DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COMF	E SURVEY PLETED
		345236	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	545250		ST	REET ADDRESS, CITY, STATE, ZIP CODE	09	/16/2016
) WELLINGTON AVENUE		
WILMING	TON HEALTH AND REHA	BILITATION CENTER		W	LMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 SS=E			F 15	57			10/30/16
	consult with the resid known, notify the resi or an interested famil accident involving the injury and has the por intervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treath consequences, or to	nent due to adverse commence a new form of ion to transfer or discharge					
	and, if known, the rest or interested family m change in room or root specified in §483.150 resident rights under regulations as specifit this section.	Federal or State law or ed in paragraph (b)(1) of					
	the address and phor	rd and periodically update ne number of the resident's or interested family member.					
		is not met as evidenced					
		ician and Physician and record review, the the facility Physician or the			Resident #3, #4, #11, #19, #20, #33, # #35 and #36 attending physician were notified of non-documented/missed	34,	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
	ically Signed						10/11/2016

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
						С
		345236	B. WING			/16/2016
NAME OF PF	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZI		
				820 WELLINGTON AVENUE		
WILMING	ON HEALTH AND REHA	ABILITATION CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIC DATE
F 157	Continued From page	a 1	F 15	7		
1 107			F IS		l of August 27 □	
	•	nat medications were not f 10 residents reviewed for		medication for the period 28, 2016 on September		
		dications (Res. #3, #4, #11,		additional physician orde		
		⁴ 34, #35, and #36) in a 48		The facility Director of Nu		
	hour period August 2	-		Designee will complete a		
	Findings included:			residents to ensure that		
	-			notified of any non docur		
	1. a. Resident #3 was	s admitted 6/20/2016 with		medications for August 2		
	-	ancer, tracheostomy,		The Director of Nursing a	-	
		obstructive pulmonary		re- educate facility licens		
	disease and depress	ion.		regarding notification to t		
		t 2010 Madiantian		and/or responsible party		
	A review of the Augus	d revealed on 8/28/2016		any medications not adm documented completed I		
		dose of the following		2016. Newly hired licens	-	
		ed at 2:00 PM that were not		receive the education du		
		nistered on 8/28/2016:		The facility will complete	•	
		amin capsule, Zoloft (an		any licensed nurse that o		
	antidepressant) 50 m	illigram (mg), Tylenol 325		the reeducation prior to v	working next	
		and Morphine Sulfate		scheduled shift.		
		(ml) for shortness of breath.		Director of Nursing and/	-	
		es revealed no notification		perform random audits d		
		d to the physician or the		weeks, weekly times 3 v		
	physician assistant c	oncerning Resident #3.		monthly times 3 to ensur		
	h Resident #4 was a	dmitted 8/9/2016 with		received medications as DON will report findings		
		y, altered mental status,		Quality Assurance Impro		
		difficulty speaking and		Committee. The QAPI c		
	swallowing and deme	, ,		evaluate the results and		
	A review of the Augus			additional interventions a		
	Administration Recor			ensure continued compli	ance.	
		ent #4 had one dose of the				
	•	s that were not documented				
		tivitamin 1 tablet at 9:00 AM,				
		l, Magnesium Oxide (a				
		AM, Omeprazole (reduces				
	stomach acid) 20 mill	ligrams (mg) at 9:00 AM,	1			1
	Dloviv (on anticacard	ant) 75 mg at 9:00 AM and				

Facility ID: 923408

If continuation sheet Page 2 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345236	B. WING				C 16/2016
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WILMING	FON HEALTH AND REHA	BILITATION CENTER			320 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	2	F	157			
		problems or notification of sician Assistant regarding					
		admitted on 8/17/2016 with uded leukemia, heart failure, ypertension.					
	Resident #11 missed medications, Aspirin & at 9:00 AM, Fluticaso Multivitamin with mine 10 milliequivalents (m hypertension, Metopr hypertension, Amlodi hypertension, Plavix 7 platelet clotting, Amio	d revealed on 8/28/2016 one dose of the following 81 milligram (mg) chewable ne nasal spray at 9:00 AM, erals at 9:00 AM, Potassium					
		admitted 1/6/2016 with a illation (irregular heart					
	for Res. #19 on 8/28/ AM of Digoxin (a med	ation Administration Record 2016 revealed the daily 8:00 lication used to control heart daily was not documented					

Facility ID: 923408

If continuation sheet Page 3 of 47

				E CONSTRUCTION		0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY PLETED
			A. BOILDING			С
		345236	B. WING		09	/16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				820 WELLINGTON AVENUE		
WILMING	TON HEALTH AND REH	ABILITATION CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 3	F 15	7		
	A review of the nurse notification to the Phy	e notes revealed no ysician or the Physician the missed medication dose				
		admitted on 1/27/2016 with nsion, diabetes mellitus and				
	the following medicat documented as giver	rd for Resident #20 indicated tion doses were not า				
	time a day for bi-pola dose on 8/28/2016 w Abilify 5 mg give 1 po	g) give 1 by mouth (po) one ir disorder. The 9:00 AM ras not documented as given. o one time a day with Abilify 2 bi-polar disorder. The 9:00				
	given. Insulin Detimir (long a	16 was not documented as acting) inject 30 units edtime for diabetes. The				
	11:30 AM and 9:00 P not documented as g Carvedilol 12.5 mg 1	M doses on 8/27/2016 were jiven. po two times a day for				
	was not documented Sliding scale insulin g	00 AM dose on 8/27/2016 as given. given after blood sugar jer stick before meals and at				
	bedtime. Sliding scal 9:00 PM on 8/27/201	e doses at 11:30 AM and 6, and at 9:00 PM on locumented as given.				
	documentation regar	progress notes revealed no ding notification to the sician Assistant concerning				

Facility ID: 923408

If continuation sheet Page 4 of 47

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 10/27/2016 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING		-		C 16/2016
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
WILMING	ON HEALTH AND REHA	BILITATION CENTER		20 WELLINGTON AVENUE VILMINGTON, NC 2840			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 157	diagnoses of diabetes and hypertension. A review of the Augus Administration Record Bumetanide 2 milligra once daily for conges dose on 8/27/2016 wa Diltiazem ER (extende once daily for atrial fit 8/27/2016 was not do Toujeo insulin inject 3 bedtime for diabetes n 8/27/2016 was not do Apixaban 5 mg 1 po t fibrillation. The 8:00 A not documented as gi Humalog sliding scale subcutaneously befor measurement by finge Insulin doses at 8:00 8/27/2016 were not do Humalog insulin inject three times a day for AM and 12 noon dose noon dose on 8/28/20 given.	for Resident #20 on 16. Idmitted on 5/27/2016 with a mellitus, atrial fibrillation at 2016 Medication d revealed: Ims (mg) 1 by mouth (po) tive heart failure. 8:00 AM as not documented as given. ed release) 300 mg 1 po orillation. 8:00 AM dose on cumented as given. 2 units subcutaneously at mellitus. 9:00 PM dose on cumented as given. 2 units subcutaneously at mellitus. 9:00 PM dose on cumented as given. wo times daily for atrial M dose on 8/27/2016 was ven. a insulin given e meals after blood sugar er stick for diabetes mellitus. AM and 12:30 PM on	F 157		EFICIENCY		
	notification to the Phy	sician or the Physician Resident #30 not receiving					

Facility ID: 923408

If continuation sheet Page 5 of 47

	-					FORM	MAPPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _			
		345236	345236 B. WING C 345236 B. WING 09/16/2 STREET ADDRESS, CITY, STATE, ZIP CODE 820 WELLINGTON AVENUE S20 WELLINGTON AVENUE WILMINGTON, NC 28401 ICIENCIES ID PREFIX EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 5/2013 with Mellitus, F 157 5/2013 with F 157 5/2013 with Antificial and attion e 1 by mouth Mose on Mdose on given. given. F 157 5/2014 dose Antificial and attion e 1 by mouth F Mdose on F given. F Entre 8:00 F				
NAME OF PI	LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345236 B. WING E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MINGTON HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE WINGTON HEALTH AND REHABILITATION CENTER WILMINGTON, NC 28401 I) ID SUMMARY STATEMENT OF DEFICIENCIES ID EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG						
WILMING	ION HEALTH AND REHA	BILITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 157	Continued From page	9 5	F	157			
g. Resident #33 was admitted 11/25/2013 with diagnoses of hypoxemia, diabetes mellitus, depressive disorder, congestive heart failure and atrial fibrillation.							
	Administration Record Dilacor XR 120 milligi (po) once daily for CH 8/27/2016 was not do Lantus insulin inject 1 bedtime for diabetes on 8/27/2016 was not Lasix 40 mg 1 po onc AM dose on 8/27/201 given. Eliquis 2.5 mg 1 po tw The 8:30 AM dose on documented as given Humalog insulin giver sugar check by finger administered subcuta bedtime for diabetes. Resident #33 had a b blood sugar level for 130), and received 4 the 11:30 AM, 4:30 Pl times was not docum	d revealed: rams (mg) give 1 by mouth HF. The 9:00 AM dose on ocumented as given. 2 units subcutaneously at mellitus. The 9:30 PM dose t documented as given. the daily for CHF. The 8:00 6 was not documented as vice daily for atrial fibrillation. a 8/27/2016 was not the sliding scale after blood the stick was to be ineously before meals and at On 8/27/2016 at 6:30 AM blood sugar of 292 (normal diabetic persons is 70 - units of insulin. Insulin at M and 9:00 PM scheduled ented as given. notes revealed no visician or Physician Assistant hedication doses for					
		admitted on 7/29/2015 with ilure, diabetes mellitus, specified convulsions.					

