PRINTED: 07/10/2018 FORM APPROVED OMB NO. 0938-0391

F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) \$483.21(b)(3) (comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality, This REGUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to follow professional standards of rursing practice during dressing changes for 1 of 3 residents (Resident #26). The findings included: To remain in compliance with lall effectal and state regulations the facility has taken or will take the actions set forth in this plan of correction will take the actions set forth in this plan of correction onstitutes the facility is allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 The findings included: The findings included in the finding included: The finding included in the finding included in finding included in the finding included in the finding included inclu	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC TAG SUMMARY STATEMENT OF DEPCIENCES EACH DEPCIENCE STATE		345571 B. WING			06/	08/2018		
FRESULT TAG REGULATORY OR LSC IDENTIFY NO INFORMATION) F 658 Services Provided Meet Professional Standards SS=D CFR(s): 485.21(b)(3)(f) \$483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (f) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to follow professional standards of nursing practice during dressing changes for 1 of 3 residents (Resident #26). The findings included: Resident #26 was admitted to the facility on 05/08/18 with cumulative diagnoses including stage 3 sacral pressure ulcer, Alzheimer's, fall at home with ferum fracture, depression, anxiety, and dementia. Resident #26's Minimum Data Set (MDS) dated 05/22/18 revealed resident had severe cognitive impairments. The resident needed extensive assistance with bed mobility, transfers, foilet use, and personal hygiene. Review of the Treatment Administration Record (TAR) revealed musting did not initial off that Resident #26's accompliated in the initial off that Resident #26's accessing to his sacral pressure ulcer was changed on 06/05/18. A pressure ulcer dressing dange observation for Resident #26's accompliated on 06/06/18 at 3.05 PM with Nurse #1 and the Director of Nursing (DON). The resident's existing stage 3 sacral pressure ulcer dressing was removed and observed not to be dated or initialed. In addition The statements made on this plan of correction are not an admission to and do not constitutes the facility all edictionates. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility all elegation of compliance with all alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan			R OF WILMINGTON LLC		74	0 DIAMOND SHOALS ROAD		
SS=D CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to follow professional standards of nursing practice during dressing changes for 1 of 3 residents (Resident #26). The findings included: Resident #26 was admitted to the facility on 05/08/18 with cumulative diagnoses including stage 3 sacral pressure ulcer, Alzheimer's, fall at home with femur fracture, depression, anxiety, and dementia. Resident #26's Minimum Data Set (MDS) dated 05/22/18 revealed resident had severe cognitive impairments. The resident needed extensive assistance with bed mobility, transfers, toilet use, and personal hygiene. Review of the Treatment Administration Record (TAR) revealed nursing did not initial off that Resident #26's dressing to his sacral pressure ulcer was changed on 06/05/18. A pressure ulcer dressing dange observation for Resident #26's was conducted on 06/06/18 at 3:05 PM with Nurse #1 and the Director of Nursing (DON). The resident's exertion for Resident #26 was conducted on 06/06/18 at 3:05 PM with Nurse #1 and the Director of Nursing (DON). The reressing was removed and observed not to be dated or initialed. In addition	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
observed not to be dated or initialed. In addition • Policy SWP-102 Daily wound		CFR(s): 483.21(b)(3) §483.21(b)(3) Compression of the services provided as outlined by the commustication of the services provided as outlined by the commustication of the services of the s	ehensive Care Plans d or arranged by the facility, imprehensive care plan, standards of quality. is not met as evidenced sew, observation, and staff ailed to follow professional practice during dressing sidents (Resident #26). : mitted to the facility on tive diagnoses including are ulcer, Alzheimer's, fall at ture, depression, anxiety, sum Data Set (MDS) dated sident had severe cognitive ident needed extensive nobility, transfers, toilet use, e. ent Administration Record and did not initial off that ing to his sacral pressure in 06/05/18. sing change observation for inducted on 06/06/18 at 3:05 d the Director of Nursing is existing stage 3 sacral	F	658	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tall or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 1. Plan for correcting specific deficiency The process that led to deficiency cited The facility failed to follow professional standards of nursing practice during dressing changes for 1 of 3 residents. On 06/20/2018, the Director of Nursing audited the June Treatment Administrate Records (TAR) for any blank spaces indicating the treatment was not signed off. 2. Procedure for implementing the acceptable plan of correction. On 06/21/2018, the Director of Nursing provided an in-service education to all time, part time, and as needed nurses.	il ken on cy. I. tion	6/29/18
ARORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		observed not to be da	ated or initialed. In addition			Policy SWP-102 Daily wound		

Electronically Signed

06/22/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L' IDENTIFICATION NUMBER.		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345571	B. WING		0	06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD	•	0.00,2010	
				740 DIAMOND SHOALS ROAD			
CAROLINA	A BAY HEALTHCARE C	TR OF WILMINGTON LLC		WILMINGTON, NC 28403			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From pag	e 1	F 65	58			
	which she applied to also failed to check to change on the reside. An interview was corp PM with Nurse #1 who worked for the facility initialed all her dress good nursing practic started at the facility,	e and initial the new dressing the resident's sacrum. She o initial the 06/6/18 dressing ent's TAR. Inducted on 06/06/18 at 3:10 no stated that before she y she always dated and ing changes, which was e. She said when she she was told that it was not date and initial dressings,		documentation requirements. 1. Daily documentation should evaluation of the status of the and if indicated the peri-wound any complications. 2. This is documented on the initialed to indicate the dressing checked and intact. If problem complications then a full assess wound is documented on the Wound Review 3. Dressing changes and other	d include an edressing and areas and TAR and ang was ans or essment of Weekly		
