PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345119	B. WING _			C 10/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD)E		
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		3015 ENTERPRISE 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		
F 607 SS=D	CFR(s): 483.12(b)(1)		F6	07		11/14/18	
	§483.12(b) The facilit implement written pol	icies and procedures that:					
	§483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re	ion of residents and					
	§483.12(b)(2) Establisto investigate any suc	sh policies and procedures ch allegations, and					
	paragraph §483.95,	training as required at					
	Based on record revi facility failed to follow by failing to report mis for 2 of 3 sampled res	iew and staff interviews, the its abuse and neglect policy sappropriation of property sidents (Resident #6 and Health Care Personnel		NorthChase Nursing and Re acknowledges receipt of the S Deficiencies and proposes th Correction to the extent that t of findings is factually correct to maintain compliance with a rules and provisions of quality	Statement is Plan of the summa and in ordapplicable	of ary ler	
	Findings included:			residents. The Plan of Correct submitted as a written allegate	tions is	•	
	dated March 10, 2017 reporting/response se in part, "The Administ ensure that incidents the appropriate local/including the state Nu allegations that do no serious bodily injury, the Division of Health Care Personnel Secti agencies are notified written report must be	e Policy and Procedure 7 (revised) in the ection #3, page 3, revealed, erator was responsible to as indicated are reported to estate/federal agencies erase Aide Registry. For all est involve abuse or result in the Administrator will ensure Service Regulation, Health on and other appropriate no later than 24 hours. A e sent to Health Service erase Personnel Section within		compliance. NorthChase Nursing and Refresponse to this Statement of does not denote agreement visite statement of Deficiencies not constitute an admission that a deficiency is accurate. Further NorthChase Nursing and Refreserves the right to refute an deficiencies on this Statemen Deficiencies through Informal Resolution, formal appeal production and or any other administration proceeding.	f Deficience vith the r does it any er, nabilitation ny of the tt of I Dispute occdure	ies	
ABORATORY	_	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	_l

11/08/2018 **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.

STREET ADDRESS. CITY. STATE, ZIP CODE 3016 NUTSIDE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
INTEREST ADDRESS. CITY, STATE, ZP CODE 3015 ENTERPRISE DRIVE WILLIMINATION, NO. 28405 SUMMARY STATEMENT OF DEHICIBIOUS (EACH DEPOSITORY) WASTE PRECEDED BY FILL (EACH DEPOSITORY) WASTE PRECEDED BY FILL (EACH DEPOSITORY) WASTE ENTERPOSITORY BY STATE PRECEDED BY FILL (EACH DEPOSITORY) WASTE ENTERPOSITORY BY STATE PRECEDED BY FILL (EACH DEPOSITORY) WASTE ENTERPOSITORY BY STATE PRECEDED BY FILL (EACH DEPOSITORY) WASTE ENTERPOSITORY BY STATE PRECEDED BY FILL (EACH DEPOSITORY) WASTE ENTERPOSITORY BY STATE PRECEDED BY FILL (EACH DEPOSITORY) WASTE PRECEDED BY FILL (EACH			3,45110	B WING				_
NORTHCHASE NURSING AND REHABILITATION CENTER DATE DAT	NAME OF D	20//DED OD CUDDUED	343113	B. WING_		TREET ADDRESS CITY STATE 7/D CODE	10	0/18/2018
Incomplete Inc	NAME OF PI	ROVIDER OR SUPPLIER						
F 607 Continued From page 1 five (5) working days from the date the facility becomes aware of the alleged incident." F 607 Continued From page 1 five (5) working days from the date the facility on 02/18/18. The Minimum Data Set (MDS) quarterly assessment dated 07/27/18 revealed the resident was cognitively aware. A review of the 24-hour initial report revealed on 05/10/18, Resident #6 alleged her money was missing in the amount of \$38.00. The 24-hour report was sent via facility failed to 24 hour report was sent via facility to the HeIDPR. The facility on 04/18/18. The MDS dated 04/25/18 5-day assessment revealed the report was completed and signed and attempted to be sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed by the facility indicated there was an error which read Error 346° and to try again. There was no fax confirming the receipt of the 5-day investigation report was confirmed the report was confirmed to the facility indicated there was an error which read Error 346° and to try again. There was no fax confirmed to report was confirmed to the facility indicated there was an error which read Error 346° and to try again. There was no fax in the facility on the	NORTHCH	IASE NURSING AND	REHABILITATION CENTER					
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						requirements		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	345119	B. WING _			C 10/18/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-! E	10/10/2010	
			3015 ENTERPRISE DRIVE			
NORTHCHASE NURSING AND	REHABILITATION CENTER		WILMINGTON, NC 28405			
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		
F 607 Continued From p	age 2	F 6	07			
and asked to notifi was received. A phone interview Complaint Intake I of North Carolina The CID reported facility reported in Resident #10. The report and the 5-d both submitted to would be incomple reported. The CID HCPR Representative was incidents for 2017 Resident #10. An interview was a Administrator on 1 Administrator state fax confirming the were faxed. The A each component of and 5-day investig	was conducted with the Department (CID) for the State NC) on 10/18/18 at 9:18 AM. they were unable to find any cidents for Resident #6 and a CID stated unless the 24-hour ay investigation report were the HCPR, the investigation set and would not appear as a forwarded the call to the ative to see if they would have a stable incidents. The HCPR is unable to find any reportable and 2018 for Resident #6 and conducted with the 0/18/18 at 9:45 AM. The ed he was unable to provide a 5-day investigation reports administrator understood that of the process (24-hour report ation report) needed to be natirety in order to be a	F 6	2. Completion of a 5 day reg summary of investigation. 5 day summary of investigation and documents should be faxed to upon completion and the facility retain fax confirmation records report was faxed per HCPR regarded. In-services related to evectorial states of the services of the services related to evectorial states of the services	ay report, supporting of HCPR ity must as as proof equiremen witnesses ent elated to the able to fax we issues PR, the pt to fax and show acility is the HCPR to I in the PR pleted by the HCPR to I in the pleted by the HCPR is a week as a wind a wi	the R ks	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345119	B. WING				C