If continuation sheet Page 6 of 47

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/27/2016 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING					C 16/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
WILMING	TON HEALTH AND REHA	BILITATION CENTER			320 WELLINGTON AVENUE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 157	morning for hypertens 8/27 and 8/28/2016 w given. Coreg 6.25 mg 1 po th hypertension. Obtain reading before admin 9:30 AM dose on 8/27 documented as medic obtained. Lantus insulin inject 5 times a day for diabet 9:30 PM doses on 8/2 documented as given Humalog insulin inject three times a day for AM and the 12:30 PM 8/28/2016 were not do Keppra 750 mg 1 po f convulsions. The 9:30 on 8/27 and 8/28/201 given. Humalog insulin on a with a blood sugar me The insulin was to be before meals and at the mellitus. On 8/27/201 was not obtained and as given. On 8/28/207 the 9:30 PM insulin w given. There was no docume	At 2016 Medication d revealed: ng) 1 by mouth (po) in the sion. The 9:00 AM dose on ras not documented as wo times a day for blood pressure and pulse istering the medication. The 7 and 8/28/2016 were not cation given or vital signs 2 units subcutaneously two es. The 9:30 AM and the 27 and 8/28/2016 were not t 18 units subcutaneously diabetes mellitus. The 8:00 doses on 8/27 and ocumented as given. three times a day related to 0 AM and the 1:30 PM doses 6 were not documented as sliding scale was ordered easurement by a finger stick. injected subcutaneously bedtime for diabetes 6 the 9:30 PM blood sugar no insulin was documented 16 the 12:30 PM insulin and ere not documented as	F	157				
	8/28/2016 were not de Keppra 750 mg 1 po f convulsions. The 9:30 on 8/27 and 8/28/201 given. Humalog insulin on a with a blood sugar me The insulin was to be before meals and at b mellitus. On 8/27/201 was not obtained and as given. On 8/28/207 the 9:30 PM insulin w given. There was no docume of the Physician or Ph	ocumented as given. three times a day related to 0 AM and the 1:30 PM doses 6 were not documented as sliding scale was ordered easurement by a finger stick. injected subcutaneously bedtime for diabetes 6 the 9:30 PM blood sugar no insulin was documented 16 the 12:30 PM insulin and ere not documented as entation in the nurse notes sysician Assistant being						

Facility ID: 923408

If continuation sheet Page 7 of 47

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/27/201 FORM APPROVE OMB NO. 0938-039
STATEMENT C	FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345236	B. WING		C 09/16/2016
NAME OF PF	OVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC	
	ON HEALTH AND REHA			820 WELLINGTON AVENUE	
WILWING	ON HEALTH AND REH			WILMINGTON, NC 28401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETION TE APPROPRIATE DATE
F 157	Continued From page	e 7	F 157		
	i. Resident #35 was a				
		stroke, diabetes mellitus and			
	A review of the Augus	st Medication Administration			
	Record revealed:				
		ms (mg) 1 by mouth (po)			
		pressure. The 9:00 AM dose t documented as given.			
		12.5 mg 1 po once daily for			
	hypertension. The 9:0	00 AM dose on 8/27/2016			
	was not documented				
		o two times a day for high and hold for BP under 110.			
	• • • •	AM no BP was recorded			
		t documented as given.			
		PM the BP was recorded as			
		lication was not documented			
	as administered. Lisinopril 10 mg 1 po	twice a day for			
		00 AM dose on 8/27/2016			
	was not documented				
	Clonidine 0.3 mg 1 pc				
	hypertension. The 2:0 8/28/2016 were not d	00 PM doses on 8/27 and locumented as given			
		o every 8 hours for vessel			
	dilation (opening up).	The 2:00 PM doses on 8/27			
	and 8/28/2016 were r	not documented as given.			
	A review of the progr	ess notes revealed no			
	notification to the Phy	sician or Physician Assistant			
	for any missed medic 8/28/2016.	cation doses on 8/27/2016 or			
	j. Resident #36 was a	admitted 11/19/2015 with			
	diagnoses of stroke a	and essential hypertension.			
	Resident #36 current pneumonia	ly has a diagnosis of			

If continuation sheet Page 8 of 47

		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	·	· · ·	IPLETED
						С
		345236	B. WING			9/16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	ON HEALTH AND REHA	ABILITATION CENTER		820 WELLINGTON AVENUE		
				WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	D BY FULL PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETIO DATE
F 157	Continued From page 8		F 15	7		
A		at Madiaatian Administration				
	A review of the Augus Record revealed:	st Medication Administration				
		nilligrams (mg) give 1 via				
		ay for pneumonia. The 9:00				
		es on 8/27 and 8/28/2016				
(were not documented	-				
		a G-tube every 12 hours for				
		or systolic blood pressure 8:30 AM dose on 8/27 and				
	8/28/2016 was not do					
		et via G-tube two times a day				
		ion. The 9:00 AM doses on				
		vere not documented as				
	given.					
		e 200 mg via G-tube every				
		nsion. Hold for systolic BP P was recorded for the 8:30				
		for the 8:30 doses on 8/27				
		not documented as given.				
	Levitiracetam 500 mg	y via G-tube every 12 hours				
		0 AM doses on 8/27 and				
	8/28/2016 were not d	0				
		id. Give 300 ml via G-tube				
	feedings on 8/27 and	eding. The 12:30 PM				
	documented as giver					
	On 0/12/2010 -+ 0-50	DM in an interview the				
		PM, in an interview, the oordinator (SDC) stated she				
	-	on August 27 and 28, 2016				
		00 PM shift. The SDC stated				
		s had walked out of the				
	-	there was a shortage of				
		the Unit Manager was				
		4 hour shift from 7:00 AM to				
	-	27 also. The SDC noted she				
1	triad to cover the 200	hall as well as the 100 and				

Facility ID: 923408

If continuation sheet Page 9 of 47

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · · ·	IPLETED
						С
		345236	B. WING		09	9/16/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
			8	820 WELLINGTON AVENUE		
WILWING	TON HEALTH AND REH	ABILITATION CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	e 9	F 157	,		
		any meds she did not give,	1 107			
		t. When asked specifically				
		ents #3, #4, #11, #19, #20,				
		nd #36 medications, the				
	SDC stated if there w	as no documentation, she				
	did not give them.					
ir w fr	On 0/12/2016 at 2:20	DM in a talanhana				
	On 9/13/2016 at 3:22	anager stated she was				
		7, 2016 for a 4 hour shift				
		1:00 AM. The Unit Manager				
		scovered there was no				
	nurse for the 300 hal	I, the SDC went to try and				
	cover the 300 hall an	d also work on the 100 and				
		of Residents #3, #4, #11,				
	#19, #20, #30, #33, #					
		e not documented as given				
		Manager she stated if she he documented it. If it was				
		could not say she gave it.				
		ated there were a lot of				
		on the 7 AM - 3 PM shift on				
		Manager also stated she				
	gave medications on	the 100 and the 200 hall.				
	In an interview on 9/2	15/2016 at 11:30 AM, the				
		ed she had worked here				
		usually at the facility two to				
		ometimes more. The				
		Physician Assistants (PA)				
		M until morning but the PA				
	could always reach n Physician stated she	did not know about missed				
	-	3/2016. The PA stated she				
		nissed medications until				
		A stated she did not receive				
		residents not receiving their				

Facility ID: 923408

If continuation sheet Page 10 of 47

		ND HUMAN SERVICES			FOF	ED: 10/27/20 [.] RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345236	B. WING		0	9/16/2016
IAME OF PF	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CC	•	
			820	WELLINGTON AVENUE		
VILIVIINGI	ON HEALTH AND REHA		WIL	MINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 157	Continued From page	e 10	F 157			
1 101		o had missed insulin to have	1 157			
		r checked immediately and				
	•	lic Panel lab drawn or				
		to make sure the resident				
		er of Diabetic Ketoacidosis (a				
		tes when there is not				
		body). The Physician stated that for any resident that				
		insulin dose. The Physician				
		concerned about these				
	•	g given In regard to the				
		on, the Physician stated she				
		a Keppra level and initiated				
	-	o make sure a resident who				
		on was watched closely. The Resident #35 ' s blood				
	-	h not to have notified me.				
		his missed doses affected				
		d pressure. The Physician				
		probably should have had an				
		is blood pressure monitored				
		nd checked every two hours				
	stated the blood pres	and normal. The Physician sure was significant.				
		2 PM, in an interview, the				
		tated her expectation was				
		d be documented as they				
	given.	the medications would be				
F 242	•	ERMINATION - RIGHT TO	F 242			10/30/16
SS=D	MAKE CHOICES					
		right to choose activities,				
		h care consistent with his or				
		ments, and plans of care;				
		s of the community both e facility; and make choices				
	inside and outside the	e lacility, and make choices				

Facility ID: 923408

If continuation sheet Page 11 of 47

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLE CO	ONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		CON	IPLETED
		345236	B. WING _			09	C 9/16/2016
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	10/2010
	TON HEALTH AND REH			820	WELLINGTON AVENUE		
WILMING	ION HEALTH AND REH	ADILITATION CENTER		WIL	MINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 242	Continued From pag	e 11	F 2	242			
	-	or her life in the facility that		- 12			
	are significant to the						
		Γ is not met as evidenced					
	by:	i is not met as evidenced					
	Based on observation	ons, record review, resident			Resident #34 and #40 were interview	ved	
		the facility failed to honor			by the Director Nursing/Designee to		
		for 2 of 3 residents reviewed			determine bathing'/showering		
	(Resident #34 and R	esident # 40).			preferences.		
	Findings included:	ealed Resident #34 was			Unit Managers will conduct interviews residents identified as inter-viewable t		
		y on 7/29/15 with cumulative			determine residents bathing preference		
	diagnoses which incl	-			The Director of Nursing and/or Design		
	-	ew of the annual MDS			will re- educate direct care staff on		
	•••	assessment of 8/4/16			resident preferences to include honori	ing	
		34 was cognitively intact and			bathing/shower preferences complete	•	
		effectively. The MDS			October 30, 2016. Newly hired license		
	indicated the residen	t required 2 person assist for			nurses will receive the education durin	ng	
		. The MDS revealed the			orientation. The facility will complete r		
		portant (but can't do or no			education on any licensed nurse that	does	
		tween a tub bath, shower,			not receive the reeducation prior to		
	bed bath or sponge t	catn. cal record revealed Resident			working next scheduled shift.	will	
		scheduled on the 7 AM-3 PM			Director of Nursing and/or Designee v perform random audits on each unit	vviii	
		dnesday and Friday. A			weekly times 4weeks and monthly tim	es 3	
		assistant records revealed			to ensure residents preferences/show		
	-	6/16 (7 weeks), there were 7			are met. The DON will report findings		
		ted Resident #34 received a			audits to the Quality Assurance Impro		
		ation did not indicate showers			Committee. The QAPI committee will		
	were given.				evaluate the results and implement		
	-	on 9/13/16 at 9:10 AM,			additional interventions as needed to		
		she did not receive showers ower days of Mondays,			ensure continued compliance.		
		days. Resident #34 stated					
	-	ny showers the previous					
		reported she asked for a					
		eduled shower day of the					
		adiod offortion day of the					