	and was told to discontinue dating and initialing on dressings, and to only check off and initial on the TAR that a dressing was done. An interview was conducted on 06/07/18 at 4:30 PM with the Director of Nursing (DON), she confirmed that sacral dressing changes for Resident #26 were not checked off or initialed as completed on the resident's TAR for 06/5/18 and 06/6/18 per facility policy. However, after reviewing the facility's policy and procedure on dressing changes dated December 2014, she stated "moving forward" it was her expectation (per professional clinical practice) that all dressings were required to be dated and initialed when placed or changed, and that they were also to be documented on the residents' TAR's.			will be documented on the TA This information has been int the standard orientation traini required in-service refresher	R. egrated into ng and in the courses for		
				all nurses and will be reviewed Quality Assurance process to the change has been sustained. 3. Monitoring Procedure to extend the plan of correction is effect specific deficiency cited remains and/or in compliance with regrequirements. The Director of Nursing or demonitor the completion of word documentation. The Quality A tool will be completed weekly then monthly for 2 months. M	verify that ed. nsure that tive and that ins corrected ulatory signee will und assurance for 4 weeks onitoring will		
	AM, and the facility's was her expectation procedure on dressir 2014, and per profes all dressing changes and initialed when fir	nducted on 06/08/18 at 10:30 at Administrator revealed it per facility's policy and ng changes dated December assional clinical practice, that were required to be dated st placed or changed, as well ed on the residents' TAR's.		include auditing 100% of all we documentation on the TAR. Report of the weekly Qentlement of the weekly Qentlement of the weekly Qentlement of the weekly Qentlement of the weekly Quality Assurance attended by the Administrator	Reports will reports will reality Administrator ditated as be monitored at reviewed at the Meeting.		

RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345571 B. W			06/08/2018		
IDER OR SUPPLIER AY HEALTHCARE C	TR OF WILMINGTON LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403	,		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
			Nursing, MDS Coordinator, Therapy Health Information Manager, and the Dietary Manager. 4. The title of the person responsiblimplementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	e for ne		
FR(s): 483.60(i)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ty requirements. re food from sources red satisfactory by federal, ies. lood items obtained directly subject to applicable State ulations. es not prohibit or prevent broduce grown in facility compliance with applicable d-handling practices. les not preclude residents les not procured by the facility. prepare, distribute and lance with professional lervice safety. T is not met as evidenced on and staff interview the cold salads made with	F 81	The statements made on this plan of correction are not an admission to a	nd do		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Dontinued From page portion of the facility must - 83.60(i) Food safe are facility must - 83.60(i)(1) - Procu- proved or consider are or local authorit This may include from local producers, and local producers, do local laws or reg and Italian provision does collities from using pardens, subject to consider for growing and food by This provision does are growing and food This provision does are gr	AY HEALTHCARE CTR OF WILMINGTON LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 2 as 60(i) Food safety requirements. The facility must - 83.60(i)(1) - Procure food from sources proved or considered satisfactory by federal, ate or local authorities. This may include food items obtained directly on local producers, subject to applicable State do local laws or regulations. This provision does not prohibit or prevent cilities from using produce grown in facility urdens, subject to compliance with applicable fe growing and food-handling practices. This provision does not preclude residents on consuming foods not procured by the facility. 83.60(i)(2) - Store, prepare, distribute and rive food in accordance with professional andards for food service safety. This REQUIREMENT is not met as evidenced	DER OR SUPPLIER AY HEALTHCARE CTR OF WILMINGTON LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DOITINUED From page 2 F 65 This may include food items obtained directly on local producers, subject to applicable State di local laws or regulations. This provision does not prohibit or prevent cilities from using produce grown in facility urdens, subject to compliance with applicable fe growing and food-handling practices. This provision does not procured by the facility. 83.60(i)(2) - Store, prepare, distribute and rive food in accordance with professional andards for food service safety. ais REQUIREMENT is not met as evidenced: assed on observation and staff interview the cility failed to keep cold salads made with aponnaise at or below 41 degrees Fahrenheit or to their leaving the kitchen. The facility also led to air dry kitchenware before stacking it in	DER OR SUPPLIER AY HEALTHCARE CTR OF WILMINGTON LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Dintinued From page 2 F 658 Nursing, MDS Coordinator, Therapy Health Information Manager, and the Dietary Manager. 4. The title of the person responsible implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction. F 812 STREET ADDRESS, CITY, STATE, 2IP CODE 749 DIAMOND SHOALS ROAD WILMINGTON, NC 28403 DIPPOVIDERS PLAN OF CORRECTIVE 17AG PREFIX TAG Nursing, MDS Coordinator, Therapy Health Information Manager, and the Dietary Manager. 4. The title of the person responsible implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction. F 812 F 812 F 812 F 813 A BOL(1)(1) - Procure food from sources proved or considered satisfactory by federal, ate or local authorities. This may include food items obtained directly min local producers, subject to applicable State do local laws or regulations. This provision does not prohibit or prevent silities from using produce grown in facility ridness, subject to compliance with applicable fe growing and food-handling practices. This provision does not proclude residents made on the facility and rivners, subject to compliance with applicable for growing and food-handling practices. The statements made on this plan or correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all fed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345571	B. WING _			6/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		0/00/2010
				740 DIAMOND SHOALS ROAD		
CAROLIN	A BAY HEALTHCARE	CTR OF WILMINGTON LLC		WILMINGTON, NC 28403		
(X4) ID	SUMMARY	/ STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	COMPLETION DATE
F 812	Continued From p	age 3	F 8	312		
	items. Findings in	cluded:		or will take the actions se	et forth in this	
				plan of correction. The p	lan of correction	
	1. At 11:45 AM on	n 06/06/18 plastic wrap was		constitutes the facility's a	Illegation of	
		plate containing three types of		compliance such that all		
	salads made with	mayonnaise.		deficiencies cited have be		
				corrected by the dates in	dicated.	
