	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
JAME OF PROVIDER OR SUPPLIER		345119	B. WING			C 05/17/2024	
	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	5/11/2024	
				5 ENTERPRISE DRIVE			
NORTHC	ASE NURSING AND R	EHABILITATION CENTER		MINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
	complaint investigat 05/13/24 through 05 found in compliance	ecertification survey and ion was conducted onsite 5/17/24. The facility was with the requirement CFR Preparedness. Event ID #					
F 000	INITIAL COMMENT	S	F 000				
	through 05/17/24. E	onducted onsite from 05/13/24 Event ID# R0B411. The re investigated: NC00215575,					
F 580	deficiency.	nt allegations resulted in njury/Decline/Room, etc.)	F 580			6/24/24	
SS=D	CFR(s): 483.10(g)(1 §483.10(g)(14) Noti (i) A facility must im consult with the resi consistent with his of representative(s) wh (A) An accident invo results in injury and physician interventio (B) A significant cha mental, or psychoso deterioration in heal status in either life-t clinical complication (C) A need to alter t a need to discontinu treatment due to ad commence a new for	4)(i)-(iv)(15) fication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident hen there is- olving the resident which has the potential for requiring on; nge in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or					

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.

06/18/2024

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/25 FORM APPR OMB NO. 0938	ROVE
TATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345119	B. WING		C 05/17/2024	
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		15 ENTERPRISE DRIVE		
			w	ILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPL	(5) LETION ATE
F 580	Continued From page	e 1	F 580			
	resident from the faci					
	§483.15(c)(1)(ii).	<i>,</i> ,				
		ification under paragraph (g)				
		the facility must ensure that				
		on specified in §483.15(c)(2) ded upon request to the				
	physician.	ded upon request to the				
		also promptly notify the				
		dent representative, if any,				
	when there is-					
	(A) A change in room	or roommate assignment				
	as specified in §483.					
		ent rights under Federal or				
		ns as specified in paragraph				
	(e)(10) of this section	record and periodically				
		mailing and email) and				
	phone number of the	c ,				
	representative(s).					
	§483.10(g)(15)					
		osite distinct part. A facility				
		istinct part (as defined in				
		e in its admission agreement				
		tion, including the various				
		se the composite distinct				
		y the policies that apply to en its different locations				
	under §483.15(c)(9).					
		is not met as evidenced				
	by:					
		iew, staff interviews, and		F 580 Notify of Changes		
		P) interview the facility failed				
		of significant weight gain		On 6/13/2024, the Director of Nursir	•	
	-	s (lbs.) in 24-hours (hrs.), or		(DON) reviewed Resident #20 weigh		
		a resident that required		from 5/1/24-6/7/24 with the physicia	in and	
		ng for possible cardiac fluid ent's history of Congestive		a new order was received for daily weights for 2 weeks then weekly, no	otify	
		This deficient practice		the provider of 3-pound weight gain	•	

Facility ID: 923038

	5 FUR MEDICARE &	MEDICAID SERVICES			OMB NO. 0	938-038
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		345119	B. WING		C 05/17/2	2024
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIF		
				3015 ENTERPRISE DRIVE		
NORTHC	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, 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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE CA	(X5) OMPLETIO DATE
F 580	Continued From page	e 2	F 58	80		
		ampled residents reviewed		hours or 5 pounds in 1 w	eek.	
	Findings included:	nge. (Resident #20)		On 6/12/24, the Director (DON), Assistant Director		
		mitted on 4/28/24. His cluded Congestive Heart		(ADON), and unit manag audit of all residents with weights to include reside	orders for daily	
	Failure (CHF).			the provider was notified weight gain greater than	of significant 3-pounds (Ibs.) in	
	revealed daily weight	tten to start on 05/01/24 is times 2-weeks and notify ht gain in 24-hours or 5-lbs.		24-hours (hrs.), or 5-lbs. resident that required we monitoring for possible ca	ight gain	
	-	ly during day shift for CHF		overload due to resident's Congestive Heart Failure documentation in the electron	s history of (CHF) with	
		20's Medical Administration 05/01/24 through 05/14/24		The DON and/or the ADC all concerns identified du	ON will address	
	gain greater than 3-lb	ily weights and report weight os. in 24-hours or 5-lbs. in a		include but not limited to when indicated, notification	on of the	
	Resident #20's MAR	24). Recorded weights in were recorded daily and		physician of significant w further recommendations		
		ted as evidenced by nursing nark daily up to 05/14/24.		documentation in the electronic and education of staff. The completed by 6/24/24.		
	05/06/24 was 182.5 l	20's daily weight: On bs. and his daily weight on s. a weight gain of 7.5-lbs. in		On 6/10/24, the Staff Fac an in-service with all nurs		
	weight on 05/10/24 w	was 189-lbs. and his daily vas 191-lbs. a weight gain of 5/11/24 was 184-lbs. and his		Daily Weight Monitoring v notification of the provide weight gain greater than	er of significant	
	-	/24 was 189.3-lbs. a weight		24-hours (hrs.), or 5-lbs. resident that required we monitoring for possible ca	in a week, for a ight gain	
	#20 revealed there w			overload due to resident's Congestive Heart Failure documentation in the electronic	s history of (CHF) with	
	ordered.	d of weight changes as		The in-service will be cor 6/24/24. After 6/24/24, ar	npleted by	
	An interview was con	ducted on 05/16/24 3:20 PM		not completed the in-serv		

Facility ID: 923038

If continuation sheet Page 3 of 84

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	OMB NO. 0938-03	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345119	B. WING		C 05/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO	
F 580	Continued From page	e 3 tioner (NP). The NP stated	F 580) it upon the next scheduled work shif	τAll	
	this was the first time Resident #20's one d from 05/06/24 throug three-day weight gair	she or MD had heard of ay weight gain of 7.5-pound h 05/07/24, and the n of 5.3-lbs. from 05/11/24		newly hired nurses will be in-service during orientation by the Staff Facilit regarding Daily Weight Monitoring.		
	weight gain 05/09/24 stated no staff had re concerns. The NP ex	the other 3 lb. one day through 05/10/24. She ported to her any weight pected the MD to be notified y weights were greater than		The Assistant Director of Nursing (ADON), Staff Facilitator (SF), and/c Quality Assurance (QA) nurse will re 10% of residents with orders for wei monitoring for possible cardiac fluid	eview	
	resident having a dia was not made aware resident's weight gair	-lbs. in a week related to gnosis of CHF. NP said she or notified by nursing staff of and should have. NP said at gains had no health		overload due to resident's history of Congestive Heart Failure (CHF) to in Resident #20, 3 times a week x 4 we then monthly x 1 month utilizing the Weight Audit Tool. This audit is to er	nclude eeks	
	outcome, but could h MD to have been not weight gain to determ	ave, and she expected the ified, per order, to treat the nine if related to CHF, and if needed to be ordered or		weights were obtained per the physic order and the provider was notified of significant weight gain greater than 3-pounds (lbs.) in 24-hours (hrs.), or in a week, for a resident that require	r 5-lbs.	
	Director of Nursing (I expectation that Resi been notified of resid weight gain in a day of week, per physician's	6/24 at 4:30 PM with the DON) revealed it was her dent #20's MD should have ent's greater than 3-lb. or 5-lb. weight gain in a s order. She said she did not		weight gain monitoring for possible cardiac fluid overload due to resider history of Congestive Heart Failure (with documentation in the electronic record. The Assistant Director of Nu (ADON), Staff Facilitator and/or Qua Assurance (QA) nurse will address a	(CHF) rsing ality all	
	know why the MD wa have per MD order.	as not notified and should		areas of concern identified during th audit, including assessment of the resident, notification of the physiciar		

Facility ID: 923038

If continuation sheet Page 4 of 84

NAME OF P NORTHCI (X4) ID PREFIX TAG	OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER HASE NURSING AND RE SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDING		CTION OULD BE	O. 0938-039 E SURVEY IPLETED C 5/17/2024
r 582	HASE NURSING AND RE SUMMARY ST (EACH DEFICIENC REGULATORY OR I	HABILITATION CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION OULD BE	(X5) COMPLETION
r 582	HASE NURSING AND RE SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION OULD BE	(X5) COMPLETION
(X4) ID PREFIX TAG F 580	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
(X4) ID PREFIX TAG F 580	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
F 582	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
F 582	Continued From page	÷ 4	F 580			
				Weight Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee for 2 months for review to determ trends and/or issues that may new further interventions put into place determine the need for further free of monitoring.	nine ed ee and to	
00 D	CFR(s): 483.10(g)(17		F 582			6/24/24
	 §483.10(g)(17) The facility must (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. 					
	resident before, or at periodically during the available in the facility services, including an covered under Medic	acility must inform each the time of admission, and e resident's stay, of services / and of charges for those y charges for services not are/ Medicaid or by the e. coverage are made to items				

Facility ID: 923038

If continuation sheet Page 5 of 84

		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03	
TATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345119	B. WING		C 05/17/2024	
NAME OF PF	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NORTHON				3015 ENTERPRISE DRIVE		
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE A		D BE COMPLÉTIO	
F 582	Continued From page 5		F 582			
1 002			F 30/	<u>-</u>		
	reasonably possible.	the change as soon as is				
		re made to charges for other				
		at the facility offers, the				
		e resident in writing at least				
		ementation of the change.				
		or is hospitalized or is				
		not return to the facility, the				
		the resident, resident				
	-	tate, as applicable, any				
		ready paid, less the facility's				
		days the resident actually or retained a bed in the				
		any minimum stay or				
	discharge notice requ					
		refund to the resident or				
		ve any and all refunds due				
) days from the resident's				
	date of discharge from	m the facility.				
	(v) The terms of an a	dmission contract by or on				
		al seeking admission to the				
	-	ict with the requirements of				
	these regulations.					
		Γ is not met as evidenced				
	by: Based on record rev	iew and staff interviews the		F 582 Liability Notice		
		te a Centers for Medicare				
		es (CMS) Skilled Nursing		On 6/11/24, the administrator compl	leted	
		neficiary Notice (SNF-ABN)		Skilled Nursing Facility Advanced		
		m Medicare Part A skilled		Beneficiary Notice (SNF-ABN) for		
	services for 2 of 3 res			Resident #126 and provided the wri	tten	
		n notification who required		copy to the resident representative.		
	•	NF-ABN form (Resident				
	#126 and #129).			On 6/11/24, the administrator compl Skilled Nursing Facility Advanced	leted	
	Findings included:			Beneficiary Notice (SNF-ABN) for		
	5			Resident #129 and provided the wri	tten	
	a. Resident #126 was 11/14/23.	s admitted to the facility on		copy to the resident representative.		

Event ID: R0B411

Facility ID: 923038

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			E SURVET
			A. BOILDING			С
		345119	B. WING		0	5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				3015 ENTERPRISE DRIVE		
NORTHCH	HASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 582	Continued From page	e 6	F 58	32		
			1.00	On 6/11/24, the adminis	strator completed	
	Review of Beneficiary	/ Notices - "Residents		an audit of all Medicare	•	
	-	, e Last Six Months" form		the past 30 days. This a	•	
		26 Medicare Part A skilled		a Skilled Nursing Facili	ty Advanced	
		/29/24. She remained in the		Beneficiary Notice (SNI		
		ays remaining, per Notice of		completed accurately, r		
	Medicare Non-Covera	age (NOMNC, Form		a written copy provided		
	CMS-10123).			resident/resident repres discharge. No addition	•	
	Record review reveal	ed that Resident #126 was		identified.	al concerns were	
		0555 Skilled Nursing Facility				
	Advanced Beneficiary			On 6/12/24, the clinical	consultant	
				completed an in-service	e with the	
		s admitted to the facility on		Administrator, Business		
	01/04/24.			and/or Social Workers		
		National "Decidents		Beneficiary Notice of N		
		/ Notices - "Residents e Last Six Months" form		with emphasis on provi notification related to no		
		29 Medicare Part A skilled		Medicare "A" and review		
		2/12/24. She remained in the		resident/resident repres		
		ays remaining, per Notice of		discharge. In-service w	-	
	Medicare Non-Covera	age (NOMNC, Form		6/24/14. After 6/24/14 a	any Administrator,	
	CMS-10123).			Accounts Receivable a		
				Workers who have not		
		ed that Resident #129 was		in-service will complete		
	Advanced Beneficiary	0555 Skilled Nursing Facility		scheduled work shift. A Administrator, Accounts		
				and/or Social Workers		
	An interview was con	ducted on 05/15/24 at 11:50		during orientation regar		
		ervices Director (SW#1).		Beneficiary Notice of N		
	The SW #1 indicated	she or SW #2, who was		(ABN).	-	
		ovided Residents #126 and				
		0555 Skilled Nursing Facility		10% audit of all Medica	-	
		y Notice (SNF-ABN) form,		will be reviewed by the		
		ovide documentation that		Administrator and/or ad x 4 weeks then monthly	-	
	they were provided.			the NOMNC-ABN Audit	÷	
	An interview was con	ducted on 05/16/2024 at		appropriate notification		
		ninistrator and she revealed		non-coverage was revie		