Facility ID: 923408

If continuation sheet Page 12 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/27/2016 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345236	B. WING				C / 16/2016
NAME OF P	ROVIDER OR SUPPLIER	·		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				820	WELLINGTON AVENUE		
WILMING	TON HEALTH AND REHA	BILITATION CENTER		WIL	MINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 242	nursing assistants the available in the facility Resident #34 said sh take the time to give l give her a shower. Re reported her preferen on her scheduled sho recall the last time sh of her scheduled day reported there were r receive a shower at a During an interview o 7AM-3PM nursing as Resident #34 stated t for a shower on Mon on the day shift. NA# were only 2 nursing a too difficult to comple because it required 2 and to the shower. No requested a shower of there was not enough days and there was ju done. NA #15 report staffed in the last few many days Resident scheduled shower. During an interview o Director of Nursing st the residents ' care to individual preferences 2. Record review reve admitted to the facility cumulative diagnoses Hypertension and An- recent comprehensiv dated 9/7/2016 indica	ere was not enough staff y to complete her shower. e felt if the staff was able to her a bed bath, they could esident # 34 stated she ice for a shower to the staff ower days but she could not e received showers on each s. Resident # 34 also nany weeks she did not ill. n 9/13/16 at 10:15 AM the sistant (NA#15) assigned to the resident was scheduled day, Wednesday and Friday 15 stated on the days there assistants on the hall it was te Resident #34 's shower people to get her in the lift A #15 stated Resident #34 each scheduled day, but n nursing assistants on most ust no way to get everything ted they had been short months and there were #34 did not receive her n 9/16/2016 at 9:18 AM, the ated the expectation was o be provided according to s and choices.	F	242			

Facility ID: 923408

If continuation sheet Page 13 of 47

		MEDICAID SERVICES				0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	E CONSTRUCTION	(X3) DATE S COMPLE	
	CONTRECTION		A. BUILDING			
					C	
		345236	B. WING	·····	09/1	6/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
				820 WELLINGTON AVENUE		
WILMING	TON HEALTH AND REHA	ABILITATION CENTER		WILMINGTON, NC 28401		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI DEFICIENC		DAIL
F 242	Continued From page	e 13	F 24	2		
	1.0	indicated the resident				
	, , , , , , , , , , , , , , , , , , ,					
	required 2 person as					
		vealed the resident felt it				
	• •	choose between a tub bath,				
	shower, bed bath or					
		cal record revealed Resident				
		scheduled on the 3 PM-11				
		and Thursday. A review of				
		records revealed numerous				
	-	g record. There were no				
	entries for completed					
		iducted with Resident #40 on				
		The resident stated he was				
		a shower on Tuesdays and				
		PM-11 PM shift. Resident #40				
		schedule was posted in his				
		evealed the shower schedule				
	was posted in the res	sident 's room and indicated				
	Resident #40 's sche	eduled shower days were				
	Tuesday and Thursda	ay on 3 PM-11 PM shift.				
	Resident #40 stated	he did not consistently get				
	his scheduled showe	rs because there was not				
	enough staff to assist	t with showers. Resident #40				
	stated the Nursing As	ssistants (NA) would tell him				
	at the beginning of th	e shift if there were enough				
		s shower. Resident #40				
	stated he preferred a	shower but he knew most				
		ough staff to give showers.				
		ducted with NA#5 on				
	9/15/16 at 5:20 PM. N	NA# 5 indicated she was the				
	NA who cared for Re	sident #40 on the 3 PM-11				
	PM shift. NA#5 repor	ted she had worked at the				
		a half. NA#5 stated most				
		t able to give Resident #40				
	-	r because there was not				
		t her. NA# 5 reported there				
	-	-				
	i was no wav to dei ev	ervtning gone in a snift and				
		erything done in a shift and vas not completed. NA#5				

Facility ID: 923408

If continuation sheet Page 14 of 47

		ND HUMAN SERVICES			PRINTED: 10/27/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345236	B. WING		C 09/16/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER	82	TREET ADDRESS, CITY, STATE, ZIP CODE 20 WELLINGTON AVENUE VILMINGTON, NC 28401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 242 F 309 SS=D	felt bad for the resided get the care needed. were short staffed too the NAs like they use been worse over the hoped the facility wor residents ' needs wo During an interview o Director of Nursing si the residents' care to individual preference 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must r provide the necessar or maintain the higher mental, and psychos	mpleted. NA#5 stated she ents because they would not NA#5 stated the nurses of and were unable to assist ed to. NA#5 reported it had last few months and she uld get more staff so the build be met. on 9/16/2016 at 9:18 AM, the tated the expectation was to be provided according to a and choices. ARE/SERVICES FOR NG ecceive and the facility must y care and services to attain est practicable physical,	F 242		10/30/16
	by: Based on observation physician interviews failed to administer m of 10 residents review Resident #11), and f dialysis assessments per the Physicians on residents reviewed for Findings included: 1. Resident #3 was a	Γ is not met as evidenced on, staff, resident and and record review, the facility nedications as ordered for 2 wed (Resident #3 and failed to complete post by not obtaining vital signs rder and care plan for 1 of 1 or dialysis (Resident #20).		Resident #3, and #11, attending physic were notified of non-documented/administered medicat for the period of August 27 28, 2016 September 12, 2016. No additional physician orders received. Resident #2 has been discharged from the facility. The facility Director of Nursing and/or Designee will complete an audit of facil residents to ensure that the physician of notified of any non documented/administered medications	tion on 0 ity vas

Facility ID: 923408

If continuation sheet Page 15 of 47

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE). 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		IG	· · ·	PLETED
						С
		345236	B. WING			16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WILMING [.]	TON HEALTH AND REH	ABILITATION CENTER		820 WELLINGTON AVENUE		
	-			WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIC DATE
F 309	Continued From page	e 15	F 3	09		
	gastrostomy, COPD	(Chronic Obstructive		August 27-28, 2016. Will	complete an	
	Pulmonary Disease),			audit of residents receivir		
	swallowing), and dep			ensure that each have ph		
		num Data Set (MDS) dated		for assessment of vital sig	gns and shunt	
		resident to be cognitively		site post dialysis .		
		nited to total assistance for		The Director of Nursing a		
		Living with the physical		will re- educate facility li		
	assistance of one pe	rson. 7/6/2016 noted a focus area		regarding notification to the and/or responsible party and the second se		
	of-			any medications not adm		
	-	pain related to cancer.		documented; re-educatio		
		minister pain medication		assessment of resident p		
		nd therapy, if indicated.		include obtaining post dia	-	
	A review of the Augu	st 2016 signed physician		and shunt site assessme	nt completed by	
	orders revealed:			October 30, 2016. Newly		
		Tablet Chewable. Give 1000		nurses will receive the ed	•	
		a percutaneous endoscopic		orientation. The facility wi	-	
		ube one time a day for		education on any license		
	supplement. On 8/28			not receive the reeducation	•	
		not documented as given in nistration Record (MAR).		working next scheduled s The Director of Nursing a		
		.Give 1 tablet via PEG-Tube		will perform random audit	-	
		pplement. On 8/28/2016 the		weeks, weekly times 3 w		
	-	ot documented as given in		monthly times 3 to ensure		
	the MAR.	<u> </u>		received medications as		
	Zoloft Tablet 50 millig	gram (mg) Give 1 tablet via		review 2 dialysis resident	s three times a	
		ng for depression. The 2:00		week to ensure assessme		
		16 was not documented as		post dialysis; to include o	• ·	
	given in the MAR.			dialysis vital signs and sh		
		g Give 2 tablets via PEG		assessment. Weekly tim	es four and	
	-	or pain. On 8/28/2016 the ot documented as given in		monthly times three. The DON will report findir	are of audite to	
	the MAR.			the Quality Assurance Im		
				Committee. The QAPI co	-	
	On 9/12/2016 at 2:50	PM, in an interview, the		evaluate the results and i		
		oordinator (SDC) stated she		additional interventions a		
	worked in the facility	on August 27 and 28, 2016		ensure continued complia	ance.	
		00 PM shift. The SDC stated				
	several staff member	s had walked out of the				

Facility ID: 923408

If continuation sheet Page 16 of 47

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	```	G	· · ·	MPLETED
						С
		345236	B. WING		0	9/16/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD)E	
	ON HEALTH AND REHA			820 WELLINGTON AVENUE		
WILWING	ON HEALTH AND KEN	ABILITATION CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 309	Continued From page	e 16	F 30			
	1.0	there was a shortage of	1.50			
		d she felt there were many				
		e, but she tried her best.				
		ally about each of Resident				
	#3 's meds she state					
	stated it was not hum	did not give them. The SDC				
	everything.					
	5 5 5					
	 2. Resident #11 was admitted on 8/17/2016 with diagnoses of coronary artery disease, Urinary Tract Infection (UTI), leukemia, heart failure, atrial fibrillation and hypertension. The Admission MDS dated 8/24/2016 noted Resident #11 to be severely impaired for cognition and needed limited to extensive assistance for all ADLs with the physical assistance of one to two persons. A review of the August 2016 signed physician orders revealed: Aspirin 81 mg chewable tablet. Take 81 mg by mouth daily. On 8/28/2016 at 9:00 AM the dose was not documented as given in the MAR. Flonase 50 microgram (mcg) nasal spray. 1 spray by nasal route daily. Spray in each nostril for allergic rhinitis. On 8/28/2016 the 9:00 AM dose was not documented as given in the MAR. Multivitamin with minerals tablet. Take 1 tablet by mouth daily for supplement. On 8/28/2016 the 9:00 AM dose was not documented as given in the MAR. 					
	the MAR.					
		tes on 8/28/2016 revealed				
	no significant docume	entation of any problems				