		6/06/18 the salad cold plate was		F812		
		tray slip was placed on the		1. Plan for correcting the		
	tray, and the tray v	was placed inside the meal cart.		deficiency. The process t	nat led to	
	At 11:49 AM on 06	6/06/18 a calibrated		deficiency cited. The facility failed to keep	sold solodo	
		to check the temperature of		made with mayonnaise a		
		gistered 51.4 degrees		degrees Fahrenheit prior		
		tuna salad, 49.6 degrees		the kitchen.	to tricii icavirig	
		egg salad, and 48.7 degrees				
	Fahrenheit for the			The Director of Food & N	lutrition on June	
				6, 2018, removed and dis	scarded the	
	At 11:50 AM on 06	6/06/18 a dietary employee		composed salad made w	ith mayonnaise.	
		checked the temperatures of		The remainder of the sale	ads were then	
		out an hour and half ago in the		placed in an ice bin to re		
	_	or they were at 40 degrees		degrees Fahrenheit. Diet		
	Fahrenheit.			instructed to make comp		
				a minimum two hours pri		
		6/08/18 a dietary employee		assure proper serving ter	· · · · · · · · · · · · · · · · · · ·	
		nade all its cold salads from could be held in refrigeration for		Temperatures of all foods		
		he day they were made) before		served on the Trayline ar		
	, , ,	d of. She reported cold salads		monitored and document Trayline Temperature Log		
		and leave the kitchen below 40		at appropriate temperatu	• •	
		eit. She commented this		reheated or chilled to app		
	_	duce the chance that residents		temperature prior to mea	•	
		g food served in the facility.		Management will monitor		
	_	-		this policy during daily wa	•	
	At 10:50 AM on 06	6/08/18 the Food Service		ensure that all food is ser	•	
	Director (FSD) sta	ted the cold salads served on		appropriate temperature.		
		d a protein source (tuna, egg,				
		nnaise, and house seasonings.		The facility failed to air dr	•	
		salads should be kept below		(tray pans) before stackir	ng it in storage.	
	40 degrees Fahrei	nheit while they were stored in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345571	B. WING _	B. WING		06/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLINA	A BAY HEAI THCARE CT	R OF WILMINGTON LLC		74	40 DIAMOND SHOALS ROAD		
OAROLINA	A DAT TIERETTIOARE OF	TO WEIMINGTON LEG		W	/ILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 4	F 8	312			
F 812	F 812 Continued From page 4 the kitchen. He commented cold salads made with mayonnaise were stored in the reach-in or walk-in refrigerators if they were made a day or so before serving, and they were placed in the walk-in freezer for a short time if they were made and served on the same day. 2. During initial tour of the kitchen, beginning at 11:37 AM on 06/04/18, 11 of 16 tray pans were stacked flush on top of one another with moisture trapped between them. During a follow-up tour of the kitchen, at 9:45 AM on 06/06/18 2 of 6 tray pans were stacked on top of one another with moisture trapped between them. At 10:41 AM on 06/08/18 a dietary employee stated she had received training about the storage of kitchenware. She reported the dietary staff was instructed to turn kitchenware upside down so it could drain and dry before stacking it on top of another in storage units. She		F	312	The Director of Food and Nutrition completed rounds to ensure that all kitchenware was appropriately cleaned, sanitized and air dried prior to storage on June 6, 2018. All pans observed with condensation were rewashed and properly air dried. The facility failed to label and date opened food items. The Director of Food & Nutrition discarded the outdated items found and instructed the staff to check the remaining items in the store room to ensure proper labeling and dating procedures were being followed. 2. Procedure for implementing the acceptable plan of correction. An in-service on Preparing and Serving Cold TCS Food was conducted for all		
		3/18 the Food Service			was put into place to monitor compliant with this policy on June 21, 2018.	ce	
	training on storing kit ago, and at that time, kitchenware had to be placing it in storage. 3. During initial tour of	I the dietary staff received chenware about two weeks staff were instructed that e completely air dried before of the kitchen and storage			An in-service on Proper Warewashing was conducted for all Dietary staff on June 7, 2018 by the Director of Food & Nutrition & Nutrition. Dietary Managem will ensure that staff will properly clean sanitize and air dry all kitchenware prio storage in cleaned and sanitized	ent	
	of pancake mix, a bas spaghetti noodles, 1 l macaroni pasta, a pa	1:37 AM on 06/04/18, a box g of rotini pasta, two bags of bag of ziti pasta, two bags of ckage of creamy buttermilk b-pound box of spice cake			equipment storage areas. Daily walk through inspections will be performed be Dietary Management. An audit tool was put into place to monitor compliance withis policy on June 21, 2018.	3	