Facility ID: 923038

		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0
ATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345119	B. WING	B. WING	
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/17/2024
				3015 ENTERPRISE DRIVE	
	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
F 582	Continued From page	o 7			
F 382	facility or Responsibl	n that the residents at the e Party (RP) should be notices prior to being	F 58	 copy provided to the resident/resider representative prior to discharge. The Assistant Administrator and/or administrator will address all areas concern identified during the audit to include completion, review and proarewritten copy of the SNF-ABN to the resident/resident representative and re-training of staff. The Administration review the NOMNC-ABN Audit Too weekly x 4 weeks then monthly x 1 to ensure all areas of concern were addressed. The Administrator will forward the NOMNC-ABN Audit Tool to the Quate Assurance and Performance Improvement (QAPI) Committee m for 2 months for review to determine the need for further frequencies. 	The of to viding he d tor will I month e ality onthly e f and to
F 641 SS=E	,	nents	F 64	of monitoring.	6/24/24
	resident's status.	of Assessments. st accurately reflect the Γ is not met as evidenced			
	Based on record rev facility failed to code	iew and staff interviews, the the Minimum Data Set		F 641 Accuracy of Assessments	
	(MDS) assessments nutrition for 4 of 11 re	accurately in the area of		On 5/16/24, the Minimum Data Set Coordinator completed a modificati	
	assessments were re			assessment dated 4/12/24	
	(Residents #107, #12			comprehensive assessment for Re #107 to reflect accurate coding for	

Event ID: R0B411

Facility ID: 923038

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	D: 06/25/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345119	B. WING				C 17/2024
NAME OF P	ROVIDER OR SUPPLIER	I		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		-
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	28	F 64	41			
	Findings included:				significant weight loss.		
	diagnosis which inclu and diabetes. Review of Resident # record revealed the for recorded: 10/2/2023- 207.3 pout 11/10/2023- 205.1 Lb 12/5/2023- 194.2 Lbs 1/19/2024- 181.8 Lbs 1/30/2024- 177.1 Lbs 2/9/2024- 177.5 Lbs. 3/26/2024- 177.5 Lbs. 3/26/2024- 147.6 Lbs 4/2/2024 1:14 PM- 15 4/10/2024 2:35 PM- 1 Review of Resident # revealed resident had in180 days (22.92 pe Review of Resident # Minimum Data Set (M a mild cognitive impa weight was 158 poun as had no weight loss in the past 30 days of days. An interview was con PM with MDS Coordii #1 stated the MDS C for the completion of	s. 5. 52.3 Lbs. 52.3 Lbs. 53.1 Lbs. 107's weights recorded 1 a 47.1-pound weight loss rcent). 107's 4/12/24 quarterly 1DS) indicated resident had irment. Resident #107's ds and resident was coded s or weight gain of 5 percent r 10 percent in the past 180 ducted on 5/16/24 at 3:15 nator #1. MDS Coordinator oordinator was responsible the nutrition section of the			On 5/16/24, the Minimum Data Set (M Coordinator completed a modification assessment dated 3/26/24 comprehensive assessment for Resid #12 to reflect accurate coding for a significant weight loss. On 5/16/24, the Minimum Data Set (M Coordinator completed a modification assessment dated 4/11/24 comprehe assessment for Resident #19 to reflect accurate weight of resident with no significant weight change. On 5/16/24, the Minimum Data Set (M Coordinator completed a modification assessment dated 3/29/24 comprehensive assessment for Resid #69 to reflect accurate coding for a significant weight gain. On 6/11/24, the MDS Coordinator und the oversight of the MDS Consultant initiated an audit of the most recent comprehensive, significant change assessment section "K" for all resident include Resident #107, Resident #12, Resident #19 and Resident #69 to en all MDS's assessments completed and coded accurately for significant weight changes. The DON will address all concerns identified during the audit to include updating assessment when include updating assessment when	of lent IDS) of nsive ct IDS) of lent der der ts to sure e t	
	MDS assessments. I Resident #107's 4/12	MDS Coordinator #1 stated /24 quarterly MDS should a significant weight change.			indicated and education of the MDS nurse. The audit will be completed by 6/24/14.		

Facility ID: 923038

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	DF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		IO. 0938-03 TE SURVEY MPLETED	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	i			
		345119	B. WING			C 05/17/2024	
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/11/2024	
				3015 ENTERPRISE DRIVE			
NORTHCH	ASE NURSING AND F	REHABILITATION CENTER		WILMINGTON, NC 28405			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF		COMPLETIO DATE	
IAG	REGULATORT		IAG	DEFICIENCY)	TROFINATE		
F 641	Continued From pa	•	F 64	1			
		1 further revealed the					
		ave a warning when a resident		On 6/11/24, the MDS Consultar			
		eight change but it had not		completed an in-service on MD			
		rnings so that may have error. MDS Coordinator #1		Assessments and Coding with a nurses and MDS Coordinator re			
		aware of how to calculate a		proper coding of MDS assessm			
		the Resident Assessment		the Resident Assessment Instru			
		anual, but she had not done it.		(RAI) Manual with emphasis that			
				assessments are completed ac			
	An interview was co	onducted on 5/16/24 at 4:35		for significant weight changes.	All newly		
		or of Nursing (DON). The		hired MDS Coordinator or MDS			
		pected that the MDS		will be in-service regarding MDS			
		d be coded accurately, that the		Assessments and Coding durin	g		
		uld be calculated, and she did esident had lost weight.		orientation.			
		esident had lost weight.		10% audit of newly completed M	MDS		
	An interview was co	onducted on 5/17/24 at 1:50		assessments- section "K", to inc			
		strator. The Administrator		assessments for Resident #107			
		d the MDS assessments to be		#12, Resident #19 and Residen			
	completed accurate	ely. The Administrator further		utilizing the MDS Accuracy Aud	it Tool will		
	stated it was impor	tant for the MDS assessments		be reviewed by the MDS consu			
		he resident care plans to be		and/or Director of Nursing week	-		
		t the resident's current		weeks then monthly x 1 month			
	condition.			accurate coding of the MDS ass			
	2 Decident #12 we	a admitted on 12/20/21 with		for significant weight changes. / identified areas of concern will b			
		is admitted on 12/20/21 with cluded in part end stage renal		addressed immediately by the N			
	disease.	sidded in part end stage renai		consultant and/or DON to include			
				retraining of the MDS nurse and			
	Review of Resident	t #12's electronic health record		completing necessary modificat			
		ing weights were recorded:		MDS assessment.			
	9/28/23- 224 pound	ds (Lbs.)		The DON will review the MDS A	Accuracy		
	2/27/24- 222.2 Lbs			Audit Tool weekly x 4 weeks an			
	3/26/24- 199.1 Lbs			monthly x 1 month to ensure an	y areas of		
	Review of Resident	t #12's weights recorded		concerns have been addressed			
		ad a 23-pound weight loss in		The DON will forward the result	s of MDS		
		nd 25-pound weight loss in 180		Accuracy Audit Tool to the Qual	ity		

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PRINTED: 06/25/2024 FORM APPROVED

	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	דאת (צצ)	E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>			IPLETED	
						С	
		345119	B. WING		0	5/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD	Ε		
		HABILITATION CENTER		3015 ENTERPRISE DRIVE			
NORTHO				WILMINGTON, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 641	Continued From page	e 10	F 64	1			
	days (greater than 10			Assurance and Performance			
	, (3	,		Improvement (QAPI) Commit	tee monthly		
		12's 3/26/24 quarterly		for 2 months for review to det			
		IDS) assessment revealed ere cognitive impairment.		trends and/or issues that may further interventions put into			
		ded as having a weight of		determine the need for furthe			
		weight loss or weight gain of		of monitoring.	rinequency		
		30 days or 10 percent in the		, , , , , , , , , , , , , , , , , , ,			
	An interview was cor	nducted on 5/16/24 at 3:15					
		nator #1. MDS Coordinator					
		oordinator was responsible					
	•	the nutrition section of the nd Resident #12's MDS					
		ded for a significant weight					
		linator #1 revealed the					
		e a warning when a resident					
		ght change but it had not					
	0 0	ings so that may have or. MDS Coordinator #1					
		vare of how to calculate a					
		e Resident Assessment					
	Instrument (RAI) mar	nual but she had not done it.					
	An intonvious was	nducted on 5/16/24 at 4:35					
		of Nursing (DON). The					
	DON stated she expe						
	assessments would b						
	An interview was cor	nducted on 5/17/24 at 1:50					
	PM with the Administ	rator. The Administrator					
	-	the MDS assessments to be					
		/. The Administrator further					
	-	nt for the MDS assessments resident care plans to be					
	accurate and reflect t	-					
	condition.						

Facility ID: 923038

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/25/2024 M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345119	B. WING			C 05/17/2024		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHC	ASE 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 LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 641	11/29/23 with diagnost and hypertension. Review of Resident # revealed the following 11/29/2023- 156.5 pot 12/1/2023- 156.5 Lbs 12/5/2023- 150.7 Lbs 12/12/2023- 148.4 Lb 12/21/2023- 143.7 Lb 12/29/2023- 143.0 Lb 1/11/2024- 147.3 Lbs 1/30/2024- 142.2 Lbs 2/9/2024- 140.0 Lbs. 3/7/2024- 141.6 Lbs. 3/12/2024- 135.0 Lbs 4/9/2024- 178.0 Lbs. 4/9/2024- 178.0 Lbs. 4/9/2024- 178.0 Lbs. Review of Resident # resident had a 43-pot (24.16 percent) and a 180 days (13.74 perc Review of Resident # Data Set (MDS) asse indicated resident wa 178 pounds. The ME Resident #19 had no 5 percent in 30 days An interview was con PM with MDS Coordii #1 stated the MDS C for the completion of	admitted to the facility on sis which included diabetes (19's electronic health record g weights were recorded: unds (Lbs.) (19's weight record revealed und weight gain in 30 days a 21.5-pound weight gain in	F	641				

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If continuation sheet Page 12 of 84

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/25/2024 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345119	B. WING			_		17/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
NORTHCI	HASE NURSING AND RE	HABILITATION CENTER			8015 ENTERPRISE DRIVE WILMINGTON, NC 2840)5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Resident #19's 4/11/2 have been coded for a MDS Coordinator #11 computer usually gav had a significant weig been giving the warni contributed to the error indicated she was aw weight change per the Instrument (RAI) man stated she had not ca and the computer pop the weight, so she ha stated maybe she sho weight that entered of assessment and revise carefully. An interview was com PM with the Director of DON stated she expe assessments would b weight change would An interview was com PM with the Administri stated she expected t completed accurately stated it was important	24 quarterly MDS should a significant weight change. further revealed the re a warning when a resident ght change but it had not ings so that may have or. MDS Coordinator #1 vare of how to calculate a e Resident Assessment nual. MDS Coordinator #1 alculated the weight change builted the assessment with id not checked it. MDS #1 build have questioned the in Resident #19's ewed the weights more ducted on 5/16/24 at 4:35 of Nursing (DON). The ected that the MDS be coded accurately, and the be calculated. ducted on 5/17/24 at 1:50 rator. The Administrator the MDS assessments to be the MDS assessments to be the to the MDS assessments a resident care plans to be	F	641				