If continuation sheet Page 17 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345236	B. WING				C / 16/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	FON HEALTH AND REHA	BILITATION CENTER			820 WELLINGTON AVENUE WILMINGTON, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Staff Development Co worked in the facility of on the 7:00 AM to 3:0 several staff members facility that week, so t staff. The SDC noted hall as well as the 100 Manager. The SDC s many meds she did n best. When asked sp Resident 11 ' s meds	PM, in an interview, the bordinator (SDC) stated she on August 27 and 28, 2016 0 PM shift. The SDC stated s had walked out of the there was a shortage of she tried to cover the 300 0 and 200 halls with the Unit tated she felt there were ot give, but she tried her ecifically about each of she stated if there was no lid not give them. The SDC	F	309			
	1/27/2016 with diagno Stage Renal Disease 3 times a week, Anen The most recent com Set (MDS) dated 8/16 #20 was cognitively in hemodialysis for End (ESRD). A Care Area with the MDS indicate with a Care Plan relat A review of the Care I indicated Resident #2 renal failure. The goa have no signs or sym dialysis. Interventions checked post dialysis post dialysis and to no abnormalities.	prehensive Minimum Data 5/2016 indicated Resident ntact and required Stage Renal Disease a Assessment associated ed nursing would proceed ted to dialysis. Plan dated 8/30/2016 20 required dialysis due to I was Resident #20 would ptoms of complications from a included vital signs to be , every shift for 24 hours otify Physician of significant					

If continuation sheet Page 18 of 47

	S FOR MEDICARE &					<u>O. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED
			A. BUILDIN	IG		
		345236	B. WING			С
		545256				9/16/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WILMING	ON HEALTH AND REHA	BILITATION CENTER		820 WELLINGTON AVENUE		
				WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page	- 1 9	Га	00		
1 303			F 3	09		
	September 1 through	•				
		obtain vital signs every				
		and Friday post dialysis and				
		rs post dialysis. Further				
		ed no documented vital signs				
	•	to September 14, 2016.				
		ducted with nurse #1 on				
		M. Nurse #1 reported she				
		e for Resident #20. Nurse #1				
	-	primary nurse on 9/14/2016				
		dent left the facility for				
		AM that morning. Nurse #1				
		lent returned from dialysis				
		supposed to be completed				
		ysis site check and vital				
		ed in the medical record to				
		vital signs and was not able				
		ented vital signs in the				
		August 6, 2016. Nurse #1				
		e if she obtained Resident				
	#20 's vital signs pos	-				
		dent was sick post dialysis				
		did not bother her to obtain				
		#1 reported she did not				
		n Resident #20's condition				
	on 9/12/2016. Nurse recent facility in-servi	#1 reported she attended a				
	-					
		nday was a " terrible day "				
	#20 was not complete	assessment on Resident				
	PM with Resident #20	ducted on 9/14/2016 at 4:15				
		notorized wheelchair outside				
	•					
	-	t entrance sitting area.				
				I. I		1
		ert, oriented and pleasant				
	during the interview.	The resident stated when				
	during the interview. she returned from dia					

Facility ID: 923408

If continuation sheet Page 19 of 47

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/27/20 FORM APPROV 0MB NO: 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	
		345236	B. WING		09/16/2016	
IAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	ON HEALTH AND REH	ABILITATION CENTER	820	0 WELLINGTON AVENUE		
			WI	LMINGTON, NC 28401		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 309	Continued From page	e 19	F 309			
	recalled anyone chec	cking her vital signs post				
	-	0 reported she asked Nurse				
		them and Nurse #1 told her				
		to. " Resident #20 stated er any nurse ever checking				
		hen she returned from				
		the reason she questioned				
	Nurse #1.					
		nducted with the facility ursing (DON) on 9/14/2016				
		N indicated her expectation				
		to obtain dialysis resident's				
		sis to assess the resident for				
		ne dialysis treatment. The sing staff attended a recent				
	-	alysis assessments for the				
	•	Plan of Correction (POC).				
		for the POC was 8/31/2016.				
F 325	483.25(i) MAINTAIN UNLESS UNAVOIDA	NUTRITION STATUS	F 325		10/30/16	
SS=D	UNLESS UNAVOIDA					
	Based on a resident's					
		lity must ensure that a				
	resident -	able parameters of nutritional				
		weight and protein levels,				
	unless the resident's	o 1				
		is is not possible; and				
	(2) Receives a therap nutritional problem.	peutic diet when there is a				
		Γ is not met as evidenced				
	by: Based on observation	on, staff interview and record		A nutritional assessment was complete	ч	

Event ID: 06ME11

Facility ID: 923408

If continuation sheet Page 20 of 47

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		C
		345236	B. WING		09/16/2016
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
WILMING	TON HEALTH AND REHA	ABILITATION CENTER		320 WELLINGTON AVENUE WILMINGTON, NC 28401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETIO
F 325		e 20 of 5 residents (Resident	F 325	The facility Director of Nursing an	d/or
	#36) reviewed for fee unintended weight los month period. Findings included:	ding tube, resulting in an ss of 9.2% over a seven		Designee will complete an audit of fed residents to ensure residents had significant weight loss and or tube fed residents are in place an accurate.	of tube have not ders for d
	diagnoses of dysphag gastrostomy tube (G	mitted 11/19/2015 with gia and placement of a tube). m Data Set (MDS) dated		The Director of Nursing and/or De will re- educate facility licensed no regarding tube fed residents to er weights are obtained weekly and for tube fed residents are in place	urses isure orders
	8/12/2016 noted Res impaired for cognitior extensive assistance Living (ADL)s with the	ident #36 was moderately and needed limited to for all Activities of Daily e physical assistance of one		accurate October 30, 2016. Newl licensed nurses will receive the e during orientation. The facility will complete re- education on any lic	y hired ducation
	The MDS noted the r 51% of his total calor	esident received more than ies from tube feeding.		nurse that does not receive the reeducation prior to working next scheduled shift. The Director of Nursing and/or De	
	weight of 163 pounds			will perform random audits on tub residents weekly times 4 then mo times 3 to ensure weights are obt	nthly ained
	3/18/2016 and was w five times a day Ente Jevity 1.5 per Percuta Gastrostomy (PEG) v	s originally ordered on ritten: Enteral Feed Order ral 1-Feeding: Administer aneous Endoscopic ria Bolus (a method of using to flow into a feeding tube).		weekly and orders for tube fed re are in place and accurate. The DON will report findings of au the Quality Assurance Improve Committee. The QAPI committee evaluate the results and impleme	udits to
	Rate: 300 milliliter (m day, to provide 2,250	l.) per feeding. 5 times per Calories per 24 hours.		additional interventions as neede ensure continued compliance.	
	orders revealed: Administer Jevity 1.5	st 2016 signed physician per PEG via Bolus Rate: 5 times per day, to provide 1 hours.			

Facility ID: 923408

If continuation sheet Page 21 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345236	B. WING				C 16/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	FON HEALTH AND REHA	BILITATION CENTER			20 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	 1.5 provides 1.5 Calo Resident #36 at 300 n Calories. On 9/11/2016 Reside weight of 148 pounds On 9/12/2016 at 2:50 Staff Development Ca worked in the facility of on the 7:00 AM to 3:0 several staff members facility that week, so t staff. The SDC stated meds she did not give When asked specificat bolus feedings she st documentation, she do stated staffing had go weeks. The SDC was for any other time in A On 9/13/2016 at 3:22 interview, the Unit Ma working on August 27 from 7:00 AM until 11 Resident #35 ' s bolus the Unit Manager stated the bolus feeds. On 9/14/2016 at 9:00 Registered Dietician (was taken off continu- bolus feeds because the facility in his whee the facility in his whee 	ries per ml. One feeding for ml. would provide 450 ht #36 had a recorded PM, in an interview, the bordinator (SDC) stated she on August 27 and 28, 2016 0 PM shift. The SDC stated is had walked out of the here was a shortage of she felt there were many e, but she tried her best. ally about Resident #35 ' s ated if there was no id not give them. The SDC tten worse in the past few not noted on the schedule august. PM in a telephone imager stated she was 7, 2016 for a 4 hour shift :00 AM. When asked if is feeding was administered,	F	325			

Facility ID: 923408

If continuation sheet Page 22 of 47

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		345236	B. WING _				_ 16/2016
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	TON HEALTH AND REHA	BILITATION CENTER			0 WELLINGTON AVENUE ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325 F 333 SS=E	loss when she comple assessment. The RD Resident #36 had mis stated missing a feed missing a meal. " The mentioned any misse Resident #36 ' s tube according to his calor have weight loss, if he feeds. On 9/15/2016 at 11:30 facility Physician and (PA), the Physician and (PA), the Physician st the tube feedings that given for Resident #3 was concerned in reg unintended weight loss On 9/15/2016 at 12:30 Director of Nursing st the tube feedings wou were given. 483.25(m)(2) RESIDE SIGNIFICANT MED E The facility must ensu any significant medication This REQUIREMENT by: Based on resident ar record review, the fac significant medication	eted his monthly stated she was not aware used any feedings and ing was " essentially e RD noted no staff had d feeding. The RD indicated feedings are calculated ic needs, and he should not e receives the ordered tube D AM in an interview with the the Physician Assistant ated she was not aware of were not documented as 6. The Physician stated she ard to Resident #36 and his as. 2 PM, in an interview, the ated her expectation was uld be documented as they ENTS FREE OF ERRORS are that residents are free of ation errors. a is not met as evidenced and staff interviews and ility failed to administer		325	Resident #3, #4, #11, #19, #20, #33, # #35 and #36 attending physician were notified of non-documented medication the period of August 27 28, 2016 on September 12, 2016 no additional physician orders received.		10/30/16