	ROVIDER OR SUPPLIER		B. WING	ST 30	TREET ADDRESS, CITY, STATE, ZIP CODE 015 ENTERPRISE DRIVE VILMINGTON, NC 28405	<u> 10/</u>	18/2018
(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 607	Continued From page	√iolations		607	review and initial the HCPR Investigation Audit Tool weekly x 4 weeks then month x 1 month to assure all areas of concernave been addressed. The QA nurse will forward HCPR Investigation Audit Tool to Executive Queenmittee monthly x 3 months to determine trends and / or issues that make require further interventions put into play and to determine the need for further at / or frequency of monitoring.	hly n A nay ace nd	11/14/18
SS=D	neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, neglimistreatment, includir source and misapproare reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not rest he administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the administration to the administration of the service of the s	that all alleged violations ect, exploitation or injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state Survey Agency and the serious here state law provides the law through established					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345119	B. WING _			10/	C 18/2018
NAME OF P	ROVIDER OR SUPPLIER	2.0		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2010
TO THE OT THE	TO VIDER OR OUT FEET				115 ENTERPRISE DRIVE		
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER			ILMINGTON, NC 28405		
				**			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page	e 4	F 6	609			
	Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on observatio	e law, including to the State n 5 working days of the eged violation is verified e action must be taken. is not met as evidenced ns, record review and staff			NorthChase Nursing and Rehabilitatio		
	reportable incidents to Registry (HCPR) by r	failed to complete facility of the Health Care Personnel not submitting the 5-day or 2 of 3 residents (Resident) observed for			acknowledges receipt of the Statement Deficiencies and proposes this Plan of Correction to the extent that the summar of findings is factually correct and in ord to maintain compliance with applicable	ary der	
	misappropriation of p	roperty.			rules and provisions of quality of care of residents. The Plan of Corrections is	of	
	Findings included:				submitted as a written allegation of compliance.		
	1) Resident #6 was a	dmitted to the facility on			NorthChase Nursing and Rehabilitation	1	
	02/18/18. The Minim	` ,			response to this Statement of Deficience	cies	
		t dated 07/27/18 revealed			does not denote agreement with the		
	the resident was cogr	nitively aware.			Statement of Deficiencies nor does it constitute an admission that any		
	A review of the 24-ho				deficiency is accurate. Further,		
		6 alleged her money was			NorthChase Nursing and Rehabilitation	1	
	_	t of \$38.00. The 24-hour			reserves the right to refute any of the		
		icsimile (fax) to the HCPR.			deficiencies on this Statement of		
		ned the report was received			Deficiencies through Informal Dispute		
		M. A review of the 5-day			Resolution, formal appeal procedure		
		as completed, but there was			and/or any other administrative or lega	i	
	HCPR.	m the report was sent to the			proceeding.		
	HOFK.				The process that led to this deficiency was the facility failed to follow its abuse		
	A raviou of the 5 day	investigation report			•	;	
	A review of the 5-day	ility revealed an allegation			and neglect policy by failing to report misappropriation of property for 2 of 3		
		nt #6 that money was taken					
	· ·	•			sampled residents (resident #6 and		
	-	t was reported and an			resident #10) to the Health Care Personnel Registry. (HCPR)		
		t was reported and an			100% audit of all resident HCPR		
	_	nediately initiated. The				6	
		arch was conducted in the in the laundry area. The			reportable events to include resident # and resident #10 x 90 days was initiate		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(C
		345119	B. WING _				18/2018
NAME OF P	ROVIDER OR SUPPLIER	•	,	S1	REET ADDRESS, CITY, STATE, ZIP CODE		
NORTHCE	IASE NURSING AND RE	HABILITATION CENTER		30	15 ENTERPRISE DRIVE		
NORTHOL	IAGE NOROING AND RE	HABIETATION GENTER		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					bei idiendi)		
F 609	allegation and came report. The deputy 's action was taken bas information. The 5-distated, based on the could not be substant staff did not yield add the whereabouts of mithorough search was physical area and the located. As part of the stated other residents interviewed and no officems were noted and information regarding provided. The report member (FM) was obtained by the may have inadverten money that was alleg were part of the facility report stated the more resident and the resident and she activities Director.	