PRINTED: 06/14/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	-	(X3) DATE SURVEY COMPLETED
		345568	B. WING _		_	05/10/2018
	ROVIDER OR SUPPLIER ALTH & WELLNESS C	TR AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, S 83 CAVALIER DRIVE WILMINGTON, NC 284		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	
F 636 SS=D	a comprehensive, a reproducible assess functional capacity. §483.20(b) Compre §483.20(b)(1) Resi A facility must make assessment of a resignals, life history and resident assessment by CMS. The assess the following: (i) Identification and (ii) Customary routing (iii) Cognitive pattern (iv) Communication (v) Vision. (vi) Mood and behad (vii) Psychological viii) Physical function (ix) Continence. (x) Disease diagnost (xii) Dental and nutring (xii) Activity pursuit (xiv) Medications. (xv) Special treatmed (xvii) Discharge pland (xvii) Documentation regarding the addition the care areas to the Minimum Data Staticular (xviii) Documentation assessment. The aninclude direct observance (xviiii) Documentation assessment.	ssessment induct initially and periodically ccurate, standardized sment of each resident's independent of each resident's independent of each resident's independent of each resident's independent instrument. It is a comprehensive independent instrument (RAI) specified instrument (RAI) specified instrument include at least indemographic information include include in instrument include at least indemographic information include in instrument include information include in instrument include information include in	F			5/14/18
ABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUI	RE	TITLE		(X6) DATE

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

05/18/2018 **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.

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345568	B. WING _		ا ا	5/10/2018	
	ROVIDER OR SUPPLIER	R AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, STATE, ZIP (83 CAVALIER DRIVE WILMINGTON, NC 28405	ALIER DRIVE NGTON, NC 28405 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 636	licensed and nonlice members on all shifts §483.20(b)(2) When timeframes prescribe chapter, a facility mu assessment of a resi timeframes specified through (iii) of this se prescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissic significant change in mental condition. (For "readmission" means following a temporary or therapeutic leave. (iii)Not less than once This REQUIREMENT by: Based on record revisacility failed to compassessment using the Instrument (RAI) for the #8, Resident #5 and were reviewed. Find 1. Review of the qual (MDS) dated 01/15/1 admitted to the facility of seizure disorder, resident #5 and the facility of seizure disorder.	well as communication with insed direct care staff s. required. Subject to the id in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not in a conduct a days after admission, and in which there is no the resident's physical or or purposes of this section, are a return to the facility of absence for hospitalization in the conduction of the resident's physical or or purposes of this section, are a return to the facility of absence for hospitalization in the conduction of the conduction in the conduction of the conduction in the conduction i	F 6	1. Identified assessments required. Process for com reviewed and revised. ME and Director of Clinical Se Coordinator) educated on requirements for timely cor RAI Manual. Administrator Responsible MDS Coordinator respons completion Director of Clinical Service for signature of completior	apletion of MDS DS Coordinator rvices (MDS RN the mpletion per the for audit. ible for MDS		
	Schedule revealed R	ed facility Assessment esident #8 was scheduled to /e assessment completed on		Audit completed of MDS Assessments completed a MDS scheduling process r	s required.		