Event ID: 06ME11

Facility ID: 923408

If continuation sheet Page 23 of 47

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/27/2016 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345236	B. WING				C 16/2016
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	ON HEALTH AND REHA	ABILITATION CENTER			20 WELLINGTON AVENUE		
				N	/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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	Continued From page		F	333	The facility Director of Nursing and/or		
	diagnoses of coronar Tract Infection (UTI), fibrillation and hyperte The Admission MDS Resident #11 to be se cognition and needed assistance for all ADL assistance of one to the A review of the Augus orders revealed: Amiodarone 200 millit tablet by mouth daily fibrillation. On 8/28/2016 the 8:0 documented as given Administration Recorn Plavix 75mg tablet. The coronary artery disea at 9:00 AM was not d MAR. Amlodipine 5 mg tabl times daily for hyperte 9:30 AM dose was not the MAR. Metoprolol 25 mg 24 mouth 2 times daily a hypertension and atri the scheduled dose a documented as given Potassium Chloride 1 tablet. Take 2 tablets hypokalemia (low pot	dated 8/24/2016 noted everely impaired for d limited to extensive swith the physical two persons. at 2016 signed physician gram (mg) tablet .Take 1 with breakfast for atrial 0 AM dose was not in the Medication d (MAR). ake 75mg by mouth daily for se. On 8/28/2016 the dose ocumented as given in the et. Take 1 tablet by mouth 2 ension. On 8/28/2016 the ot documented as given in hour tablet. Take 1 tablet by t 0600 and 1800 for al fibrillation. On 8/28/2016 at 9:30 AM was not			Designee will complete an audit of factoresidents to ensure that the physician notified of any non documented medications for August 27-28, 2016. The Director of Nursing and/Designee Nursing will re-educate facility licens nurses regarding notification to the resident and/or responsible party and physician of any medications not administered / not documented medications completed by October 30 2016. Newly hired licensed nurses wit receive the education during orientati. The facility will complete re-education any licensed nurse that does not receive the reeducation prior to working next scheduled shift. Director of Nursing and/or Designee perform random audits daily times 2 weeks, weekly times 3 weeks and monthly times 3 to ensure residents hereceived medications as ordered. The DON will report findings of audits to to quality Assurance Improvement Committee. The QAPI committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	cility was e of ed), ll on. n on sive will ave e he	
	2. Resident #19 was	admitted 1/6/2016 with					

If continuation sheet Page 24 of 47

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/27/2016 MAPPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345236	B. WING					16/2016
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
	ON HEALTH AND REHA				820 WELLINGTON AVENUE			
					WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	E	(X5) COMPLETION DATE
F 333	diagnoses of atrial fib rhythm) and diabetes The admission Minim 1/25/2016 noted Res	rillation (irregular heart mellitus. um Data Set (MDS) dated ident #19 to be impaired for	F	333	3			
	Activities of Daily Livi assistance of one per	I extensive assistance for all ng (ADLs) with the physical rson. d physician orders for						
	August, 2016 reveale Digoxin 125 microgra (gastrostomy tube) da 8/28/2016 was not do	d:						
	Staff Development Co worked in the facility on the 7:00 AM to 3:0 several staff member facility that week, so the staff. The SDC stated scheduled to work a 4 11:00 AM on August 2 tried to cover the 300 200 halls with the Un she felt there were m but she tried her best about Resident #19 '	PM, in an interview, the bordinator (SDC) stated she on August 27 and 28, 2016 00 PM shift. The SDC stated s had walked out of the there was a shortage of t the Unit Manager was 4 hour shift from 7:00 AM to 27 also. The SDC noted she hall as well as the 100 and it Manager. The SDC stated any meds she did not give, . When asked specifically s medication, she stated if entation, she did not give it.						
	working on August 27 from 7:00 AM until 11 stated when it was di nurse for the 300 hall	PM in a telephone anager stated she was 7, 2016 for a 4 hour shift :00 AM. The Unit Manager scovered there was no , the SDC went to try and d also work on the 100 and						

Facility ID: 923408

If continuation sheet Page 25 of 47

		ND HUMAN SERVICES MEDICAID SERVICES				FC	FED: 10/27/201 RM APPROVE NO. 0938-039	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		345236	B. WING				C 09/16/2016	
NAME OF P	ROVIDER OR SUPPLIER	1		STREE	T ADDRESS, CITY, STATE, ZIP CODE			
WILMING	TON HEALTH AND REHA	ABILITATION CENTER			ELLINGTON AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 333	200 hall. When Resid was not documented Unit Manager, she st medication, she docu documented she cou Unit Manager stated medications on the 7. 8/27/2016. The Unit I gave medications on At 11:30 AM on 9/15/ the Facility Physician (PA), the Physician ir of the medication tha given for Resident #1 missing Digoxin dose thorough assessmen 2 hours. If the Digoxin	dent #19 ' s medication that as given was read to the ated if she gave a umented it. If it was not Id not say she gave it. The there were a lot of missed AM - 3 PM shift on Manager also stated she the 100 and the 200 hall. 2016, in an interview with and the Physician Assistant dicated she was not aware t was not documented as 19. The Physician stated for es the Physician would do a t and obtain vital signs every n was dosed based on stated she would have a	F	333				
	diagnoses of End Sta Diabetes Mellitus and The Admission MDS cognitively intact and assistance for all ADI assistance of one per in the area of psycho went to care plan. The care plan dated 2 Resident #20 receive and a goal of Reside drug related complicat included: Administer	noted Resident #20 to be needed limited to extensive Ls with the physical rson. The CAA noted a focus tropic drug use and this area 2/9/2016 noted a focus of es anti-psychotic medications nt #20 will remain free of						

If continuation sheet Page 26 of 47

				FOR	ED: 10/27/2016 RM APPROVED O. 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED		
345236	B. WING			09	C 9/16/2016	
	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BILITATION CENTER						
		W	ILMINGTON, NC 28401			
Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE	
) to consider dosage ally appropriate at least iily about ongoing need for oserve /document / report s of psychotropic e/record occurrence of for toms and document per d physician orders for August D indicated the following: g) give 1 by mouth (po) one r disorder. Take with 5 mg to 9:00 AM dose on 8/28/2016 as given in the Medication d (MAR). one time a day with Abilify 2 bi-polar disorder. The 9:00 6 was not documented as acting) inject 30 units dtime for diabetes. The 9:00 6 and 8/28/2016 were not in the MAR. po two times a day for 00 AM dose on 8/27/2016 as given in the MAR. sulin given subcutaneously bedtime. The 11:30 AM and 27/2016, and the 9:00 PM ere not documented as PM, in an interview, the bordinator (SDC) stated she on August 27 and 28, 2016 	F	333				
	IDENTIFICATION NUMBER:	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 345236 B. WING BELITATION CENTER D ATEMENT OF DEFICIENCIES /MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) PREF TAG 226 F atily about ongoing need for pserve /document / report s of psychotropic F d physician orders for August 0 indicated the following: 9) give 1 by mouth (po) one r disorder. Take with 5 mg to 9:00 AM dose on 8/28/2016 as given in the Medication d (MAR). one time a day with Abilify 2 bi-polar disorder. The 9:00 6 was not documented as atcting) inject 30 units dtime for diabetes. The 9:00 6 and 8/28/2016 were not in the MAR. po two times a day for 10 AM dose on 8/27/2016 as given in the MAR. sulin given subcutaneously pedtime. The 11:30 AM and 27/2016, and the 9:00 PM ere not documented as PM, in an interview, the pordinator (SDC) stated she on August 27 and 28, 2016 0 PM shift. The SDC stated	MEDICAID SERVICES (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE A. BUILDING 345236 B. WING BILITATION CENTER B. WING ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ID PREFIX TAG 226 F 333 ally appropriate at least iily about ongoing need for poserve /document / report is of psychotropic //record occurrence of for toms and document per d physician orders for August D indicated the following: g) give 1 by mouth (po) one r disorder. Take with 5 mg to 9:00 AM dose on 8/28/2016 as given in the Medication d (MAR). one time a day with Abilify 2 bi-polar disorder. The 9:00 6 was not documented as acting) inject 30 units dtime for diabetes. The 9:00 6 and 8/28/2016 were not in the MAR. po two times a day for 10 AM dose on 8/27/2016 as given in the MAR. sulin given subcutaneously pedtime. The 11:30 AM and 27/2016, and the 9:00 PM ere not documented as PM, in an interview, the poordinator (SDC) stated she on August 27 and 28, 2016 0 PM shift. The SDC stated	MEDICAID SERVICES (X1) PROVIDERSUPPLERICLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345236 B. WING BILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE B2 WELLINGTON AVENUE WILLINGTON, NC 28401 ATEMENT OF DEFICIENCIES WINGTOP, NC 28401 D PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ATON SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 226 F 333 10 to consider dosage ally appropriate at least illy about ongoing need for isserve /document / report is of psychotropic //record occurrence of for tooms and document per 4 physician orders for August 0 indicated the following: 1) give 1 by mouth (po) one r disorder. Take with 5 mg to 9:00 AM dose on 8/28/2016 as given in the Medication 1 (MAR), one time a day with Abilify 2 -i-plar disorder. The 9:00 6 was not documented as horting) inject 30 units ditime for diabetes. The 9:00 6 and 8/28/2016 were not in the MAR, 90 DAM dose on 8/27/2016 as given in the MAR. Sullin given subcutaneously vedtime. The 11:30 AM and 27/2016, and the 9:00 PM are not documented as PM, in an interview, the pordinator (SDC) stated she on August 27 and 28, 2016 0 PM shift. The SDC stated	D HUMAN SERVICES OMB N MEDICAID SERVICES OMB N MEDICAID SERVICES OMB N A BUILDING 345236 B VING 345236 B VING BUILDING 345236 B VING 345236 B VING BUILDING BUILDING 345236 B VING BUILDING BUILDING 345236 B VING BUILDING	

Facility ID: 923408

If continuation sheet Page 27 of 47

	-	ID HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATI	E SURVEY PLETED		
		345236	B. WING			09	C / 16/2016
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	TON HEALTH AND REHA	BILITATION CENTER			820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	facility that week, so it staff. The SDC states meds she did not give When asked specifica #20 's meds she stat documentation, she c On 9/13/2016 at 3:22 interview, the Unit Ma working on August 27 from 7:00 AM until 11 Resident #20 's med documented as given Manager, she stated she documented it. If could not say she gay stated there were a lo the 7AM - 3 PM shift At 11:30 AM on 9/15/ the Facility Physician w medications that were for Resident #20. The have wanted Resider checked immediately Panel lab drawn or pe sure the resident was Diabetic Ketoacidosis when there is not enc Physician stated she any resident that miss dose.	there was a shortage of d she felt there were many a, but she tried her best. ally about each of Resident ed if there was no lid not give them. PM in a telephone anager stated she was 7, 2016 for a 4 hour shift :00 AM. When a list of ications that were not a was read to the Unit if she gave a medication, it was not documented she ve it. The Unit Manager ot of missed medications on on 8/27/2016. 2016, in an interview with and the Physician Assistant as not aware of the e not documented as given Physician stated she would at #20's blood sugar and then a Basic Metabolic erhaps blood gases to make	F	33:	3		
		s mellitus, atrial fibrillation					

