intravenous (IV) catheter insertion for 1 of 1 sampled residents (Resident #1). Findings included: Review of Resident #1's Admission Minimum Data Set (MDS) dated 05/20/16 revealed an admission date of 05/13/16 and diagnoses of adult failure to thrive, difficult walking and hypertension. Resident #1 had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. Review of the Nursing Progress Notes dated 07/30/16 and written by Nurse #1 revealed Resident #1 had stat bloodwork sent to the laboratory at 6:30 PM. At 8:00 PM the laboratory results were reported to PA #1. A stat chest x-ray was ordered and the results were reported to PA #1 at 10:30 PM. Orders were received to start an IV and to infuse 1 liter of Normal Saline Solution (NSS) at 100 ml (milliliters) per hour. Review of the Physician's Telephone Orders dated 07/30/16 revealed orders for stat bloodwork, a stat chest x-ray, and to start an IV of NSS at 100 ml per hour.	F 309	1. Resident # 1 was discharged from the facility 9/27/16. 2. Current residents requiring IV therapy are at risk for the same alleged deficient practice. Current residents receiving IV therapy were re- assessed to ensure there were no negative finding related to the IV therapy on 10/5/16 by the Assistant Director of Nursing. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur are: The Director of Nursing, Assistant Director of Nursing or Unit Manager will re-educate Licensed Nurses on peripheral IV access with completion of skills validation. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe 1 □ 2 residents with new orders for IV therapy weekly times four weeks and monthly times one. Negative findings will be corrected when noted. 4. Results of the re-education and random observation audits will be reviewed by the Quality Assessment	11/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/17/2016

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 309	Continued From page 1 Review of the Nursing Progress Notes dated 07/30/16 at 11:25 PM revealed an IV was started in Resident #1's right arm by Nurse #2. The IV fluid was started and Resident #1 tolerated the procedure well. Review of the Nursing Progress Notes dated 07/31/16 and written by Nurse #3 revealed at approximately 1:00 PM a family member approached the nurse to ask what was on Resident #1's arm. On examination, Nurse #3 discovered a white colored tourniquet on Resident #1's right upper arm. There was minimal swelling noted to the right hand. The Assistant Director of Nursing (ADON) and PA #1 were notified. In an interview on 10/03/16 at 12:30 PM the Administrator stated Nursing Assistant (NA) #1, who was assigned to Resident #1 the morning of 07/31/16, no longer worked at the facility and no contact information was available. She was unavailable for interview. In an interview on 10/03/16 at 3:43 PM PA #2 stated when he examined Resident #1's right arm on 08/10/16 there was a previous area of trauma that appeared to be in the late stages of healing from the tourniquet placement. In an interview on 10/04/16 at 12:19 PM the ADON stated Nurse #3, who had reported to her that a tourniquet had been left on Resident #1's arm after an IV insertion, had resigned the previous day and was unavailable for an interview. The ADON stated it had been reported to her by Nurse #3 that a family member had come to visit Resident #1 and found a tourniquet wrapped around the right upper arm. The ADON stated when she went in to assess Resident #1 she examined the right arm from the shoulder down to the fingers. She indicated she noted minimal swelling to the right hand.	F 309	Performance Improvement Committee times 2 months. The Committee will monitor for negative patterns/trends and determine if additional interventions are necessary to maintain substantial compliance.	

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F 309	Continued From page 2 In a telephone interview on 10/04/16 at 12:58 PM Nurse #1 stated she received the order to draw stat lab tests and later the order to start the IV. She indicated she drew the labs using a blue tourniquet and when she was done she brought the tourniquet with her when she exited the room. Nurse #1 stated Nurse #2 started Resident #1's IV. Nurse #1 indicated the IV start kits contained white tourniquets. In an interview on 10/04/16 at 1:43 PM the Director of Nursing (DON) stated Nurse #2 had not responded to several calls from the facility for an interview. The DON was able to provide a typed summary from Nurse #2 stating she had "popped" the tourniquet but it may have stayed on Resident #1's arm. In an interview on 10/04/16 at 1:45 PM the DON stated it was her expectation that when a nurse started an IV the tourniquet should be removed from the arm and disposed of outside the resident's room.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide fresh water and a clean washcloth after a visibly soiled washcloth was placed in the bath basin during perineal care and failed to thoroughly rinse the soap from a	F 312	Corrective action for Resident #7 was accomplished as she was rinsed with clean water and perineal care was provided on 10/3/16 by the Assistant Director of Nursing. Certified Nursing	11/1/16