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F 812 Continued From page 5 mix in the dry storage room were opened, but without a label and date on them. In the walk-in freezer a bag of chicken fingers and a bag of diced chicken were opened, but were without a label and date on them. During a follow-up tour of the kitchen and storage areas, at 9:56 AM on 06/06/18, two fish filets, two bags of French fries, a bag of raspberries, and an angel food cake which were opened and found in the walk-in freezer were without labels and dates. At 10:41 AM on 06/08/18 a dietary employee stated it was the responsibility of all dietary employees to monitor storage areas daily as they went in and out of them to make sure that opened food items had labels and dates on them, and foods past their use-by dates were discarded. She reported this practice helped to avoid food spoilage, and ensured the quality of the food remained exceptional. At 10:50 AM on 06/08/18 the Food Service Director (FSD) stated all food items in storage should have a receive and open date on them. He reported the labeling and dating policy was posted in all storage areas. According to the FSD, this FIFO (first in, first oul) policy helped make sure the freshest food possible was served to the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS.CITY, STATE, ZIP CODE 740 DIAMOND SHOALS ROAD 740 DIAMOND SHOALD BE (CROIL SERVICE CONTINUED AND THE REGULATORY OR LSC IDENTIFYING INFORMATION) 750 DIAMOND SHOALD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE O			345571	B. WING		06/08/2018	
CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC WILMINGTON, NC 28403	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00:00:20:0	
CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC WILMINGTON, NC 28403					740 DIAMOND SHOALS ROAD		
F 812 Continued From page 5 mix in the dry storage room were opened, but without a label and date on them. In the walk-in freezer a bag of chicken fives; and a bag of diced chicken were opened, but were without a label and date on them. During a follow-up tour of the kitchen and storage areas, at 9:56 AM on 06/06/18, two fish filets, two bags of French fries, a bag of raspberries, and an angel food cake which were opened and found in the walk-in freezer were without labels and dates. At 10.41 AM on 06/08/18 a dietary employee stated it was the responsibility of all dietary employees to monitor storage areas daily as they went in and out of them to make sure that opened food items had labels and dates on them, and foods past their use-by dates were discarded. She reported this practice helped to avoid food spoilage, and ensured the quality of the food remained exceptional. At 10:50 AM on 06/08/18 the Food Service Director (FSD) stated all food items in storage should have a receive and open date on them. He reported the labeling and dating policy was posted in all storage areas. He commented all employees were expected to place labels and dates on fload thems in storage. According to the FSD, this FIFO (first in, first out) policy helped make sure the freshest food possible was served to the	CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC			WILMINGTON, NC 28403			
mix in the dry storage room were opened, but without a label and date on them. In the walk-in freezer a bag of chicken fingers and a bag of diced chicken were opened, but were without a label and date on them. During a follow-up tour of the kitchen and storage areas, at 9:56 AM on 06/06/18, two bags of French fries, a bag of raspberries, and an angel food cake which were opened and found in the walk-in freezer were without labels and dates. At 10:41 AM on 06/08/18 a dietary employee stated it was the responsibility of all dietary employees to monitor storage areas daily as they went in and out of them to make sure that opened food items had labels and dates on them, and foods past their use-by dates were discarded. She reported this practice helped to avoid food remained exceptional. At 10:50 AM on 06/08/18 the Food Service Director (FSD) stated all food items in storage should have a receive and open date on them. He reported the labeling and dating policy was posted in all storage areas and a bag of an object of the first out) policy helped make sure the freshest food possible was served to the	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION	
without a label and date on them. In the walk-in freezer a bag of chicken fingers and a bag of diced chicken were opened, but were without a label and date on them. During a follow-up tour of the kitchen and storage areas, at 9:56 AM on 06/06/18, two fish filets, two bags of French fries, a bag of raspberries, and an angel food cake which were opened and found in the walk-in freezer were without labels and dates. At 10:41 AM on 06/08/18 a dietary employee stated it was the responsibility of all dietary employees to monitor storage areas daily as they went in and out of them to make sure that opened food items had labels and dates on them, and foods past their use-by dates were discarded. She reported this practice helped to avoid food spoil and according to the FSD, this posted in all storage areas. He commented all employees were expected to place labels and dates on food items when they opened them, but were unable to use them all, and had to place the remainder in storage. According to the FSD, this FIFO (first in, first out) policy helped make sure the freshest food possible was served to the	F 812	12 Continued From page 5		F 812	2		