If continuation sheet Page 28 of 47

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL			E CONSTRUCTION	(X3) DATE SUF COMPLET C			
		345236	B. WING				_ 16/2016
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WILMING	TON HEALTH AND REHA	BILITATION CENTER			820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 333	The Admission MDS of Resident #30 to be co supervision to extensi with supervision or 1 The care plan dated & diabetes and is at risk secondary to the dise therapy related to hig focus of anti-coagular fibrillation. The interve diabetes, diuretic and as ordered by the phy effects and effectiven A review of the Augus orders revealed: Bumetanide 2 milligra once daily for conges AM dose on 8/27/201 given in the Medication (MAR). Diltiazem ER (extendo once daily for atrial fits on 8/27/2016 was not MAR. Toujeo insulin inject 3 bedtime for diabetes for on 8/27/2016 was not MAR. Apixaban 5 mg 1 po t fibrillation. The 8:00 A not documented as gi Humalog sliding scale subcutaneously befor mellitus. The insulin of PM on 8/27/2016 and 8/28/2016 were not do MAR.	dated 6/3/2016 noted ognitively intact and needed ive assistance for all ADLs person assist. 3/2/2016 noted a focus for a for complications ase. Also a focus of diuretic h blood pressure, and a nt therapy related to atrial entions included: Administer anti-coagulant medications visician and observe for side ess every shift. at 2016 signed physician and (mg) 1 by mouth (po) tive heart failure. The 8:00 6 was not documented as on Administration Record ed release) 300 mg 1 po orillation. The 8:00 AM dose a documented as given in the 2 units subcutaneously at mellitus. The 9:00 PM dose a documented as given in the wo times daily for atrial M dose on 8/27/2016 was iven in the MAR. a insulin given	F	333	3		

If continuation sheet Page 29 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/27/2016 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345236	B. WING		_		C 16/2016
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WILMING	ON HEALTH AND REHA	BILITATION CENTER	-				
				VILMINGTON, NC 2840			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page	29	F 333				
	three times a day for AM and 12 noon dose	diabetes mellitus. The 8:00 es on 8/27/2016 and 12					
	given in the MAR.	16 were not documented as					
	Staff Development Co	PM, in an interview, the bordinator (SDC) stated she					
	on the 7:00 AM to 3:0	on August 27 and 28, 2016 0 PM shift. The SDC stated s had walked out of the					
	facility that week, so t	here was a shortage of she felt there were many					
	meds she did not give	e, but she tried her best. ally about each of Resident					
	#30 's meds she stat						
	documentation, she d	lid not give them.					
	On 9/13/2016 at 3:22						
		nager stated she was /, 2016 for a 4 hour shift					
	from 7:00 AM until 11	:00 AM. When a list of					
	Resident #30 's medi						
	documented as given Manager, she stated	if she gave a medication,					
	she documented it. If	it was not documented she					
		ve it. The Unit Manager ot of missed medications on					
	the 7AM - 3 PM shift						
	At 11:30 AM on 9/15/2	2016, in an interview with					
		and the Physician Assistant					
	(PA), the Physician w medications that were	as not aware of the e not documented as given					
		Physician stated she would					
	have wanted Residen	•					
		and then a Basic Metabolic erhaps blood gases to make					
	sure the resident was						

Facility ID: 923408

If continuation sheet Page 30 of 47

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	```	3		IPLETED	
					С		
		345236	B. WING		0	9/16/2016	
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	CODE		
	TON HEALTH AND REHA			820 WELLINGTON AVENUE			
WILWING	ION REALIN AND REAL	ABILITATION CENTER		WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 333	Continued From page	e 30	F 33	33			
	Diabetic Ketoacidosis	s (a complication of diabetes					
		ough insulin in the body). The					
	-	would have done that for					
	dose. The Physician	sed a scheduled insulin stated she was verv					
		se medications not being					
	given.						
	5. Resident #33 was	admitted 11/25/2013 with					
	•	s mellitus, congestive heart					
	failure (CHF) and atri						
		ated 6/28/2016 noted noderately impaired for					
	cognition and needed						
	assistance for all ADI						
	assistance of one per						
	-	6/30/2016 noted a focus of					
		ute and chronic congestive nd a goal of clear lung					
		e and rhythm within normal					
		t review. There was also a					
	focus of Resident #33	3 had diabetes mellitus and					
		ations related to diabetes					
		s for both CHF and diabetes					
	diabetes medication	c meds as ordered and as ordered.					
		Resident #33 received					
		y related to atrial fibrillation					
	-	erse reactions related to					
	-	ough next review. The					
		d: administer anticoagulant ed by physician. Observe for					
		tiveness. Teaching included					
		tion at the same time each					
		so had a focus of Resident					
	#33 receives diuretic	therapy related to heart				1	

Facility ID: 923408

If continuation sheet Page 31 of 47

		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345236	B. WING				C / 16/2016
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
WILMING	TON HEALTH AND REHA	BILITATION CENTER			820 WELLINGTON AVENUE WILMINGTON, 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) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 333	failure and included in diuretic medications a and observe for side every shift. A review of the Augus orders revealed: Dilacor XR 120 milligr (po) once daily for CH 8/27/2016 was not do Medication Administra Lantus insulin inject 1 bedtime for diabetes on 8/27/2016 was not MAR. Lasix 40mg 1 po once AM dose on 8/27/201 given in the MAR. Eliquis 2.5mg 1 po tw The 8:30 AM dose on documented as given Humalog insulin injec subcutaneously befor diabetes. On 8/27/201 had a blood sugar of level for diabetic pers received 4 units of ins had no documentation the 11:30 AM, 4:30 Pl times on 8/27/2016. F sugar level of 374 at 0 received 8 units of ins On 9/12/2016 at 2:50 Staff Development Co worked in the facility o on the 7:00 AM to 3:0	hterventions of administer as ordered by the physician effects and effectiveness at 2016 signed physicians rams (mg) give 1 by mouth IF. The 9:00 AM dose on ocumented as given in the ation Record (MAR). 2 units subcutaneously at mellitus. The 9:30 PM dose a documented as given in the e daily for CHF. The 8:00 6 was not documented as ice daily for atrial fibrillation. 8/27/2016 was not in the MAR. t per sliding scale e meals and at bedtime for 16 at 6:30 AM Resident #33 292 (normal blood sugar ons is 70 - 130), and sulin. Resident #33 's MAR n of insulin administration at M and 9:00 PM scheduled Resident #33 had a blood 6:30 AM on 8/28/2016 and	F	333	3		

Facility ID: 923408

If continuation sheet Page 32 of 47

	DF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
						С
		345236	B. WING		09	9/16/2016
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				820 WELLINGTON AVENUE		
WILWING	ON HEALTH AND REHA	ABILITATION CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 333	Continued From page	a 32	F 33	3		
1 000		d she felt there were many	F 33	3		
		e, but she tried her best.				
	-	ally about each of Resident				
	#33 's meds she stat	-				
	documentation, she o	did not give them.				
	On 9/13/2016 at 3:22	-				
		anager stated she was				
	• •	7, 2016 for a 4 hour shift :00 AM. When a list of				
		lications that were not				
		was read to the Unit				
		if she gave a medication,				
		it was not documented she				
		ve it. The Unit Manager				
		ot of missed medications on				
	the 7AM - 3 PM shift	on 8/27/2016.				
	At 11:30 AM on 9/15/	2016, in an interview with				
		and the Physician Assistant				
	(PA), the Physician w					
		e not documented as given				
		Physician stated she would				
		nt #33 ' s blood sugar				
	-	and then a Basic Metabolic erhaps blood gases to make				
		s not in any danger of				
		s (a complication of diabetes				
		bugh insulin in the body). The				
	Physician stated she	would have done that for				
	any resident that miss	sed a scheduled insulin				
	dose. The Physician	-				
		se medications not being				
		noted missing a diuretic				
		ugh assessment, including a easure oxygen in the blood),				
	an edema assessme					
		g or worsening heart failure)				

Facility ID: 923408

If continuation sheet Page 33 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/27/2016 MAPPROVED D. 0938-0391	
STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345236	B. WING				/16/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	TON HEALTH AND REHA			8	20 WELLINGTON AVENUE			
				V	VILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 333	heart failure " brewin	g " . The Physician stated	F	333				
		gative findings from the uld have ordered a chest						
	diagnoses of diabetes unspecified convulsion The annual MDS date #34 to be cognitively to total assistance with a focus of medication The care plan dated of risk of hypotensive ep- included give antihyp ordered and observe effectiveness. The care plan also for deficits related to the intervention of admin and observe for side Diabetes mellitus was of diabetic medication side effects and effect sugar as ordered. The #34 has a seizure dis was to give anti-seizu and observe for side A review of the Augus orders revealed: Lasix 40 milligrams (r morning for hypertens 8/27 and 8/28/2016 w	ed 8/4/2016 noted Resident intact and needed extensive th all ADLs . The CAA noted is and this went to care plan. 9/7/2016 noted a focus of bisodes and the intervention ertensive medications as for side effects and cused on fluid volume use of diuretics with an ister medications as ordered effects and effectiveness. Is a focus with an intervention in as ordered and observe for tiveness. Also fasting blood ere was a focus of Resident order and the intervention ure medication as ordered effects and effectiveness. st 2016 signed physician mg) 1 by mouth (po) in the sion. The 9:00 AM doses on vere not documented as on Administration Record						

Facility ID: 923408

If continuation sheet Page 34 of 47

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/27/2016 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345236	B. WING					C 16/2016
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CC	DE	-	
	ON HEALTH AND REHA				820 WELLINGTON AVENUE			
WILWING		BILITATION CENTER			WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
	F 333 Continued From page 34 hypertension. The BP check, the pulse reading and the 9:30 AM dose were not documented as taken and given on 8/27 and 8/28/2016 in the MAR. Lantus insulin inject 52 units subcutaneously two times a day for diabetes. The 9:30 AM and the 9:30 PM doses were not documented as given on 8/27 and 8/28/2016 in the MAR. Humalog insulin inject 18 units subcutaneously three times a day for diabetes mellitus. The 8:00 AM and the 12:30 PM doses were not documented as given on 8/27 and 8/28/2016 in the MAR. Keppra 750 mg 1 po three times a day related to convulsions. The 9:30 AM and the 1:30 PM doses on 8/27 and 8/28/2016 were not documented as given in the MAR. Humalog insulin inject per sliding scale subcutaneously before meals and at bedtime for			33	3			
	in the MAR, of insulin 8/27/2016. The 9:30 PM insulin was the MAR. On 8/28/20 had a blood sugar lev units of insulin. The 1 documented as given sugar level checked a Resident #34 receive was noted Resident # vomiting. There was n was given for a 9:30 I MAR. On 9/12/2016 at 2:50 Staff Development Co worked in the facility on the 7:00 AM to 3:0	ere was no documentation given at 12:30 PM on not documented as given on 16 at 6:30 AM Resident #34 vel of 243, and received 2 2:30 PM insulin was not in the MAR. The blood at 5:30 PM was 314 and d 6 units of insulin and it #34 had nausea and no documentation insulin PM dose on 8/28/2016 in the PM, in an interview, the pordinator (SDC) stated she on August 27 and 28, 2016 10 PM shift. The SDC stated s had walked out of the						