tment was notified of the to the facility to make a serport stated no further and on the lack of any investigation, the allegation tiated and interviews with litional information regarding money. The report stated a conducted throughout the emoney could not be the investigation, the report in the area were ther incidents of missing the allegation was stated the resident 's family obtaining money from the cell and the discovery was made and the obtained the money. The feely taken were funds that they's activities fund. The ney was returned to the dent provided the funds to the discovery was made and the discovery was made and the money. The feely taken were funds that they's activities fund. The ney was returned to the dent provided the funds to the discovery was made and the discovery was made and they activities fund. The ney was returned to the dent provided the funds to the discovery was made and they activities fund. The new was returned to the dent provided the funds to the facility never indicated that the money to the sadmitted to the facility on	F	609	on 10/18/18 by the Administrator and Director of Nursing (DON) to ensure all investigative folders are complete to include a 24 hour report and 5 day report with written summary of investigation a proof of fax confirmation, police report when applicable, statements from staff and other documentation as indicated areas of concern will be immediately addressed by the Administrator/DON to include faxing 24 hour/5 day report and obtaining confirmation of fax completion and completion of investigation. Audit we completed on 10/19/18. 100% in-service was completed by the Facility Nurse Consultant with the Administrator, DON, Social Worker on 10/18/18 in regards to HCPR Reportable Investigation Folders to include: The facility must initiate an investigative folder for all required HCPR reportable events to include but is not limited to the following: 1. Completion of a 24 hour report times the completion and the facility must retain fax confirmation records as proof report was faxed per HCPR requirements 2. Completion of a 5 day report with summary of investigation. 5 day report, summary of investigation and supporting documents should be faxed to HCPR upon completion and the facility must completion and the facility must man and the facility must completion and the facility must completed and completed areas of concern with the complete and completed areas and complete and complete areas and comple	ort nd All of no vas	
	assessment revealed aware.	dated 04/25/18 5-day I the resident was cognitively			retain fax confirmation records as prooreport was faxed per HCPR requirements. 3. Statements from staff or witnesses. 4. In-services related to event.	nts	
	A review of a facility of	grievance form written on			Police report if indicated		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
			7 5012511			С	
		345119	B. WING _			10/18/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u> E	10/10/2010	
				3015 ENTERPRISE DRIVE			
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
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F 609	Continued From page	e 6	F 6	509			
	05/10/18 revealed Re	esident #10 stated when a		6. All other documents as re	elated to th	e	
		the morning of 05/10/18 at		investigation			
	10:00 AM, Resident			If at any time the facility is una	able to fax		
		ureau drawer and the money		the 24hr or 5 day report or ha			
	-	nvelope. Resident #10		with fax being received by HC			
	reported that he and	the FM were going on an		facility must continue to attem	pt to fax		
	outing to a grocery st	tore. Resident #10 stated a		reports daily until completed a			
	•	05/09/18 at 2:00 PM and had		proof of each attempt. If the fa			
	_	cash (2 20 ' s and 4 1 ' s) in a		unsure if report was received,			
	•	m to use. Resident #10		Administrator should contact I			
		FM came to get him at 10:00		confirm and document the cal	I in the		
	AM, he went to grab			investigative folder.			
	•	oureau drawer and the money		100% Audit of all resident HC			
	_	nvelope. Resident #10		reportable events will be comp	-		
		oney 05/09/18 at around 5:00 report stated the room was		Social Worker/ADON utilizing Investigation Audit Tool weekl			
	searched and no mo			then monthly x 1 month to ens	-		
		ed Resident #10 's FM who		investigative folders are comp			
	_	was notified and she stated		include a 24 hour report and 5		rt	
		ut 05/09/18 around 2:00 PM		with written summary of inves			
		10 the money in a white		proof of fax confirmation, police	-		
	envelope.	•		when applicable, statements f			
				and other documentation as ir	ndicated A	dl	
	A record review revea	aled the 24-hour initial report		areas of concern will be imme	diately		
		sent via fax to the HCPR on		addressed by the Administrate			
		The 5-day investigation		include faxing 24 hour/5 day r			
		d and signed and attempted		obtaining confirmation of fax of			
		he HCPR on 05/16/18 at		and/or completion of investiga			
		ne fax log for the facility		The Quality Assurance Nurse		_	
		an error which read Error		review and initial the HCPR In	•		
	346* and to try again			Audit Tool weekly x 4 weeks to x 1 month to assure all areas		-	
	- ·	t of the 5-day investigation		have been addressed.	or concen	'	
	report.			The QA nurse will forward HC	PR		
	The 5-day investigati	on report indicated a full		Investigation Audit Tool to Exe			
		npleted by interviewing all		committee monthly x 3 month			
	•	with Resident #10 and		determine trends and / or issu		av	
		its that were in proximity to		require further interventions p		-	
		m. There were no further		and to determine the need for	-		
ORM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: XD1R1	1	Facility ID: 923038	If continu	ation sheet Page 7 of 23	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010
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NORTHCE	IASE NURSING AND RE	HABILITATION CENTER		٧	VILMINGTON, NC 28405		
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F 609	Continued From page	e 7	F 6	809			
	local sheriff's depart indicated there was no investigate a crime. On the investigation, regarding the whereas substantiated and the Resident #10 as a continuous An interview was continuous.	ducted with Resident #10 on			/ or frequency of monitoring.		
	and oriented and rephis bureau drawer where Resident #10 stated the money and they have tigate it. Resident the room and were un Resident #10 reporter facility staff to keep h	Resident #10 was alert orted \$44.00 was taken from hich was in a white envelope, the facility never recovered had the police come and ent #10 stated they searched hable to locate the money. It was asked by the is money locked up at the fused and wanted to keep it mes.					
