PRINTED: 09/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED C		
		345537	B. WING _		08/18/2017		
	ROVIDER OR SUPPLIER  TREAM HEALTH AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 0 2305 SILVER STREAM LANE WILMINGTON, NC 28401	CODE		
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F 164 SS=D	PRIVACY/CONFIDE  483.10 (h)(I) Personal prival medical treatment, vommunications, permeetings of family a does not require the room for each reside (h)(3)The resident has of personal and medical personal and personal and personal and personal and personal personal and personal personal and personal	as a right to secure and all and medical records.  the right to refuse the release dical records except as er applicable federal or state except as except a	F1	TITLE		9/15/17  (X6) DATE	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/08/2017

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.

**Electronically Signed** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION  G	C	(X3) DATE SURVEY COMPLETED		
		345537	B. WING _			C 08/18/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/10/2017	
				2305 SILVER STREAM LANE			
SILVER S	TREAM HEALTH AND RE	EHABILITATION CENTER		WILMINGTON, NC 28401			
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F 164	Continued From page	e 1	F 1	64			
F 164	purposes, research p medical examiners, for a serious threat to he by and in compliance This REQUIREMENT by: Based on observation record review the fact confidentiality of the I The findings included During an observation medication cart with to observed to be parket #173's room, and the medical information of unattended.  An interview was con AM with Nurse #10 w stepped away from h administration and the the MAR, but did not should have closed ti away from the cart.  An interview was con AM with the Director DON stated the MAR	urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512.  is not met as evidenced  n, staff interviews, and ility failed to maintain MAR for Resident #173.  in o 08/16/17 at 9:00 AM the he resident's MAR was d just outside Resident resident's personal and	F 1	F164  1. The EMAR for resident #173 velosed immediately by the Direct Nursing. Nurse #10 was termina 2. Current residents are at risk for same alleged deficient practice. Director of Nursing (DON) and/ordesignee conducted an audit of a computers to ensure that if unatted the computer was closed and not health information was visible on and 8/17/17.  3. Systemic measures to be impleted to prevent the same alleged defining practice are: Current Licensed Nand Certified Medication Aides were-educated on privacy/confident include closing of the EMAR who unattended. New Hires will be traduring the orientation process. To Director of Nursing and/or design conduct daily audits for 1 week to the EMARs are closed when left unattended and there is no personal the information visible. Negatifindings will be addressed if note results of the daily audits will be during the Interdisciplinary Team Monday through Friday. The Directon of Version of Sweel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the daily audits for 3 weel monthly audits for 2 months to element of the	tor of ted. or the The related opersona 8/16/17 lemented in 8/16/1	d d	

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	345537		B. WING		08/18/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	1 33.10.2011	
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F 164	Continued From page	e 2	F 164	4. The Quality Assessment Performa Improvement Committee will review results of all audits to determine the effectiveness of the plan based on tridentified. Additional interventions will developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	the ends vill be	
F 224 SS=D			F 224	The state of the s	9/15/17	
	by: Based on observation interview, and record 3 of 6 sampled resident #155), who complain	on, resident interview, staff review the facility neglected ents (Resident #28, #90 and ed about care during the ty, by leaving residents in		F224  1. Resident #28 was bathed dressed assisted out of bed. #155 received incontinent care and was assisted or bed. #90 received personal care an	ut of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345537	B. WING		<del></del>	08/	18/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	-		
SII VER S	TREAM HEAI TH AND RI	EHABILITATION CENTER		23	805 SILVER STREAM LANE			
OILVER	INCAM HEACHT AND K	ENABLEMATION SERVER		W	/ILMINGTON, NC 28401			
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F 224	included:  1. Resident #28 was 03/22/15. The reside included chronic kidn diabetes, osteoarthrit cardiac arrhythmias, pulmonary disease.  The resident's 08/04/set (MDS) document she exhibited no beh care, except for eatin assistance to being to members for her actifus he was always incomended and she had no presson the resident's care pulling 18/04/17, identified by incontinence and AD problems. A goal for keep the resident cletimely incontinent can ADL deficit was staff reposition in bed. The documented Resider via lift and two-person At 2:50 PM on 08/14/in her gown. She state appointment today be enough staff to get heresident.	changing, and/or ver multiple shifts. Findings of admitted to the facility on ent's documented diagnoses bey disease stage III, tis, bladder dysfunction, and chronic obstructive of the facility of the facil	F:	224	assisted out of bed.  2. Current residents who require assistance with activities of daily living and/or mobility are at risk for the same alleged deficient practice. Nursing Administration assisted with providing personal care for those residents on 8/14/17.  3. Systemic Measures Implemented to ensure the same alleged deficient practices not recur is as follows: Current swill be educated on Mistreatment/Negle by the Director of Nursing and/or designee. Additional short and long teagency Licensed Nurses and Certified Nurse Aides have been contracted to provide additional staffing coverage. To Director of Nursing/designee will condupersonal care audits and resident interviews weekly times 4 and then monthly times 2 to ensure care needs a being met. Negative findings will be addressed if noted.  4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trenidentified. Additional interventions will to developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	etice staff ect rm he uct are		
	At 8:33 PM on 08/15	/17 Resident #28 stated she						

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had to remain in b 08/13/17, until 7:00 She commented s morning hours of 0 changed, and rece same evening at 7 she was "sopping changed. Accordi assistants (NAs) to when they could, but staffed. The resid on the wall across time. She commer when she was first she eventually fell someone had cut she did not ring the it would be ignored promises to return under-staffed to go commented that the had developed in the of months. Reside to be wet, but ther about it. She state when therapy wou was not out of bed commented that it the therapists to ke to get her into the reported she missible because staff had finally her pastor we (DON) about the petting written up.	def from 10:00 PM on Sunday, 0 PM on Monday, 08/14/17. The stayed wet from the early 08/14/17 until she was eived a quick bed bath later that 1:00 PM. The resident reported wet" by the time she was ing to the resident, her nursing old her they would get to her out they were extremely short ent stated she used the clock from her bed to gauge the need she rang the call bell once to wet, but had to wait so long asleep, and when she awoke the call light out. She explained the call bell again because either do returned off by staff with later because they were too et to her right then. The resident his was the type of culture that the facility over the last couple ent #28 stated she did not like the was not much she could do not deter were multiple days lid come to get her, and she was frustrating for herself and the properties and green waking repeated attempts therapy gym. She also not gotten her out of bed, and went to the Director of Nursing problem which resulted in staff	F2	224			
	Continued From polad to remain in be 08/13/17, until 7:00 She commented s morning hours of 0 changed, and recessame evening at 7 she was "sopping changed. According assistants (NAs) to when they could, be staffed. The reside on the wall across time. She commended to the word on the wall across time. She commended that it would be ignored promises to return under-staffed to go commented that the had developed in the form of months. Reside to be wet, but there about it. She state when therapy wou was not out of bed commented that it the therapists to ke to get her into the reported she missible because staff had finally her pastor we (DON) about the progetting written up.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 had to remain in bed from 10:00 PM on Sunday, 08/13/17, until 7:00 PM on Monday, 08/14/17. She commented she stayed wet from the early morning hours of 08/14/17 until she was changed, and received a quick bed bath later that same evening at 7:00 PM. The resident reported she was "sopping wet" by the time she was changed. According to the resident, her nursing assistants (NAs) told her they would get to her when they could, but they were extremely short staffed. The resident stated she used the clock on the wall across from her bed to gauge the time. She commented she rang the call bell once when she was first wet, but had to wait so long she eventually fell asleep, and when she awoke someone had cut the call light out. She explained she did not ring the call bell again because either it would be ignored or turned off by staff with promises to return later because they were too under-staffed to get to her right then. The resident commented that this was the type of culture that had developed in the facility over the last couple of months. Resident #28 stated she did not like to be wet, but there was not much she could do about it. She stated there were multiple days when therapy would come to get her, and she was not out of bed, bathed, and dressed. She commented that it was frustrating for herself and the therapists to keep making repeated attempts to get her into the therapy gym. She also reported she missed Bible study multiple times because staff had not gotten her out of bed, and finally her pastor went to the Director of Nursing (DON) about the problem which resulted in staff	ROVIDER OR SUPPLIER  TREAM HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  had to remain in bed from 10:00 PM on Sunday, 08/13/17, until 7:00 PM on Monday, 08/14/17.  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At 3:04 PM on 08/17/17 Resident #28's certified occupational therapy assistant (COTA) #1 stated	ROUDER OR SUPPLIER  TREAM HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 had to remain in bed from 10:00 PM on Sunday, 08/13/17, until 7:00 PM on Monday, 08/13/17, until 7:00 PM on Monday, 08/13/17, be commented she stayed wet from the early morning hours of 08/14/17 until she was changed, and received a quick bed bath later that same evening at 7:00 PM. The resident reported she was "sopping wet" by the time she was changed, According to the resident, her nursing assistants (NAs) told her they would get to her when they could, but they were extremely short staffed. The resident stated she used the clock on the wall across from her bed to gauge the time. She commented she tasked she used the clock on the wall across from her bed to gauge the time. 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WIND  STREET ADDRESS, CITY, STATE, 2IP CODE  2305 SILVER STREAM LANE WILMINGTON, NC 28401  PROVIDER OR SUPPLIER  READ HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  READ HERCENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 4  had to remain in bed from 10:00 PM on Sunday, 08/13/17, until 7:00 PM on Monday, 08/14/17. She commented she stayed wet from the early morning hours of 08/14/17 until she was changed, According to the resident, her nursing assistants (NAs) told her they would get to her when they could, but they were extremely short staffed. The resident stated she used the clock on the wall across from her bed to gauge the time. She commented she rang the call bell once when she was first wet, but had to wait so long she eventually fell asleep, and when she awoke someone had cut the call light out. 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	ROVIDER OR SUPPLIER	EHABILITATION CENTER			NDDRESS, CITY, STATE, ZIP CODE	<u>  U8/</u>	18/2017	
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F 224	Continued From page	e 5	F 2	224				
	resident was unable and strengthening ex reported she heard the get the resident out of	on 08/14/17 because the to complete range of motion sercises in the gym. She here were not enough staff to of bed and bathed.						
	who brought resident from their rooms, sta when he had to visit times before staff had	is to the therapy department ted there were multiple days Resident #28's room several d the resident up out of bed, so he could take her to the						
		8/17 Nurse #12 stated erviewable and reliable.						
	#4, who were assign 08/14/17 stated there scheduled to work or building which house They reported that in receive timely and quathere needed to be for halls and three NAs of They commented with two halls they were used out of bed, could only the most once a shift reposition residents. residents who suffere Resident #28 who has because it was almost with a second NA to According to the NAs most all residents prebed on first shift and	ed to work first shift on e were only two NAs neach of the two halls in the d the heavier care residents. The order for residents to sality care on these halls our NAs on the longer of the on the other heavy care hall. The only four NAs between the smalle to get some residents or provide incontinent care at and could not turn and they explained that those ed the most were those like at the operate the lift safely. So, even though they realized eferred to be up and out of preferred to be clean and had to leave residents in						