PRINTED: 06/14/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345568	B. WING _			05/	10/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIS HE	ALTH & WELLNESS CTF	R AT CAMBRIDGE VILLAG			3 CAVALIER DRIVE		
				W	/ILMINGTON, NC 28405		
(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 636	04/09/18. In an interview on 05/Coordinator indicated schedule that showed needed to be done. Sassessments were laworking on them. The indicated she had not Administrator or the ECONS) that the compression of the ECONS that the CONS the CONS that the CONS the CONS that the CONS that the CONS that the CONS the CONS that	109/18 at 4:15 PM the MDS Is she had an assessment Is her which assessments She stated she knew the It the but that she had been It informed the facility Director of Nursing Services Informed the passessments were Informed the passessments were Informed the passessment that the Informed that the Informed the man pleted she was informed Inputer and validated the Informed the assessment Informed the ments were due. The DNS Informed the ments were due. The DNS Informed the MDS Coordinator was Informed the most completing the Informed the MDS Coordinator was Informed the most completing the Informed the most completin	F6	536	revised. MDS completion process reviewed and revised from scheduling completing signature attestation. The Quality Care Committee responsit for the QAPI Plan established an MDS Action Team. The Action team will monitor the MDS schedule for required MDS completion with RN completion attestation. Administrator responsible 3. The MDS Action Team will monitor MDS completion on a weekly basis for weeks to ensure the staff training was successful and the monitoring system effective. The monitoring results will be reported to the Quality Care Committee monthly for 3 months to ensure ongoin compliance. Administrator Responsible	ole 4 disse	
	completion.	d that the DNS oversee the					

Facility ID: 130545

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONS	STRUCTION	(X3) DATE COMF	SURVEY PLETED
		345568	B. WING _			05/	10/2018
	ROVIDER OR SUPPLIER ALTH & WELLNESS CTI	R AT CAMBRIDGE VILLAG		83 CAV	ALIER DRIVE NGTON, NC 28405		
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 636	revealed Resident #8 facility on 04/07/17 w dementia, hemiplegia had short and long to was severely impaired decision making. Review of the undate Schedule revealed R have a comprehension 02/20/18. In an interview on 05 Coordinator indicated schedule that showen needed to be done, assessments were laworking on them. The indicated she had not Administrator or the lassessments were lawed asked for help obut she had not. In an interview on 05 stated she had just lecomprehensive assecompleted on time. Sassessment was con and went into the cor completion and signed She indicated she did	arterly MDS dated 11/26/17 by was readmitted to the rith diagnoses of vascular a, and aphasia. Resident #5 arm memory problems and ad in cognitive skills for daily and facility Assessment esident #5 was scheduled to be assessment completed on 1/09/18 at 4:15 PM the MDS as the had an assessment do her which assessments She stated she knew the stee but that she had been the MDS Coordinator to informed the facility DNS that the comprehensive the she indicated she could completing the assessments	F	336			
	periodically that she assessments but that	dinator had informed her was behind in completing the t the MDS Coordinator was not requested assistance.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE COMF	E SURVEY PLETED
		345568	B. WING _		05	/10/2018
	ROVIDER OR SUPPLIER	R AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405	, 33	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 636	Continued From pag	ge 4	F 6	36		
	Administrator stated Coordinator was so assessments. She is resources that could she known. The Ad appeared to be a proprocess. She indicated that the comprehens completed on time a completion. 3. Review of the querevealed Resident # facility on 04/03/17 of failure, malnutrition and Review of the undated Schedule revealed Ferview on 09/18/18. In an interview on 09/18/18.	5/09/18 at 5:20 PM the she did not know the MDS far behind in completing the ndicated there were other. I have been implemented had ministrator stated there oblem with the assessment ited it was her expectation sive assessments be and that the DNS oversee the marterly MDS dated 11/24/17 4 was readmitted to the with diagnoses of heart and atrial fibrillation. It cognitively impaired. Bed facility Assessment Resident #4 was scheduled to live assessment completed on the state of the which assessments and at a sasessment which assessments are but that she had been the MDS Coordinator of informed the facility DNS that the comprehensive ate. She indicated she could completing the assessments				
	stated she had just I	5/09/18 at 5:05 PM the DNS earned that the essments had not been				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345568	B. WING		05/10/2018
	ROVIDER OR SUPPLIER ALTH & WELLNESS CT	R AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D.4TE
F 636 F 638 SS=D	completed on time. assessment was con and went into the corompletion and signs. She indicated she dishowed when assess stated the MDS Cooperiodically that she assessments but the catching up and had. In an interview on 05 Administrator stated Coordinator was so f assessments. She in resources that could she known. The Adrappeared to be a proprocess. She indicath that the comprehens completed on time at completion. Qrtly Assessment at CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instrand approved by CM once every 3 months. This REQUIREMEN' by: Based on record reviacility failed to compassessments for 4 of Resident #3, Resident	She indicated when an inpleted she was informed imputer and validated the ed off on the assessment. In the dot off on the assessment in the dot off on the assessment. In the dot off on the assessment in the dot off on the assessment in the dot off on the assessment in the dot off off off off off off off off off o	F 638		DS tor RN

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTIO			(X3) DATE SURVEY COMPLETED			
		345568	B. WING _			0:	5/10/2018
NAME OF P	ROVIDER OR SUPPLIER		· I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIS HE	ALTH & WELLNESS CT	R AT CAMBRIDGE VILLAG		83	3 CAVALIER DRIVE		
	7.E G 77.E	(7th 67th 67th 67th 67th 67th 67th 67th 6		W	/ILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 638	Continued From page	e 6	F 6	38			
	(MDS) dated 11/27/1 admitted to the facility of anemia, hypertens Resident #6 was mod Review of the undate Schedule revealed R have a quarterly asse 02/21/18.	rterly Minimum Data Set 7 revealed Resident #6 was y on 09/30/16 with diagnoses ion and depression. derately cognitively impaired. d facility Assessment esident #6 was scheduled to essment completed on //09/18 at 4:15 PM the MDS If she had an assessment			RAI Manual. Administrator Responsible for audit. MDS Coordinator responsible for MDS completion Director of Clinical Services responsible for signature of completion 2. Audit completed of MDS assessment Assessments completed as required. MDS scheduling process reviewed and revised. MDS completion process reviewed and revised from scheduling	e nts.	