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345119	B. WING			, 7/2024
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	9 13	F 64	1		
	09/10/23 with diagnos renal disease, mild pr dependence on renal Diabetes Mellitus.					
	dated 03/29/24 docur	d 169 pounds. He had no				
	revealed he weighed	ed weights for Resident #69 135.3 pounds on 09/29/23 3/29/24 showing a weight				
	stated they expected coded correctly to ref	e DON and the 6/24 at 8:45 AM they both the MDS assessment to be lect that Resident #69 had a e six month assessment				
F 657	13:51 PM she stated 03/29/24 was coded i resident did not have in the previous six mo weight gain of 24.91 p She did not know why coded incorrectly.	IDS Nurse #1 on 05/16/24 at the MDS assessment dated ncorrectly documenting the a 10% or more weight gain onths because he did have a percent during this period. y the assessment had been	F 65	7		6/24/24
SS=E	§483.21(b) Comprehe					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/25/20 FORM APPROVE <u>OMB NO. 0938-03</u> 9
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345119	B. WING _		C 05/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		3015 ENTERPRISE DRIVE	
Northon				WILMINGTON, NC 28405	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE CIENCY)
F 657	Continued From page	⊃ 1 4	F6	57	
1 001		7 days after completion of			
	the comprehensive a				
		terdisciplinary team, that			
	includes but is not lim				
	(A) The attending phy				
		e with responsibility for the			
	resident.				
	(C) A nurse aide with resident.	responsibility for the			
		and nutrition services staff.			
	· · ·	cticable, the participation of			
		resident's representative(s).			
	An explanation must	be included in a resident's			
		participation of the resident			
		presentative is determined			
	not practicable for the	e development of the			
	resident's care plan.	staff or professionals in			
		ined by the resident's needs			
	or as requested by th	-			
		ised by the interdisciplinary			
	team after each asse	ssment, including both the			
	comprehensive and c	quarterly review			
	assessments.				
		is not met as evidenced			
	by: Based on record rev	iew, and staff and resident		F 657 Care Plan Timin	and Revision
	interviews, the facility			On 5/15/24, the Minimu	-
		plan to reflect changes in		Nurse updated the care	. ,
	•	the areas of mobility and		#107 to accurately refle	
		r 3 of 11 residents whose		current state of nourish	
		ewed (Resident #107,		body requirement to inc	
	Resident #12, and Re	esident #19).		goals and interventions	
	Findings included:			On 5/17/24, the MDS N care plan for Resident a reflect the resident's m	#107 to accurately
	1.Resident #107 was	admitted on 10/5/22 with		non-compliance with sp	
	diagnosis which inclu			On 5/16/24, the MDS C	
		ilure to thrive and diabetes.		the care plan for Resid	

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BOILDING	3	с
		345119	B. WING		05/17/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				3015 ENTERPRISE DRIVE	
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE
F 657	Continued From page	e 15	F 65	57	
	1.0			accurately reflect the resident's cu	rrent
	a. Review of Resider	nt #107's nutrition care plan		state of nourishment and potential	
		2024 revealed a problem of		weight fluctuations related to heme	odialysis
		more than body requirement		to include measurable goals and	
		ght gain, obesity, excessive		interventions.	
		creased caloric and fat		On 5/15/24, the MDS Nurse updat	
	intake, and sedentary indicated the residen			care plan for Resident #19 to accure reflect the resident's current state	•
		d eat food only from their		nourishment; less than body requi	
	-	l eliminate snacking between		to include measurable goals and	rement
	-	n did not include a goal of a		interventions.	
		achieved. Interventions		On 6/11/24, the Director of Nursing	g (DON)
	-	ng food as a reward, using		the initiated an audit of care plans	
		ve encouragement, and		residents to include Resident #107	
	referring to the dietitia			Resident #12, and Resident #19 to	
	evaluation/recommer	ndations.		the care plan accurately reflects th	
	- · · · · · · · ·	//		resident's current state of nourishr	
		107's record revealed the		with measurable goals and interve	
	recorded:	d physician orders were		residents' mobility status, and use splints/braces. The DON will addre	
				concerns identified during the aud	
	10/2/23- 207.3 pound	ds (lb.)		include updating the care plan who	
	11/10/23-205.1 lb.			indicated and education of staff. T	
	12/5/23- 194.2 lb.			will be completed by 6/24/24.	
	1/19/24- 181.8 lb.			On 6/11/24, Staff Development	
				Coordinator (SDC) initiated an in-s	
		n order was written for		with all nurses regarding Care Pla	
		nal supplement three times		emphasis is on ensuring the care	
		nd regular diet with enriched		updated timely and accurately with	
		107 due to weight loss.		aspects of resident care to include limited to nutritional and mobility s	
	1/30/24- 177.1 lb.			and use of splints/braces. In-service	
	2/9/24- 172.5 lb.			be completed by 6/24/14. After 6/2	
	3/26/24- 147.6 lb.			any nurse who has not completed	the
				in-service will complete in-service	
		order for Resident #107 to		the next scheduled work shift. All r	-
	have weekly weights	measured.		hired nurses will be in-service duri	ng
	4/0/04 450 0 "				01-#
					ng

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	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345119	B. WING		05/17/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHC	ASE NURSING AND RE	HABILITATION CENTER		8015 ENTERPRISE DRIVE WILMINGTON, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC	
F 657	 4/10/24- 158.1 lb. Review of Resident # Data Set (MDS) date was 158 pounds and gain. An interview was con AM with the Register revealed she was in t 2024, her role was to the nutritional status of was not involved in th The RD stated she w was not eating well a amount of weight. An interview was con PM with MDS Coordi #1 stated she was re- resident care plans a Resident #107's care reflect the weight loss She explained this has An interview was con PM with the Administ stated she expected accurate and up to da information and interview b. Review of Resider Data Set (MDS) asse- indicated she had imp 	4107's quarterly Minimum d 4/12/24 noted her weight had no weight loss or weight ducted on 5/15/24 at 11:30 ed Dietitian (RD). The RD the position since January complete a clinical review of of the residents, and she he care planning process. ras aware Resident #107 nd had lost a significant ducted on 5/16/24 at 3:10 nator #1. MDS Coordinator sponsible for updating nd it was an error that plan was not revised to s and current interventions. ad been an oversight.	F 657		% of % of kly x 4 izing the to lely and and oraces. Quality s all it to r Nursing ol 1 month d the to the ce nonthly ne d and to	

If continuation sheet Page 17 of 84

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FOR	D: 06/25/2024 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		345119	B. WING _				C 5/17/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
NORTHCH	ASE NURSING AND REI	HABILITATION CENTER			015 ENTERPRISE DRIVE /ILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 657	A review of Resident i last reviewed on 4/26, requires assistance for maintain maximum ful mobility characterized positioning, locomotio at risk for limitation of and lower extremities resident will walk 50 fit walker for a resident w or arm) and left ankle Interventions included minimal assist of 1 pe feet with hemi walker An interview on 5/16/2 Rehabilitation Directo last received therapy April 2024 to address transfers. The Rehab Resident #107 was no was non-ambulatory, with therapy. An interview was cond PM with MDS Coordin #1 stated she was res resident care plans an Resident #107's care reflect her current nor explained this had be An interview was cond AM with Nurse #1. N assigned to Resident familiar with her care.	 #107's mobility care plan /24, included a focus of or potential to restore or nction of self-sufficiency for I by the following functions: on and ambulation related to range of motion in upper The goal indicated eet with a hemi walker (a with the use of only 1 hand brace through next review. I providing verbal cues and orson for ambulation of 50 and left ankle brace. 24 at 10:15 AM with the r revealed Resident #107 from January 2024 through mobility, positioning, and oilitation Director stated on-compliant with splints, and did not progress well ducted on 5/16/24 at 3:10 nator #1. MDS Coordinator sponsible for updating nd it was an error that plan was not revised to n ambulatory status. She 	F 6	57			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/25/2024 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345119	B. WING			05/ [,]	C 17/2024
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE	, ZIP CODE		
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER	-	015 ENTERPRISE DRIVE VILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 657	PM with the Administr stated she expected to revised to reflect char interventions. 2. Resident #12 was a Resident's diagnoses renal disease and dep Review of Resident # revised on 1/24/23 ind of nourishment related diabetes mellitus, incr therapeutic diet. Inter- diet, regular texture, s monitor weight, and n The resident had actr renal carbohydrate-cod dialysis which was no nutrition care plan. Review of Resident # following weights wer 9/28/23- 224 pounds 2/27/24- 222.2 lb. 3/26/24- 199.1 lb. Review of the weights had a 23-pound weight and 25-pound weight than 10%).	ducted on 5/17/24 at 1:50 rator. The Administrator he resident care plans to be nges in condition and admitted on 12/20/21. included in part end stage bendence on renal dialysis. 12's nutrition care plan last dicated a problem for state d to diagnosis of obesity, reased protein needs and on ventions indicated cardiac supplement as ordered, otify physician as indicated. ual weight loss, received a ontrolled diet and was on t updated/included in this 12's record revealed the e recorded: (lb.)	F 657				
	Resident #12 was coo	12's 3/26/24 quarterly IDS) assessment revealed ded as having a weight of /eight loss or weight gain					

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		D HUMAN SERVICES MEDICAID SERVICES				INTED: 06/25/2024 FORM APPROVED IB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION) DATE SURVEY COMPLETED
		345119	B. WING			C 05/17/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, 2	ZIP CODE	
NORTHCH	IASE NURSING AND REI	HABILITATION CENTER		015 ENTERPRISE DRIVE VILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 657	Continued From page and received a therap		F 657			
	physician order dated	12's record revealed a 3/29/24 for renal ed diet regular texture.				
	4/19/24 Registered D which indicated reside reviewed due to dialys resident received a re diet with regular textu	12's record revealed a ietitian (RD) progress note ent's nutritional status was sis. The note indicated nal carbohydrate-controlled re and thin liquids and had a 1.5# (6.7 percent) over 30				
	AM with the Registere stated she had been i 2024 and was followin the significant weight	ducted on 5/15/24 at 11:05 ed Dietitian (RD). The RD n the position since January ng Resident #12 regarding change. The RD stated she the resident care plans.				
	PM with MDS Coordir #1 stated she was res resident care plans ar	nd it was an error that lan was not revised to ritional status. She				
	PM with the Administr stated she expected t	ducted on 5/17/24 at 1:50 ator. The Administrator he resident care plans erson centered and revised				
		admitted to the facility on is which included diabetes.				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/25/2024 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345119	B. WING _				(05/	C 17/2024
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP C	CODE		
NORTHCH	IASE NURSING AND REP	HABILITATION CENTER			015 ENTERPRISE DRIVE /ILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BI		(X5) COMPLETION DATE
F 657	following weights were 11/29/2023- 156.5 por 12/5/23- 150.7 lb. Review of Resident # plan indicated a proble which indicated state body requirement cha obesity, excessive app diabetes, and heart di Resident #19 would a would eat food only fre eliminate snacking be intake would meet ress evidenced by weight s included avoiding usir other means of positiv carbohydrate/no adder refer to dietitian for ev and weigh per facility Review of Resident # following weights were 12/12/23- 148.4 lb. 1/11/24- 147.3 lb. 2/9/24- 140.0 lb. 3/12/24- 135.0 lb. 4/9/24- 178.0 lb. A 4/12/24 physician or received a consistent texture with nectar cor	19's record revealed the e recorded: unds (lb.) 19's current nutrition care em last revised on 12/11/23 of nourishment more than racterized by weight gain, petite related to overweight, sease. The goals indicated dhere to the prescribed diet, om her own plate, would tween meals and total ident's nutritional needs as stability. Interventions of food as a reward, using re reinforcement, consistent ed salt diet, regular texture, aluation/recommendations, protocol. 19's record revealed the e recorded: rder indicated Resident #19 carbohydrate diet pureed nsistency liquids.	F 6	57				
	. ,	ssment dated 4/11/24 noted Is with no weight loss or						

Facility ID: 923038

If continuation sheet Page 21 of 84

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345119	B. WING				C / 17/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
NORTHC	HASE 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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	weight gain and they altered diet. A review of Resident record revealed a 4/1 daily weights for 2 we 43-pound weight gain 4/12/24- 138.4 lb. 4/19/24- 132.4 lb. A 4/19/24 physician of was to receive [brand supplement one time and protein and a reg 5/14/24- 129.7 lb. A 5/14/24 Nurse Prace indicated Resident #1 unintentional weight I Resident #19's diet w to increase intake. An interview was con Dietitian (RD) on 5/15 stated she was in the 2024, her role was to the residents' nutrition in the care planning p Resident #19 had sig An interview was con PM with MDS Coordii #1 stated it was an er plan was not updated and current interventi responsible for the co	received a mechanically #19's electronic health 1/24 physician order for seks then weekly due to a in 1 month. order indicated Resident #19 I name] nutritional a day for additional calories jular diet. titioner progress note 19 was evaluated due to oss. The note indicated vas advanced to regular diet ducted with the Registered 5/24 at 11:10 AM. The RD position since January complete clinical reviews of a and she was not involved process. The RD indicated nificant weight loss. ducted on 5/16/24 at 3:10 nator #1. MDS Coordinator rror that Resident #19's care I regarding the weight loss ons. She explained she was pompletion of the nutrition	F	65	7		
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR I REGULATORY OR I Continued From page weight gain and they altered diet. A review of Resident record revealed a 4/1 daily weights for 2 we 43-pound weight gain 4/12/24- 138.4 lb. 4/19/24- 132.4 lb. A 4/19/24 physician of was to receive [brand supplement one time and protein and a reg 5/14/24- 129.7 lb. A 5/14/24 Nurse Prace indicated Resident #1 unintentional weight I Resident #19's diet w to increase intake. An interview was con Dietitian (RD) on 5/15 stated she was in the 2024, her role was to the residents' nutrition in the care planning p Resident #19 had sig An interview was con PM with MDS Coordii #1 stated it was an er plan was not updated and current interventi responsible for the cor focus in the care plan	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) = 21 received a mechanically #19's electronic health 1/24 physician order for beks then weekly due to a in 1 month. order indicated Resident #19 I name] nutritional a day for additional calories jular diet. titioner progress note 19 was evaluated due to oss. The note indicated ras advanced to regular diet ducted with the Registered 5/24 at 11:10 AM. The RD position since January complete clinical reviews of a and she was not involved process. The RD indicated nificant weight loss. ducted on 5/16/24 at 3:10 nator #1. MDS Coordinator ror that Resident #19's care I regarding the weight loss ons. She explained she was	PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	