residents. attended by The Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Director of Food & Nutrition. 4. The title of the person responsible for		mix in the dry storage without a label and da freezer a bag of chick diced chicken were o label and date on the During a follow-up to areas, at 9:56 AM on bags of French fries, angel food cake which the walk-in freezer we At 10:41 AM on 06/08 stated it was the respemployees to monitor went in and out of the food items had labels foods past their use-based should have a received He reported the label posted in all storage a employees were expedited to use the remainder in storage. FIFO (first in, first out the freshest food pos	e room were opened, but ate on them. In the walk-in ten fingers and a bag of pened, but were without a m. It of the kitchen and storage 06/06/18, two fish filets, two a bag of raspberries, and an howere opened and found in the without labels and dates. It is a dietary employee onsibility of all dietary storage areas daily as they are to make sure that opened and dates on them, and by dates were discarded. It is to a dietary of the food it the quality of the food it is and open date on them. If is a dietary employee onsibility of all dietary storage areas daily as they are to make sure that opened and dates on them, and by dates were discarded. It is a dietary of the food it is a dietary of the food it is and open date on them. It is and open date on them, and open date on them. It is and open date on them, but the all, and had to place the According to the FSD, this of policy helped make sure		An in-service on Proper Labeling and Dating was conducted for all Dietary Son June 7, 2018 by the Director of For Nutrition. Dietary Management will monitor food storage areas on daily w through. An audit tool was put into plat to monitor compliance with this policy June 21, 2018. 3. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains correand/or in compliance with regulatory requirements. The Director of Food & Nutrition or designee will monitor temperatures of TCS/PHF; the proper cleaning, sanitizair drying, and storage of kitchenware and proper labeling and dating of ope food items in all food storage areas unthe Dietary QA Audit Tool. This will be done 5 days per week, including week days, for two months and then weekly one additional month. Reports will be presented to the weekly Quality Assurance meeting by the Administration to ensure corrective action initiated as appropriate. Compliance will be monitiand ongoing auditing program reviews the weekly Quality Assurance Meetin attended by The Administrator, Direct Nursing, MDS Coordinator, Therapy, Health Information Manager and the Director of Food & Nutrition.	alk alk ace on hat that that ected cold ting, ; ned sing kend of for tor sored ed at ttee. g is or of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345571	B. WING _		06/08/2018
	ROVIDER OR SUPPLIER A BAY HEALTHCARE C	TR OF WILMINGTON LLC		STREET ADDRESS, CITY, STATE, ZIP CO 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403	DE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		ON SHOULD BE COMPLETION IE APPROPRIATE DATE
F 812	Continued From pag	ge 6	F 8	implementing the plan of cor The Administrator is respons implementation and complet acceptable plan of correction	sible for tion of the
F 842 SS=D	Resident Records - CFR(s): 483.20(f)(5)	Identifiable Information , 483.70(i)(1)-(5)	F 8		6/29/18
	(i) A facility may not resident-identifiable (ii) The facility may r resident-identifiable accordance with a cagrees not to use or	elease information that is			
	professional standar	ordance with accepted ds and practices, the facility cal records on each resident nented;			
	all information conta regardless of the for records, except whe (i) To the individual, representative where (ii) Required by Law (iii) For treatment, pa	or their resident e permitted by applicable law; ; ayment, or health care itted by and in compliance			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345571	B. WING	·	06/08/2018
	ROVIDER OR SUPPLIER	TR OF WILMINGTON LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403	,
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 842	Continued From pag		F 84	12	
	neglect, or domestic activities, judicial and law enforcement pur purposes, research predical examiners, a serious threat to he by and in compliance §483.70(i)(3) The far record information a unauthorized use. §483.70(i)(4) Medica for- (i) The period of time (ii) Five years from the there is no requirem (iii) For a minor, 3 years legal age under State §483.70(i)(5) The medical information (ii) A record of the research purpose in the second of the research purpose in the second information (iii) A record of the research purpose in the second information (iii) A record of the research purpose in the second information (iii) A record of the research purpose in the second information (iii) A record of the research purpose in the second i	ars after a resident reaches			
	(iv) The results of an and resident review determinations cond (v) Physician's, nurs professional's progre (vi) Laboratory, radio services reports as r	ucted by the State; e's, and other licensed			
	Based on record rev facility failed to keep medical records for 2	view and staff interview the complete and accurate 2 of 4 sampled residents 29) who had pressure ulcers.		The statements made on this plan or correction are not an admission to ar not constitute an agreement with the alleged deficiencies.	nd do

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345571	B. WING _			06/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•	0.00,2010	
				740 DIAMOND SHOALS ROAD			
CAROLIN	A BAY HEALTHCAR	E CTR OF WILMINGTON LLC		WILMINGTON, NC 28403			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		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 842	Continued From p	page 8	F 8	42			
	Findings included	-		To remain in compliance with	ı all federal		
	Tillianigo infolació	•		and state regulations the faci			
	1. Resident #29	was admitted to the facility on		or will take the actions set for	-		
		cumented diagnoses included		plan of correction. The plan of	of correction		
	pressure ulcers, o	diabetes, hypertension, and		constitutes the facility's alleg	ation of		
	gout.			compliance such that all alleg	•		
				deficiencies cited have been			
		ng Admission Review		corrected by the dates indica	ited.		