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F 312	Continued From page 3 resident's body durimg perineal care for 1 of 1 sampled residents (Resident #7). Findings included: Resident #7's Minimum Data Set (MDS) dated 07/22/16 revealed she was re-admitted to the facility on 08/28/15 with diagnoses of hypertension, cerebrovascular accident (CVA) and muscle weakness. Resident #7 was cognitively aware and needed the extensive assistance of one person for hygiene and was dependent on one person for bathing. Resident #7 was frequently incontinent of urine. In an observation of perineal care on 10/03/16 at 2:05 PM Nursing Assistant (NA) #10 provided privacy for Resident #7. A basin of water was brought to the bedside. A washcloth was placed in the water and bar soap was applied to the cloth. The cloth was used to wash Resident #7's perineal area. When the labia was cleansed with the soapy washcloth, stool was removed and was visible on the cloth. The cloth was dipped into the soapy water and was used to rinse Resident #7's perineal area. The cloth was then placed back into the basin with the soapy water. The placement of the washcloth in the basin of soapy water allowed for the visibly soiled area to be out of the water and to be seen. NA #10 made no attempt to provide a fresh basin of water or a clean washcloth at that time. When the soiled washcloth was pointed out to NA #10 she changed the water in the basin and provided a clean washcloth which she used to cleanse Resident #7. In an interview on 10/03/16 at 2:50 PM NA #10 stated she should have rinsed the soap off Resident #7's perineal area with clear water. She indicated she should not have used the washcloth on Resident #7 after it became contaminated with stool. NA #10 indicated she had not realized the	F 312	Assistant # 10 was re-educated and skills validation completed on perineal care on 10/3/16 by Assistant Director of Nursing. The Director of Nursing and/or Clinical Manager will observe facility Certified Nursing Assistants during perineal care and/ or a bath to ensure that residents wash clothes are changed , if visibly soiled , prior to continuing perineal care or bathing. Also the observation will be to ensure that soap is thoroughly rinsed from a resident□s body during perineal care and/or bath. This will be completed by 11/1/16 Certified Nursing Assistants will be re-educated with skills validation completion regarding proper technique for providing perineal care and bathing of residents by Director of Nursing and/or Clinical Manager. This will be completed by 11/1/16. Newly hired Certified Nursing Assistants will receive the education during orientation. The facilities Certified Nursing Assistants that do not receive the re- education by 11/1/16 will receive it prior to working their next shift. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager will conduct random observation audits of perineal care on 5 dependant residents weekly times 4 weeks and then monthly times 1 month. The results of the audits will be reviewed weekly during the Interdisciplinary Team meeting. Negative findings will be addressed if noted. The results of all audits will be reviewed monthly for 2 months by the Quality Assurance Performance Improvement	

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F 312	Continued From page 4 cloth had become soiled and would have continued to use the soiled water and soiled washcloth to complete perineal care. In an interview on 10/04/16 at 1:45 PM the Director of Nursing (DON) stated it was her expectation that soap be rinsed from resident's bodies using clear water. She indicated a washcloth visibly soiled with stool should not be used on a resident's body and a cloth contaminated with stool should not be placed back in the basin of water.	F 312	Committee. The Committee will monitor for negative patterns/trends and determine if additional interventions are necessary to maintain substantial compliance.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		11/1/16

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F 356	Continued From page 5 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post nursing staffing for 2 consecutive days for staff, residents, and visitors in the nursing facility. Findings included: At 11:05 AM on 10/02/16, an observation of the posted nursing staffing revealed that nursing staffing had not been posted since 9/30/16. The staff posting displayed on Sunday, 10/02/16 was dated for Friday, 9/30/16 and there were no sheets available with the staffing for information for 10/01/16 and 10/02/16 at that time. In an interview with the Administrator at 12:31 PM on 10/02/16, she stated that the Director of Nursing (DON) was responsible for completing the staffing sheets for the weekend and leaving them for the 200 Hall nurse to update, as needed, and post on Saturday and Sunday. She stated that she was not sure if all of the nurses who worked weekends were aware of this expectation and that reeducation of this process would be necessary. In an interview on 10/02/16 at 3:15 PM with the first shift 200 Hall nurse on duty, Nurse # 9, she stated that she was not aware that she was supposed to post nursing staffing and did not know where the sheets were kept that would have been posted. This nurse stated that she	F 356	Staffing was posted for 10/2/16. The Scheduler/designee will post the staffing sheet at the nurse's station daily Monday through Friday at the beginning of the 7-3 shift. Weekend staffing sheets will be made in advance and placed on the clip board. Licensed staff will be educated on the process of changing out the daily staffing sheets and making any adjustments at the beginning of the 7-3 shift on the weekends. Department Managers will be educated regarding the change to their duties regarding weekend staff posting documentation by the Administrator and completed on 10/21/16. Newly hired department managers will receive the education during orientation. The facilities department managers that do not receive the re- education by 10/21/16 will receive it prior to working their next shift. The weekend Manager on Duty will validate the staffing is posted and document on the Manager on Duty Checklist. Negative findings will be corrected if noted. Daily monitoring of the staffing sheets will be conducted by the Administrator, Director of Nursing or Assistant Director of Nursing. The sheets will be reviewed	

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F 356	Continued From page 6 worked weekends often and was always assigned the 200 Hal and had never posted any nursing staffing on the weekends. An observation of the posted nursing staffing at 3:45 PM on 10/02/16 revealed that nursing staffing had been updated to reflect staffing and facility census for 10/02/16. In an interview with the DON at 2:18 PM on 10/04/16, she stated that she prints the nursing staffing on Fridays for Saturday and Sunday and the 200 Hall nurse and/or the Manager on Duty (MOD) was responsible for updating and posting the staffing information. She reported that it was her expectation that the staffing was updated and posted daily.	F 356	weekly for 4 weeks and monthly times 2 months. The results of all staffing sheets will be reviewed monthly for 2 months by the Quality Assurance Performance Improvement Committee. The Committee will monitor for negative patterns/trends and determine if additional interventions are necessary to maintain substantial compliance.	