Facility ID: 923038

If continuation sheet Page 22 of 84

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI	LE CONSTRUCTION	(X3) DA	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
						С
		345119	B. WING		0	5/17/2024
NAME OF PI	ROVIDER OR SUPPLIER	.		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
NORTHCH	IASE NURSING AND RE	EHABILITATION CENTER		3015 ENTERPRISE DRIVE		
				WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 657	Continued From pag	e 22	F 65	7		
		Coordinator #1 also explained				
	U	who left in December				
		the nutrition care plans but				
	the new RD did not.					
	An interview was cor	nducted on 5/17/24 at 1:50				
		trator. The Administrator				
	stated she expected	the resident care plans				
		nd revised to reflect changes				
	in condition and inter		- 07			0/04/04
F 676 SS=D	CFR(s): 483.24(a)(1)	g (ADLs)/Mntn Abilities	F 67	6		6/24/24
33-D	CIT(S): 403.24(a)(T)	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	§483.24(a) Based or	n the comprehensive				
		dent and consistent with the				
		l choices, the facility must				
	-	ry care and services to nt's abilities in activities of				
		ninish unless circumstances				
	of the individual's clir	nical condition demonstrate				
		was unavoidable. This				
	includes the facility e	ensuring that:				
	\$483.24(a)(1) A resid	dent is given the appropriate				
		es to maintain or improve his				
		out the activities of daily				
	living, including those of this section	e specified in paragraph (b)				
	§483.24(b) Activities	of daily living.				
	• • • • •	vide care and services in				
	accordance with para activities of daily livin	agraph (a) for the following ng:				
	§483.24(b)(1) Hygier	ne -bathing, dressing,				
	grooming, and oral c					
	§483.24(b)(2) Mobilit					

Facility ID: 923038

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345119	B. WING		C 05/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
NODTHOL		HABILITATION CENTER		3015 ENTERPRISE DRIVE		
NORTHO				WILMINGTON, 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 676	Continued From page	e 23	F 67	6		
	including walking,					
	§483.24(b)(3) Elimina	ation-toileting,				
	§483.24(b)(4) Dining- snacks,	-eating, including meals and				
		unication, including communication systems. Γ is not met as evidenced				
	Based on observation	ons, record review, resident		F 676 Activities Daily Living	g (ADLs)	
		he facility failed to provide				
		tance with eating to maintain		On 6/11/24, the Director of		
		ed themselves for 3 of 3 #112, #126, and #131)		updated the care plan/care Resident #112 for partial/mo	-	
	, , , , , , , , , , , , , , , , , , ,	s of daily living (ADL).		assistance with meals to inc		
				up.		
	The findings included	t:		On 6/11/24, the DON updat	ted the care	
				plan/care guide for Residen	nt #126 for set	
		s admitted 11/28/22 with		up/clean up assistance with		
		led: dysphagia, dementia,		include cutting meats per re	esident	
	#112 was receiving p	rie malnutrition. Resident		preference.		
	hospice services.			On 6/11/24, the DON updat	ted the care	
				plan/care guide for Residen		
	The resident's Quarte	erly Minimum Data Set		up/clean up assistance with		
	, ,	4 indicated the resident had		include cutting meats per re	esident	
		ognitive impairments and		preference.		
		and set up only for meals		On 6/12/24, DON and admi		
	during the assessme	ni perioa.		initiated an audit of meal de include all meals for resider	-	
	Resident #112's care	plan dated 03/26/24		report. This audit is to ensu		
		for fluid volume deficit related		provided appropriate assist		
	· ·	shment less than body		mealtime to include tray set	-	
		ate intake, and decreased		feeding assistance per care	-	
	appetite.			guide. The DON and admin	nistrator will	

Event ID: R0B411

Facility ID: 923038

If continuation sheet Page 24 of 84

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	· · · ·	OMPLETED
			, a boilebill	<u> </u>		С
		345119	B. WING			05/17/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				3015 ENTERPRISE DRIVE		
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLETIO DATE
F 676	Continued From page	e 24	F 6	76		
				address all concerns ider	0	
	-	05/10/24 at 10:41 AM for		audit to include providing		
	Resident #112 reveal			set up when indicated an		
	triggered a 110% wei			staff. The audit will be con	mpleted by	
	-	ent's Health Care Provider		6/24/14.		
		ty (RP) was notified with no ne. The resident continued		On 6/11/24, the Admissio	n Director	
	Hospice services and			initiated questionnaires w		
		al supplement) 120 mL by		oriented residents regard		
		and enriched meals with		with meals to include (1)		
	staff encouragement.			you with setting up your r		
				include opening drinks or	food items and	
	-	n (RD) note dated 05/10/24		(2) Do staff cut up food p		
	at 1:37 PM for Reside			The Social Worker will no	•	
		receive hospice care, with re diet and thin liquids. Her		all concerns identified due The questionnaires will be	-	
		cts 50-75%, occasionally		6/24/14.	e completed by	
	-	d-pass supplement two		On 6/11/24, the Director of	of Nursina	
	times per day.			(DON), Assistant Director (ADON), Quality Assuran	r of Nursing	
	An interview and obse	ervation were conducted on		unit managers initiated ar		
	05/14/24 at 8:45 AM	with Resident #112. She		resident's care plan/care		
	said her breakfast tra	y was not set up and should		the care plan/care guide	accurately	
		observed trying to punch a		reflects assistance neede	•	
	-	ntainer with a plastic straw		mealtime. The DON and		
		e the aluminum lid and		address all concerns ider	-	
		straw onto the floor. She nd she was not able to open		audit to include updating when indicated. The audi	-	
		lk carton, or juice, or cut her		completed by 6/24/14.		
	sausage or French to					
				On 6/11/24, the Staff Fac	ilitator initiated	
	An interview was con	ducted on 05/14/24 at 9:15		an in-service with all nurs	es nursing	
		ation Director. She said all		assistants (NA) regarding	•	
		hould be set-up by facility		with emphasis on setting		
		vere not independent. She		include opening food item		
		as in Hospice and needed		inserting straws when ind		
	tray set-up assistance	e with meals.		food per resident preferen		
	0-05/44/04 -+ 40.40	PM Resident #112 was		providing feeding assistation indicated. The in-service		

Facility ID: 923038

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	OF DEFICIENCIES					<u>NO. 0938-03</u> TE SURVEY	
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	MPLETED	
						С	
		345119	B. WING			5/17/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
NORTHCH	ASE 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 676	Continued From page	e 25	F 67	76			
		bed with her lunch tray in		demonstration on where t	o find feeding		
		sing Aide (NA) was not		assistance required on the	-		
		12 made several attempts to		providing care. The in-ser			
		of a juice cup and was		completed by 6/24/14. Aft	ter 6/24/14, and		
		as observed trying to grasp		NA who has not complete			
	-	rton with her fingers and		will complete it upon the r			
	failed.			work shift. All newly hired			
	An interview was con	ducted on 05/15/24 at 11:30		in-service during orientation Meal Delivery.	on regarding		
		ed Dietitian. She said all		Mear Derivery.			
	-	should be set up unless they		The Unit Managers, admi	ssions director.		
		to set-up their meal tray		social worker, medical red			
	themselves.			payable, and scheduler w	vill complete 10		
				meal observations to inclu			
		ducted on 05/15/24 at 2:06		twice weekly x 4 weeks th	•		
		of Nursing. She said all		month utilizing the Reside			
	residents who needed	s means tray set-up and		Audit-Meal Delivery. This ensure staff provided app			
		ded. She further stated		assistance during mealtin			
		s should be set up unless		set up and/or feeding ass	•		
		ested to set-up their meal		plan/care guide. The Unit	•		
	tray themselves.			admissions director, socia	al worker,		
				medical records, account			
		ducted on 05/16/24 at 3:20		scheduler, and ADON will			
		ractitioner. She expected		concerns identified during			
	the NAs, unless the r	neal trays to be set up by		include providing assistar when indicated and re-tra			
		heir own meal tray. She said		The Administrator and/or	0		
		ctice to do so, by improving		Nursing will review the Re			
		ging eating, and by getting to		Audit-Meal Delivery Tool t			
		and dislikes, and time to		weeks then monthly x 1 n	nonth to ensure		
	offer alternates.			all concerns are addresse	ed.		
		ducted on 05/17/24 at 9:45		The Director of Nursing w			
		e (NA#2). NA#2 stated, she		Resident Care Audit-Mea	-		
		e and could not remember le 500-hall (the hall where		the Quality Assurance and Improvement (QAPI) Con			
		ed) needed their meal trays to		for 2 months for review to	-		
		was not aware Resident		trends and/or issues that			

Event ID: R0B411

Facility ID: 923038

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				E CONSTRUCTION		IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
						С
		345119	B. WING		0	5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHC	ASE 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 676	Continued From page	e 26	F 67	6		
	said she rarely worke told which residents r	ance with her meals. She ed on the 500-hall and wasn't needed meal tray set-up or ng. She said she could not about that day.		further interventions put into pla determine the need for further t of monitoring.		
	10/12/18 with diagnos	s admitted to the facility on ses that included diabetes, ease, adult failure to thrive,				
	04/30/24 revealed res	mum Data Set (MDS) dated sident had had no cognitive ded supervision with eating.				
	deficit due to: 1500m diuretic use. State of body requirement cha Ms. Warren required of Daily Living/Person adult failure to thrive	r or Actual fluid volume I fluid restriction, daily nourishment; more than aracterized by weight gain. assistance with the activities nal Care due to weakness, and congestive heart failure. d: Eating (oral intake):				
	05/14/24 at 8:50 AM said her breakfast tra have been. She was with a round sausage eating around the edu was also observed no juice container and w and fork together to c	ervation were conducted on with Resident #126. She by was not set up and should observed holding up a fork e patty stuck to the end, ges of the sausage. She bot able to open her milk or was unable to use the knife cut her French toast into would have been easier to				

Facility ID: 923038

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	-	D HUMAN SERVICES				FORM	06/25/2024 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	LETED
		345119	B. WING			(05/	C 17/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
NORTHCH	IASE NURSING AND REI	HABILITATION CENTER		015 ENTERPRISE DRIVE VILMINGTON, 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 P (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 676	AM with the Rehabilita resident meal trays sh staff if the residents w said Resident #126 w Therapy (PT) in her ro assistance with meals An interview was cond AM with Nursing Aide only worked part-time which residents on the Resident #126) neede set-up or not. She wa assistance with her m worked on the 500-ha residents needed mea with feeding. She said anything about that da 3. Resident #131 was diagnoses that include cerebral infarction (str The resident's Minimu 04/08/24 indicated the impairments and neede Resident #131's care revealed a potential for to anemia, with nouris requirement, inadequa assistance with meal set-up/clean-up assist hemiplegia/hemipares infarction affecting left An interview was cond	ation Director. She said all hould be set-up by facility vere not independent. She as receiving Physical bom and needed tray set-up s. ducted on 05/17/24 at 9:45 (NA#2). NA#2 stated, she and could not remember e 500-hall (the hall where ed their meal trays to be s not aware #126 received eals. She said she rarely ill and wasn't told which al tray set-up or assistance d she could not remember ay. admitted 04/02/24 with ed hemiplegia, dysphagia, roke), and diabetes. Im Data Set (MDS) dated e resident had no cognitive ded supervision with eating. plan dated 04/08/24 or fluid volume deficit related shment less than body ate intake, and decreased is included: Provide as indicated, with tance, due to sis following cerebral	F 676				

Facility ID: 923038

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345119	B. WING		C 05/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		3015 ENTERPRISE DRIVE	
				WILMINGTON, NC 28405	1
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 676	Continued From page	<u>- 28</u>	F 67	6	
		nd should have been. She	1.07		
		nd she was not able to open			
		lk carton, or juice, or cut her			
	sausage or French to	oast.			
	An interview was con	ducted on 05/14/24 at 8:30			
		he said Resident #131 could			
		nd due to a stroke and			
	-	s (NAs) to set-up her tray eals. The nurse said she			
		NAs did not set up Resident			
	#131 meal tray.				
F 684 SS=E	Quality of Care CFR(s): 483.25		F 68	4	6/24/24
33-E	CFR(S). 403.25				
	§ 483.25 Quality of ca				
		ndamental principle that nt and care provided to			
		ed on the comprehensive			
	assessment of a resid	dent, the facility must ensure			
		treatment and care in			
		essional standards of nensive person-centered			
	care plan, and the res				
		is not met as evidenced			
	by: Based on observatio	ns, record review, staff, and		F 684 Quality of Care	
		r interviews the facility failed			
	to 1.) obtain blood pro	essure readings or heart rate		On 6/1/24, the hall nurse assessed	
	prior to administering			Resident #17 blood pressure (BP) ar	
		ol which had parameters to f the systolic blood pressure		pulse. The BP and pulse did not exce parameters for administration of bloo	
		mHg (millimeters of mercury)		pressure medication per physician or	
		n 60 beats per minute.		The electronic medication administra	
		.) obtain physician ordered resident with congestive		record (eMAR) was updated to includ assessing BP and pulse prior to	le
	heart failure. (Reside	nt #44). This occurred for 2		administering medication.	