	needed to be done. assessments were la working on them. Th indicated she had no Administrator or the I (DNS) that the quarte She indicated she co				completing signature attestation. The Quality Care Committee responsit for the QAPI Plan established an MDS Action Team. The Action team will monitor the MDS schedule for required MDS completion with RN completion attestation.	ole	
	stated she had just leassessments had not she indicated when a completed she was in computer and validate signed off on the assessments were did not have a list whas sessments were did MDS Coordinator had that she was behind assessments but that catching up and had. In an interview on 05.	nformed and went into the ed the completion and essment. She indicated she ich showed when ue. The DNS stated the d informed her periodically			Administrator responsible 3. The MDS Action Team will monitor MDS completion on a weekly basis for weeks to ensure the staff training was successful and the monitoring system effective. The monitoring results will b reported to the Quality Care Committee monthly for 3 months to ensure ongoin compliance. Administrator Responsible	is e e	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345568	B. WING _			05/10/2018
	ROVIDER OR SUPPLIER	TR AT CAMBRIDGE VILLAG	•	STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 638	assessments. She resources that could she known. The Adappeared to be a process. She indicated that the quarterly as time and that the Diameter of the facility on 12/2 anemia, malnutrition Resident #3 was seen the seen of the facility on 12/2 anemia, malnutrition Resident #3 was seen the seen of the facility on 12/2 anemia, malnutrition Resident #3 was seen the seen of the se	far behind in completing the indicated there were other d have been implemented had dininistrator stated there roblem with the assessment ated it was her expectation assessments be completed on NS oversee the completion. Ignificant change MDS dated Resident #3 was re-admitted in indicated it with diagnoses of an and Parkinson's disease. Everely cognitively impaired. Ited facility Assessment Resident #3 was scheduled to sessment completed on in indicated she had an assessment ed her which assessments. She stated she knew the late but that she had been the MDS Coordinator informed the facility in informed the facility. In informed the facility is DNS that the quarterly late. She indicated she could be completing the assessments. In informed that the quarterly of been completed on time. In an assessment was informed and went into the	F6			
	completed she was computer and validation					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345568	B. WING _			05/10/2018
	ROVIDER OR SUPPLIER	TR AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, STATE, ZIP CO 83 CAVALIER DRIVE WILMINGTON, NC 28405	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 638	MDS Coordinator hat that she was behind assessments but the catching up and had assessments but the catching up and had an interview on the coordinator was so assessments. She resources that could she known. The Ad appeared to be a process. She indicated that the quarterly assessments and that the DN 3. Review of the an revealed Resident # facility on 12/16/17 hypothyroidism, and had short and long the was severely impair decision making. Review of the undate Schedule revealed I	hich showed when due. The DNS stated the ad informed her periodically in completing the at the MDS Coordinator was into the not requested assistance. 5/09/18 at 5:20 PM the she did not know the MDS far behind in completing the indicated there were other in have been implemented had ministrator stated there oblem with the assessment atted it was her expectation sessments be completed on NS oversee the completion. nual MDS dated 01/07/18 To was re-admitted to the with diagnoses of depression, in chronic pain. Resident #7 erm memory problems and ed in cognitive skills for daily ed facility Assessment Resident #7 was scheduled to	F	538		
	04/01/18. In an interview on 0. Coordinator indicate schedule that show needed to be done. assessments were I working on them. Tindicated she had needed to be had needed to be done.	5/09/18 at 4:15 PM the MDS and she had an assessment ed her which assessments. She stated she knew the ate but that she had been the MDS Coordinator of informed the facility.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345568	B. WING			05/10/2018	
	ROVIDER OR SUPPLIER ALTH & WELLNESS CT	R AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, STATE, ZIP COI 83 CAVALIER DRIVE WILMINGTON, NC 28405	CITY, STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 638		ate. She indicated she could	F 6	38			