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		345537	B. WING		C <b>08/18/2017</b>		
NAME OF PROVIDER OR SUPPLIER  SILVER STREAM HEALTH AND REHABILITATION CENTER		EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		0/10/2017	
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F 224	shift would be more at the shift would be more at the shift would be more at the shift on the shift otherwise), that residents be up and dressed on first shift otherwise), that resident shift otherwise), that resident shift otherwise), that resident shift otherwise), that reside and reduction of pressitioned frequent and reduction of pressitioned frequent and reduction of pressitioned Parkinson's arthritis, chronic pain.  The resident's 05/17 (MDS) documented exhibited no behavior care, except for eating assistance to being the member for her actives the was occasionally always continent of the pressure ulcer (sacra 08/13/17, identified in pressure ulcer as a pathat included "offer to frequently" and "provindicated." The care	soiled and hope that second heavily staffed.  /17 the DON stated it was ility expectation that out of bed, bathed, and (unless the residents voiced lents be checked and very two hours during and that residents be tly to help with pain control source ulcer formation.  as admitted to the facility on ent's documented diagnoses disease, rheumatoid and anxiety, and depression.  /17 annual minimum data set the recognition was intact, she are including resistance to the gashe required extensive otally dependent on a stafficities of daily living (ADLs), and she had a stage III all ulcer since healed).  olan, last updated on lisk for and existence of a problem with interventions of turn and reposition ride incontinent care as plan also documented red assistance from staff with	F 2	224			
	addressed the provis	ent's care plan also sion of appropriate activities, as a preferred activity. d "invite the resident to					

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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2011	
SILVER S	TREAM HEALTH AND RE	EHABILITATION CENTER			805 SILVER STREAM LANE /ILMINGTON, NC 28401			
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F 224	she would like to be of wet since 12 noon. Sabout an hour earlier nursing assistant (NA to her yet because the She commented that care was a reoccurring couple of months.  At 8:42 PM on 08/15/month a NA got her unwith a quick partial be extremities and slipping wear. She reported thave to stay in bed all enough staff to get he also remained wet an 8:00 PM that same exchanged. According to call bell to be changed once on second shift, informed her she would changed. She stated diligently to heal her she sure did not want remarked she did not but it was getting to be the facility so she did deal with it. Resident play Bingo, and she his several times becaus out of bed. She also to get to therapy, and	17 Resident #155 stated changed since she had been she reported she asked to be changed, but the changed short of staff. It is inability to get timely ag problem over the last pat 5:30 AM, providing her at 5:30 AM, providing her at 5:30 AM, providing her at 5:40 Am, providing h	F2	224				

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F 224	who brought reside from their rooms, st when he had to visit before staff had the bathed, and dresse therapy gym.  At 10:33 AM on 08/Resident #155 was  At 2:40 PM on 08/1 #4, who were assig 08/14/17 stated the scheduled to work obuilding which hous (Resident #155 res They reported that receive timely and of the the the halls and three NAs They commented with two halls they were out of bed, could or the most once a sh reposition residents though they realize to be up and out of to be clean and dry	ge 8 7/17 Therapy Assistant #4, nts to the therapy department rated there were multiple days t resident rooms several times residents up out of bed, d so he could take them to the  18/17 Nurse #12 stated interviewable and reliable.  8/17 three NAs, #1, #3, and ned to work first shift on re were only two NAs on each of the two halls in the sed the heavier care residents ided on one of these halls). in order for residents to quality care on these halls four NAs on the longer of the son the other heavy care hall. with only four NAs between the unable to get some residents ally provide incontinent care at ift, and could not turn and so According to the NAs, even d most all residents preferred bed on first shift and preferred many times they had to leave d wet and/or soiled and hope	F 224	DEFICIENCY)		
	At 3:35 PM on 08/1 (DON) stated it was expectation that result bathed, and dresse residents voiced otherwood of the cked and change	buld be more heavily staffed.  8/17 the Director of Nursing sher personal and facility sidents be up and out of bed, d on first shift (unless the nerwise), that residents be ged if needed every two hours ounds, and that residents be				

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F 224	Continued From page repositioned frequer and reduction of pressure and reduction of pressure as a session of the session of th	ge 9  Intly to help with pain control issure ulcer formation.  Is admitted to the facility on mented diagnoses included the, right foot drop, and  Interventions of daily living the resident had arthritis in the resident had arthritis pain of complications related to so, joint stiffness, swelling, and linterventions for the problem reposition frequently" and cian) signs and symptoms of did to arthritis." The care plan resident #90 had a "personal"	F 2	DEFICIENCY)			
	reported she had be turned and repositio the previous night. had asked to get up but was told that the	een in the bed, without being ned, since about 10:00 PM According to the resident, she out of bed twice so far today, ere was not enough staff to do ommented she had not told					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345537	B. WING		C 08/18/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	1 00/10/2011	
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F 224	got Resident #90 ou	surveyor intervention, a NA	F 22	24		
	At 2:40 PM on 08/18 (NAs), #1, #3, and # work first shift on 08/18 two NAs scheduled thalls in the building ware residents (Residents to receive these halls there need longer of the halls ar heavy care hall. The NAs between the two get residents who re	/17 three nursing assistants 4, who were assigned to /14/17 stated there were only to work on each of the two which housed the heavier dent #90 resided on one of eported that in order for timely and quality care on eded to be four NAs on the and three NAs on the other ey commented with only four to halls they were unable to quired lift transfers out of ide incontinent care at the and could not turn and				
F 242 SS=E	(DON) stated it was expectation that resibathed, and dressed residents voiced other checked and change during incontinent rorepositioned frequent and reduction of present 483.10(f)(1)-(3) SEL RIGHT TO MAKE CI	the Director of Nursing her personal and facility dents be up and out of bed, on first shift (unless the erwise), that residents be ad if needed every two hours unds, and that residents be tly to help with pain control esure ulcer formation.  F-DETERMINATION -HOICES  as a right to choose activities, sleeping and waking times), iders of health care services	F 24	12	9/15/17	

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345537	B. WING		08/18/2017		
NAME OF P	ROVIDER OR SUPPLIER		<del>-</del>	STREET ADDRESS, CITY, STATE, ZIP CODE		0/10/2017	
			2305 SILVER STREAM LANE				
SILVER ST	FREAM HEALTH AND R	EHABILITATION CENTER		WILMINGTON, NC 28401			
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F 242	Continued From pag	e 11	F 2	42			
		her interests, assessments, other applicable provisions					
	, , , ,	ns a right to make choices or her life in the facility that resident.					
	members of the com community activities facility. This REQUIREMEN	is a right to interact with munity and participate in both inside and outside the Γ is not met as evidenced					
	by: Based on observation, resident interview, staff interview, and record review the facility failed to honor preferences regarding bathing and getting out of bed in the mornings for 4 of 6 sampled residents (Resident #28, #90, #155, and #181) who expressed care concerns during intial tour of the facility. Findings included:			F242 1. Resident #155, #28, #90 and have been evaluated for their preferences and their preferences and plan of care updated. 2. Current residents are at risk affected by the same alleged designed.	personal ces have has been to be		
	07/13/15. The reside included Parkinson's arthritis, chronic pain	, anxiety, and depression.		practice. Residents who are ca making needs known have bee interviewed by the Director of N and/or designee regarding per- preferences. Their preferences	apable of en Nursing sonal s have		
	(MDS) documented it exhibited no behavio care, and except for extensive assistance on a staff member fo (ADLs).  At 8:42 PM on 08/15.	to being totally dependent r her activities of daily living /17 Resident #155 stated		been honored and the plans of updated accordingly.  3. Systemic Measures Implementation of the same alleged deficition does not recur are as follows:  Nurses and Certified Nurse Aid re-educated regarding resident related to personal preferences resident choice. The Director of	ented to ient practice Licensed des will be t rights s and of		
	but therapy had beer	ed today at about 10:00 AM, n to her room a couple times and see if she was ready to		Nursing/designee will conduct resident interviews weekly time then monthly times 2 to ensure	es 4 and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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SILVER STREAM HEALTH AND RI	EHARII ITATION CENTER		23	305 SILVER STREAM LANE		
SILVER STREAM HEALTH AND RE	ENABILITATION CENTER		W	VILMINGTON, NC 28401		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
month a nursing assist AM, providing her with her upper extremities her head to wear. She she would have to stathere was not enough resident commented would like to be gotte each morning, but she choices was not possishort-staffed. Reside play Bingo, and she his several times becaus out of bed. She also to get to therapy, and had to change her so participate. According enjoyed getting a she since the residents where offered showers asked to receive a she thought it was far were offered showers asked to receive a she there was not enough provide one. The resident much cleaner who versus a bed bath.  At 3:38 PM on 08/17/1 who brought resident from their rooms, stat when he had to visit in before staff had the resident staff had the resident from staff had the resident staf	n. She also reported last stant (NA) got her up at 5:30 th a quick partial bed bath to and slipping a T-shirt over the reported the NA told her ay in bed all day because in staff to get her up. The she had relayed to staff she an out of bed about 8:00 AM the guessed honoring sible when the facility was so ent #155 stated she loved to the admissed the activity the staff did not have her up reported it was a challenge of once recently the therapist of she could get to the gym to get to Resident #155, she ower, but had not gotten one there treated for bugs onths ago (a 02/21/17)	F	242	preferences are being honored. Negati findings will be addressed if noted.  4. The Quality Assessment Performant Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trenidentified. Additional interventions will the developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	ce e ds	