If continuation sheet Page 35 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/27/2016 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345236	B. WING				C 16/2016
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	ON HEALTH AND REHA	BILITATION CENTER			20 WELLINGTON AVENUE VILMINGTON, NC 28401		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	COMPLETION DATE
F 333	Continued From page	35	F:	333			
		here was a shortage of					
	,	she tried to cover the 300					
	hall as well as the 100	0 and 200 halls with the Unit					
		tated she felt there were					
	-	ot give, but she tried her					
		ecifically about each of					
		s she stated if there was no					
	documentation, she d	lid hot give them.					
	On 9/13/2016 at 3:22	PM in a telephone					
		inager stated she was					
		, 2016 for a 4 hour shift					
	from 7:00 AM until 11	:00 AM. When a list of					
	Resident #34 's medi						
	documented as given						
	-	f she gave a medication, she					
		as not documented she					
		ve it. The Unit Manager of missed medications on					
	the 7AM - 3 PM shift						
		2016, in an interview with					
		and the Physician Assistant					
	(PA), the Physician w	e not documented as given					
		Physician stated she would					
	have wanted Residen						
		and then a Basic Metabolic					
		erhaps blood gases to make					
	sure the resident was	, ,					
		a complication of diabetes					
		ough insulin in the body). The					
	•	would have done that for					
	•	sed a scheduled insulin					
	dose. The Physician s	-					
		e medications not being					
		e anti-seizure medication,					
	-	she would have ordered a ated seizure precautions to					

Facility ID: 923408

If continuation sheet Page 36 of 47

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 10/27/2016 1 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/16/2016		LETED
		345236	B. WING					
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE			
WILMING	TON HEALTH AND REHA	ABILITATION CENTER			820 WELLINGTON AVENUE			
					WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	Ξ	(X5) COMPLETION DATE
F 333	Continued From page	e 36	F	33	3			
	make sure Resident	#34 was watched closely.						
	diagnoses of stroke,	admitted 4/20/13 with diabetes mellitus, and high						
	blood pressure. The quarterly MDS d	ated 8/3/2016 noted only only						
	needed 2 person ass The care plan dated a							
	goal was Resident #3	5 would remain free from f hypertension through next						
	blood pressure readi	included: avoid taking the ng after physical activity or bserve abnormal urine						
	output. Report signific physician. Obtain blo and as needed.	cant changes to the od pressure readings weekly						
	revealed:	st signed physician orders						
	once daily for blood p on 8/27/2016 was no	ms (mg) 1 by mouth (po) pressure. The 9:00 AM dose t documented as given in the						
		ation Record (MAR). 12.5 mg 1 po once daily for 00 AM dose on 8/27/2016						
	Carvedilol 25 mg 1 p	as given in the MAR. o two times a day for disease and hold for blood						
	pressure (BP) under 8/26/2016 at 5:30 PM	110. The BP recorded for I was 142/78 and the						
	8/27/2016 at 9:30 AM	mented as administered. On I no BP was recorded and cumented as given in the						
	MAR. On 8/27/2016	at 5:30 PM the BP was						

Facility ID: 923408

If continuation sheet Page 37 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 10/27/2016 RM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		345236	B. WING			C 09/16/2016		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
WILMING	TON HEALTH AND REHA	BILITATION CENTER			820 WELLINGTON AVENUE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	I IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 333	recorded as 186/106 documented as admi Lisinopril 10 mg 1 po hypertension. The 9:0 was not documented Clonidine 0.3 mg 1 po hypertension. The 2:0 8/28/2016 was not do MAR. Isosorbide 20 mg 1 p arteriosclerotic heart on 8/27 and 8/28/201 given in the MAR. On 9/12/2016 at 2:50 Staff Development Co worked in the facility on the 7:00 AM to 3:0 several staff member facility that week, so t staff. The SDC noted hall as well as the 10 Manager. The SDC s many meds she did n best. When asked sp Resident #35 ' s med documentation, she co On 9/13/2016 at 3:22 interview, the Unit Ma working on August 27 from 7:00 AM until 11 Resident #35 ' s med documented as given Manager she stated i documented it. If it was	and the medication was nistered. twice a day for 00 AM dose on 8/27/2016 as given in the MAR. o every 8 hours for 00 PM dose on 8/27 and ocumented as given in the o every 8 hours for disease. The 2:00 PM dose 6 was not documented as PM, in an interview, the cordinator (SDC) stated she on August 27 and 28, 2016 00 PM shift. The SDC stated s had walked out of the there was a shortage of she tried to cover the 300 0 and 200 halls with the Unit tated she felt there were not give, but she tried her ecifically about each of s she stated if there was no did not give them.	F	333	3			

Facility ID: 923408

If continuation sheet Page 38 of 47

		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 10/27/20 FORM APPROVE 1B NO. 0938-039
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		NSTRUCTION	(X3	DATE SURVEY COMPLETED
		345236	B. WING			C 09/16/2016	
NAME OF PI	ROVIDER OR SUPPLIER	L		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	'	
WILMINGTON HEALTH AND REHABILITATION CENTER				VELLINGTON AVENUE MINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 333		ot of missed medications on	F 3	33			
	the Facility Physician (PA), the Physician w medications that were for Resident #35. The Resident #35 's bloo to have notified her. T missed doses affecte pressure. The Physic should have had an e and had his blood pre- next dose and checke	e not documented as given e Physician indicated d pressure was too high not The Physician stated his d Resident #35 ' s blood ian stated Resident #35 extra dose of his medication essure monitored after his ed every two hours or until it al. The Physician stated the					
	cumulative diagnoses hypertension, seizure failure with tracheoste (G tube). The quarterly MDS d Resident #36 was mo cognition and needed assistance for all ADI	es, and acute respiratory omy and gastrostomy tube ated 8/12/2016 noted oderately impaired for d limited to extensive					
	revealed: Augmentin 500-125 r (gastro-intestinal tube pneumonia. The 9:00	st signed physician orders nilligrams (mg) give 1 via e) G-tube two times a day for 0 AM and 5:00 PM doses on vere not documented as					

Facility ID: 923408

If continuation sheet Page 39 of 47

		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 10/27/2 FORM APPRO B NO. 0938-0	VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í) DATE SURVEY COMPLETED	
		345236	B. WING		C 09/16/2016			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	TON HEALTH AND REHA				820 WELLINGTON AVENUE			
WILWING					WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE	TION
F 333	Continued From page	<u>-</u> 39	Í F	333	3			
	given in the Medicatio	on Administration Record		00.				
	(MAR).							
		a G-tube every 12 hours for or systolic blood pressure						
		The 8:30 AM dose on 8/27						
		ot documented as given in						
	the MAR.							
		t via G-tube two times a day ion. The 9:00 AM dose on						
		vas not documented as						
	given in the MAR.							
		e 200 mg via G-tube every						
		sion. Hold for systolic BP						
		3:30 dose on 8/27 and ocumented as given in the						
	MAR.	scutterited as given in the						
		via G-tube every 12 hours						
		OAM dose on 8/27 and						
	8/28/2016 was not do MAR.	ocumented as given in the						
		PM, in an interview, the						
	-	oordinator (SDC) stated she						
		on August 27 and 28, 2016 00 PM shift. The SDC stated						
		s had walked out of the						
		there was a shortage of						
	-	I she felt there were many						
		e, but she tried her best.						
	•	ally about each of Resident						
	#36 's meds she stat							
	documentation, she c	nu nut give them.						
	On 9/13/2016 at 3:22	PM in a telephone						
	interview, the Unit Ma	anager stated she was						
		7, 2016 for a 4 hour shift						
		:00 AM. When a list of						l
		ications that were not was read to the Unit						
	accumented as given							

If continuation sheet Page 40 of 47

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	ECONSTRUCTION	(X3) DAT	O. 0938-039	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		345236	B. WING		C 09/16/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WILMING	TON HEALTH AND REHA	ABILITATION CENTER		320 WELLINGTON AVENUE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			
F 333	Continued From page	e 40	F 333				
	Manager she stated i documented it. If it wa could not say she gay	f she gave a medication, she as not documented she ve it. The Unit Manager ot of missed medications on					
	the facility Physician a (PA), the Physician w medications that were for Resident #36. Th Physician Assistants until morning but the any time. The PA stat in regard to missed m The Physician stated anti-seizure medication anti-seizure medication seizure precautions to was watched closely. on a seizure medication would have used the Physician indicated for anti-hypertensives, R had his blood pressur dose and checked ev stable and normal. The thought the medication her were significant, I time. The Physician so ordered labs, vital sig assessments, seizure that missed anti-seizure	e not documented as given e Physician stated the (PA) take call from 5:00 PM PA could always reach me at ted she had not been called nedication doses. for residents that missed ons she would have ordered cation level and initiated o make sure the resident For any resident that was ion, the Physician stated she same interventions. The or missed doses of esident #36 should have re monitored after his next very two hours or until it was ne Physician stated she ons that were described to but were for a particular stated she would have ins and more frequent e precautions for residents ure medications, closer ents, and extended the					
	assessments, seizure that missed anti-seizu observations of reside missed doses of antit On 9/15/2016 at 12:3	e precautions for residents ure medications, closer ents, and extended the					