Facility ID: 923038

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PRINTED: 06/25/2024 FORM APPROVED

		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 06/25/202 MAPPROVE D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	COMF	SURVEY PLETED
		345119	B. WING _				C / 17/2024
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		30	15 ENTERPRISE DRIVE		
				W	/ILMINGTON, NC 28405		1
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	e 29	F	584			
	reviewed for quality c				On 6/12/24, the Director of Nursing reviewed Resident #44 weights from		
	Findings included.				6/1/24 to 6/12/24 and the resident wa assessed with no signs or symptoms	of	
		admitted to the facility on ses including hypertension, disease.			fluid overload or weight gain. Weight obtained weekly per physician's orde		
	06/18/24 revealed Re	/10/23 with a target date of esident #17 had end stage			On 6/11/24, the Assistant Director of Nursing (ADON) initiated an audit of residents' orders for anti-hypertensive		
		ed hemodialysis and was at . Interventions included to			medication with parameters for administration to include but not limit monitoring of blood pressure and pul		
		ated 04/02/24 for Resident			This audit is to ensure the nurse follo physician orders to include obtaining	vital	
	release 50 milligrams	olol Succinate extended (mgs). Give one tablet by tension. Hold for systolic			signs prior to administering medication when indicated and/or holding medications when vital signs exceed	ons	
		han 110 mmHg or heart rate			parameters, notification of the medica provider when vital signs exceed	al	
	Review of Resident #				parameters with documentation in the electronic record. The ADON will add		
	revealed Metoprolol \$ 50 milligrams was sc	d (MAR) dated April 2024 Succinate extended release heduled for administration			all concerns identified during the aud include assessing the resident, obtain vitals and notification of the provider	ning	
	administered on the f	e medication was signed as following dates with no pressure or heart rate			indicated with documentation in the electronic record and education of sta The audit will be completed by 6/24/1		
		with no blood pressure or			On 6/12/24, the DON and ADON initi an audit of all residents' orders for we	eight	
	heart rate recorded.	with no blood pressure or			monitoring to include Resident #44 a residents with the diagnosis of conge heart failure (CHF). This audit is to entry the failure interview.	stive	
	heart rate recorded. 04/22/24 at 8:00 AM	with no blood pressure or with no blood pressure or			the facility is obtaining weights per physician orders to include residents required weight gain monitoring for		
	heart rate recorded. 04/24/24 at 8:00 AM	with no blood pressure or			possible cardiac fluid overload due to resident's history of Congestive Hear		

Event ID: R0B411

Facility ID: 923038

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SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	vith no blood pressure or	. ,	STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 34	JLD BE COMPLETIC
ASE NURSING AND REA SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From page heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	HABILITATION CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2:30 with no blood pressure or	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 34	05/17/2024 TION (X5) JLD BE COMPLETIO
ASE NURSING AND REA SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From page heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	HABILITATION CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2:30 with no blood pressure or	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 34	TION (X5) JLD BE COMPLETIC
ASE NURSING AND REA SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From page heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2:30 with no blood pressure or	PREFIX TAG	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIC
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2:30 with no blood pressure or	PREFIX TAG	WILMINGTON, NC 28405 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIC
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2:30 with no blood pressure or	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
(EACH DEFICIENCY REGULATORY OR L Continued From page heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 30 with no blood pressure or	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIC
heart rate recorded. 04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	vith no blood pressure or	F 68		
04/26/24 at 8:00 AM v heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	·			
heart rate recorded. 04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v	·		Failure (CHF) with documentation	in the
04/28/24 at 8:00 AM v heart rate recorded. 04/29/24 at 8:00 AM v			electronic record. The ADON, Sta	
heart rate recorded. 04/29/24 at 8:00 AM v			Facilitator, Quality Assurance Nurs	
04/29/24 at 8:00 AM v	with no blood pressure or		unit managers will address all cond	
	with no blood pressure or		identified during the audit to include	
	with no blood pressure or			
nean fale recorded.				
Review of Resident #	17's progress notes dated		recommendations with documenta	tion in
			the electronic record and education	n of
-			staff. The audit will be completed b	у
	letoprolol administration		6/24/14.	
time.				4° - 4
Poviow of Posidont #	17's Modication			
				ling
				or blood
•				
			with designated parameters, holdir	
administered on the fo	ollowing dates with no		medications when vitals/blood sug	
	pressure or heart rate			-
recorded.				
05/03/2/ at 8.00 AM	with no blood pressure or			
	man no bioor pressure of			
	vith no blood pressure or			
heart rate recorded.			physician with vitals, blood sugars	
05/05/24 at 8:00 AM v	vith no blood pressure or		weight gain exceeds designated	
heart rate recorded.			parameters with documentation in	
	with no blood pressure or			
	with no blood pressure or			4, and
	na no bioda pressure or			next
	vith no blood pressure or			
heart rate recorded.			will be in-service during orientation	
			regarding Following Physician's Or	rders.
Poviow of Posidort #	17's prograss potes dated		The Assistant Director of Nursing	ctoff
	heart rate recorded. Review of Resident # 04/19/24 through 04/2 pressure or heart rate corresponded to the M time. Review of Resident # Administration Record revealed Metoprolol S 50 milligrams was sch daily at 8:00 AM. The administered on the for corresponding blood p recorded. 05/03/24 at 8:00 AM w heart rate recorded. 05/04/24 at 8:00 AM w heart rate recorded. 05/05/24 at 8:00 AM w heart rate recorded. 05/08/24 at 8:00 AM w heart rate recorded. 05/08/24 at 8:00 AM w heart rate recorded. 05/12/24 at 8:00 AM w heart rate recorded. 05/12/24 at 8:00 AM w heart rate recorded. 05/12/24 at 8:00 AM w	Review of Resident #17's progress notes dated 04/19/24 through 04/29/24 revealed no blood pressure or heart rate recordings that corresponded to the Metoprolol administration time. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The medication was signed as administered on the following dates with no corresponding blood pressure or heart rate recorded. 05/03/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/04/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/05/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or	heart rate recorded. Review of Resident #17's progress notes dated 04/19/24 through 04/29/24 revealed no blood pressure or heart rate recordings that corresponded to the Metoprolol administration time. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The medication was signed as administered on the following dates with no corresponding blood pressure or heart rate recorded. 05/03/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/03/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/01/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. Review of Resident #17's progress notes dated	heart rate recorded.indicated, notification of the physic significant weight gain for further recommendations with documenta the electronic record and education staff. The audit will be completed b 6/24/14.Review of Resident #17's Medication time.On 6/10/24, the Staff Facilitator init an in-service with all nurses regard Following Physician's Orders with daily at 8:00 AM. The medication was signed as administered on the following dates with no corresponding blood pressure or heart rate recorded.On 6/10/24, the Staff Facilitator init an in-service with all nurses regard Following Physician's Orders with emphasis on obtaining vitals and/o sugar prior to administering medica with designated parameters, holdin medications when vitals/blood sug exceeds parameters, obtaining we per physician orders for residents I required weight gain monitoring for possible cardiac fluid overload due resident's history of Congestive He Failure (CHF), and notification in electronic record. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE 10. 0938-039
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	E SURVEY
		345119	B WING		С	
	ROVIDER OR SUPPLIER	545119		STREET ADDRESS, CITY, STATE, ZI		5/17/2024
NAME OF P	ROVIDER OR SUPPLIER					
NORTHC	ASE 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 684	Continued From page	- 21	For			
F 004	Continued From page		F 68	-		
	pressure or heart rate			will review 10% of reside		
	-	Metoprolol administration		for weight monitoring for		
	time.			/fluid overload due to res	-	
	The Minimum Data S			Congestive Heart Failure resident #44, 3 times a v		
		1/19/24 revealed Resident		then monthly x 1 month,		
	-	impaired cognition. She had		Weight Audit Tool. This a		
	-	ind received hemodialysis.		weights were obtained p		
				order and the provider w		
	A progress note docu	imented by the Nurse		significant weight gain g		
		/15/24 revealed in part;		3-pounds (lbs.) in 24-ho		
		ert and oriented to person,		in a week, for a resident		
	place, and time. She	•		weight gain monitoring for	-	
	• •	ses station in no distress.		cardiac fluid overload du	•	
	She was appropriate	and not drowsy. Her blood		history of Congestive He		
		(systolic/diastolic), pulse		with documentation in th	. ,	
		r minute. The cardiovascular		record. The Assistant Di	rector of Nursing,	
	exam indicated Resid	dent #17 was at her baseline.		staff facilitator and/or Qu nurse will address all are	-	
	During an interview o	on 05/17/24 at 12:45 PM		identified during the aud	it, including	
	Resident #17 was ob	served in her wheelchair in		assessment of the reside	ent, notification of	
	the hallway. She was	alert and oriented to		the physician of signification	ant weight gain for	
		me. She was pleasant and		further recommendation	s with	
		nversation. She stated she		documentation in the ele		
		y and voiced no concerns.		and re-training of staff. T		
		e had no concerns with her		review the Weight Audit		
		not aware of the times her		4 weeks then monthly x		
	medications were sch	neduled for administration.		ensure all areas of conc	ern are	
	During on interview of	on 05/17/24 at 2:00 DM tha		addressed.		
		on 05/17/24 at 2:00 PM the tated Nurse #4 and Nurse #5		The Interdisciplinery Tea	am to include	
		e Metoprolol on the dates		The Interdisciplinary Tea Quality Assurance (QA)		
		res or heart rate recorded		Facilitator, and Assistant		
	-	r interview. She stated Nurse		Nursing will review 10%		
		ation and she made attempts		for anti-hypertensive me		
		se #5 and there was no		parameters for administe		
		I the Medical Director was		to include blood pressur		
	unavailable for interv			monitoring 3 times a we	-	
		cated a blood pressure and		monthly x 1 month utilizi		