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		345537	B. WING			C 8/18/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		0/10/2017	
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F 242	At 2:40 PM on 08/18 #4, who were assign stated sometimes the scheduled to work of building which house They reported that in receive timely and querie there needed to be for halls and three NAs They commented the showers could not be staff, and about all the quick bed baths. Ac there were only four heavy-care halls the residents out of bed much less honor any the time they were go dressed.  At 3:35 PM on 08/18 (DON) and Administr resident preferences to be honored. They acceptable for reside bed before lunch ead second shift for staff of bed, bath them, an commented currently documentation as to showers or bed bath	8/17 Nurse #12 stated nterviewable and reliable.  1/17 three NAs, #1, #3, and ed to work first shift a lot ere were only two NAs n each of the two halls in the ed the heavier care residents. In order for residents to uality care on these halls our NAs on the longer of the on the other heavy care hall. ere were many times when e given due to a shortage of nat were able to provide were cording to these NAs, when NAs between the two y could not even get who required lift transfers of resident choices regarding otten of bed, bathed, and	F 2	42			
	week that different re offered showers. A	pecified the two days of the esidents were supposed to be eccording to the DON, the so follow the schedule, and if					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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ttl p 200 iii co p T s s co iii p ttl p tt	2. Resident #28 was 03/22/15. The residencluded chronic kidraliabetes, osteoarthricardiac arrhythmias, oulmonary disease.  The resident's 08/04, set (MDS) document she exhibited no behave, and except for extensive assistance on two staff member fiving (ADLs).  At 2:50 PM on 08/14 observed in bed in homissed her therapy at here was not enouge outhed, and dressed at 8:33 PM on 08/15 and to remain in bed 08/13/17, until 7:00 Fishe commented she she liked to be out of 09/11:00 AM daily, be because for the last over y short staffer any good to ring the under-staffed becaus NAs) and nurses we not get you up at all of the staff	were to be notifying her of the sadmitted to the facility on ent's documented diagnoses bey disease stage III, tis, bladder dysfunction, and chronic obstructive  17 quarterly minimum data ed her cognition was intact, aviors including resistance to eating she required to being totally dependent is for her activities of daily  17 Resident #28 was er gown. She stated she appointment today because th staff to get her out of bed,	F 24	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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F 242	her, and she was not dressed. She common for herself and the three trepeated attempts to gym. She also reported the times becaused out of bed, and final Director of Nursing which resulted in statement of Nursing which resulted electric resident in her room resident was unable and strengthening or reported she heard get the resident out.  At 3:38 PM on 08/11 who brought resider from their rooms, statement was unable and strengthening or reported she heard get the resident out.  At 3:38 PM on 08/11 who brought resident from their rooms, statement was unable and dressed therapy gym.  At 10:33 AM on 08/18 was in At 2:40 PM on 08/18 was in Nursident was unable to work of the Nursident was unable and strengthening the Nur	therapy would come to get but out of bed, bathed, and bented that it was frustrating prerapists to keep making or get her into the therapy of the staff had not gotten her ly her pastor went to the (DON) about the problem aff getting written up.  7/17 Resident #28's certified by assistant (COTA) #1 stated cal stimulation (e-stim) to the let of complete range of motion exercises in the gym. She there were not enough staff to	F 24	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 242	Continued From pag	ge 16	F 2	42		
	They commented w two halls they could bed who required lif any resident choices gotten of bed, bathe					
	(DON) and Administ resident preferences to be honored. The acceptable for resid bed before lunch ea	8/17 the Director of Nursing trator stated they expected is and choices about their care by reported it was not ents who wanted to be out of each day to have to wait until if to assist or transfer them out and dress them.				
	05/08/15. Her docu	is admitted to the facility on mented diagnoses included ne, right foot drop, and				
	set (MDS) documer she exhibited no be care, and except for extensive assistance	6/17 quarterly minimum data sted her cognition was intact, haviors including resistance to reating she required e to being totally dependent members for her activities of				
	on 08/09/17, docum	#90's care plan, last updated lented the resident had a e to be out of bed early."				
	observed in bed. So the bed, without bei since about 10:00 P According to the res	4/17 Resident #90 was he reported she had been in ng turned and repositioned, 'M the previous night. sident, she had asked to get so far today, but was told that				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 242	she had shared multi she would like to be a around 7:00 AM beca stayed in bed much lithe past couple monthonored because she enough direct care stated and the past couple monthonored because she enough direct care stated and the past couple monthonored because she enough direct care stated and the past care	staff to do so.  8/17 Resident #90 stated ple times with the staff that gotten out of bed each day at ause she got stiff if she onger. She reported within the her request was not a was told there was not eaff.  8/17 Nurse #12 stated the erviewable and reliable.  7/17 three NAs, #1, #3, and the downk first shift on the ware only two NAs the each of the two halls in the dother heavier care residents. The order for residents to the part of the control of	F 2	242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 242	Continued From page	e 18	F 2	242			
	on 11/11/16. The residiagnoses included patage 4 of the sacral dysfunction of bladded. Resident #181's quark (MDS) dated 07/20/1 cognition was intact, total assistance by stansfers, and toiletin incontinent of bowel a catheter. Resident # wheelchair for mobility. Resident #181 was of (Monday) at 4:30 PM supine in the bed was cell phone. The reside been out of bed for to that he was placed in bedtime and hadn't be Saturday. The reside multiple times over the up and be placed in the stated that his request that nurse aide (NA) stating that they would could but there were more attention. The nurse aide #1 reported staffed and couldn't general resident #181 was of 11:00 AM in his wheel	terly Minimum Data Set 7 revealed the resident's and he required extensive to aff for bed mobility, g. The resident was always and had an indwelling 181's assistive device was a ry.  bserved on 08/14/2017 The resident was lying teching television and using a dent stated that he had not wo days. The resident stated a bed on Saturday evening at een out of bed at all since ent stated that he requested are last couple of days to get his wheelchair. The resident st was never honored and #1 responded to his request d get to him as soon as they other residents who needed resident also stated that the ed that the facility was short get him up at that time.  bserved on 8/15/2017 at					
		wheelchair and out of the					

