## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  NORTHCHASE NURSING AND REHABILITATION CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE   3015 ENTERPRISE DR   WILMINGTON, NC 28405	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  NORTHCHASE NURSING AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3015 ENTERPRISE DR WILMINGTON, NC 28405  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  STREET ADDRESS, CITY, STATE, ZIP CODE  3015 ENTERPRISE DR WILMINGTON, NC 28405  CEACH CORRECTION (CACH CORRECTION SHOULD BE COMPLETING CROSS-REFERENCED TO THE APPROPRIATE)						<del></del>	С	
NORTHCHASE NURSING AND REHABILITATION CENTER  3015 ENTERPRISE DR WILMINGTON, NC 28405  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  3015 ENTERPRISE DR WILMINGTON, NC 28405			345119	B. WING	·		04/	08/2014
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE					3	8015 ENTERPRISE DR		
	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP		BE	COMPLETION
F 000  INITIAL COMMENTS  The facility is in compliance with the requirement of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey). No deficiences were cited as part of the complaint investigation. Event ID WF1Q11.	F 000	The facility is in co of 42 CFR Part 483 Care Facilities (Ger deficiences were ci	mpliance with the requirement B, Subpart B for Long Term neral Health Survey). No ted as part of the complaint	F	000			

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

(X6) DATE

Electronically Signed 04/10/2014

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.

TITLE