		essure ulcer on top of right foot		F842	I6:_:		
	inches x I inch."	inches. Side of right foot if 2		Plan for correcting specification of the process that lad to define	-		
	inches x i inch.			The process that led to defice The facility failed to keep cor			
	On 4/19/18 three	electronic Weekly Wound		accurate medical records for	-		
		eated. One documented, "no		sampled residents who had			
		The other two reviews		ulcers.	21 000 til. 0		
		ident #29 had pressure ulcers to		On 06/21/2018, the Director	of Nursing		
		e of the right foot, left heel, and		audited all current residents			
	top of the left foot			pressure ulcer to ensure wou	ınd		
				documentation utilizing the w			
		/26/18 admission minimum data		pressure ulcer wound UDA w			
		ented his cognition was		completed for each identified	•		
		red, he exhibited no behaviors		ulcer at least every 7 days ar	nd was		
	_	ce to care, he required		complete.	ng tha		
		inimal to extensive assistance activities of daily living, he was		Procedure for implementing acceptable plan of correction	-		
		of bladder and occasionally		On 06/22/2018, the Director			
		vel, his weight was stable, and		provided an in-service educa	-		
		able ulcers present on		time, part time, and as neede			
	admission.			Topics included:			
				 Initiating a progress note 	e for all newly		
	The 04/27/18 We	ekly Clinical handwritten		identified in-house developed	-		
		esident #29's four ulcers		ulcers and pressure ulcers ne	oted on		
		ements and type of tissue in the		admission.	_		
		ever, this assessment did not		Documentation requirem			
		on about the percentage of		wound in facility or on admiss			
		tissue in the wound bed,		On 06/21/2018, the Nurse Co			
	exudate, odor, or	pain.		provided an in-service educa			
	The 05/02/19 har	ndwritten Weekly Clinical		management nurses (Director Assistant Unit Manager, and	_		
	inte oblozi to fial	iuwiilleli vveekiy ollilledi		Assistant unit Manager, and	ui c Stail		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345571	B. WING _	B. WING		06/	08/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				74	0 DIAMOND SHOALS ROAD		
CAROLINA	A BAY HEALTHCARE CT	R OF WILMINGTON LLC		W	ILMINGTON, NC 28403		
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	F 842 Continued From page 9		F8	342			
F 842	assessment and the or Pressure Ulcer Reviet to capture measurem percent of that tissue all four of Resident #2 There was no 05/09/29's wounds either informat. At 12:20 PM on 06/07 (DON) stated Nurse #2 resident wounds on 07 document the informat The resident's treatm (TAR) documented or began receiving the shydrogel covered with stage II sacral pressure A 05/26/18 Skilled Nurdocumented Resident ulcer to his sacrum as to his right heel, the trand his left heel. "Air delivery." A 06/01/18 handwritte assessment included wound bed description ulcer. There was no Pressure Ulcer Revieresident's sacral ulce	205/02/18 electronic Weekly were the first documents ents, wound tissue and the exudate, odor, and pain on 29's wounds. 19 assessment of Resident's a handwritten or electronic 7/18 the Director of Nursing #2 measured and assessed 15/09/18, but forgot to ation. ent administration record in 05/25/16 the resident eacral wound treatment of in a dry dressing daily for a lire ulcer. It is great as pre-existing ulcers op and side of his right foot, in mattress ordered, awaiting en Weekly Clinical the first measurements and in of Resident #29's sacral 06/01/19 electronic Weekly we completed on the riso there was still no	F 8	342	Development Coordinator). Topics included: • At least every 7 days, all pressure ulcer wounds are assessed and the weekly pressure ulcer wound UDA is completed. • How to complete a weekly wound pressure ulcer wound UDA. This information has been integrated in the standard orientation training and in required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed be the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the completion of weekly pressulcer wound documentation. The Quality Assurance tool will be completed week for 4 weeks then monthly for 2 months. Monitoring will include auditing 100% of pressure ulcers for wound documentation at least every 7 days in the weekly pressure ulcer wound UDA. Reports will be presented to the weekly Quality Assurance committee by the Administration ensure corrective action initiated as appropriate. Compliance will be monitor and ongoing auditing program reviewer.	the or y t t nat cted II sure ty ly f all on III ator	
	•	•			the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting attended by the Administrator, Director Nursing, MDS Coordinator, Therapy, Health Information Manager, and the	is	

		` IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345571	B. WING _			06/08/2018			
	ROVIDER OR SUPPLIER	TR OF WILMINGTON LLC	•	740 DIAMOND	ESS, CITY, STATE, ZIP CODE D SHOALS ROAD IN, NC 28403				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PI		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL OSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	Resident #29's bed. 05/25/18 on the med (MAR) nursing was i observed that the resproperly inflated. On 06/06/18 at 4:55 Resident #2 felt the auncomfortable, and oplace. She reported decision after sleeping Resident #29's care 06/06/18, identified, ulcers) and potential development r/t (in reproblem. On 06/07/18 at 5:00 wound assessments wounds, location of wounds, type and pebeds, drainage/exudinformation about od the wounds. She regand measurement of Wednesday, but she who initially viewed aulcer to document ageneral description of any drainage and On 06/08/18 at 10:56 an air mattress did in Resident #29 because the facility that was restaff members told here.	ular/standard mattress on However, starting on lication administration record nitialing off that they sident's air mattress was PM Nurse #2 stated air mattress was did not want it to remain in the resident made this ng on it for two night. plan, last revised on "I currently have (pressure for (future) pressure ulcer regard to) immobility" as a PM the DON stated weekly should include type of wounds, stage of pressure ercent of tissue in wound ate information, and or and pain associated with ported official assessment if wounds took place every still expected the nurses a newly emerged pressure poroximate size, location, of wound bed, and presence	F8	Dietary M 4. The timpleme The Admimpleme	Manager. title of the person responsible of the plan of correction. Ininistrator is responsible for entation and completion of the plan of correction.				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345571	B. WING _		,	06/08/2018	