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F 242	bed. The resident st and felt great. In an interview with N 3:38 PM, she reported to her when she came that he had not been bed on Saturday everesident #181 was we he was being truthful of bed since Saturda. Resident #181 was in 9:46 AM. The resident placed in bed around was in the bed conting on 8/15/2017 when he was to various staff out of bed. The resident stated to times to various staff out of bed. The resident wanted to and would Resident stated that they were short residents had more under the wanted to and would Resident #181 stated laid for long periods of because of being a pand it took him a long warming up his extreof bed.  During an interview was taffed. She reported running behind with passed with the facility had me because of the short that the facility had me to the short that the short that the facility had me to the short that the short the short that the short that the short the short that t	Nurse #1 on 08/16/2017 at ed that Resident #181 stated are on 2nd shift on Monday out of bed since being put to ening. Nurse#1 stated that ery reliable and she felt that about not being assisted out	F2	242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 242	there was not eno stated that most of and were in need stated that when the trays arrived to the and the NAs passing residents who need stated that she deschedule based of and their acuity. No provided incontine all residents, but so the residents out of bed on here the resident requed idn't have enough him. NA#1 stated two or more persongetting out of bed, help to get him up 4. b Resident #13 on 11/11/16. The rediagnoses include stage 4 of the sact dysfunction of black Resident #181's quite (MDS) dated 07/2 cognition was intated total assistance by transfers, and toile incontinent of bow catheter. Resident wheelchair for more stated to the state of the sact dysfunction of bow catheter. Resident wheelchair for more stated to the state of the sact dysfunction of bow catheter. Resident wheelchair for more stated that most incontinent of bow catheter. Resident wheelchair for more stated to the state of the sact dysfunction of bow catheter. Resident wheelchair for more stated that when the sact dysfunction of bow catheter in the stated that when the sact dysfunction of bow catheter. Resident wheelchair for more stated that when the sact dysfunction of bow catheter. Resident wheelchair for more stated that when the sact dysfunction of bow catheter.	to care for other patients when ugh staff already. The NA #1 f her residents were incontinent of extensive to total care. NA #1 he breakfast, lunch, and snack et hall, all patient care stopped ed out food trays and assisted eded feeding assistance. NA #1 termined her patient care in the needs of the residents lA#1 stated that she always ent care in a timely manner for the was not able to always get of bed when they wanted to get that she didn't get resident #181 shift this past weekend when ested to get up because she in time or help to accommodate that Resident #181 required ons to assist when he was and she was unable to get any .  81 was admitted to the facility resident's documented doparaplegia, pressure ulcer ral region, and neuromuscular dider.  warterly Minimum Data Set 0/17 revealed the resident's ct, and he required extensive to a staff for bed mobility, eting. The resident was always rel and had an indwelling Foley at #181's assistive device was a	F 2	242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED	
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F 242	watching television a resident stated that over a week. The rescheduled to have so Fridays every week. The rescheduled to have so Fridays every week. The resident so a shower, and a week long. The resident so shower, but was told enough staff since how two persons to show the resident #181 was an teleform that it is and felt great. The resident so and felt great. Resident #181 was and stated shower even though shower twice a weeld that he received that he received with two-person asson became weak during the month of August #181 did not received 8/1/17 through 8/9/1	was lying supine in the bed and using a cell phone. The he had not had a shower in esident stated that he was howers on Tuesdays and The resident stated that he daily but really enjoyed getting ek with no shower was too stated that he asked to get his by NA#1 that there wasn't be required the assistance of ver.  Subserved on 8/15/2017 at chair in the hallway resident stated that he was so wheelchair and out of the tated that they had a shower should have the was scheduled for a con Tuesday and Friday. That he requested a shower of given one. The resident well his shower this week on the felt that was only one were in the facility. The ne required a sit and stand istance to shower because he	F	242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	FIPLE CONSTRUCTION  NG	' '	(X3) DATE SURVEY COMPLETED	
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F 242	on 8/18/2017 at 10 was always short swere always running daily care. NA #1 suffered greatly be NA #1 stated that the residents that reguland in turn this requand snack trays and snack trays and snack trays and stopped and the Nassisted residents and receives a bed bat on a shower schedon assist staff to provide saffition (ADL) were of a NA was with an anotebook kept at edocumentation of reflected that the above NA's docume provided for a residucumentation in twere not usually documented there #181 not receiving #1 stated that it was having enough sta	w with nursing assistant (NA) #1 0:45 AM she stated the facility staffed. She reported the NA's ng behind with providing patient stated that patient care cause of the shortage of staff. The facility had many full assist lired heavy attention to needs fuced the time to care for other we was not enough staff already. That most of her residents were were very demanding of care. That when the breakfast, lunch, rived to the hall, all patient care A's passed out food trays and who needed feeding stated that she determined Thedule based on the needs of Their acuity. Every resident the daily and each resident was fulle that can be showered. There were days that residents theduled shower if they were a the showers. Activities of daily documented in the computer. If the agency, they document in a the number "8" in the computer that if a shower was not dent in the bathing schedule the computer. Daily bed baths ocumented, but showers were When asked about resident a shower for over a week, NA as very possible because of not off at the time because resident	F	242			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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				23	305 SILVER STREAM LANE		
SILVER S	IREAM HEALIH AND RE	EHABILITATION CENTER		W	/ILMINGTON, NC 28401		
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F 250 SS=D	social services to atta practicable physical, well-being of each restrained processes and practicable physical, well-being of each restrained processes and practicable physical, well-being of each restrained processes and processes and processes and practical physical processes and practical physical processes and processe	provide medically-related ain or maintain the highest mental and psychosocial sident.  T is not met as evidenced are and record review the e 1 of 1 cognitively impaired as sent out of the facility to y unaccompanied by give consent for treatment. In gnitively impaired and could reatment. The facility also diarrange transportation to a for 1 of 2 residents awed for medically-related ings Included:  admitted on 08/19/13. The diagnosis included and included and she had on both sides of upper and the resident required by staff for bed mobility, dressing, eating, toileting,	F	250	F250  1. Resident #88 was discharged from the facility on 7/26/17. Resident #217 attended her appointment scheduled on 6/30/17.  2. Current residents requiring transportation to appointments have the risk of being affected by the same alleged deficient practice. Residents going out an appointment will be evaluated by the Director of Nursing or designee to determine if it is necessary for an escort of attend. An escort will accompany the resident as deemed appropriate.  3. Systemic Measures Implemented to ensure the same alleged deficient pracedoes not recur are as follows: The Soc Worker and Scheduler/Transporter will educated regarding our transportation policy and providing escorts to those residents in need. Current residents will be reviewed by the Director of Nursing/designee to evaluate if they will need an escort if going out on an appointment. The Director of Nursing/designee will provide the scheduler/transporter a list of residents needing an escort based on the evaluation.  Newly admitted resident sist of sischarge	n e ged on e rt e tice cial be	9/15/17
	-	sported for an outpatient			records will be reviewed by the Directo	r of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	245527	D WING			С	
	345537	B. WING _			08/18/2017	
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP (	CODE		
SILVER STREAM HEALTH AN	ND REHABILITATION CENTER		2305 SILVER STREAM LANE			
OLVER OTREAM TEACHTA	TO REHADILITATION SERVICE		WILMINGTON, NC 28401			
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT		
F 250 Continued From	page 24	F 2	50			
appointment to he transported Resignation unaccompanied resident was plathe transport drive the outpatient ap x-ray. The reside Guardian also stognitive impairment treatment. The office guardian to make was there and the Guardian stated facility to be with received the phoconsented to tree. During an intervity Coordinator (HIC stated that it was was transported member or famile She also stated should be taken for transport to a that it was her expensible particular made aware of a resident was going HIC also stated for an outpatient planned with an take Resident #8 reported that Reand that the hos the day she was stated that she as	page 24 have an x-ray. The facility ident #88 to the appointment by a facility staff member. The ced on the transport vehicle and ver dropped Resident #88 off at opointment at the hospital for an ent was left there alone. The rated that the resident had severe ment and could not consent to outpatient facility contacted the re him aware that the resident hey needed consent to treat. The that he drove to the outpatient resident #88 as soon as he one call notification and atment on behalf of the resident.  The with the Health Information C) on 08/18/17 at 9:10 AM, she is her expectation when a resident to an appointment that a staff y member go with the resident. That a resident's cognitive status into consideration with planning appointments. The HIC reported expectation that family or y should always be called and a resident appointment or if a ang to be off facility property. The that Resident #88 was sent out ex-ray at the hospital, and she outside transport company to 88 for treatment. The HIC sident #88 was a hospice patient pice nurse was with the resident being transported. The HIC assumed that the hospice nurse esident #88 to the appointment	F 2	Nursing and/or designee to there are any follow-up apple scheduled. An in-house cowill be provided to the transcheduler for any new resinew appointments in which is required. The Director of designee will review the scappointments weekly times monthly times 2 months to are provided as needed. Note reviewed weekly times 4 wonthly times 2 months to appointments/transportations scheduled accordingly. An finding will be addressed if 4. The Quality Assessmen Improvement Committee working results of all audits to dete effectiveness of the plan be identified. Additional intervolution developed and implemented Committee as deemed near maintain substantial complexity.	pointments or munication sportation sportation dents and/or in transportation for Nursing and/or cheduled so 4 weeks and the ensure escort lewly admitted for swill also be reeks and the ensure on has been by negative for noted. It Performance will review the rmine the ased on trend fentions will be defect by the cessary to	on /or d tts d e n	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345537	B. WING _			C 8/18/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		10/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 250	HIC reported that she that was cognitively in appointment without the resident but in the provide a chaperone appointment.  The facility administro of clinical services where at 12:30 PM. They be facility should follow having a facility empaccompany a resident Concerning Resident stated that the facility transportation policy employee or family in Resident #88 to here at treatment. The district services reported that transport a resident, impaired, to an appointment with Resider failed provision of a saccompany the resident with Resider failed provision of a saccompany the resident with Resider failed provision of a saccompany the resident with Resider failed provision of a saccompany the resident with cumular pneumonia and lung.  A hospital discharge revealed she had a cappointment schedul with the cancer specific provided that the same provided that the cancer specific provided that the same provided that the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees or family in Resident #88 to here at the facility transportation policy employees with the facility employees where the facility employees with the faci	the transport service. The ewould not send a resident impaired out to an a staff member going with its incident, she failed to with Resident #88 to an attor and the district manager ere interviewed on 08/18/17 both had the expectation that the transportation policy by loyee or family member into a medical appointment. It #88, the administrator if alled to follow the and didn't secure an inember to accompany appointment to consent for the transportation policy by appointment to consent for the transportation will be will	F 2	50			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345537	B. WING		C 08/18/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2305 SILVER STREAM LANE  WILMINGTON, NC 28401	1 00/10/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 250	impairments.  A review of the care Resident #217 require cancer specialist relations and the residual Administration Records to schedule all appointments; and the chemotherapy at the A review of the facility 06/30/17 revealed not Resident #217.  A note from the facility revealed that to her it was not scheduled for the care impairments.	plan dated 08/1/17 revealed red chemotherapy at the ated to lung cancer.  ent's August 2017 Medication rd (MAR) revealed the facility lent #217's (family member) remember, the (family with the resident to all re resident was to receive all cancer specialist's office.  by's transportation log for the scheduled transportation for the scheduled transportation for the scheduled transportation.	F 25	50		
F 279 SS=D	and 3:00 PM with the and Administrator revexpectation the facili and transported Reschemotherapy infusion 483.20(d);483.21(b)(COMPREHENSIVE 483.20(d) Use. A facility meassessments complete	ty should have scheduled ident #217 to her 06/30/17 on appointment and did not.  1) DEVELOP	F 27	79	9/15/17	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		345537	B. WING			C 8/18/2017
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		J. 10. 20 11
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279		sments to develop, review ent's comprehensive care	F 27	79		
	(1) The facility must comprehensive perseach resident, consiste forth at §483.10(includes measurable to meet a resident's and psychosocial necomprehensive associate plan must describe for maintain the reside physical, mental, and required under §483.24, §483 provided due to the under §483.10, inclustreatment under §48 (iii) Any specialized sprovide as a result or recommendations. If findings of the PASA rationale in the resident set of the resident set of the passive set of the passi	develop and implement a on-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that e objectives and timeframes medical, nursing, and mental leds that are identified in the essment. The comprehensive ribe the following -  are to be furnished to attain lent's highest practicable d psychosocial well-being as .24, §483.25 or §483.40; and a would otherwise be required 8.25 or §483.40 but are not resident's exercise of rights liding the right to refuse 3.10(c)(6).  services or specialized less the nursing facility will f PASARR a fa facility disagrees with the lark, it must indicate its ent's medical record.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	ATE, ZIP CODE		
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F 279	Continued From page (A) The resident's g desired outcomes.  (B) The resident's p future discharge. Fawhether the resident community was ass local contact agencientities, for this purpose (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMENT by:  Based on observative review the facility famanagement for 1 of Findings included:  Resident #118 was 06/19/17 with diagning including Cerebral Dominant Side.	ge 28  oals for admission and  reference and potential for acilities must document t's desire to return to the essed and any referrals to es and/or other appropriate cose.  in the comprehensive care in accordance with the th in paragraph (c) of this  IT is not met as evidenced on, staff interview and record illed to care plan contracture or 1 residents (#118).  admitted to the facility on coses that included Cerebral plegia of Upper Limb Infarction Affecting Left	F 27	F279  1. Resident #28 care plan was uninclude interventions for contract management.  2. Current residents requiring commanagement have the potential affected by the same alleged depractice. The care plans of those residents requiring contracture management were reviewed and as needed.	updated to sture to be sficient e		
	(MDS) dated 06/26/ had intact cognition, assistance with active exception of locomo which required supe had no skin impairm Review of the care p did not include inter	vities of daily living with the tion (wheelchair) and eating ervision only. The resident		3. Systemic measures implement ensure the same alleged deficied does not recur include: The Interdisciplinary Team was re-eddeveloping comprehensive care The Director of Nursing, Reside Management Director and/or dereview new orders daily Monday Friday during the Interdisciplinal meeting. Orders requiring care pupdates for contracture manage	ducated on plans. Int Care signee will by Thru Ty Team		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345537	B. WING _				C <b>18/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2017
				23	305 SILVER STREAM LANE		
SILVER S	FREAM HEALTH AND RE	EHABILITATION CENTER			/ILMINGTON, NC 28401		
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F 279	Continued From page	e 29	F 2	79			
	Restorative Therapy.				be entered on to the plan of care and		
	Record review showed discharged from Occawith discharge recommon the left hand daily bathing or exercising required.	ed that the resident was upation Therapy on 07/26/17 imendations to wear a splint at all times except when . No physician order was		be entered on to the plan of care and implemented accordingly. The Directo Nursing and/or designee will conduct weekly audits times 4 weeks and mon times 2 months to ensure orders for contracture management have been documented on the plan of care.  4. The Quality Assessment Performan Improvement Committee will review the results of all audits to determine the		hly	
	10:30 AM she stated putting the splint on h	that no one had been er left hand. She stated that			effectiveness of the plan based on trenidentified. Additional interventions will l		
		he splint but that none of the w to put it on. The resident's ed to be contracted.			developed and implemented by the Committee as deemed necessary to maintain substantial compliance.		
		15/17 at 11:15 AM and on evealed that the resident lint on her left hand.					
	with the Rehab Mana resident's contracture Occupational Therapi the contraction had n revealed that the resi	ger, she stated the had been screened by the sist that morning. She stated ot worsened. She also dent's splint could not be one would be ordered.					
	#3, he stated that it work of care to wear a spliit that it had not been considered was to wear therefore he did not pure In an interview with the 08/18/17 at 11:46 AM expectation that the form	vas not on the resident's plan on the nerident's plan on the left hand. He said communicated to him that the a splint on her left hand and out it on the plan of care.  The Director of Nursing on a she stated that it was her acility follow therapy discontinue therapy after a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279 F 281 SS=D	Continued From paresident is dischargervices as a part of 483.21(b)(3)(i) SER PROFESSIONAL SERVICES provides as outlined by the omust-  (i) Meet profession This REQUIREMED by:  Based on record minterview the facility standard of nursing during dressing charged from the continuent of the continuent o	age 30 ged from skilled therapy of a resident's plan of care. RVICES PROVIDED MEET STANDARDS  ive Care Plans ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced eview, observation, and staff of failed to follow professional gractice resident dressings anges for 3 of 3 residents dent #181, and Resident	F 2	79	7 had their 7 the 10 be standard of ssings when be deficient ereviewed edressings eded.		
	assistance with bertoilet use, dressing bathing.  A pressure ulcer dr Resident #6 was composed with Nurse #6. 4 sacral pressure users.	d mobility, transfers, eating, personal hygiene, and essing change observation for onducted on 08/16/17 at 3:29 The resident's existing stage elect dressing was removed to be dated or initialed. After		prevent the same alleged defice practice does not recur include staff will be educated on the dainitialing of a dressing when it is as the standard of practice. The of Nursing and/or designee will weekly audits times 4 weeks a monthly times 2 months to enside dressings are dated and initialed.	cient  E: Licensed  ating and  is changed  ie Director  I conduct  and then  sure		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			(X3) DATE SURVEY COMPLETED	
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		345537	B. WING			08/	18/2017
	ROVIDER OR SUPPLIER  TREAM HEALTH AND RE	HABILITATION CENTER		23	TREET ADDRESS, CITY, STATE, ZIP CODE 305 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	pressure ulcer dressin did not date and initial An interview was con PM with Nurse #6 wh worked for the facility initialed all her dressin good nursing practice started as the facility's told that it was not the initial dressings, and dating and initialing or do.  An interview was con PM with the Director of DON stated that dressinitialed per facility por reviewing the facility's dressing changes dat reported moving forw (per professional clini dressings were require when placed and when p	esident #6's stage 4 sacral and with a new dressing, she I the new dressing.  ducted on 08/16/17 at 4:00 to stated that before she she always dated and and changes, which was to she said when she is treatment nurse, she was the facility's policy to date and was told to discontinue and dressings, which she did ducted on 08/16/17 at 4:30 for Nursing (DON). The sings were not dated and dicy. However, after a policy and procedure on the dicy and the repuired diagnoses or the dicy and the resident's and he required extensive to the facility of the dicy Minimum Data Set and he required extensive to the for bed mobility, go the resident was always.	F	281	Negative findings will be addressed if noted.  4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trensidentified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	e ds	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		7071072017	
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F 281	Resident #181 was of 10:03 AM with Nurse resident's sacral ulco observed not to be do provided wound care to the pressure ulcer initial the new dressi.  During an interview of Nurse #6 concerning she always dated and to starting her employ stated that she was sto not date dressing policy. She reported she has been notified dressing changes but nursing practice to do Nurse #6 reported the wound care nurse for admitted that she for Resident #181's new because she wasn't initialing dressing changes in the properties of the properti	ssing change observation for conducted on 08/16/17 at 2 #6. The dressing on the er was removed and lated or initialed. Nurse #6 er and applied a new dressing to but she did not date and lated or initialed and lated l	F 2	81			
	initialing all dressing	d of practice by dating and changes.  as admitted to the facility on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	` '	ATE SURVEY DMPLETED
		345537	B. WING _			C 08/18/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2305 SILVER STREAM LANE WILMINGTON, NC 28401		00/10/2017
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F 281	included cerebral in hemiparesis, dysph infarction, generaliz unstageable sacral During an interview Nurse #6 concernin she always dated a to starting her empl stated that she was to not date dressing policy. She reporte she has been notified dressing changes best nursing practic changes. Nurse #6 designated wound Nurse #6 admitted initial Resident #18 dressing, because shating and initialing facility.  A pressure ulcer dread Resident #227 was 10:30 AM with Nurse sacral pressure ulcer dobserved not to be #6 provided wound dressing to the sacrand signed the new An interview was compared that initialed per the facility becember 2009 on	dents documented diagnosis farction, hemiplegia, agia, aphasia post cerebral ed muscle weakness, and pressure ulcer.  on 08/16/17 at 10:15 AM with g wound care, she stated that not initialed all dressings prior oyment at this facility. She told by the director of nursing g changes per the facility d that today was the first time ed that she needed to date ut she felt strongly that it was e to date all dressing reported that she was the care nurse for the facility. That she forgot to date and 1's new pressure ulcer she wasn't in the habit of dressing change observation for conducted on 08/16/17 at e. #6. The resident's existing er dressing was removed and dated or initialed. After Nurse care and applied a new ral pressure ulcer, she dated	F2	281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345537	B. WING		C 08/18/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	00/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 281 F 312	expectation that nurs professional standar initialing all dressing	moving forward, it was her ses should follow the d of practice by dating and	F 28		9/15/17	
SS=E	(a)(2) A resident who activities of daily livir services to maintain personal and oral hy This REQUIREMEN' by: Based on observation interview, and record provide activity of damultiple shifts for 4 of (Resident #11, #28, scomplained about cathe facility. The facil residents out of bed assistance from staff required extensive a dependent on staff for #90, and #155). The resident who was de (Resident #28). The resident who required staff for dressing (Resident #28) in the required extensive a mobility and was dependent was dependent to provide incomplete the required extensive a mobility and was dependent #90). The fingernails for one resident required extensive a mobility and was dependent #90). The fingernails for one resident who required extensive a mobility and was dependent #90). The fingernails for one resident who required extensive a mobility and was dependent #90). The fingernails for one resident who required extensive a mobility and was dependent #90). The fingernails for one resident who required extensive a mobility and was dependent #90). The fingernails for one resident who required extensive a mobility and was dependent #90). The fingernails for one resident who required extensive a mobility and was dependent #90).	o is unable to carry out and receives the necessary good nutrition, grooming, and giene.  T is not met as evidenced  on, resident interview, staff a review the facility failed to ily living (ADL) care over of 6 sampled residents  #90 and #155) who are during the initial tour of ity failed to get three who required extensive with bed mobility and saist from staff to being or transfers (Resident #28, a facility failed to dress one dextensive assistance from esident #28). The facility on the facility failed to dress one desident #28). The facility on the facility failed to cut		F312  1. Resident #28 was bathed dressed out of bed. #155 received incontinent and was assisted out of bed. #90 recepersonal care and assisted out of bed following their interview with the surve Resident #11 received nail care immediately following the surveyor notifying the DON.  2. Current residents requiring assistar with activities of daily living (ADLs) arrisk for the same alleged deficient practice. Nursing Administration provithe care needed for those residents requiring assistance on 8/14/17.  3. Systemic measures implemented to ensure the same alleged deficient pradoes not recur include: Additional shound long term agency Licensed Nurse and Certified Nurse Aides have been contracted to provide additional staffing coverage. The Director of Nursing/designee will review the staffindaily to ensure coverage is adequate based on the needs of the residents.	and care eived eyor.  nce e at ded ctice ort es	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345537	B. WING _			08/	18/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SILVER ST	TREAM HEALTH AND I	REHABILITATION CENTER			305 SILVER STREAM LANE			
				W	/ILMINGTON, NC 28401			
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F 312	Continued From page	ge 35	F3	312				
	(Resident #11). Fin	<del>-</del>			Staffing assignments will also be			
	,	· ·			evaluated by the Director of			
		as admitted to the facility on			Nursing/designee and adjusted			
		dent's documented diagnoses			accordingly based on resident need.	**		
		Iney disease stage III,			Current employees who are reporting of			
		ritis, bladder dysfunction, s, and chronic obstructive			of work on their scheduled time will not the Director of Nursing/designee	пу		
	pulmonary disease.				personally. The Director of			
	paintenary alocaco.				Nursing/designee will then attempt to			
	The resident's 08/04	4/17 quarterly minimum data			ensure there is adequate coverage to			
		nted her cognition was intact,			provide care for those residents who			
		haviors including resistance to			require assistance. In the event covera	•		
	•	extensive assistance from staff			is unable to be obtained the Administra	tive		
		ssing/toileting, she was for bathing and transfers, she			Nursing Team will report to facility to assist with care needs. The Director of	f		
		nent of bowel and bladder, and			Nursing/designee will conduct care aud			
	she had no pressure				daily for 1 week and then weekly times			
	•				weeks and monthly times 2 to ensure of			
		plan, last updated on			is being provided as needed. Resident			
	08/04/17, identified				interviews weekly times 4 and then			
		DL self-care deficit as			monthly times 2 to ensure care needs a	are		
	-	or the incontinence was to ean and dry with provision of			being met. Negative findings will be addressed if noted.			
		are by the staff, and a goal for			4. The Quality Assessment Performant	'e		
		ff assistance to turn and			Improvement Committee will review the			
	reposition in bed. T				results of all audits to determine the			
	documented Reside	ent #28 had to be transferred			effectiveness of the plan based on tren	ds		
	via lift and two-pers	on staff assist.			identified. Additional interventions will t	е		
	A+ 0.50 D*4 00/4	4/47 D:			developed and implemented by the			
		4/17 Resident #28 was in bed lso reported she was wet, and			Committee as deemed necessary to maintain substantial compliance.			
	needed to be chang							
	At 8:33 PM on 08/1	5/17 Resident #28 stated she						
		d from 10:00 PM on Sunday,						
		PM on Monday, 08/14/17.						
		e stayed wet from the early						
		3/14/17 until she was ved a quick bed bath later that						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345537	B. WING _			08/	C <b>18/2017</b>	
	ROVIDER OR SUPPLIER  TREAM HEALTH AND R	EHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP COD 2305 SILVER STREAM LANE WILMINGTON, NC 28401	)Ε			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 312	same evening at 7:00 she was "sopping we changed. According assistants (NAs) told when they could, but staffed. The resident on the wall across frotime. She commente when she was first we she eventually fell as someone had cut the she did not ring the cit would be ignored of promises to return late under-staffed to get to commented that this had developed in the of months. Resident to be wet, but there we about it.  At 10:33 AM on 08/18. He was interested to work or building which houses they reported that in receive timely and que there needed to be for halls and three NAs of They commented with two halls they were used to not a shift reposition residents.	o PM. The resident reported of by the time she was to the resident, her nursing her they would get to her they were extremely short to stated she used the clock of her bed to gauge the disher and the call bell once et, but had to wait so long eleep, and when she awoke encall light out. She explained eall bell again because either returned off by staff with the terbecause they were too to her right then. The resident was the type of culture that the facility over the last couple effect was not much she could do the service was and reliable.	F3	.12				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345537	B. WING _		C	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  2305 SILVER STREAM LANE  WILMINGTON, NC 28401		08/18/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIC	
F 312	because it was almowith a second NA to According to the NA most all residents probed on first shift and dry, many times they bed and wet and/or shift would be more. At 3:35 PM on 08/18 her personal and factoresidents be up and dressed on first shift otherwise), that residents be up and dressed or first shift otherwise), that resident frequer and reduction of presidents. The resident #155 w 07/13/15. The resident would preside exhibited no behavior care, she required exhibited no	ad to be transferred via lift est impossible to come up help operate the lift safely. s, even though they realized eferred to be up and out of preferred to be clean and y had to leave residents in soiled and hope that second	F3	12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345537	B. WING _		<u> </u>	C 08/18/2017
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		30/10/2017
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	indicated." The care Resident #155 requir transfers. The reside addressed the provis with Bingo identified a Interventions includes scheduled activities of At 2:56 PM on 08/14/she would like to be of wet since 12 noon. Subout an hour earlier nursing assistant (NATO) to her yet because the She commented that care was a reoccurring couple of months.  At 8:42 PM on 08/15/month a NA got her of with a quick partial be extremities and slipping wear. She reported that have to stay in bed at enough staff to get he also remained wet ar 8:00 PM that same exchanged. According to call bell to be changed once on second shift, informed her she wood changed. She stated diligently to heal her she sure did not want remarked she did not but it was getting to be	plan also documented ed assistance from staff with ent's care plan also ion of appropriate activities, as a preferred activity. d "invite the resident to of interest."  17 Resident #155 stated changed since she had been she reported she asked to be changed, but the style to be changed, but the style to be the shear of staff. The inability to get timely and problem over the last of 17 Resident #155 stated last and part 5:30 AM, providing her and bath to her upper and a T-shirt over her head to the NA told her she would all day because there was not be up. She commented she and soiled before lunch until and soiled before lunch until and once on first shift and and but both times staff	F3	12		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345537	B. WING _		C 08/18/2017	7
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 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 PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLI THE APPROPRIATE DAT	ETION
F 312	Resident #155 was in  At 2:40 PM on 08/18, #4, who were assign 08/14/17 stated there scheduled to work or building which house (Resident #155 resid They reported that in receive timely and quathere needed to be for halls and three NAs of They commented with two halls they were used to be up and out of bed, could only the most once a shift reposition residents. though they realized to be up and out of be to be clean and dry, residents in bed and that second shift wou.  At 3:35 PM on 08/18, (DON) stated it was been expectation that residents voiced other checked and change during incontinent roor repositioned frequent and reduction of pressidents #90 was 05/08/15. Her documents with the control of the checked and they are sidents with the checked and change during incontinent roor repositioned frequents and reduction of pressidents #90 was 05/08/15. Her documents with the checked and they are sidents with the checked and change during incontinent roor repositioned frequents and reduction of pressidents.	B/17 Nurse #12 stated nterviewable and reliable.  (17 three NAs, #1, #3, and ed to work first shift on ewere only two NAs each of the two halls in the did the heavier care residents ed on one of these halls). order for residents to rality care on these halls our NAs on the longer of the four the other heavy care hall. In only four NAs between the nable to get some residents or provide incontinent care at	F3	312		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		OMPLETED
		345537	B. WING _			C 08/18/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	'	30, 10, 20 11
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	set (MDS) documer she exhibited no be care, she required a bed mobility and trapressure ulcers.  The resident's care 08/09/17, documen her bilateral should. The goal for the mawas to remain free arthritis, contracture decline in mobility. included "turn and r"report to MD (phys complications relate also documented R preference to be out. At 3:25 PM on 08/1 was in discomfort d muscle spasms in h reported she had be turned and reposition the previous night. had asked to get up but was told that the so. However, she cataff about the discontractions.	of/17 quarterly minimum data anted her cognition was intact, shaviors including resistance to extensive assist from staff with unsfers, and she had no plan, last updated on ted the resident had arthritis in ers and lower extremities. Inagement of this arthritis pain of complications related to es, joint stiffness, swelling, and Interventions for the problem reposition frequently" and ician) signs and symptoms of ed to arthritis." The care plan resident #90 had a "personal to fobed early."  4/17 Resident #90 stated she use to stiffness, cramping, and her legs and feet. She even in the bed, without being oned, since about 10:00 PM According to the resident, she out of bed twice so far today, ere was not enough staff to do commented she had not told comfort that she was surveyor intervention, a NA	F3	12		
	Resident #90 was in At 2:40 PM on 08/1 (NAs), #1, #3, and	18/17 Nurse #12 stated nterviewable and reliable.  8/17 three nursing assistants #4, who were assigned to 8/14/17 stated there were only				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345537	B. WING _			C 98/18/2017		
	ROVIDER OR SUPPLIER	O REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2305 SILVER STREAM LANE WILMINGTON, NC 28401		05/10/2017		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 312	halls in the building care residents (Rothese halls). The residents to receive these halls there longer of the halls heavy care hall. NAs between the get residents who bed, could only promost once a shift, reposition resident At 3:35 PM on 08 (DON) stated it we expectation that reposition that residents voiced of checked and characteristic to the checked and characteristic to the checked and reduction of promostion of promostic promos	ed to work on each of the two ag which housed the heavier esident #90 resided on one of y reported that in order for we timely and quality care on needed to be four NAs on the and three NAs on the other They commented with only four two halls they were unable to required lift transfers out of rovide incontinent care at the and could not turn and	F3	312				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		345537	B. WING _		C 08/18/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	1 00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 312		ge 42 5 AM, Resident #11 was ng jagged fingernails on both	F 3	12	
F 318 SS=D	Resident #11 was c Nursing (DON). Sh staff to monitor, cleat fingernails during m baths. The DON ob fingernails, and said should have been c Resident #11 stated		F 3	18	9/15/17
	receives appropriate increase range of medicrease in range of medicr	mited mobility receives s, equipment, and assistance eve mobility with the maximum dence unless a reduction in rably unavoidable. IT is not met as evidenced ion, resident interview, staff d review the facility failed to management for 1 of 1		F318 1. On 8/17/17 resident # 118 was screened by therapy and it was determined there was no worsening	g of the