	Administrator stated I investigation reports Resident #10 were se	7/18 at 5:45 PM. The he was sure the 5-day					
	of North Carolina (NC The CID reported the facility reported incide Resident #10. The C report and the 5-day both submitted to the	ss conducted with the coartment (CID) for the State C) on 10/18/18 at 9:18 AM. By were unable to find any cents for Resident #6 and CID stated unless the 24-hour investigation report were HCPR, the investigation and would not appear as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345119	B. WING			C 10/18/2018	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405			
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F 684 SS=D	HCPR Representative record of the reportal representative was un incidents for 2017 and Resident #10. An interview was con Administrator on 10/1 Administrator stated if fax confirming the 5-c were faxed. The Admeach component of the and 5-day investigation completed in its entire completed reported in Quality of Care CFR(s): 483.25 § 483.25 Quality of care used a facility residents. Based assessment of a resident residents received accordance with profession practice, the comprehence plan, and the residents received accordance with profession and the residents received accordance	rwarded the call to the et to see if they would have a ble incidents. The HCPR hable to find any reportable d 2018 for Resident #6 and ducted with the 8/18 at 9:45 AM. The ne was unable to provide a day investigation reports hinistrator understood that he process (24-hour report on report) needed to be ety in order to be a neestigation. The are indamental principle that he and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of hensive person-centered sidents' choices. The is not met as evidenced in some record review and staff failed to follow physician and ordered blood work (labs) for 1 of 3 residents	F 6	The process that led to this deficient was the facility failed to follow physorders by not obtaining ordered blowork (labs) and a Urine Analysis for residents (resident #2) sampled.	ician od 1 of 3	11/14/18	
	Findings included:			100% audit of all physician lab (MD orders, discharge summaries and admissions lab orders to include re-	•		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD CUIDDUED	343113	B: Wiito		TREET ADDRESS CITY STATE ZID CODE	10/	18/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER			015 ENTERPRISE DRIVE		
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F 684	hospitalized on 09/29	nitted to the facility on mit of 10/04/18 after being n/18. Diagnoses included, in	F	684	#2 x 30 days was initiated on 10/17/18 the Director of Nursing (DON), Quality Assurance Nurse (QA) and clinical tear		
	and high blood press	weakness, hypothyroidism ure. et (MDS) dated 08/28/18			to ensure all labs were drawn per MD order. All areas of concern will be immediately addressed by the DON to include assessment of resident,		
	severely cognitively in not exhibit any mood	t revealed Resident #2 was mpaired. Resident #2 did or behaviors, required			notification of MD of any missed labs to obtain new orders, completion of labs p MD order, notification of MD and reside	er	
	with all activities of da impairments and use	with one staff assistance ally living (ADLs), had no d a walker and wheelchair.			representative (RR) of lab results with documentation in electronic record. Audional completed on 10/17/2018.		
	and always continent				On 10/1/2018 MD was notified by the L Supervisor that facility failed to obtain la per MD order for resident #2 with no ne	abs ew	
	revealed a plan of car complications due to interventions included	hypothyroidism. The d to monitor lab values,			orders due to labs being completed at to local emergency room. 100% in-service of all nurses was initiately the Staff Facilitator on 10/18/18 in		
		symptoms such as fatigue, sleepiness and es and notify physician of			regards to Lab Orders to include: 1. Nursing staff are responsible to ensure that the admitting physician is alerted to all lab recommendations per		
	A review of a progres	s note written by the Nurse 9/27/18 revealed the NP was			discharge summaries for all new admissions. 2. Nursing staff are responsible to		
	and tremors. The NF she would obtain a C	nt due to lethargy (fatigue) P stated in her progress note BC (complete blood count), c Panel), TSH Thyroid			ensure all standing admission lab order are completed as ordered with notificat of MD/RR of lab results. 3. Nursing staff must notify the physical description.	ion	
	Stimulating Hormone), urinalysis (U/A), and urine ensitivity) to evaluate for a			of any refusal of lab draw or failure to obtain labs and obtain new orders, as appropriate, with documentation in electronic record.	Sidii	
	revealed an order for	cian orders dated 09/27/18 CBC, BMP, TSH, sphorous level, a U/A and			 Nursing staff must notify RR of any refusal of lab attempts and document in electronic record. All labs orders will be written on the 	า	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2010
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F 684	Continued From pag	e 10	F 6	584			
	A review of the medic	cal record revealed there			appropriate lab log for the appropriate date to be drawn.		
	were no results for blon 09/27/18.	lood work or a U/A obtained			6. Once labs are drawn, the lab orde will be dated and initial as complete in lab log.		
		evening Nurse Supervisor			7. Once lab results are received, the	lab	
	` '	10/16/18 revealed he could			order will be highlighted in the lab log.		
		work or a urinalysis being			8. Nurses must document in electron	ic	
		. The NS stated, the process was to fill out a lab slip of			record utilizing the Phlebotomist Note		
		nd place the slip in the lab			under PCC progress notes and include a. All lab attempts whether successful		
		station under the numbered			 a. All lab attempts whether successfunct 	וט וג	
		be drawn. The NS stated			b. Refusal of labs		
		ut into their computer system.			c. Response to lab attempt/draw		
	-	the technicians from the lab			d. Condition of site after lab draw		
	company arrived, the	ey would go to the lab book			e. Notification of MD of any refusals	or	
	for that specific day a	and pull the slip of what was			inability to obtain lab as ordered.		
	needed to be drawn.	The NS stated if they were			f. A follow up note that MD/RR were		
	ordered, they would	have been in the lab book.			notified of lab results. RR should be		
	The NS reported no	labs were put in the system			notified of all lab results both normal ar	ıd	
		was unable to find the lab slip			abnormal		
	· ·	e book. The NS stated if			All lab results will be reviewed dur	ing	
		or U/A, then the facility would			Cardinal IDT.		
		ine to do the U/A the day the			10. The lab log will be reviewed daily		
	order was written wh				during Cardinal IDT to ensure all labs a		
		onfirmed there was no U/A			marked as obtained and orders receive		
		18 and there were no orders			Any labs not marked as complete will be		
	work drawn.	09/27/18 to have the blood			followed up on by the Clinical Coordina		
	WOIK GIAWII.				11. Procedure for Initiating lab orders:a. All orders for labs will be obtained		
	Δn interview was cor	nducted with Nurse #2 on			the next scheduled lab day unless orde		
		. Nurse #2 reported if the			as STAT or for same day draw	00	
		rder for a U/A then that			b. All orders for Urinalysis or Urine		
	1	one on 09/27/18. Nurse #2			culture will be obtained the same day a	ıs	
		e no results of a U/A and no			ordered on the shift it is ordered. Notify		
	orders for blood work	were put in the computer			MD if unable to obtain.		
		on 09/27/18 for Resident #2.					