	NAME OF PROVIDER OR SUPPLIER CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC			STREET ADDRESS, CITY, STATE, ZIP CO 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	or administer someth the MAR or TAR that According to the Adm was being taken aga been incorrectly initia air mattress was inflated. Resident #21 was on 03/30/18, discharg 05/22/18, and readm 06/01/18. The reside included pressure uld vascular disease, and A 04/20/18 Weekly S Resident #21 had a relectronic Weekly Prolocation and complet was captured in an a An electronic Weekly completed for Reside ulcer on 05/02/18. The resident's 05/8/1 minimum data set (M cognition was intact, including resistance of anywhere from minim with her activities of coccasionally incontinus he experienced sign had one unstageable	nented staff should observe ing before initialing off on the task was completed. Initiation, corrective action inst the nurses who had aling off that Resident #29's ated correctly. It admitted to skilled nursing ged to assisted living on itted to skilled nursing on ent's documented diagnoses per, osteoarthritis, peripheral di iron-deficiency anemia. It is check documented new pressure ulcer. It is of the 04/23/18 essure Ulcer Review that the ele description of the wound essessment. It is pressure Ulcer Review was ent #21's sacral pressure 8 significant change in its pressure 8 significant change in its pressure in the exhibited no behaviors to care, she required that to extensive assistance daily living, she was ent of bowel and bladder, inficant weight loss, and she	F8	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		345571	B. WING		06/08/2	018	
	ROVIDER OR SUPPLIER	CTR OF WILMINGTON LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403		1 00:00:20:10		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE CO	(X5) MPLETION DATE	
F 880 SS=D	21's ulcer either in a format. At 12:20 PM on 06/(DON) stated Nurse resident wounds on document the information. The resident's care identified, "I current sacrum /potential for development" as a possible of the wounds, location of wounds, location of wounds, type and possible of the wounds. She reand measurement of Wednesday, but she who initially viewed ulcer to document a general description of any drainage and Infection Prevention CFR(s): 483.80 (a)(*\frac{3}{483.80} Infection CThe facility must estimated in the wounds of the woun	20/19 assessment of Resident's a handwritten or electronic 20/18 the Director of Nursing e #2 measured and assessed 05/09/18, but forgot to nation. plan, last updated 6/1/18, ly have a pressure ulcer to my or (future) pressure ulcer problem. 20 PM the DON stated weekly should include type of wounds, stage of pressure ercent of tissue in wound date information, and dor and pain associated with exported official assessment of wounds took place every estill expected the nurses a newly emerged pressure approximate size, location, of wound bed, and presence if odor. 21 & Control (1)(2)(4)(e)(f) 22 ontrol tablish and maintain an and control program as a safe, sanitary and ament and to help prevent the ansmission of communicable	F 84		6/2:	9/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345571	B. WING		,	06/08/2018	
NAME OF PROVIDER OR SUPPLIER CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403		1 00.00.20.0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A syst reporting, investigating and communicable distaff, volunteers, visity providing services ure arrangement based acconducted according accepted national states §483.80(a)(2) Written procedures for the pubut are not limited to (i) A system of surve possible communication infections before the persons in the facility (ii) When and to who communicable diseate reported; (iii) Standard and trate to be followed to previously full of the procedure of the persons in the facility (iii) Standard and trate to be followed to previously full of the persons in the facility (iii) Standard and trate to be followed to previously full of the persons in communication of the involved, and (B) A requirement that least restrictive possible circumstances. (v) The circumstance must prohibit employ	prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, ng, and controlling infections iseases for all residents, tors, and other individuals nder a contractual upon the facility assessment to §483.70(e) and following andards; n standards, policies, and rogram, which must include, illiance designed to identify ble diseases or y can spread to other (f) m possible incidents of se or infections should be ensmission-based precautions went spread of infections; olation should be used for a	F 84	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345571	B. WING _			06/08/2018	
	ROVIDER OR SUPPLIER	TR OF WILMINGTON LLC	•	STREET ADDRESS, CITY, STATE, ZIP CO 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	contact will transmit (vi)The hand hygiene by staff involved in d §483.80(a)(4) A systidentified under the ficorrective actions tal §483.80(e) Linens. Personnel must hand transport linens so a infection. §483.80(f) Annual retransport linens so a infection. §483.80(f) Annual retransport linens so a infection. §483.80(f) Annual retransport linens so a infection. Find facility will conduit IPCP and update the This REQUIREMENT by: Based on observation interviews, the facility gown and gloves proon contact isolation (Findings included: A review of the facility revealed the housek on infection control of Resident #17 was accomplete the control of the facility revealed Spectrum her urine, urinary tradementia, Alzheimer dementia, Alzheimer	s or their food, if direct the disease; and e procedures to be followed irect resident contact. em for recording incidents acility's IPCP and the ken by the facility. dle, store, process, and is to prevent the spread of view. uct an annual review of its ir program, as necessary. T is not met as evidenced ons, record review, and staff by staff failed to dispose of a operly for one of two residents	F	The statements made on the correction are not an admiss not constitute an agreementalleged deficiencies. To remain in compliance with and state regulations the factor will take the actions set of plan of correction. The plan constitutes the facility's alled compliance such that all alled deficiencies cited have been corrected by the dates indicated by the dates in	sion to and do t with the th all federal cility has taken orth in this of correction gation of eged n or will be eated. fic deficiency. ciency cited.		