Facility ID: 923038

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDING			С
		345119	B. WING		0	5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
		HABILITATION CENTER		3015 ENTERPRISE DRIVE		
VORTHEI	TASE NORSING AND RE	HABILITATION CENTER		WILMINGTON, 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 C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	a 32	F 68	34		
	heart rate should have		1 00	Parameters Audit Tool. T	his audit is to	
		ninistering the Metoprolol.		ensure the nurse followed		
		here were no corresponding		orders to include obtainin		
		heart rate recorded in		to administering medicati		
		al record during the time the		indicated and/or holding i		
	medication was admi	nistered for the dates listed.		when vital signs exceed p	parameter,	
		ion would be provided to		notification of the medica	-	
		g medication administration		vital signs exceed param		
	and monitoring blood	pressures and heart rate.		documentation in the elec		
	During a phone inter	1004 on 05/17/24 of 2:20 DM		The Interdisciplinary Tear		
	the Nurse Practitione	view on 05/17/24 at 3:30 PM		Quality Assurance (QA) Facilitator, and Assistant		
		17 and last examined her on		Nursing will address all c		
		ed she was not aware that		identified during the audit		
		t having her blood pressure		assessing the resident, o		
		olol administration. She		and notification of the pro		
	stated the Metoprolol	was prescribed to Resident		indicated with documenta	ation in the	
		ood pressure and her blood		electronic record and re-t		
	pressure reading on			The DON will review the		
	(systolic/diastolic). Sl			Tool 3 x a week x 4 week	•	
	pressures have been	-		1 month to ensure all are	as of concern	
		d hemodialysis and her uated at times which was		are addressed.		
	why parameters were			The DON will present the	findings of the	
		d pressure or heart rate was		Weight Audit Tool and the		
		had been no reports to her		Audit Tool to the Quality A		
	regarding a change c	f condition and blood		Performance Improveme		
		rate should be obtained prior		Committee monthly for 2		
	to administering the r	nedication.		review to determine trend that may need further inte		
	2.) Resident #44 was	admitted to the facility on		into place and to determine	-	
		ses including congestive		further frequency of moni	itoring.	
	heart failure.					
	A physician's order d	ated 02/16/24 for Resident				
	#44 revealed Furose	mide (diuretic) 40 milligrams				
	(mgs). Give one table					
	congestive heart failu	ire.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COME	D. 0938-0391 E SURVEY PLETED C
	C
	/17/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NORTHCHASE NURSING AND REHABILITATION CENTER 3015 ENTERPRISE DRIVE 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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
F 684 Continued From page 33 F 684 A physician's order dated 02/16/24 for Resident #44 #44 revealed Aldactone (a potassium sparing diuretic) 25 milligrams (mgs). Give one tablet by mouth daily for hypertension. The Minimum Data Set (MDS) admission assessment dated 02/21/24 revealed Resident #44 was cognitively intact. She had no rejection of care. A physician's order dated 03/20/24 for Resident #44 revealed to obtain weekly weights for congestive heart failure. Review of Resident #44's electronic medical record from 03/20/24 hrough 05/17/24 revealed the following weights recorded: 03/27/24 the recorded weight was 196.1 Lbs. (pounds) 04/02/24 the recorded weight was 201.5 Lbs. 04/02/24 the recorded weight was 202.5 Lbs. 05/14/24 the recorded weight was 202.6 Lbs. 05/14/24 the recorded weight was 202.0 Lbs. During an interview on 05/17/24 at 1:23 PM the Nurse Practitioner stated she was not aware Resident #44 was not getting weekly weights were ordered to monitor fluid retention due to congestive heart failure. She stated weekly weights weekly weights to get done according to the order. During an interview on 05/17/24 at 1:48 PM Resident #44 was observed sitting in her wheelchair. She was alert, and oriented to person, place, and time. She stated weekly	

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY IMPLETED
		345119	B. WING				C)5/17/2024
	ROVIDER OR SUPPLIER	HABILITATION CENTER		30	IREET ADDRESS, CITY, STATE, ZIP CODE D15 ENTERPRISE DRIVE VILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	weighed 2 or 3 days a refuse care and want During an interview o Director of Nursing st Resident #44's Medic (MAR) the order for w MAR but it had an "x' therefore it would not obtain a weekly weigl was due to the way the electronic medical rec populating on the MA weekly. She indicated the nurse would have obtain the weight. Sh corrected immediated was weighed on 05/1 the Registered Dietic she expected weight electronic medical rec to nursing staff would Treatment/Devices to CFR(s): 483.25(a)(1) §483.25(a) Vision and To ensure that reside and assistive devices hearing abilities, the f assist the resident- §483.25(a)(2) By arra and from the office of the treatment of visio	en done, but she did get ago. She stated she did not ed her weight monitored. In 05/17/24 at 2:00 PM the tated upon reviewing cation Administration Record veekly weights was on the ' on the MAR each day and populate on the MAR to ht. She indicated the error ne order was entered into the cord that prevented it from IR to obtain the weight d if it had shown on the MAR e informed a nurse aide to e stated it would be y. She stated Resident #44 4/24 and was evaluated by ian on 05/15/24. She stated orders to be entered into the cord correctly and education I be provided. Maintain Hearing/Vision (2)		684			6/24/24

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	S FUR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	· · · ·	TE SURVEY
		345119	B. WING _			C)5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		0,11/2024
				3015 ENTERPRISE DRIVE		
NORTHC	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, 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 X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 685	Continued From page	e 35	F	685		
	This REQUIREMENT	hearing assistive devices. Γ is not met as evidenced				
	by: Based on record rev	iew, observation, and		F 685 Treatment/Devices	to Maintain	
		urse Practitioner interviews,		Hearing/Vision		
		btain an appointment with an				
		valuation of vision for 1 of 1		On 6/5/24, the transporter	scheduled an	
	resident (Resident #	22) reviewed for vision.		eye appointment for Resid		
				7/8/24. The resident was r	notified of the	
	Findings included:			scheduled appointment.		
		dmitted to the facility on		On 6/14/24, the administra		
		22's medical diagnoses		worker completed an audi		
	included cataracts ar	nd diabetes.		most recent eye exams ar		
	Bovious of the facility	grievenes lag revealed a		ophthalmology. The audit	-	
		grievance log revealed a I 12/4/23 completed by		to ensure residents receive treatment and assistive de		
	•	ceived by the Director of		maintain vision and that re		
		he Assistant Administrator.		referrals for eye care servi		
		egarding Resident #22's		completed timely per phys		
	request for a referral			and/or resident preference		
	-	#22 stated the request had		administrator and/or the so	ocial worker will	
	previously been mad	e to the hall nurse. The		address all concerns ident	tified during the	
		errals and appointments		audit. The audit will be cor	npleted by	
		ndings of the grievance		6/24/24.		
		0N stated Resident #22 sees				
		e provider for her eye care		On 6/10/24, the Administra		
		12/6/22. The grievance		an audit of grievances for		
	indicated an annual v	ry 2024. The grievance		days. This audit is to ident concerns related to reques		
		ident #22 would be placed		medical appointments to in		
		t in- house eye care visit. If		limited to request for ophth		
		vant to wait for the in-house		had not been completed p		
		ce indicated will discuss an		preference/request. No ad		
		he provider. The grievance		concerns were identified d		
		d to the resident on 12/6/23.				
		letter addressed to Resident		On 6/10/24, the Activity Di		
		nt requested a referral to see		social worker initiated resid		
	an eye doctor. The	letter stated after an		questionnaires with all ale	rt and oriented	

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		MEDICAID SERVICES				0.0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		345119	B. WING			C
	ROVIDER OR SUPPLIER	040110		STREET ADDRESS, CITY, STATE, ZIP C		17/2024
	NOVIDEN ON SOLT EIEN			3015 ENTERPRISE DRIVE	ODL	
NORTHC	HASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 685	Continued From page	e 36	F 68	35		
1 000	-	tion supervised by the	FUC		Appointmente	
		vas determined that the		residents regarding Medica to identify any resident con		
	•	nouse eye care provider for		regarding obtaining outside		
		eye exams. The letter		appointments per preference		
	-	t would be informed of the		appointments requested the		
	next visit with the eye	e care company.		been scheduled. The Socia	al Worker and	
				the Director of Nursing will		
		physician progress note		concerns identified during t		
		22 was evaluated and		include scheduling appoint		
i		Imologist appointment		indicated and education of		
		The physician progress note as written for referral to an		questionnaires will be comp 6/24/14.	bleted by	
				On 6/12/24, the administrat	tor initiated an	
		#22's 2/14/24 physician		in-service with the transpor		
		rder for follow up with		scheduler, social worker, D		
	ophthalmology regard	ding cataracts.		Nursing and Assistant Dire		
	Desident #22's quart	arky Minimum Data Sat		regarding Requests for Me		
		erly Minimum Data Set indicated the resident was		Appointments with emphas residents receive proper tre		
		d impaired vision and did not		assistive devices to mainta		
	have glasses.			vision/hearing/dental and th		
				and/or referrals for eye		
	Review of Resident #	22's electronic health record		care/hearing/dental service	s were	
	revealed a 2/26/24 N	urse Practitioner progress		completed timely per physi		
		the resident required a		resident preference to inclu		
		ology. The progress note		outside providers when ind		
	Indicated an order wa	as written for the referral.		in-service also includes not		
	Review of Resident +	22's Nurse Practitioner		provider, resident, and Adn appointment cannot be sch		
		3/7/24 indicated resident		reason, or the appointment	-	
		e ophthalmology appointment		scheduled in the requested		
		requested. The progress		The in-service was completed		
		ng the scheduling of the		newly hired transportation/s		
	ordered appointment			social workers, DONs, and	or ADONs will	
				be in-serviced during orient		
		22's care plan revealed a		Requests for Medical Appo	intments.	
		3/7/24 for impaired vision		T	17	
	and risk for complicat	tions. The goal indicated		The Assistant Administrator	r and/or the	