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3)	B) DATE SURVEY COMPLETED	
		345537	B. WING			C	
NAME OF D	DOVIDED OD CURRUER	34337	D. WING_	OTDEET ADDRESS SITV STATE ZID SON	<u> </u>	08/18/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	JE		
SILVER S	TREAM HEALTH AND	REHABILITATION CENTER		2305 SILVER STREAM LANE			
				WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 318	Continued From pa	age 43	F3	18			
F 318	Resident #118 was 06/19/17 with diag Infarction and Mon Following Cerebra Dominant Side.  Review of the adm (MDS) dated 06/26 had intact cognition assistance with act exception of locom which required suphad no skin impair.  Review of the care did not include intecontracture, range Restorative Therap Record review shot discharged from O with discharge recon the left hand data bathing or exercisi required.  Review of the Resident March, April, May,	s admitted to the facility on noses that included Cerebral oplegia of Upper Limb Infarction Affecting Left sission Minimum Data Set 6/17 revealed that the resident notion, required extensive tivities of daily living with the notion (wheelchair) and eating pervision only. The resident ments.  In plan dated 07/10/17 showed it reventions for a left hand of motion, splinting or by.  In wed that the resident was accupation Therapy on 07/26/17 commendations to wear a splint illy at all times except when notion. No physician order was accupative Aide schedule for June, July and August of 2017	F3	resident s contracture. The splint was written and the cal updated.  2. Other resident requiring sprisk for the same alleged defipractice. Resident was screetherapy to ensure there was of contractures. Physician on splinting were written/transcr care updated and splints appaccordingly.  3. Systemic measures to ensulleged deficient practice doe include: Therapy to re-educa Nurses and Certified Nursing on the current residents have how to apply and remove the Kardexes will be updated acception will be placed inside the closet for future reference. The Nursing, Resident Care Mana Director and/or designee will orders daily Monday thru Fric Interdisciplinary Team meetir requiring care plan updates for contracture management will on to the plan of care and im accordingly. The staff will be	re plan was plints are at icient ened by no worsening ders for ribed, plans of plied sure the same es not recur ate Licensed g Assistants e splints and e splint. cordingly. ections for the e resident s he Director of agement I review new day during the ng. Orders for I be entered uplemented educated by		
	a staff nurse aide	Restorative Aide had worked as every scheduled day except for when weights were obtained.		therapy when a new splint is Director of Nursing and/or de conduct weekly audits times monthly times 2 months to er	esignee will 4 weeks and		
	10:30 AM she state putting the splint o she wanted to wear nurse aides knew to the state of the	n Resident #118 on 08/14/17 at ed that no one had been in her left hand. She stated that in the splint but that none of the now to put it on. The resident's erved to be contracted.		for contracture management documented on the plan of c staff have been educated.  4. The Quality Assessment P Improvement Committee will results of all audits to determ	have been eare and the Performance review the		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345537	B. WING _			l	C
NAME OF DE	ROVIDER OR SUPPLIER	0-2007	1	ST.	REET ADDRESS, CITY, STATE, ZIP CODE	08/	18/2017
NAIVIE OF FI	NOVIDER OR SUFFLIER						
SILVER ST	TREAM HEALTH AND RE	EHABILITATION CENTER			05 SILVER STREAM LANE		
				VV	ILMINGTON, NC 28401		T.
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 318	Continued From page 44 F 318						
	8/16/17 at 2:30 PM mas not wearing a sp In an interview conduction AM with Occupational revealed that she had put the splint on the masses aide lately. She Restorative Therapy stated that she often apply splints and the motice that the aide sl	ucted on 08/17/2017 at 9:25 Il Therapy Aide #1 she Il trained a nurse aide how to esident's left hand Il she had not seen that			effectiveness of the plan based on tren identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.		
	with the Rehab Mana resident's contracture Occupational Therapithe contraction had nevealed that the resifound and that a new. In an interview with NPM he revealed that a showing that a splint resident. He stated the on the plan of care task for the nurse aid not. He said the Resident because the facility he	e had been screened by the ist that morning. She stated ot worsened. She also dent's splint could not be one would be ordered.  Jurse #2 on 8/17/17 at 1:10 there was no documentation had been applied for the hat normally splinting would e in Point Click Care as a es to complete but it was torative Therapy aide had					
	In an interview on 08/	/17/17 at 1:15 PM with Nurse					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345537	B. WING		C 08/18/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
F 318 F 323 SS=D	of care to wear a specification of care to wear a specification was able to locate to the floor behind a classification of the floor behind of the floor	was not on the resident's plan blint on her left hand. He said communicated to him that the ar a splint on her left hand and a put it on the plan of care. He he resident's missing splint on hair in the resident's room on the plan of care. He he resident's missing splint on hair in the resident's room on the plan of care.  The provided the plan of care are an ed from skilled therapy of a resident's plan of care.  The plant of care are are are that -  Wironment remains as free rods as is possible; and the provided the provident of the plant of	F 32		9/15/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345537	B. WING		C 08/18/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	2	06/16/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 323	informed consent processions of the resident solution was sever physical impairment lower extremsive assistance transfers, locomotion and personal hygier appointment to have transported Residert Solutions appointment to have transported Residert was the facility. The Consense of the resident solution was sever physical impairment lower extremities. The extensive assistance transfers, locomotion and personal hygier at the facility. The Consense of the resident solution is the resident to have transported Residert to the resident to have transported Residert was the resident to have transported Residert the resident to have transported Residert to provide the resident to have transported Residert to the resident to	ent representative and obtain ior to installation.  Ded's dimensions are esident's size and weight. It is not met as evidenced views and record review the ide supervision for 1 of 1 residents (Resident #88) by amily accompany the resident timent. Findings included:  Idmitted on 08/19/13. The ed diagnosis included bodies, dysphagia, and weakness.  In mum Data Set (MDS)  In old Trevealed the resident's ely impaired and she had on both sides of upper and the resident required else by staff for bed mobility, in, dressing, eating, toileting,	F 323		ents ent on ne ort ne octice II be
	the transport driver the outpatient appoi	on the transport vehicle and dropped Resident #88 off at ntment at the hospital for an was left there alone. The		effectiveness of the plan based on tre identified. Additional interventions will developed and implemented by the Committee as deemed necessary to	l l