	06/5/18 revealed the	resident was on antibiotic dverse therapy related to		On 06/21/2018, the Staff De Coordinator completed infe			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345571	B. WING _			06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•	00,00,2010	
				740 DIAMOND SHOALS ROAD			
CAROLIN	A BAY HEALTHCARE	CTR OF WILMINGTON LLC		WILMINGTON, NC 28403			
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From p	age 15	F 8	380			
F 880	E-coli, and had ES isolation. Interven mask when chang soiled linens in ballinens, and close to laundry. An observation of 06/06/18 at 9:08 A Protective Equipm Resident #17's do two red hazardous the resident's roon contact precaution resident's door. An observation on Housekeeper #1 e gowned and glove outside the reside up in her hands. Sigarbage can locate the gown and glove outside the gown and glove outside the reside up in her hands. Sigarbage can locate the gown and glove outside the resident with the gown and glove outside the resident the gown and glove. In an interview on Housekeeper #1 sidisposed of her go garbage can in the hazardous waste I resident's room. An interview on 06 stated Resident # for ESBL in her univexpectation that P exiting the resident.	BBL UTI and required contact tions included: wear gloves and ing contaminated linen, place gs marked biohazard, bag bag tightly before taking to Resident #17's room on M revealed PPE (Personal ent) was available outside or in a closed cart, there were waste cans located just inside in next to the door, and a sign was posted on the 06/06/18 at 9:10 AM revealed exiting Resident #17's room d. The housekeeper stood int's room with the gown balled She went to a large black end in the hall and disposed of es. 06/06/18 at 09:15 AM tated she did not know why she own and gloves in the black en hallway rather than in the red bins located inside the 16/6/18 at 9:20 AM Nurse #2 17 was on contact precautions ine. She said it was her PE should be removed prior to t's room and disposed of in the	F 8	rounds to observe staff enter exiting resident rooms who a isolation precautions. The straudited for donning PPE price the room and doffing the PPI exiting the room and the PPI properly disposed. 2. Procedure for implementi acceptable plan of correction On 06/06/2018 and 06/22/20 Development Coordinator prin-service education to all ful time, and as needed nurses, Tech's, House Keeping Staff Staff, Maintenance Staff, and Manager staff. Topics include Donning PPE prior to erresident room that is on isolar precautions. Doffing the PPE prior to resident's room and how to precautions. Hand hygiene after exiting isolation room. This information has been in the standard orientation train required in-service refresher all staff as identified above a reviewed by the Quality Assurprocess to verify that the characteristic deficiency cited remained/or in compliance with regrequirements.	re on aff were aff were ar to entering E prior to E was Ing the Ing the Ing the staff povided an I time, part I CNA's, Med I, Dietary I Department I detering a Intition I time the properly I determined the properly I determin		
	resident's room. S	ste bins located just inside the he stated the staff just had an tion precautions months ago.		The Staff Development Coor designee will monitor the cor of PPE when exiting a reside	rect disposal		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345571	B. WING _			06/08/2018	
NAME OF PROVIDER OR SUPPLIER CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC			•	STREET ADDRESS, CITY, STATE, ZIP COD 740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403	E		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 880	was conducted on ODON reported that is resident was on cornwould place a precatance and power and government of the gown and glove redinated providing cathe gown and glove red hazardous bins hands with soap and room. The DON regithat the staff follow aresidents were on, were in-serviced on during orientation and An interview with the conducted on 06/08 Administrator reports	e Director of Nursing (DON) 16/06/18 at 9:40 AM. The 15 twas her expectation when a 15 tact precautions that the staff 16 tution sign on the door and 17 tiside the resident's room. The 18 sher expectation that all staff 18 when providing care to the 18 tering the room. She reported 19 to that when the staff was 19 tare that they would remove 19 tand dispose of them in the 19 tocated in the room and wash 10 d water prior to leaving the 19 torted it was her expectation 19 tand precautions that the 19 The DON reported all staff 19 infection control practices 19 tand yearly. 10 tand yearly 11 tand yearly 12 tand yearly 13 tand yearly 14 tand yearly 16 tand yearly 17 tand yearly 18 tand yearly 18 tand yearly 19 tand yearly 19 tand yearly 10 tand yearly 10 tand yearly 11 tand yearly 12 tand yearly 13 tand yearly 14 tand yearly 15 tand yearly 16 tand yearly 17 tand yearly 18 tand yearly 18 tand yearly 19 tand yearl	F8	isolation precautions. The Quassurance tool will be completed for 4 weeks then monthly for a Monitoring will include auditing correct disposal of PPE upon resident's room on isolation preports will be presented to the Quality Assurance committee Administrator to ensure corresinitiated as appropriate. Complete monitored and ongoing authorogram reviewed at the weet Assurance Meeting. The weet Assurance Meeting is attended Administrator, Director of Nurt Coordinator, Therapy, Health Manager, and the Dietary Material Administrator is responsional implementation and completion acceptable plan of corrections.	eted weekly 2 months. 12 months. 13 g for the exiting the exiting the executions. 14 he weekly 15 by the exitive action pliance will diting 16 kly Quality 16 kly Quality 17 kly Quality 18 kly Quality 18 kly Quality 19 kly Quality 1		