	In an interview on 05 stated she had just I assessments had not. She indicated when completed she was computer and validated signed off on the assessments were of MDS Coordinator has that she was behind assessments but the catching up and had In an interview on 05 Administrator stated Coordinator was so assessments. She is resources that could she known. The Adappeared to be a proprocess. She indicated that the quarterly as time and that the DN 4. Review of the quarterly as time and that the DN 4. Review of the quarterly as time and that the DN 4. Review of the quarterly as time and that the DN 4. Review of the quarterly as time and that the DN 4. Review of the quarterly as time and that the DN 5. Review of the quarterly cog Review of the undate Schedule revealed F	informed and went into the ted the completion and sessment. She indicated she nich showed when lue. The DNS stated the ad informed her periodically in completing the at the MDS Coordinator was not requested assistance. 5/09/18 at 5:20 PM the she did not know the MDS far behind in completing the ndicated there were other have been implemented had ministrator stated there oblem with the assessment ted it was her expectation sessments be completed on IS oversee the completion. arterly MDS dated 01/16/18 9 was admitted to the facility gnoses of anxiety disorder, and insomnia. Resident #9					

PRINTED: 06/14/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345568	B. WING _		C	5/10/2018	
	ROVIDER OR SUPPLIER ALTH & WELLNESS CTI	R AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, STATE, ZIP CO 83 CAVALIER DRIVE WILMINGTON, NC 28405			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 638	Coordinator indicated schedule that showed needed to be done. assessments were laworking on them. Thindicated she had no Administrator or the Lassessments were lahave asked for help obut she had not. In an interview on 05 stated she had just leassessments had not She indicated when a completed she was in computer and validated signed off on the assedid not have a list who	d she had an assessment dher which assessments She stated she knew the steep but that she had been to the MDS Coordinator the informed the facility DNS that the quarterly steep indicated she could completing the assessments assessment was an assessment was an assessment was an assessment. She indicated she cich showed when	F 6	38			
F 642	MDS Coordinator had that she was behind assessments but that catching up and had. In an interview on 05 Administrator stated Coordinator was so fassessments. She in resources that could she known. The Admappeared to be a proprocess. She indicate that the quarterly assessments assessments.	the MDS Coordinator was not requested assistance. /09/18 at 5:20 PM the she did not know the MDS ar behind in completing the edicated there were other have been implemented had eninistrator stated there blem with the assessment led it was her expectation essessments be completed on S oversee the completion.	F 6	42		5/14/18	

Facility ID: 130545

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345568	B. WING		0	5/10/2018
	ROVIDER OR SUPPLIER ALTH & WELLNESS CTF	R AT CAMBRIDGE VILLAG		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 642 SS=D	each assessment wit participation of health \$483.20(i) Certification §483.20(i) (1) A regist certify that the assess \$483.20(i)(2) Each in portion of the assess the accuracy of that possible the accuracy of that possible statement in the participation of the assessment penalty of not more that assessment; or (ii) Causes another in and false statement in subject to a civil mone \$5,000 for each asses \$483.20(j)(2) Clinical constitute a material at This REQUIREMENT by: Based on record revisable facility failed to coord	ion. Just conduct or coordinate In the appropriate In professionals. Just Inc. Just I	F 64	1. Identified assessments conrequired. Process for complet reviewed and revised. MDS C	tion of MDS	
	assessments for 7 of Resident #5, Resident	11 residents (Resident #8, at #4, Resident #6, Resident Resident #9) whose records		and Director of Clinical Service Coordinator) educated on the requirements for timely comple RAI Manual.	es (MDS RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345568	B. WING _)5/10/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
				83 CAVALIER DRIVE			
DAVIS HE	ALTH & WELLNESS	CTR AT CAMBRIDGE VILLAG		WILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 642	Continued From p	age 12	F 6	42			