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345537	B. WING _			C <b>8/18/2017</b>	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  2305 SILVER STREAM LANE  WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	During an intervier Coordinator (HIC) stated that it was I was transported to member or family. She also stated the should be taken in for transport to ap that it was her expresponsible party made aware of a resident was going HIC also stated the for an outpatient x planned with an or take Resident #88 reported that Resi and that the hospi the day she was be stated that she as accompanied Resident will HIC reported that that was cognitive appointment without the resident but in provide a chapero appointment.  The facility adminior clinical services at 12:30 PM. The facility should follohaving a facility er	ed that the resident had severe	F3	maintain substantial comp	liance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 501251	_			c
		345537	B. WING			08/	18/2017
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		23	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353 SS=E	stated that the facility transportation policy a employee or family m Resident #88 to her a manager of clinical se facility would never tr cognitively impaired, them there without a in this incident with R facility failed provision to accompany the resappointment.  483.35(a)(1)-(4) SUF STAFF PER CARE P  483.35 Nursing Servion The facility must have the appropriate comp provide nursing and resident safety and a practicable physical, well-being of each resresident assessments and considering the rediagnoses of the faciliaccordance with the fat §483.70(e). [As linked to Facility Assessments and considering the rediagnoses of the faciliaccordance with the fat §483.70(e).	#88, the administrator failed to follow the and didn't secure an amber to accompany appointment. The district ervices reported that the ansport a resident, who was to an appointment and leave staff or family member. But esident #88, she stated the n of a staff or family member sident to an off-site  FICIENT 24-HR NURSING LANS  ces  e sufficient nursing staff with etencies and skills sets to related services to assure train or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care		3323	DEFICIENCY		9/15/17
	sufficient numbers of of personnel on a 24-	st provide services by each of the following types hour basis to provide sidents in accordance with					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING			COMPLETED		
		345537	B. WING		08/18/2	047
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401	06/16/2	017
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) MPLETION DATE
F 353	this section, licensed  (ii) Other nursing per limited to nurse aide  (a)(2) Except when we this section, the facilinurse to serve as a conduty.  (a)(3) The facility munurses have the species necessary to calidentified through residentified through residentified in the plant (a)(4) Providing care assessing, evaluating resident care plans aneeds.  This REQUIREMEN by:  Based on observation	red under paragraph (e) of d nurses; and resonnel, including but not is.  vaived under paragraph (e) of ity must designate a licensed charge nurse on each tour of its ensure that licensed cific competencies and skill are for residents' needs, as is ident assessments, and it of care.  Includes but is not limited to g, planning and implementing and responding to resident's its not met as evidenced on, resident interview, staff	F3	F353		
	provide a sufficient remeet the needs of refailure to provide act for 4 of 6 sampled refailure to provide act for 4 of 6 sampled refailure to graph and #155) who during the initial tour honor care preference residents (Residents who expressed care tour of the facility. To sampled residents	d review the facility failed to number of nursing staff to esidents as evidenced by ivity of daily living (ADL) care esidents (Resident #11, #28, expressed care concerns of the facility and failure to ces for 4 of 6 sampled #28, #90, #155, and #181) concerns during the initial The facility also neglected 3 of (Resident #28, #90, and gotheir care needs over		1. Resident #28 was bathed dressed assisted out of bed. #155 received incontinent care and was assisted obed. #90 received personal care a assisted out of bed. Resident #11 hails cut on 8/15/17.  2. Current residents requiring assis with activities of daily living (ADLs) risk. Nursing Administration provide care needed for those residents recassistance on 8/14/17.  3. Systemic measures implemented ensure the same alleged deficient process.	out of and her tance are at differentiating	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345537	B. WING			08/	18/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER ST	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	observation, staff interacility failed to provide (ADL) care over multivesidents (Resident # complained about cathe facility. The facility residents out of bed wassistance from staff required extensive as dependent on staff for #90, and #155). The resident who was dependent who was dependent who required staff for dressing (Resident #28). The resident who required staff for dressing (Refailed to provide incomplained extensive as mobility and was dependent #90). The fingernails for one resextensive assistance (Resident #11).  2. Cross reference to observation, staff interacility failed to honor bathing and getting of 4 of 6 sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who during initial tour of the sampled reside #155, and #181) who	o tag F312: Based on erview, and record review the de activity of daily living iple shifts for 4 of 6 sampled \$11, #28, #90 and #155) who re during the initial tour of ty failed to get three who required extensive with bed mobility and sist from staff to being or transfers (Resident #28, facility failed to bathe one bendent on staff for bathing facility failed to dress one dextensive assistance from sident #28). The facility intinent care to two residents we assistance from staff with 88 and #155). The facility osition one resident who esistance from staff for transfers facility failed to cut sident who required from staff for hygiene  of tag F242: Based on erview, and record review the references regarding out of bed in the mornings for ents (Resident #28, #90, expressed care concerns	F	353	does not recur include: Additional shor and long term agency Licensed Nurses and Certified Nurse Aides have been contracted to provide additional staffing coverage. The Director of Nursing/designee will review the staffind daily to ensure coverage is adequate based on the needs of the residents. Staffing assignments will also be evaluated by the Director of Nursing/designee and adjusted accordingly based on resident need. Current employees who are reporting of work on their scheduled time will not the Director of Nursing/designee personally. The Director of Nursing/designee personally. The Director of Nursing/designee personally. The Director of Nursing/designee is adequate coverage to provide care for those residents who require assistance. In the event coverage is unable to be obtained the Administra Nursing Team will report to facility to assist with care needs. Resident interviews weekly times 4 and then monthly times 2 to ensure care needs being met. Negative findings will be addressed if noted.  4. The Quality Assessment Performant Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trenidentified. Additional interventions will the developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	off geotive	
		erview, and record review the					