					In-service will be completed by		
	An interview with the	NP on 10/18/18 at 9:45 AM			10/22/2018. After 10/22/2018 no nurse	will	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345119	B. WING _			C 10/18/2018	
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, Z	I ZIP CODE	10/10/2010	
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NORTHC	HASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405			
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F 684	Continued From page	e 11	F 6	84			
F 684	was conducted via place recalled seeing Residuals was noted to have treated to have treated and awake at the tim NP reported after assistance blood work to include Magnesium and Phosurine C & S to deterricate based on the I she would have expected on 09/27/the labs requested to draw. An interview with the on 10/18/18 at 10:30 expectation of the nuthey obtained a urine	none. The NP stated she dent #2 on 09/27/18 and she dent #2 on 09/27/18 and she demors and increased atted the resident was alert to e of her assessment. The design her, she ordered at a CBC, BMP, TSH, sphorous level, a U/A and mine if there was a reversible ab results. The NP stated acted the U/A to be 18 and for the remainder of 18 be ordered for the next lab. Director of Nursing (DON) AM revealed her resing staff was to ensure 18 to complete an analysis on d and any orders for blood	F6	be allowed to work until been completed. All newly hired nurses of the staff Facilitator of regards to Lab Orders to 1. Nursing staff are resensure that the admitting alerted to all lab recommendischarge summaries for admissions. 2. Nursing staff are resensure all standing admare completed as ordered for MD/RR of lab results. 3. Nursing staff must of any refusal of lab drasobtain labs and obtain rappropriate, with docume electronic record. 4. Nursing staff must refusal of lab attempts a electronic record. 5. All labs orders will appropriate lab log for the date to be drawn. 6. Once labs are draw will be dated and initial lab log. 7. Once lab results are order will be highlighted. 8. Nurses must docur record utilizing the Phle under PCC progress not a. All lab attempts who not b. Refusal of labs c. Response to lab at d. Condition of site afficiency.	will be in-service during orientation to include: esponsible to ag physician is mendations per or all new esponsible to nission lab order led with notification or all new or failure to new orders, as mentation in notify RR of any and document in the appropriate with the lab order as complete in the din the lab log. The reference of the lab log. The reference of the lab log. The lab log the sand include the resuccessful tempt/draw	n in rs ion cian r the lab ic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405		10/18/2018	
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F 684	Continued From page	ge 12	F	inability to obtain lab at f. A follow up note to notified of lab results. notified of all lab result abnormal 9. All lab results will Cardinal IDT. 10. The lab log will be during Cardinal IDT to marked as obtained at Any labs not marked at followed up on by the solid and the next scheduled late as STAT or for same of b. All orders for Uring culture will be obtained ordered on the shift it MD if unable to obtain	that MD/RR were RR should be Its both normal and I be reviewed during e reviewed daily e ensure all labs are and orders received. as complete will be Clinical Coordinator. tiating lab orders: s will be obtained on b day unless ordered day draw nalysis or Urine ed the same day as is ordered. Notify		
				100% in- service of all initiated on 11/8/2018 Draws with Quest Lab 1. Nursing staff are provide the requisition for lab orders. If nurse complete the requisition the nurse then must cowritten requisition and book. 2. If an order for a Lethen the nurse that receive obtain the specimen be shift. If the specimen obtained by the nurse	in regards to Lab coratory to include: responsible to in in the lab system is is unable to on in the lab system, complete a hand d place in the lab JA C&S is received, es the order must by the end of the is unable to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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NORTHC	ASE NURSING AND RI	EHABILITATION CENTER		3015 ENTERPRISE DRIVE WILMINGTON, NC 28405		
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F 684	Continued From page	e 13	F	notified and a note doc Click Care. 3. STAT lab orders mimmediately upon rece STAT labs will be trans Hanover Regional Med designated courier. 4. Quest phlebotomis per lab logs 3 days a wellab day. 5. If Quest is unable any reason the assigned sign the requisition form call supervisor by the experiment in the provided MD notification. In-service will be computed. An In-Service provided Laboratory Services made and phlebotomist on schedular facility. 1. Nursing staff are reprovided the requisition for lab orders. If nurse complete the requisition for lab orders. If nurse complete the requisition the nurse then must convict the nurse	nust be obtained iving the order. A ported to New dical Center Lab by st will obtain labs week on scheduled to obtain labs for ed staff nurse must mand notify the order of shift to an and notify the order of shift to an and notify the order of shift to an anger on to the process for uled lab days at the esponsible to in the lab system is unable to n in the lab system of place in the lab system of the lab	ill y it in ine m,

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NAME OF P	ROVIDER OR SUPPLIER	0.101.10	1 1	STREET ADDRESS, CITY, STATE, ZIP	CODE	10/	18/2018