Facility ID: 923408

If continuation sheet Page 41 of 47

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVE D. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/16/2016		
		345236	B. WING					
	ROVIDER OR SUPPLIER	ABILITATION CENTER		82	TREET ADDRESS, CITY, STATE, ZIP CODE 20 WELLINGTON AVENUE /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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE		
F 333	Continued From page 41 the medications would be documented as they were given, and that the medications would be given.		F	333				
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF		F	353			10/30/16	
	provide nursing and r maintain the highest							
	numbers of each of the personnel on a 24-ho	vide services by sufficient ne following types of our basis to provide nursing n accordance with resident						
	Except when waived section, licensed nurs personnel.	under paragraph (c) of this ses and other nursing						
	section, the facility m	under paragraph (c) of this ust designate a licensed harge nurse on each tour of						
	by: Based on observatio interviews and record provide sufficient staf received medications residents reviewed for (Residents #3, #11, #	is not met as evidenced on, staff and resident d review, the facility failed to fing to ensure residents as ordered for 9 of 25 or missing medications (19, #20, #30, #33, #34, #35, tenance by way of tube			Resident #3, #4, #11, #19, #20, #33 #35 and #36 attending physician we notified of non-documented medicati the period of August 27 28, 2016 of September 12, 2016 no additional physician orders received. Resident and #40 were interviewed by the Dire	re ion for on #34		

L

Event ID: 06ME11

Facility ID: 923408

If continuation sheet Page 42 of 47

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					С
		345236	B. WING		09/16/2016
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
	TON HEALTH AND REHA			820 WELLINGTON AVENUE	
WILMING				WILMINGTON, NC 28401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLE
F 353	Continued From page	e 42	F 35	3	
		sidents reviewed (Res.#36)		Nursing/Designee to determine	
		Living (ADL) care for		bathing/showering preferences.	
	showers as schedule	d for 2 of 3 residents		nutritional assessment was com	
	reviewed (Res. #34 a	ind Res. #40).		resident # 36. Resident #20 has	s been
	Findings included:			discharged from the facility.	
				The facility Director of Nursing a	
		ss referenced to F333.		Designee will complete an audit	-
		d staff interviews and record		residents to ensure that the phy	
n re	medications ordered	led to administer significant		notified of any non documented medications for August 27-28, 2	
		#19, #20, #30, #33, #34,		complete an audit of residents r	
	#35, and #36).	+10, #20, #00, #00, #0 1 ,		dialysis to ensure that each hav	-
				physician orders for assessmen	
	2. This citation is cros	ss referenced to F309.		signs and shunt site post dialy	
	Based on observatior	n, staff, resident and		Managers will conduct interview	/s with
	physician interviews a	and record review, the facility		residents identified as inter-view	
		edications as ordered for 2		determine residents bathing/sho	
		ved (Resident #3 and		preferences. Will complete an a	audit of
		ailed to complete post		tube fed residents to ensure no	
		by not obtaining vital signs		unintended weight loss has occ	
		der and care plan for 1 of 1		orders for tube fed residents are	e in place
		r dialysis (Resident #20).		and accurate. The Director of Nursing and/or I	Designee
	3. This citation is cros	ss referenced to F325.		will re- educate facility licensed	-
		n, staff interview and record		regarding notification to the resi	
		led to maintain a nutritional/		and/or responsible party and ph	
		of 5 residents (Resident		any medications not administer	-
		ding tubes, resulting in an		documented medications, reside	
	-	ss of 9.2% over a seven		preferences to include honoring	
	month period.			bathing/shower,regarding asses	
	, , , , , ,			resident post dialysis to include	
		ss referenced to F242.		post dialysis vital signs and shu	
		ns, record review, resident		assessment and tube feed resid	
		he facility failed to honor for 2 of 3 residents reviewed		ensure weights are obtained we orders for tube fed residents are	
	(Resident #34 and Re			and accurate completed by Oct	-
		$\pi + 0$		2016. Newly hired licensed nurs	
	On 9/13/2016 at 9:10	AM, in an interview, Res.		receive the education during ori	
		othered by the lack of help		The facility will complete re- edu	

Facility ID: 923408

If continuation sheet Page 43 of 47

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	со	MPLETED
						С
		345236	B. WING	· · · · · · · · · · · · · · · · · · ·		9/16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E	
WILMING	TON HEALTH AND REHA	ABILITATION CENTER		820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 353	Continued From page	e 43	F 35	3		
	in the facility. Res #34 11:00 PM to 7:00 AM and one Nursing Assi building. Res. #34 sta nurse in the building of and there was a fire, worry about that som In an interview on 9/1 stated she worked the 8/28/2016 on the 7AM when the Unit Manag tried to cover that hal #2 stated there is not at the facility. On 9/13/2016 at 10:4 Scheduler who was a and an NA stated the through the shift on 8 stated she was on ca began to look for som but she was physicall Scheduler noted the was on vacation, and (MDS) nurses cannot carts. The Scheduler times when there was for the entire building the agency nurses was	4 stated some nights on the shift, there is only one nurse istant (NA) in the entire ated " if there was only one on the eleven to seven shift, how would they get us out? I etimes. " 13/2016 at 10:10 AM, NA #2		any licensed nurse that does a the reeducation prior to workin scheduled shift. Director of Nursing and/or De perform random audits daily ti weeks, weekly times 3 weeks monthly times 3 to ensure res received medications as order Director of Nursing and/or De perform random audits on eac weekly times 4 weeks and mo 3 to ensure residents preferences/showers are met. Director of Nursing/Designee dialysis residents three times ensure assessment of resider dialysis; to include obtaining p vital signs and shunt site asse Weekly times four and monthl three. The Director of Nursing Designee will perform random tube fed residents weekly time monthly times 3. The DON wil daily staffing patterns to ensure staffing daily times 2 weeks, v 3 weeks and monthly x 3 mon The DON will report findings of the Quality Assurance Improv Committee. The QAPI comm evaluate the results and imple additional interventions as new	ng next esignee will mes 2 s and idents have red. esignee will ch unit onthly times . The will review 2 a week to nt post ost dialysis essment. y times g and/or a udits on es 4 then Il review the re adequate weekly times ths. of audits to ement ittee will ement	
	with 2 or 3 NAs for th On 9/13/2016 at 3:22	-		ensure continued compliance.		
	26, she was asked to Sun. Aug. 28 for 4 ho	work on Sat. Aug.27 and burs from 7:00 AM until 11:00 er stated staffing had been				

Facility ID: 923408

If continuation sheet Page 44 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 10/27/2016 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DA1	TE SURVEY MPLETED
		345236	B. WING			C 09/16/2016	
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	TON HEALTH AND REHA	BILITATION CENTER			820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 353	The Unit Manager stat facility and they count for the 100/200 halls. Manager stated she of been seen on the 300 SDC nurse went to try well as help the Unit I hall. The Unit Manage the cart, so it was up stayed, I emailed the Assistant Director of I help. " The Unit Man was just giving water. she texted the Admin come help. The Unit I Administrator texted I being a team player." when the agency nurse cart with him and left. she called the Assistat (ADON), who called the stated she texted the safe and she refused line. The Unit Manage medications not giver shift that day (8/27). In an interview on 9/1 Assistant (NA) #4 stat of 2016 had been aw enough staffing. NA # everything done, and NAs with 20 residents	urs seemed like nothing. ated she met the SDC in the ted narcotics on both carts At 7:30 AM the Unit discovered no nurse had 0 hall since 3:30 AM, so the y and cover the 300 hall, as Vanager on the 100/200 er noted she had counted to her to be there. " I Administrator and the Nursing and begged for ager stated at that point she . The Unit Manager noted istrator and asked him to Vanager indicated the her back and thanked her for The Unit Manager stated se arrived, she counted the The Unit Manager stated ant Director of Nursing he corporate nurse who i town and told the ADON ndle it. The Unit Manager DON and told her it was not to put her license on the er stated there were lots of n on the 7:00AM- 3:00 PM 5/2016 at 3:00 PM, Nursing ted August and September ful, and there was not 44 stated she could not get sometimes there were 2 s each, so you just had to do VA #4 indicated some al care and if you had to use	F	35	3		

Facility ID: 923408

If continuation sheet Page 45 of 47

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		345236	B. WING				C 16/2016			
NAME OF PI	ROVIDER OR SUPPLIER	I	I	STREET ADDRESS, CITY, STATE, ZIP CODE						
WILMINGTON HEALTH AND REHABILITATION CENTER					20 WELLINGTON AVENUE VILMINGTON, NC 28401					
(X4) ID PREFIX TAG			ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 353	Continued From page	9 45	F	353						
	stated she did not fee and that the lack of st 2 months and had be weeks. NA #8 stated care to the residents NA #8 indicated she h scheduler and the SD facility needed more st On 9/15/2016 at 3:30 stated there were not shift. NA #6 stated wh the facility there was but it had changed, at last month. NA #6 ind the NAs worked short receive their schedule tried to make sure the baths. NA #6 stated th 17 residents effective s needs were met. NA evenings there were of extensive and total ca was impossible.	PM, in an interview, NA #6 enough NAs on the 3-11 nen she started working at not a problem with staffing, nd was much worse in the licated there were times if t, the residents did not ed showers, but the staff e residents got good bed here was no way to care for ly and ensure the resident ' A #6 reported some only 3 NAs and with the are residents, complete care								
	stated there was not a indicated the staffing	shortage had gotten worse nonths. NA #7 reported call wered timely on some								
	stated the lack of staf	5/2016 at 11:11 PM. NA #13 fing had gotten worse in the 3 stated the previous night								

Facility ID: 923408

If continuation sheet Page 46 of 47

	-	D HUMAN SERVICES MEDICAID SERVICES				RINTED: 10/27/2016 FORM APPROVED MB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 7	LE CONSTRUCTION		(3) DATE SURVEY COMPLETED
		345236	B. WING			C 09/16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
WILMING.	TON HEALTH AND REHA	BILITATION CENTER		820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 353	had worked alone with reported if she neede changing a resident, s hall and an NA would On 9/16/2016 at 12 m Administrator stated w shortage of staff on 8 building and worked a stated there were 7 w there were 3 new num oriented. Also stated before our interview. there were arrangement nurses and a wound n employed as long as continues to search for stated he had gotten to contract with anoth	:00 PM to 7:00 AM shift, she h 37 residents. NA #13 d help with turning or she would call to another come over to help her. oon, in an interview, the vhen he was informed of the /27/2016, he came to the as an NA. The Administrator acancies for nursing, and ses hired that were to be another was hired the day The Administrator stated ents made for 5 travel nurse who would be needed, and the facility or staff. The Administrator permission from corporate er agency staffing group in thad not been completed	F 35			

If continuation sheet Page 47 of 47