Facility ID: 923038

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			()(0)			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		ATE SURVEY
			A. BUILDING			С
		345119	B. WING			05/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		JJ/17/2024
				3015 ENTERPRISE DRIVE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLETIO DATE
F 685	Continued From page	e 37	F 68	35		
	Resident #22 would u			social workers will review 10	% of all new	
		eased vision through next		referrals for outside medical	appointments	
	review. Interventions	Ū.		and concerns related to med		
	eyeglasses are clean	, appropriate and being worn		appointment request per resi	dent	
		in eye exam consultation for		preference to include but not		
	-	propriate medications and		request for eye care services		
	compensatory mecha	anisms are in place.		weeks then monthly x 1 mon	•	
	A :			Consult Audit Tool. This audi		
		ducted on 5/13/24 at 12:04 2. Resident #22 stated she		residents receive proper trea assistive devices to maintain		
		an eye doctor appointment.		that requests and/or referrals		
		she thought her eyesight		services were completed time		
		d she was concerned since		physician order and resident		
		of diabetes and cataracts.		include referrals to outside p	•	
				when indicated.		
	A following up intervie	ew was conducted on		The Assistant Administrator a	and/or the	
	5/16/24 at 12:26 PM	with Resident #22. Resident		social workers will address a		
		d talked to her this week		identified during the audit to i		
	-	see an ophthalmologist.		scheduling an appointment w		
		e Social Worker had not		indicated, notification of the p		
	talked to her. Reside			resident/resident representat		
		aining the appointments as		appointment with documenta		
		eye doctor in over a year. she filed a grievance in		electronic record and re-train The DON will review the Con	-	
	December and still ha	0		Tool weekly x 4 weeks then r		
	requested appointme			month to ensure all concerns addressed.	-	
	An interview was con	ducted on 5/15/24 at 12:10				
		tation Specialist. The		The DON will present the find	dings of the	
	Transportation Specia	•		Consult Audit Tool to the Qua	•	
		luling appointments and		Assurance and Performance		
	-	residents. She stated she		Improvement (QAPI) Commi		
	was in the position fo			for 2 months for review to de		
	Transportation Specia			trends and/or issues that may		
		by the nursing staff, family		further interventions put into		
		oviders. The Transportation		determine the need for furthe	er trequency	
	Specialist stated she	-		of monitoring.		
		or Resident #22. She stated while back that Resident #22				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · ·	PLETED	
					С		
		345119	B. WING		0	5/17/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		E		
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		3015 ENTERPRISE DRIVE WILMINGTON, NC 28405			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO	
F 685	Continued From page	e 38	F 68	5			
		ent with an ophthalmologist.					
		pecialist stated she was still					
		the appointment but had not					
	-	ated when she had extra					
	-	halmologist offices to see if					
		esident. She stated the last was a few weeks ago. The					
		alist stated she did not have					
		what offices she called, when					
		e was. The Transportation					
	•	was not sure how Resident					
		nsported and it was difficult					
	to obtain stretcher tra	-					
		alist stated she was not nce that Resident #22 filed					
	•	nd was not made aware of					
		ule the appointment in					
	December 2023.						
		ducted on 5/15/24 at 12:30					
		er (SW) #1. SW#1 stated					
	2023. SW #1 stated	position since December					
		site allanged the swith the in-house provider.					
		t in-house ophthalmologist					
		s in August 2023. Resident					
	#22 was not seen in a	-					
		22 was not seen by the					
	•	ovider since December					
		know why Resident #22 Ist 2023. SW #1 stated the					
		ovider should be seeing					
	•	ty in August 2024. SW #1					
	stated if a resident ha	ad a concern or needed to be					
	• •	ologist sooner than the					
		d reach out to the company					
	and request a visit to	be arranged sooner. SW					
	#1 atotad aba	t informed Resident #22 had					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/25/2024 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE COMP	LETED
		345119	B. WING		_		, 17/2024
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
NORTHCH	HASE NURSING AND REI	HABILITATION CENTER	-	015 ENTERPRISE DRIVE VILMINGTON, NC 2840	95		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 685	went on maternity lea she may have been g written in February. S to Resident #22 abou in-house ophthalmolo An interview was com PM with Social Worke she was new to the po- January 2024. SW# 2 of the physician order Resident #22 to see t An interview was com PM with the Unit Man stated she was not av a referral for Resident ophthalmologist writte February 2023. The U she was not aware of by Resident #22 in De request to see an oph An interview was com PM with the Nurse Pr a resident with a diag evaluation at least an facility used a compar facility to provide oph stated she expected t not complete a referra An interview was com PM with the Director of DON stated they shot	Imology. SW #1 stated she ive in February 2024, and ione when the referral was SW #1 stated she would talk it obtaining a visit with the ogist. ducted on 5/15/24 at 12:40 er (SW) #2. SW #2 stated osition having started in 2 stated she was not notified r written in February 2024 for the ophthalmologist. ducted on 5/15/24 at 1:45 iager. The Unit Manager ware of a physician order for t #22 to see the en by the provider in Unit Manager further stated r a grievance that was filed ecember 2023 regarding her inthalmologist. ducted on 5/16/24 at 3:30 actitioner. The NP indicated nosis of cataracts required nually. The NP stated the ny that comes into the thalmology care. The NP to be notified if the facility did al for an appointment. ducted on 5/17/24 at 4:30 of Nursing (DON). The uld have arranged the ident #22 but there was a	F 685				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345119	B. WING				C 17/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER			15 ENTERPRISE DRIVE ILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 685 F 692 SS=E	An interview was composite of the administration of the administration stated Resident #22 of having an ophthalmol. The Administrator state eligible to be seen by ophthalmologist that of wasn't a year since he Administrator stated as have tried to obtain the outside provider. The had been a delay in fi accept the resident's was a long time and r to obtain the appoint Administrator stated if only reason the resided with the ophthalmologist and r to obtain the appoint Administrator stated if only reason the resided with the ophthalmologiner iPad. Nutrition/Hydration St CFR(s): 483.25(g)(1)-§483.25(g) Assisted r (Includes naso-gastric both percutaneous endosc enteral fluids). Based comprehensive assesses ensure that a residern §483.25(g)(1) Maintai of nutritional status, s desirable body weight balance, unless the redemonstrates that this preferences indicate of the state of the	ducted on 5/17/24 at 12:20 rator. The Administrator expressed a concern about ogy appointment scheduled. ted Resident #22 was not the in-house came in August 2023 since it er last exam. The she guessed they could be appointment with an Administrator stated there nding a provider that would insurance, but 5 months maybe they could have tried nent sooner. The t was her understanding the ent wanted the appointment gist was so she could see atus Maintenance -(3) nutrition and hydration. c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and d on a resident's asment, the facility must t- ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition is is not possible or resident		585 592			6/24/24	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	M APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345119	B. WING _		o [;]	C 5/17/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3015 ENTERPRISE DRIVE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		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 CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 692	Continued From page maintain proper hydra §483.25(g)(3) Is offer there is a nutritional p provider orders a then This REQUIREMENT by: Based on record revi resident and Nurse P facility failed to provic nutritional supplement to obtain physician or residents reviewed for and Resident #19). 1Resident #107 wa Resident's medical di failure to thrive, prote diabetes. Review of Resident #	e 41 ation and health; ed a therapeutic diet when problem and the health care apeutic diet. is not met as evidenced ew, observations and staff, ractitioner interviews, the le physician ordered ts on meal trays and failed dered weights for 2 of 10 r nutrition (Resident #107 s admitted on 10/5/22. agnosis included stroke, in calorie malnutrition and 107's electronic health blowing weights were nds (Lbs.) s.	F 6	DEFICIENCY)	served to ensure ician d per tified noted served o ensure ician d per tified noted with stable lietary ated an eal trays to a per ements	
	4/13/2024 No weight 4/30/2024 No weight 5/7/2024- 161.3 Lbs. 5/14/2024- 157.8 Lbs	recorded. recorded.		consultant, administrator, and/or Dietary Manager will address all identified during the audit to inclu providing a meal tray that reflects accurate diet to include supplem	the concerns ude s an	

Event ID: R0B411

Facility ID: 923038

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						<u>NO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. DOILDING			С
		345119	B. WING			5/17/2024
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COD	E	
		HABILITATION CENTER		3015 ENTERPRISE DRIVE		
NORTHEI				WILMINGTON, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 692	Continued From page	e 42	F 69	2		
		107's electronic health	103	physician orders and resident	preference	
		26/2024 physician order for		and education of dietary staff		
		nal supplement three times		will be completed by 6/24/14.		
		nd regular diet with enriched		On 6/12/24, the Director of Nu		
	meals.			initiated an audit of all resider		
				for weight monitoring to includ		
		ctitioner (NP) progress note		#107 and #19. This audit is to		
	appetite with stable d	ntinued with decreased		facility is obtaining weights pe orders for monitoring of reside		
	appente with stable u	lecime in weight.		significant weight changes.		
	Review of Resident #	107's electronic health		and/or the Assistant Director		
	record revealed a 3/2	26/2024 physician order for		(ADON) will address all conce		
	weekly weights.			identified during the audit to in	nclude but	
				not limited to obtaining weigh		
		107's 4/12/24 quarterly		indicated, notification of the p	-	
		IDS) indicated resident had irment. Resident #107's		significant weight loss for furth		
		ids and the resident was		the electronic record and edu		
		ght loss or weight gain of 5		staff. The audit will be comple		
	percent in past 30 da	ys or 10 percent in past 180		6/24/14.	,	
	days.			On 6/13/24, the administrator	and dietary	
	A 4/24/24 NP progres	ss note indicated resident		manager initiated an in-servic	•	
		r appetite and weight loss.		dietary staff regarding Prepar		
		dicated to continue with the		Trays with emphasis on ensu	•	
		utritional supplement and		tray is accurate with the meal	•	
		he progress note did not		per physician's order to includ		
	indicate Resident #10 care.)7 was receiving end of life		supplements and per residen The in-service also includes t		
				staff must notify the Dietary M	•	
	Observation of Resid	ent #107's lunch meal tray		any instance that the meal tra	-	
		2:40 PM revealed resident		meet the physicians order to i		
	was to receive enrich			supplements or resident prefe		
		of soup, a peanut butter and		in-service will be completed b	-	
		Mighty Shake nutritional		After 6/24/14, any dietary stat		
		al tray card further indicated		not completed the in-service	•	
		ti squash, zucchini, rice, s. Observation of the meal		it upon the next scheduled wo newly hired dietary staff will b		
	tray revealed Resider			I newly mieu uletal y Stall Will D	reparing	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY IPLETED
		345119	B. WING			0	C 5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		0/11/202 4
				30 [.]	15 ENTERPRISE DRIVE		
NORTHC	HASE NURSING AND RE	HABILITATION CENTER		W	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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 692	Continued From page	e 43	F 69	92			
	double vegetables, so	oup, a sandwich, or a Mighty plement on the meal tray.			Meal Trays.		
		I tray consisted of 2 chicken			On 6/10/24, the Staff Facilitator initiate	ed	
		ving of macaroni and cheese			an in-service with the nursing assistan		
	and a single serving of	of coleslaw.			(NA) and nurses regarding Meal Deliv		
					with emphasis on (1) ensuring meal tra		
		ent #107's lunch meal tray			accurate for the meal tray card to inclu		
		PM revealed resident did not			supplements and resident preferences immediately notifying the dietary	s (2)	
	her meal tray.	ke nutritional supplement on			department when the meal tray is not		
	nor mour ady.				accurate and (3) obtaining a new mea	I.	
	An interview was con	ducted on 5/14/24 at 12:45			supplements or items per resident	,	
	PM with Resident #10	07. Resident #107 stated			preference when indicated. The in-ser	vice	
		milk shake on her meal tray.			will be completed by 6/24/14.		
		would really like a milk			After 6/24/24, any nurse or nursing		
	shake.				assistant who has not completed the in-service will complete it upon the nex	v t	
	An interview was con	ducted on 5/15/24 at 11:30			scheduled work shift. All newly hired	×ι	
		ed Dietitian (RD). The RD			nurses or NAs will be in-serviced durir	na	
		ted a clinical review of the			orientation regarding Meal Delivery.	.9	
		status and did not routinely			On 6/10/24, the Staff Facilitator initiate	ed	
	observe or interview t	the residents. The RD			an in-service with all nurses regarding		
		e Resident #107 was not			Following Physician's Orders with		
		osing weight. The RD stated			emphasis on obtaining weights per		
	-	/ Resident #107 continued to further stated she was not			physician orders for residents that required weight monitoring for significa	ant	
		#107 had not received her			weight changes, notification of the	ann	
	nutritional supplemen				physician for further recommendations	S.	
					notification of the resident/resident	,	
	An interview was con	ducted on 5/16/24 at 3:30			representative of weight changes with		
		actitioner (NP). The NP			documentation in the electronic record	Ι.	
	-	ed that residents would			The in-service will be completed by		
		pplements as ordered and			6/24/14. After 6/24/14, any nurse who		
	weekiy weights would	be completed as ordered.			not completed the in-service will comp it upon the next scheduled work shift.		
	An interview was con	ducted on 5/17/24 at 9:50			newly hired nurses will be in-service	/ All	
		Anager. The Dietary			during orientation regarding Following		
		expected that supplements			Physician's Orders.		
		l trays as ordered. The			The Dietary Manager and/or the assis	tant	

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/25/202 MAPPROVE: 0. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY PLETED
		345119	B. WING		05	C 5/17/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	/////2024
				3015 ENTERPRISE DRIVE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 692	Continued From page	e 44	F 69	2		
		ed she received the order for	1 00	administrator will audit 10% of n	peal trave	
		ment from nursing and then		to include all meals weekly x 4 v		
		ray card along with the likes		monthly x 1 month utilizing the N		
		special items the resident		Audit Tool. This audit is to ensur	•	
	was to receive. The			meal trays were accurate per ph		
	responsible for placir	ng the supplements on the		order to include supplements an	d per	
	trays. The Dietary M	anager stated sometimes		resident preference. The Dietary	/ Manager	
	she ran out of supple	ments including Mighty		and/or the assistant administrate		
	Shakes. The Dietary	-		address all concerns identified of	-	
		hty Shake supplement in		audit to include providing a mea	-	
	-	anager stated it was an		reflects an accurate diet to inclu		
		ent #107 did not receive her		supplements per physician orde		
		dered and that the extra r lunch tray on 5/13/24. The		resident preference and re-train dietary staff. The Administrator	•	
		ed she had a lot of new staff,		the Meal Tray Audit tools weekly		
		t them to pay attention to the		weeks then monthly x 1 month t		
	-	Dietary Manager further		all concerns are addressed.	e eneure	
	-	of staff turnover, and she				
		to train new staff and trying		The Assistant Director of Nursin	g, staff	
		ere doing things properly.		facilitator and/or Quality Assurar	nce Nurse	
				will review 10 % of residents wi	th orders	
	An interview was con	nducted on 5/17/24 at 1:50		for weight monitoring for signific	ant weight	
		rator. The Administrator		changes weekly x 4 weeks then		
		the residents to receive		1 month utilizing the Weight Auc		
		nts as ordered and weekly		This audit is to ensure weights v		
	weights were to be co	ompleted as ordered.		obtained per the physician order		
	The physician was n	ot available for interview on		provider was notified of significa changes with documentation in	-	
	5/17/24.	ot available for interview on		electronic record. The Assistant		
				of Nursing, staff facilitator and/o		
	2. Resident #19 was	admitted to the facility on		Assurance Nurse will address a		
		sis which included diabetes		concern identified during the au		
	and hypertension.			including assessment of the res		
				notification of the physician of si		
	Review of Resident #	#19's electronic health record		weight changes for further		
	revealed the following	g weights were recorded:		recommendations with documer		
				the electronic record and re-train	-	
	11/29/2023- 156.5 pc			staff. The DON will review the W	•	
	12/1/2023- 156.5 Lbs	3.		Audit Tool weekly x 4 weeks the	n monthly	