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F 684	Continued From page	e 14	F6	4. Quest is responsible formmunicating with nursing to obtain any labs as orderform must be signed by nurgarding lab refusals, inallab as scheduled. 100% Audit of all MD lab of discharge summaries and orders to include resident completed by the nurse sumurses, and Clinical Coordinates, weekly x 4 weeks month to ensure all labs and MD order with MD/RR not results. All areas of conceimmediately addressed by supervisor, hall nurses, and Coordinators to include restaff, assessment of reside of MD of any missed labs orders, completion of labs notification of MD and resirepresentative (RR) of lab documentation in electroni DON/ADON/Administrator initial the Lab Audit Tool withen monthly x 1 month to areas of concern have been and labs are completed performed to executive QI committee months to determine trendissues that may require furinterventions put into placed determine the need for fur frequency of monitoring.	ng staff if una red. Requisit ursing staff bility to obtain bridger, admissions I #2 will be upervisor, hald dinators utilizing a week x 4 then monthly redrawn as prification of latern will be under the nurse and Clinical deducation of ent, notification to obtain new per MD order ident results with it record. It will review a result will review a result of the monthly x 8 were ensure all the addressed or MD order. Lab Audit To the monthly x 3 ds and / or or ther e and to	tion n lab ling x 1 per b fon ver, and eks	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ´	PLE CONSTRUCTION	СОМ	E SURVEY PLETED
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	ROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405		•	710/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 692 F 692 SS=D	Nutrition/Hydration S CFR(s): 483.25(g)(1) §483.25(g) Assisted (Includes naso-gastr both percutaneous endos enteral fluids). Base comprehensive asse ensure that a resider §483.25(g)(1) Mainta of nutritional status, s desirable body weigh balance, unless their demonstrates that the preferences indicate §483.25(g)(2) Is offer maintain proper hydrovider orders a the This REQUIREMENT by: Based on observation in record review the facitems requested by ton the resident's mediate.	nutrition and hydration. Ic and gastrostomy tubes, Indoscopic gastrostomy and copic jejunostomy, and d on a resident's Issment, the facility must Int- Intins acceptable parameters Issuch as usual body weight or Intir range and electrolyte Iesident's clinical condition Is is not possible or resident Iotherwise; Ired sufficient fluid intake to Iation and health; Ired a therapeutic diet when Ioroblem and the health care Irapeutic diet. In is not met as evidenced Intir nurse practitioner Iterview, staff interview, and Intir failed to provide food Inter family and documented	F 69	92	le food items ocumented os for 1 of 3 9) reviewed	11/14/18
	failed to provide the nutrition intervention the registered dietitia	s. In addition, the facility nurse practitioner (NP) with recommendations made by in (RD) for consideration in #9's continued weight loss.		facility failed to provide the nur practitioner (NP) with nutrition recommendations made by the dietitian (RD) for consideration addressing resident #9 continu- loss. 100% audit of all meal tray car	intervention e registered n in ued weight	

NAME OF PROVIDER OR SUPPLIER NORTHCHASE NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405	ED .
NAME OF PROVIDER OR SUPPLIER NORTHCHASE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405	2018
NORTHCHASE NURSING AND REHABILITATION CENTER WILMINGTON, NC 28405	
WILMINGTON, NC 28405	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) MPLETION DATE
F 692 Continued From page 16 F 692	
Continued From page 16 Record review revealed Resident #9 was admitted to the facility on 02/23/15 and readmitted to the facility on 05/18/18. The resident's documented diagnoses included dementia without behavioral disturbance, atrial fibrillation, congestive heart failure, hyperlipidemia, and constipation. The resident's Weight Summary documented on 01/09/18 she weighed 117.7 pounds, on 02/14/18 and 02/16/18 she weighed 117.7 pounds, on 02/14/18 and 02/16/18 she weighed 119.5 pounds, on 05/09/18 she weighed 119.5 pounds, on 06/06/18 she weighed 119.5 pounds, on 06/06/18 she weighed 119.5 pounds, on 06/06/18 she weighed 101.8 pounds, on 08/08/18 she weighed 101.8 pounds. Resident #9's 08/22/18 quarterly minimum data set (MDS) documented her cognition was moderately impaired, she was independent in eating requiring set-up assistance only, she was 63 inches tall and weighed 99 pounds, and she experienced a significant weight loss of 5.3% x 30 days and 15% x 180 days, and the resident's reported she thought the resident would better tolerate her supplement if it was provided with the evening medications. The RD's recommendations included moving the resident's Resource 2.0 to the evening medication pass 90 cubic centimeters (cc) to aid with energy intake and compliance, entired med as a facility and compliance, enteried medication and the program (EMP)	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		345119	B. WING		40	C
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•	0/18/2018
TVAIVIL OF T	NOVIDER OR OUT FIER			3015 ENTERPRISE DRIVE	JL	
NORTHCH	IASE NURSING AND	REHABILITATION CENTER		WILMINGTON, NC 28405		
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F 692	Continued From p	page 17	F 6	92		
	energy intake.			and care plan/ care guide wa	as undated	
	chergy intake.			All areas of concern will be in	•	
	The resident's car	re plan, last updated on		addressed by the DON to inc	-	
		ed "State of nourishment:		assessment of resident, MD/		
	Resident is at risk	for weight loss (due to) poor		referrals as indicated, notificated	ation of RR of	
		. She has had significant weight		weight change and initiation	of appropriate	
	•	n. Interventions to this problem		interventions.		