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		345537	B. WING _			1	C 18/2017
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS  2305 SILVER STR  WILMINGTON, N		1 00,	10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B -REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	(Resident #28, #90 a about care during the leaving residents in the changing, and/or repshifts.  Review of facility stat that there were only scheduled on each of in the building on 07/second shift, 08/12/1 shift, and 08/14/17 fill.  At 2:42 PM on 08/16 hall where Residents resided 80% of the retransferred using a limany of the resident activities, many of the to eat in the dining resided to the hall. NAs on the hall care on first and second seven with three NAs second shift it might long time to get the coton Nurse #4, the facilistaff which proved times.	f 6 sampled residents and #155), who complained to initial tour of the facility, by bed without bathing, ositioning them over multiple offing assignments revealed two nursing assistants (NAs) of the two heavier care halls 103/17 first shift, 07/27/17 first shift, 08/13/17 second test shift.	F3	553			
	needs so large amoureviewing resident cawith the residents the for.  At 10:00 AM on 08/1 (NAs) #1 and #8 state	ints of time had to be spent ardexes to familiarize them bey were going to be caring 8/17 nursing assistants and care as few I to each of the two heavier					

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	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		00/10/2011
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F 353	apiece. They report manageable, and no gotten out of bed, sh residents were lucky once a shift, and no repositioned. They name the without care being possible to the without care being possible to without care b	ment was 20 - 22 residents ed this assignment was not all residents could be nowers could not be given, to receive incontinent care residents were turned and commented even with two eavier care halls and three avier care hall residents went rovided. According to the none heavy care hall and 3 avier care hall to provide idents.  18/17 Nurse #12 stated aides halls often had as many as assignments which resulted aiving the care that they  18/17 the Administrator and DON) stated in attempts to situation in the building the agency staff on 05/28/17. A accumented 2 agency 0 agency licensed practical ed, and 12 agency NAs had those agency employees acceptive. The summary also by as 13 agency openings in progress/fulfillment from awaiting hire. The DON is not there yet, but its goal on one heavy care hall and 3	F3	53		
F 368 SS=E	483.60(f)(1)-(3) FRE MEALS/SNACKS A	QUENCY OF	F 3	68		9/15/17