	(MDS) dated 01/1: admitted to the factor of seizure disorder and anxiety disorder cognitively impaired. Review of the und Schedule revealed have a compreher 04/09/18. In an interview on	uarterly Minimum Data Set 5/18 revealed Resident #8 was cility on 04/25/17 with diagnoses r, major depressive disorder, ler. Resident #8 was severely ed. ated facility Assessment d Resident #8 was scheduled to nsive assessment completed on 05/09/18 at 4:15 PM the MDS ated she had an assessment		Administrator Responsit MDS Coordinator respo completion Director of Clinical Servi for signature of completion 2. Audit completed of M Assessments completed MDS scheduling proces revised. MDS completion reviewed and revised frocompleting signature attentions.	ices responsible ion IDS assessments. d as required. ss reviewed and on process om scheduling to		
	schedule that shown needed to be done Nurse (RN) was noff the completion Coordinator stated filled out in the corto the Director of Nwas an RN, and the assessments sign and completed the	wed her which assessments e. She indicated a Registered eeded to coordinate and sign of each MDS. The MDS d after the assessments were mputer she would provide a list Nursing Services (DNS), who he DNS would sign the ifying that she had coordinated e assessments. She indicated d signed the MDS it was not		The Quality Care Comm for the QAPI Plan estab Action Team. The Actio monitor the MDS schedi MDS completion with RI attestation. Administrator responsib 3. The MDS Action Tear MDS completion on a w weeks to ensure the sta successful and the mon	lished an MDS on team will ule for required N completion le m will monitor reekly basis for 4 off training was itoring system is		
	stated she had just comprehensive as out and submitted completion. She it was ready for her the MDS Coordinated and validated the the assessment. When the resident expected the MDS	05/09/18 at 5:05 PM the DNS at learned that the quarterly and seessments had not been filled to her for her signature to show andicated when an assessment signature she was informed by after and went into the computer completion and signed off on She indicated she did not track as assessments were due and a Coordinator to inform her nents were ready for her		effective. The monitorin reported to the Quality C monthly for 3 months to compliance. Administrator Responsit	ng results will be Care Committee ensure ongoing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345568	B. WING _			05/10/2018	
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG				STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 642	Administrator stated Coordinator was so assessments. The Aappeared to be a process. She stated the DNS oversee the MDS process to mawas signed as comprequired. 2. Review of the quarevealed Resident facility on 04/07/17 dementia, hemipleg had short and long the was severely impair decision making. Review of the undate Schedule revealed have a comprehens 02/20/18. In an interview on 0 Coordinator indicate schedule that show needed to be done. needed to coordinator of each MDS. The the assessments we she would provide a	5/09/18 at 5:20 PM the I she did not know the MDS far behind in filling out the Administrator stated there oblem with the assessment of it was her expectation that the MDS Coordinator and the ke sure each resident's MDS obleted and submitted as solution and submitted as arterly MDS dated 11/26/17 stowas readmitted to the with diagnoses of vascular itia, and aphasia. Resident #5 term memory problems and the ed in cognitive skills for daily seed facility Assessment Resident #5 was scheduled to ive assessment completed on 5/09/18 at 4:15 PM the MDS and she had an assessment seed her which assessments She indicated an RN was the and sign off the completion MDS Coordinator stated after the filled out in the computer is list to the DNS, who was an ould sign the assessments	F 6	42			
	completed the asse	ssments. She indicated that ed the MDS it was not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENITIEICATION NILIMPED:		IPLE CONSTRUCTION	$\langle \rangle$	(X3) DATE SURVEY COMPLETED	
		345568	B. WING _		_	05/10/2018	
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG			STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405			1 00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 642	stated she had just lest comprehensive assess out and submitted to completion. She indivas ready for her signed the MDS Coordinator and validated the contine assessment. She when the resident's a expected the MDS Cowhen the assessment signature. In an interview on 05. Administrator stated a Coordinator was so for assessments. The Adappeared to be a proprocess. She stated the DNS oversee the MDS process to mak was signed as complication.	/09/18 at 5:05 PM the DNS parned that the quarterly and essments had not been filled her for her signature to show cated when an assessment enature she was informed by and went into the computer expletion and signed off on the indicated she did not track essessments were due and coordinator to inform her	F6	42			
	revealed Resident #4	was readmitted to the ith diagnoses of heart nd atrial fibrillation.					