		g the diet as ordered, providing		On 10/23/2018 resident #9 w		
	l · · · · · ·	ntation, referral to dietitian for		by nursing staff and referred		
		mendations, and taking weights		MD/RD by the Dietary Mang		
	per facility protoco	JI.		continued weight loss with the new orders/interventions Enro	•	
	The resident's We	eight Summary documented on		Plan, ice cream, whole milk t		
		It #9 weighed 97.7 pounds.		with meals resident reported	-	
	Coronne neoridan	it no weighted or in poditide.		mashed potatoes, food prefe		
	A 09/11/18 progre	ess note documented the		provided to family. Resident		
		body weight was 97.7 pounds,		Representative is aware of w		
	she was on a regi	ular diet, her meal intake varied		monitoring and interventions	by nursing	
	from 0 - 25%, and	I the family refused a feeding		staff.		
	tube.			100% in-service of all nurses		
				on 10/18/18 by the Staff Fac		
		ogress note documented the		regards to RD Recommenda	itions to	
		body weight was 97.7 pounds,		include:	DD.	
		aried between 25 - 75%, she		Notification of MD of all	KD	
		se supplements although staff ging her to eat/drink them, and		recommendations 2. Documentation that MD	has reviewed	
		en fed by family. The RD's		RD recommendation with ap		
		s included moving the resident's		orders received or reason	provantiew	
		he evening medication pass 90		recommendation was not init	tiated. This	
		(cc) to aid with energy intake		documentation will be linked		
		enriched meal program (EMP)		Progress note.		
		d an evening snack to aid with		3. Implementing new order	rs	
	energy intake.			4. Notification of RR of all I	new	
				orders/interventions		
		eight Summary documented on		5. MD must initial RD reco	mmendation	
	10/10/18 she wei	ghed 96.5 pounds.		and return to DON.		
	On 10/10/10 =± 10	DEO DM Dooidant #0		In consider will be accounted.	by 10/00/10	
		2:50 PM Resident #9 was eating She received stew beef,		In-service will be completed After 10/22/18no nurse will b		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
			A. BOILDI			, ا	
		345119	B. WING			10/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		30	015 ENTERPRISE DRIVE		
NORTHOL	IAOL NOROING AND RE	INDICITATION SERVER		W	/ILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From pag	e 18	F	692			
F 692	mashed potatoes an cookie. Her tray slip Orders: deli turkey s meat and two slices chips, and soup. No foods were on the re On 10/17/18 at 12:43 lunch in her bed. Sh vegetables, and masher tray slip docume turkey sandwich with slices of whole whea soup. None of the state resident's meal to the facility provided hould eat what she wher plate. She commalways good, but she facility. On 10/17/18 at 3:08 stated the enriched food 10/16/18 and 10/17/16 that standing order for to Resident #9's star On 10/17/18 at 3:17 (DM) provided a list oprogram, and Reside On 10/17/18 at 3:36	d gravy, carrots, a roll, and a documented Standing andwich with two ounces of of whole wheat bread, bag of ne of the standing order sident's meal tray. B PM Resident #9 was eating e received chicken, mixed hed potatoes and gravy. Inted Standing Orders: deligible two ounces of meat and two to bread, bag of chips, and standing order foods were on tray. PM Resident #9 stated what there to eat was fine, and she wanted and leave the rest on mented her appetite was not be was never hungry in the expectation. The was soup. She reported toods were foods added daily	F	692	work until in-service has been complete All newly hired nurses will be in-service by the Staff Facilitator during orientation regards to RD Recommendations to include: 1. Notification of MD of all RD recommendations 2. Documentation that MD has review RD recommendation with approval/new orders received or reason recommendation was not initiated. This documentation will be linked to the RD Progress note. 3. Implementing new orders 4. Notification of RR of all new orders/interventions 5. MD must initial RD recommendation and return to DON. 100% in-service was initiated on 11/2/1 by the Staff Development Coordinator was in regards to Significant Weig Loss/Gain to include: 1. Nursing staff will obtain weights on admission and re-admission to the facilithen weekly until weight stable x 4 wee 2. All residents will be weighed month by the 10th of each month 3. Any resident who triggers for +/- 50 or +/- 10% weight change will be immediately re-weighed to verify weigh change. If significant weight change is noted then resident will be weighed weekly until weight is stable x 4 weeks. 4. MD must be notified of all significa	ed n in ved v s on 8 with ght lity ks nly %	
	favorite foods at lunc salads. However, th family into adding the	h, deli sandwiches and chef e DM reported she talked the			weight loss/gain with documentation in electronic medical record 5. RD referrals should be submitted f all admissions, re-admissions and	the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
			7 56.25				С	
		345119	B. WING _				/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				30	15 ENTERPRISE DRIVE			
NORTHCH	IASE NURSING AND	REHABILITATION CENTER		W	ILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	3E	(X5) COMPLETION DATE	
					DEFICIENCY)			
F 692	Continued From p	page 19	F 6	592				
	-	ek and adding the deli			residents with significant weight loss/g	ain		
		ther five days at lunch. In			6. Nursing staff should submit thera			
		commented she and the family			referral as appropriate with weight los			
		#9 to get soup with each lunch			concerns related to resident ability to f			
	meal.				self or swallow.			