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F 368	must provide at leas times comparable to community or in acc preferences, reques  (f)(2)There must be between a substanti breakfast the followin nourishing snack is shours may elapse be meal and breakfast the group agrees to this (f)(3) Suitable, nouris snacks must be provide eat at non-tradition scheduled meal services resident plan of care This REQUIREMEN by:  Based on observation interview, and record offer all residents and included:  Review of resident con 08/03/17 meeting do brought up a concerbeing offered an every attention of the control of the c	must receive and the facility three meals daily, at regular normal mealtimes in the ordance with resident needs, its, and plan of care.  In o more than 14 hours all evening meal and and day, except when a served at bedtime, up to 16 etween a substantial evening he following day if a resident meal span.  Is shing alternative meals and rided to residents who want hall times or outside of rice times, consistent with the control of the review the facility failed to evening snack. Findings	F3	F368  1. Resident # 239, #999, #14 #155 were provided snacks. 2. Current residents are at risame alleged deficient pract snacks are being provided b 3. Systemic measures imple prevent the same alleged de practice does not recur inclu Dietary Department was edu providing a variety of evenin all residents not only those of snack. The Nursing Departmere-educated on ensuring the	sk for the ice. Evening y dietary. mented to efficient de: The ucated on g snacks for ordered a nent was		
		/17 Resident #999, residing ed that he doesn't usually get		offered to all residents and prequested. Resident intervie	rovided as		

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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		23	REET ADDRESS, CITY, STATE, ZIP CODE 805 SILVER STREAM LANE VILMINGTON, NC 28401	, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 368	receive something like milk.  At 8:24 PM on 08/15, delivered to the 200 I contained 15 snacks and five extra snacks (two packs of cracket Graham crackers, and At 8:30 PM on 08/15, on the 300 hall, state offered an evening stenjoy one.  At 8:33 PM on 08/15, residing on the 200 hall been offered evening commented she had depending on how we sometimes share a set the evenings. However, would be much nicer nightly so that they concur the stated she and Resides of a snack would held control. According to pre-meal morning blocouple of times received.	nack, but would like to e ice cream or chocolate  17 a tray of snacks was hall nurse's station. The tray labeled with resident names, without resident names rs, an oatmeal cake, d a bag of chips).  17 Resident #143, residing d she had never been hack, but would possibly  17 Resident #28 and #155, all, stated they had never snacks. Resident #28 her own refrigerator, and ell it was stocked, she would hack with Resident #155 in ver, both residents reported it if the facility offered snacks buld consistently receive hedtime. Resident #155 hent #28 were both diabetics p with better blood sugar Resident #155, her hod sugar was in the 60s a	F3	368	times 4 and then monthly times 2 to ensure snacks are being offered and provided. Negative findings will be addressed if noted.  4. The Quality Assessment Performand Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trenidentified. Additional interventions will the developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	e ds	
	6:14 AM with pre-bre 70s on 07/31/17, 08/0 At 8:50 PM on 08/15/1 labeled snack sitting	3 AM and on 08/17/17 at akfast blood sugars in the 05/17, and 08/11/17).  17 there was only one at the 100 hall nurse's tated the 100 hall only					

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received labeled snoonly one resident or evening snack which commented the 100 snacks in the evening residents who were. At 9:04 PM on 08/11 residents on the 300 on the hall were offer. At 9:10 PM on 08/11 stated the staff only snacks at night becaproviding incontiner back into bed.  At 9:14 AM on 08/11 mostly labeled snac providing PM care to them in bed for the staff on the 100 hall, staff at night, but he wou yogurt or ice cream. At 12:22 PM on 08/10 on the 100 hall, staff evening snack, but been getting very hundled to PM and eating a healthy sna around 8:30 PM wo health.  At 3:35 PM on 08/13	acks at night, and currently in the hall had an order for an in justified labeling. She is hall never received extraing to offer and pass out to still awake.  5/17 Nurse #1, caring for is hall, stated not all residents ered evening snacks.  5/17 nursing assistant (NA) #6 had time to pass out labeled ause they were so busy int care and getting residents exist if she had time between to her residents and putting night.  18/17 Resident #231, residing fixed he was not offered snacks and like something healthy like is head time the something healthy like is she was not offered and would love one since she had aungry between 10:00 PM and grandy. She commented fack provided by the facility and be much better for her	F	368				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER)  Continued From page received labeled smooth on the summer such whice commented the 100 snacks in the evening residents who were  At 9:04 PM on 08/11 residents on the 300 on the hall were offer the staff only snacks at night becaproviding incontiner back into bed.  At 9:10 PM on 08/11 stated the staff only snacks at night becaproviding incontiner back into bed.  At 9:14 AM on 08/11 mostly labeled snac providing PM care to them in bed for the staff only snacks at night, but he wou yogurt or ice cream  At 12:15 PM on 08/11 on the 100 hall, staff at night, but he wou yogurt or ice cream  At 12:22 PM on 08/11 on the 100 hall, staff evening snack, but been getting very he 11:00 PM and eating a healthy sna around 8:30 PM wo health.  At 3:35 PM on 08/13 (DON) stated all residents	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 55 received labeled snacks at night, and currently only one resident on the hall had an order for an evening snack which justified labeling. She commented the 100 hall never received extra snacks in the evening to offer and pass out to residents who were still awake.  At 9:04 PM on 08/15/17 Nurse #1, caring for residents on the 300 hall, stated not all residents on the hall were offered evening snacks.  At 9:10 PM on 08/15/17 nursing assistant (NA) #6 stated the staff only had time to pass out labeled snacks at night because they were so busy providing incontinent care and getting residents back into bed.  At 9:14 AM on 08/15/17 NA #7 stated she passed mostly labeled snacks if she had time between providing PM care to her residents and putting them in bed for the night.  At 12:15 PM on 08/18/17 Resident #231, residing on the 100 hall, stated he was not offered snacks at night, but he would like something healthy like yogurt or ice cream  At 12:22 PM on 08/18/17 Resident #213, residing on the 100 hall, stated she was not offered an evening snack, but would love one since she had been getting very hungry between 10:00 PM and 11:00 PM and eating candy. She commented eating a healthy snack provided by the facility around 8:30 PM would be much better for her	ROVIDER OR SUPPLIER  TREAM HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 55  received labeled snacks at night, and currently only one resident on the hall had an order for an evening snack which justified labeling. She commented the 100 hall never received extra snacks in the evening to offer and pass out to residents who were still awake.  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She commented eating a healthy snack provided by the facility around 8:30 PM would be much better for her health.  At 3:35 PM on 08/18/17 the Director of Nursing (DON) stated all residents in the building should	ROUDER OR SUPPLIER  TREAM HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 55 received labeled snacks at night, and currently only one resident on the hall had an order for an evening snack which justified labeling. She commented the 100 hall never received extra snacks in the evening to offer and pass out to residents who were still awake.  At 9:04 PM on 08/15/17 Nurse #1, caring for residents on the 300 hall, stated not all residents on the hall were offered evening snacks.  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F 431 SS=D	The facility must prodrugs and biological them under an agree §483.70(g) of this parameters personnel away permits, but only supervision of a licer (a) Procedures. A far pharmaceutical serve that assure the accurate dispensing, and admitiologicals) to meet (b) Service Consultate employ or obtain the pharmacist who (2) Establishes a system detail to enable an amaintained and periodical servers and the servers of the servers personal control of the servers of the ser	vide routine and emergency is to its residents, or obtain ement described in art. The facility may permit el to administer drugs if State vunder the general insed nurse.  acility must provide ices (including procedures irate acquiring, receiving, ninistering of all drugs and the needs of each resident.  Action. The facility must eservices of a licensed in services of a licensed in order and in courate reconciliation; and in controlled drugs is podically reconciled.  It is and Biologicals. It is used in the facility must be services of a licensed in the facility must be serviced in t	F 43		9/15/17	
		e all drugs and biologicals in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345537	B. WING _				C 18/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
0111/55 0				2305 SILVER STREAM LANE			
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F 431		s under proper temperature only authorized personnel to	F 4	31			
	(2) The facility must permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distributed quantity stored is minimal be readily detected. This REQUIREMENT by:  Based on observation record review the facture an insulin pentolock 2 of 5 medical medication pass. The During a medication pass. The During a medication pass are sident insulin pentolock 2 of 5 medical medication pass. The During a medication pass are sident insulin pentolock 2 of 5 medication pass. The During a medication pass are sident insulin pentolock 2 of 5 medication caron the 300 hall left examples and the side ped away from hadministration and the medications sitting or the cart when she step but did not. She repo	provide separately locked, compartments for storage of d in Schedule II of the pabuse Prevention and other drugs subject to the facility uses single unit ution systems in which the himal and a missing dose can is not met as evidenced an, staff interviews, and dility failed to secure a plastic ushed medication, failed to in a locked cart, and failed tion carts during a		F431  1. The medications were imm removed from the top of the consecured in the medication carn was then locked.  2. Current residents have the be affected by the same alleg practice. All medication carts on 8/16/17 and 8/17/17 to ensimedications were stored propications were stored propications. Systemic measures implementary the same deficient pranot recur include: Licensed Niccertified Medication Aides were-educated on the storage of and locking the medication caunattended. The Director of Nursing/designee will conduct for 1 week, weekly for 3 week monthly times 2 of the medications not being properly or carts are left unlocked. The Quality Assessment Pelimprovement Committee will in the second committee will in the second carries are left unlocked.	potential ed deficie were audi sure perly. In the care of medication art when less and the ation carts ng stored cked.	to ent ited s s d ons eft dits en	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	00/10/2017	
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SILVER S	IREAM HEALIH AND RE	HABILITATION CENTER		WILMINGTON, NC 28401			
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F 431	Continued From page	÷ 58	F4	31			
	at 5:58 AM a 30 millili crushed medication w of Nurse #5's medicat unattended.	ing facility tour on 08/17/17 ter plastic cup partially full of vas observed sitting on-top tion cart left exposed and		results of all audits to de effectiveness of the plan identified. Additional inte developed and impleme Committee as deemed r maintain substantial con	based on trends erventions will be nted by the necessary to		
	AM with Nurse #5 wh away from her cart do administration and that cart when stepped int not. She reported she	ducted on 08/17/17 at 6:00 o stated she just stepped oing medication at she usually locked the o a resident room, but did e should have locked the she stepped away from the					
	AM with the Director of DON stated the medic	ducted on 08/17/17 at 9:30 of Nursing (DON). The cations and carts should be t all times when the nurse					