	Schedule revealed R	d facility Assessment esident #4 was scheduled to re assessment completed on					
		/09/18 at 4:15 PM the MDS I she had an assessment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345568	B. WING_			05/10/2018	
	ROVIDER OR SUPPLIER	CTR AT CAMBRIDGE VILLAG	1	STREET ADDRESS, CITY, STATE, ZIF 83 CAVALIER DRIVE WILMINGTON, NC 28405	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 642	schedule that showneeded to be done needed to coordinator each MDS. The the assessments with she would provide RN, and the DNS signifying that she completed the assunless the RN signifying that she completion. She in was ready for her strength of the assessment. So when the resident expected the MDS when the assessments when the assessments. The appeared to be a process. She state the DNS oversee the MDS process to move the signed as contrequired.	ved her which assessments as the and sign off the completion a MDS Coordinator stated after were filled out in the computer a list to the DNS, who was an would sign the assessments had coordinated and essments. She indicated that ned the MDS it was not 05/09/18 at 5:05 PM the DNS t learned that the quarterly and sessments had not been filled to her for her signature to show indicated when an assessment signature she was informed by tor and went into the computer completion and signed off on She indicated she did not track as assessments were due and Coordinator to inform her tents were ready for her 05/09/18 at 5:20 PM the ad she did not know the MDS of far behind in filling out the Administrator stated there broblem with the assessment ed it was her expectation that he MDS Coordinator and the ake sure each resident's MDS inpleted and submitted as	F	542			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I ` '		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345568	B. WING _		,	05/10/2018	
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG				STREET ADDRESS, CITY, STATE, ZIP CO 83 CAVALIER DRIVE WILMINGTON, NC 28405	•	, 03.10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 642	Continued From page	ge 16 ity on 09/30/16 with diagnoses	F 6	42			
	of anemia, hyperter	nsion and depression. oderately cognitively impaired.					
	Schedule revealed	ted facility Assessment Resident #6 was scheduled to sessment completed on					
	Coordinator indicate schedule that show needed to be done. needed to coordinat of each MDS. The the assessments we she would provide a RN, and the DNS we signifying that she hompleted the asses	15/09/18 at 4:15 PM the MDS and she had an assessment ed her which assessments She indicated an RN was the and sign off the completion MDS Coordinator stated after ere filled out in the computer a list to the DNS, who was an would sign the assessments and coordinated and assments. She indicated that ed the MDS it was not					
	stated she had just comprehensive ass out and submitted to completion. She incompletion. She incompletion was ready for her sit the MDS Coordinate and validated the country the assessment. So when the resident's expected the MDS completely stated in the second	15/09/18 at 5:05 PM the DNS Ilearned that the quarterly and essments had not been filled to her for her signature to show dicated when an assessment ignature she was informed by or and went into the computer completion and signed off on the indicated she did not track assessments were due and Coordinator to inform her ents were ready for her					
		5/09/18 at 5:20 PM the d she did not know the MDS					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345568	B. WING _			05/10/2018	
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG				STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405	•	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 642	Continued From page		F 6	42			
	assessments. The A appeared to be a proprocess. She stated the DNS oversee the MDS process to ma was signed as comprequired.	far behind in filling out the administrator stated there oblem with the assessment it was her expectation that e MDS Coordinator and the ke sure each resident's MDS oleted and submitted as					
	12/18/17 revealed R to the facility on 12/ anemia, malnutrition	desident #3 was re-admitted 11/17 with diagnoses of and Parkinson's disease. Werely cognitively impaired.					