					7. Weight loss interventions should	эе		
	On 10/17/18 at 4:			initiated with any significant weight los				
	interview, the faci			Nursing staff should notify Reside				
	building weekly, and provided copies of her				Representative of any significant weig	ht		
	nutrition recommendations to the Director of				change to include any new orders or			
		ho was responsible for obtaining			interventions with documentation in th	Э		
	' '	to put them in place. According			electronic medical record.			
		ility's NP was very receptive to			In conting will be completed by 11/14/	10		
		tions and expertise as a RD, orders quickly to support her			In-service will be completed by 11/14/ After 11/14/18 no nurse will be allowed			
	_	s. The RD commented that it			work until in-service has been comple			
		discontinue ineffective nutrition			work until in-service has been comple	,cu.		
		put new ones in place for			All newly hired nurses will be in-service	ed		
		ntinued to experience weight			by the Staff Facilitator during orientation			
	loss.	, ,			regards to Significant Weight Loss/Ga			
					include:			
	On 10/17/18 at 5:	24 PM the DON stated the RD			1. Nursing staff will obtain weights o	n		
	was supposed to	make copies of her progress			admission and re-admission to the fac			
		visit and provide them to herself			then weekly until weight stable x 4 we			
		vever, the DON commented she			All residents will be weighed mon	thly		
		y copies of progress notes from			by the 10th of each month			
		3 visit until 10/02/18, and then			3. Any resident who triggers for +/- §	j%		
		ommendations for Resident #9			or +/- 10% weight change will be			
	included in her co	pies.			immediately re-weighed to verify weig			
	On 10/19/19 at 11	:02 AM the Kitchen Manager			change. If significant weight change is			
		1:03 AM the Kitchen Manager Resident #9 did not eat a lot of			noted then resident will be weighed weekly until weight is stable x 4 weeks	•		
		d deli sandwiches in the past,			4. MD must be notified of all significations.			
		Il appeared on the resident's			weight loss/gain with documentation in			
		en the resident should continue			electronic medical record			
		t her lunch meals. The Kitchen			5. RD referrals should be submitted	for		
		d a list of resident's receiving			all admissions, re-admissions and			
		ia physician order, and Resident			residents with significant weight loss/g	ain		
	#9 did not appear				6. Nursing staff should submit thera			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345119	B. WING _			C 10/1	8/2018	
NAME OF PI	ROVIDER OR SUPPLIER	-	<u> </u>	STREET ADDRESS, CITY, STATE, Z	IP CODE	1 10/11	0,2010	
NODTUCE	IASE NUIDSING AND DE	ELIADII ITATION CENTED		3015 ENTERPRISE DRIVE				
NORTHER	IASE NURSING AND RE	EHABILITATION CENTER		WILMINGTON, NC 28405				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE	
F 692	facility relied on the erecommendations of from losing weight, at to supply all the food tray slips at meals. On 10/18/18 at 11:18 conversation with the was not aware of any recommendations for when she was made recommendations, so to write orders to imprecommendations. So sure how effective Revening medication pure the wast supplement prostated the EMP programment pro	D AM the DON stated the expertise and if the RD to keep residents and she expected the kitchen as that were listed on resident. B AM, during a telephone of facility's NP, she stated she are recent nutrition of the resident #9. She reported the aware of new RD the immediately took the time oblement the she commented she was not resource supplement with the pass would be for Resident that a history of refusing coducts. However, the NP aram and a bed time snack according to the NP, Resident slikes, but the resident's or resort to a feeding tube to urished. The resident #9 in	F6		with weight loss dent ability to fe ntions should be cant weight loss do notify Resider ignificant weigh new orders or mentation in the rd. tiated on 11/2/1 with all Dietary shout added to tray card durary manger will added to tray of about added to tray of a tray card durary references on aps the meal tray of meal tray to are correct. The upgraded per eted by 11/8/18 and staff will be service has been	ed ee s. nt nt e 18 staff cool li card ring n		
				include resident #9 will the ADON and Clinical (be completed b			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		;TION	(X3) DATE SURVEY COMPLETED				
		345119	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343113	B: 111110	STDEET ADDE	RESS, CITY, STATE, ZIP CODE	10/	18/2018
NAME OF T	NOVIDER OR 3011 LIER				PRISE DRIVE		
NORTHC	HASE NURSING AND R	EHABILITATION CENTER			ON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	ge 21	F	weekly utilizing Tool to o have be any rec impleme concerr the ADO include recomm as indic orders/i residen The DO Recom weeks t all area address 10% Au residen Dietary Manger 3 times times a times a all resid preferer request immedia Manage food ite meal tra staff. Th initial th weeks t 25% Au residen Supervi	x 8 weeks then monthly x 1 mon	it it is at peen of been of d by ors RD 8 are ery ool (s, 3) are d ate at a t x 8 are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345119	B. WING			C 10/18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u> E	10/10/2010
NODTHOL	ASE NUIDSING AND D	EHABILITATION CENTER		3015 ENTERPRISE DRIVE		
NORTHOL	IASE NUKSING AND K	ENABILITATION CENTER		WILMINGTON, NC 28405		
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F 692	Continued From page	ge 22	F6	Data Set Nurse, utilizing the V Tool 3 times a week x 4 week weekly x 4 weeks then month to ensure all residents with sig weight loss/gain was assesse of weight change, referrals to completed for significant weig therapy referral completed as RR notified of significant weig appropriate interventions were and care plan/ care guide was All areas of concern will be im addressed by the ADON, Qua Assurance nurse (QA) and cli staff to include assessment of MD/RD/therapy referrals as in notification of RR of weight los initiation of appropriate weigh interventions. The DON will re Weight Audit Tool weekly x 8 v ensure all areas of concern ha addressed. The Quality Assurance Nurse forward all RD Recommendat Tools, Meal Card Audit Tool at Weight Audit Tool to Executive committee monthly x 3 month determine trends and / or issu need further interventions put and to determine the need for / or frequency of monitoring.	s, then ly x 1 mon gnificant d for cause MD/RD th change indicated, th change e initiated supdated mediately ality nical nursi f resident, adicated, ss and t loss eview the weeks to ave been (QA) will tion Audit nd the e QA s to ues that ma into place	ath e