	Schedule revealed F	ed facility Assessment Resident #3 was scheduled to essment completed on					
	Coordinator indicate schedule that showe needed to be done. needed to coordinat of each MDS. The I the assessments we she would provide a RN, and the DNS wisignifying that she h completed the assess	d she had an assessment and her which assessments. She indicated an RN was an and sign off the completion MDS Coordinator stated after are filled out in the computer list to the DNS, who was an ould sign the assessments and coordinated and assents. She indicated that d the MDS it was not					
	stated she had just I comprehensive asset out and submitted to	5/09/18 at 5:05 PM the DNS earned that the quarterly and essments had not been filled her for her signature to show licated when an assessment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345568	B. WING		05/10/2018	
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG				STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 642	Continued From pa	ge 18	F 64	12		
	the MDS Coordinate and validated the country the assessment. So when the resident's expected the MDS when the assessments ignature. In an interview on Country the Administrator stated Coordinator was so assessments. The Administrator be a process. She state the DNS oversee the MDS process to many the Administrator that is appeared to be a process. She state the DNS oversee the MDS process to many the Administrator stated coordinator was so assessments. The Administrator that is appeared to be a process.	ignature she was informed by or and went into the computer ompletion and signed off on he indicated she did not track assessments were due and Coordinator to inform her ents were ready for her 15/09/18 at 5:20 PM the d she did not know the MDS of far behind in filling out the Administrator stated there roblem with the assessment d it was her expectation that he MDS Coordinator and the ake sure each resident's MDS pleted and submitted as				
	revealed Resident a facility on 12/16/17 hypothyroidism, and had short and long was severely impai decision making. Review of the unda Schedule revealed have a quarterly as 04/01/18. In an interview on 0 Coordinator indicate schedule that show needed to be done.	nnual MDS dated 01/07/18 #7 was re-admitted to the with diagnoses of depression, d chronic pain. Resident #7 term memory problems and red in cognitive skills for daily ted facility Assessment Resident #7 was scheduled to sessment completed on 15/09/18 at 4:15 PM the MDS ed she had an assessment ed her which assessments She indicated an RN was te and sign off the completion				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345568	B. WING _)5/10/2018	
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG			1	STREET ADDRESS, CITY, STATE, ZIP COI 83 CAVALIER DRIVE WILMINGTON, NC 28405		1 337.10723.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 642	she would provide a RN, and the DNS we signifying that she had completed the assess unless the RN signed validated. In an interview on 05 stated she had just I comprehensive asses out and submitted to completion. She individually she may be a seady for her signed the MDS Coordinated and validated the conthe assessment. She when the resident's expected the MDS Coordinator when the assessment signature. In an interview on 05 Administrator stated Coordinator was so assessments. The Adappeared to be a proposess. She stated the DNS oversee the DNS oversee the MDS process to may was signed as comprequired. 7. Review of the quirevealed Resident # on 10/04/17 with dia	the filled out in the computer list to the DNS, who was an ould sign the assessments and coordinated and sements. She indicated that did the MDS it was not searned that the quarterly and essments had not been filled to her for her signature to show licated when an assessment gnature she was informed by or and went into the computer indicated she did not track assessments were due and coordinator to inform her ints were ready for her she did not know the MDS far behind in filling out the diministrator stated there oblem with the assessment at it was her expectation that the MDS Coordinator and the ke sure each resident's MDS eleted and submitted as seatherly MDS dated 01/16/18 gnoses of anxiety disorder, and insomnia. Resident #9	F 6	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345568	B. WING	·	0	5/10/2018	
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG				STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE WILMINGTON, NC 28405	•	•	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 642	Continued From pa	ge 20	F 64	2			
	Schedule revealed have a quarterly as 04/10/18. In an interview on 0 Coordinator indicat schedule that show needed to be done needed to coordinator feach MDS. The the assessments with she would provide RN, and the DNS vignifying that she completed the assessmented the assessmented the second that the	ted facility Assessment Resident #9 was scheduled to sessment completed on 05/09/18 at 4:15 PM the MDS ed she had an assessment red her which assessments She indicated an RN was te and sign off the completion MDS Coordinator stated after ere filled out in the computer a list to the DNS who was an yould sign the assessments had coordinated and essments. She indicated that ed the MDS it was not					
	stated she had just comprehensive assout and submitted to completion. She in was ready for her signal that the MDS Coordinate and validated the country that the assessment. So when the resident's expected the MDS when the assessment signature. In an interview on Coordinator was so assessments. The appeared to be a point of the signal that the coordinator was so assessments. The appeared to be a point of the signal that the coordinator was so assessments.	15/09/18 at 5:05 PM the DNS I learned that the quarterly and sessments had not been filled to her for her signature to show dicated when an assessment ignature she was informed by or and went into the computer ompletion and signed off on the indicated she did not track assessments were due and Coordinator to inform her tents were ready for her 15/09/18 at 5:20 PM the dishe did not know the MDS of far behind in filling out the Administrator stated there roblem with the assessment did it was her expectation that					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	PLE CONSTRUCTION IG	(X3) D.	(X3) DATE SURVEY COMPLETED	
		345568	B. WING _			05/10/2018
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG				STREET ADDRESS, CITY, STATE, ZIP COD 83 CAVALIER DRIVE WILMINGTON, NC 28405		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 642	the DNS oversee the MDS process to make	MDS Coordinator and the e sure each resident's MDS eted and submitted as	F6	42		