Event ID: R0B411

Facility ID: 923038

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		MEDICAID SERVICES					NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	ATE SURVEY
			A. BUILDING	G			
		345119	B. WING				C)5/17/2024
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1 1	J5/1//2024
					15 ENTERPRISE DRIVE		
IORTHCH	IASE NURSING AND RE	HABILITATION CENTER			LMINGTON, NC 28405		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	١	(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETIO DATE
F 692	Continued From page	e 45	F 69	92			
	12/5/2023- 150.7 Lbs				x 1 month to ensure all areas of conc	ern	
	12/12/2023- 148.4 Lb	DS.			are addressed.		
	12/21/2023- 143.7 Lb						
	12/29/2023- 143.0 Lb				The Administrator and/or DON will protect the findings of the Magil Trave Audit Te		
	1/11/2024- 147.3 Lbs 1/30/2024- 142.2 Lbs			the findings of the Meal Tray Audit To and the Weight Audit Tool to the Qual			
	2/9/2024- 140.0 Lbs.	5.			Assurance and Performance	пу	
	3/7/2024- 141.6 Lbs.				Improvement (QAPI) Committee mon	thly	
	3/12/2024- 135.0 Lbs				for 2 months for review to determine	uny	
	4/9/2024- 178.0				trends and/or issues that may need		
	4/9/2024- 178.0 docu	imented as incorrect			further interventions put into place an	d to	
	documentation.				determine the need for further freque	ncy	
	4/9/2024- 178.0 Lbs.				of monitoring.		
	Review of Resident #	t19's quarterly Minimum					
		essment dated 4/11/2024					
		d a weight of 178 pounds.					
	The MDS assessmer	nt indicated Resident #19					
	•	r weight gain of 5 percent in					
	30 days or 10 percen	it in 180 days.					
	A review of Resident	#19's electronic health					
	record revealed a 4/1	1/2024 physician order for					
	daily weights for 2 we	eeks then weekly due to					
	43-pound weight gair	n in 1 month.					
	4/12/2024- 138.4 Lbs	8.					
	4/13/2024- 136.2 Lbs	S.					
	4/13/2024- 136.2 Lbs						
	4/14/2024- 135.6 Lbs						
	4/15/2024- 133.2 Lbs						
	4/16/2024- 133.9 Lbs						
	4/17/2024- 132.6 Lbs 4/18/2024- 132.2 Lbs						
	4/18/2024- 132.2 Lbs 4/19/2024- 132.4 Lbs						
	4/19/2024- 132.4 Lbs 4/20/2024 No weight						
	4/20/2024 No weight						
	4/22/2024-133.3 Lbs						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-039		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345119	B. WING				C 17/2024	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER			015 ENTERPRISE DRIVE VILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
F 692	 4/23/2024- 133.4 Lbs 4/24/2024- 131.5 Lbs 4/25/2024- 134.7 Lbs 5/2/2024 No weight re 5/6/2024- 132.6 Lbs. 5/13/2024 No weight 5/14/2024- 129.7 Lbs A physician order data regular diet. A 4/19/2024 physiciar #19 was to receive M time a day for addition Observation of Reside 5/13/2024 at 12:45 Pl received a regular car carbohydrate diet. Th Resident #19 was to receive a regular car carbohydrate diet. Th Resident #19 was to receive a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to receive a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #19 was to received a regular carbohydrate diet. Th Resident #12:45 Pl was observed on the Interview with Reside 12:45 PM revealed sh meal that was served appetizing to her. Re thought she had lost whad crackers and juic indicated Resident #11 room of foods that he A 5/14/24 Nurse Prace indicated resident was 	 	F	692				

Facility ID: 923038

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345119	B. WING				/17/2024
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		-
NORTHC	ASE NURSING AND RE	HABILITATION CENTER			3015 ENTERPRISE DRIVE WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 692	and it appeared to be of the food at the facil regular diet. The prog that Resident #19 wa An interview was con Dietitian on 5/15/2024 stated she was follow significant weight loss #19 had a nutritional had not heard of any receiving it. The RD a chart review to eval nutritional status and trays or interview the receiving the nutrition contribute to continue Observation of Reside 5/16/2024 at 12:45 Pl was observed on the An interview was con PM with the Nurse Pr indicated if a resident nutritional supplement to receive the suppler further stated residen obtained as ordered. An interview was con PM with the Director of DON stated she expen nutritional supplement weights to be obtaine An interview was con AM with the Dietary M	from the dislike of the taste lity. Diet was advanced to press note did not indicate s receiving end of life care. ducted with the Registered 4 at 11:10 AM. The RD ring Resident #19 for s. The RD stated Resident supplement ordered and she issues with the resident not stated she mainly completed uate the resident's did not observe the meal resident. The RD stated not al supplement would ed weight loss. ent #19's meal tray on M revealed no Magic Cup meal tray. ducted on 5/16/2024 at 3:30 ractitioner (NP). The NP thad an order for a t, she expected the resident ment as ordered. The NP t weights were to be ducted on 5/16/2024 at 4:30 of Nursing (DON). The exted the residents to receive ts as ordered and resident d as ordered.	F	692			

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED: 06/25/2024 FORM APPROVED		
STATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY PLETED	
		345119	B. WING		C 05/17/2024		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,		
NORTHON			3	015 ENTERPRISE DRIVE			
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER	\	VILMINGTON, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692	Continued From page	e 48	F 692				
		l trays as ordered. The					
	Dietary Manager stat from nursing with ord	ed she received a diet slip					
	•	nges in the diet. The Dietary					
	Manager stated she	put the nutritional					
		eal tray ticket along with the I any special items the					
	resident received. Th	• •					
	responsible for placin	ng the supplements on the					
	meal trays. The Diet						
		ut of nutritional supplements Cups but currently she had					
		Dietary Manager stated it was					
		sident #19 did not receive her					
	÷ .	d this week. The Dietary had a lot of new staff, and it					
	•	to pay attention to the meal					
		ary Manager further stated					
		turnover, and she was ain new staff and trying to					
		doing things properly.					
	An interview was son	ducted on 5/17/2024 at 1:50					
		rator. The Administrator					
		the residents to receive					
		nts as ordered and resident					
E 745	weights to be obtained	ed as ordered. y Related Social Service	F 745			6/24/24	
	CFR(s): 483.40(d)		1745			0/24/24	
	§483.40(d) The facilit	ty must provide					
		cial services to attain or					
		practicable physical, mental Il-being of each resident.					
		Γ is not met as evidenced					
	by:						
		iew, and resident, staff and		F 745 Provision of Medically Related			
	Nurse Practitioner int	erviews, the facility failed to		Social Service			

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	ATE SURVEY	
	CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING	<u> </u>			
						С	
		345119	B. WING			05/17/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
		HABILITATION CENTER		3015 ENTERPRISE DRIVE			
NORTHO				WILMINGTON, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETIO DATE	
				DEFICIEN	CY)		
F 745	Continued From page		F 74	15			
		d an appointment scheduled					
		ed mammogram (Resident		On 5/24/24, Resident #22	received a		
	#22) for 1 of 1 reside	nt sampled for medically		mammogram per request.			
	related social service	S.					
				On 6/10/24, the administra			
	Findings included:			audit of grievances for the			
				This audit is to identify any	y resident		
	Resident #22 was ad	mitted to the facility on		concerns related to reques	sting outside		
	10/7/20. Resident #2	22's diagnoses included		medical appointments to in	nclude but not		
		of left breast keloid (thick		limited to requests for mar			
	-	from excessive growth of		had not been completed p	-		
	fibrous tissue).			preference/request. The tr			
				unit managers will address			
	Resident #22's quarte	erly Minimum Data Set		identified during the audit			
		indicated the resident was		scheduling an appointmer			
	cognitively intact.			indicated, notification of th			
	Deview of the facility			resident/resident represen			
		grievance log revealed a		appointment with docume			
		1 12/4/23 completed by the		electronic record and educ			
		the Director of Nursing/		The audit will be complete	d by 6/24/14.		
		or. The grievance was					
		22's request for a referral for		On 6/10/24, the Activity Di			
	-	ident #22 stated she had		resident questionnaires wi			
		tment for a mammogram,		oriented residents regardin	-		
		cheduled. The outcome of		Appointments to identify a			
	-	ed an appointment for a		concerns regarding obtain			
		be made for Resident #22.		medical appointments per			
		ance indicated Resident #22		appointments requested the			
		tial resection of the left		been scheduled. The Soci			
		uest for a mammogram.		the Director of Nursing wil			
		ted follow up was to be		concerns identified during			
		er regarding the request for		include scheduling appoin	tments when		
	a mammogram. Griev	vance resolution was issued		indicated and education of	f staff. The		
	to the resident on 12/	/6/23. Review of a 12/6/23		questionnaires will be com	pleted by		
	letter addressed to R	esident #22 indicated		6/24/14.			
	resident requested ar	n appointment for a					
	-	an appropriate investigation		On 6/10/24 the administra	tor initiated an		
	supervised by the gri			in-service with the transpo			
		w up would be made with the		scheduler, social worker, a			

Facility ID: 923038

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	דאם (צצ)	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
						С
		345119	B. WING		0	5/17/2024
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
		HABILITATION CENTER		3015 ENTERPRISE DRIVE		
				WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 745	Continued From page	e 50	F 74	5		
		quest for a mammogram.		regarding Requests for	Medical	
				Appointments with emp		
		ohysician progress note		residents are provided		
	revealed Resident #2			social services to attain		
	• • • • • •	intment. The progress note		highest practicable phy		
	schedule a mammog	an would write an order to		psychosocial well-being and/or referrals for serv		
				completed timely per pl		
	Review of Resident #	22's physician orders		and/or resident prefere		
		hysician order to schedule a		referrals to outside prov		
	mammography appoi	intment.		indicated. The in-servic		
				provider, resident and A		
		22's electronic health record		should be notified if an		
		urse Practitioner progress resident again requested a		cannot be scheduled fo appointment cannot be	-	
		gram. The order was		the requested time fram		
		schedule the mammogram.		will be completed by 6/2		
		0		6/24/24, any transporta		
	An interview was con	ducted on 5/13/24 at 12:04		social worker, or nurse	that has not	
		2. Resident #22 stated she		completed the in-servic	-	
		ment for a mammogram,		upon the next schedule		
		cheduled. Resident #22		newly hired transportati		
		ory of a cyst in her breast ammogram for several		social workers, and nur in-serviced during orien		
	years.			Requests for Medical A		
		ew was conducted on		The Assistant Administr		
	5/16/24 at 12:26 PM			worker will review 10%		
		she filed a grievance in		for outside medical app		
	mammogram to be s	rding her request for a cheduled and the		concerns related to me request per resident pre		
	appointment had still			but not limited to reque		
		indicated she had breast		mammograms weekly >		
	-	ned about the appointment		monthly x 1 month utiliz	zing the Consult	
		Resident #22 stated she		Audit Tool. This audit is		
		urse Practitioner had written		residents receive prope		
	a referral several mo	-		assistive devices to ma		
	appointment, but it ha	ad not been scheduled.		that requests and/or ref	enals for eye care	

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FOR	D: 06/25/2024 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345119	B. WING				C / 17/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
NORTHCH	HASE 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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	An interview was con PM with the Transpor Transportation Specia responsible for scheo transportation for the position for the past y Specialist stated she the nursing staff, fam providers. The Trans she had not made an Resident #22. She si while back that Resid appointment for a ma Transportation Specia working on trying to g resident for a mamma Specialist stated she #22 needed to be tran to obtain stretcher trans An interview was con PM with the Unit Man stated she was not an Resident #22 to have the provider in Februar indicated the Transpon have been notified of in February to schedu Resident #22. An interview was con PM with the Nurse Pr revealed she would e facility was not able to or if there was a delat appointment for a ma	ducted on 5/15/24 at 12:10 tation Specialist. The alist stated she was luling appointments and residents and was in the year. The Transportation was informed of referrals by ily members and the portation Specialist stated y appointments lately for tated she was informed a lent #22 required an immogram. The alist stated she was still let an appointment for the ogram. The Transportation was not sure how Resident insported and it was difficult insportation. ducted on 5/15/24 at 1:45 lager. The Unit Manager ware of a referral for a mammogram written by ary. The Unit Manager ortation Specialist should the physician order written ule a mammogram for ducted on 5/16/24 at 3:25 factitioner (NP). The NP expect to be notified if the o schedule an appointment y in obtaining an immogram. The NP mammogram was indicated should have been	F	745	physician order and resident preferent include referrals to outside providers when indicated. The transporter/ scheduler and unit manager will addread all concerns identified during the audi include scheduling appointments whe indicated, notification of the provider, resident/resident representative of the appointment with documentation in the electronic record and re-training of st. The DON will review the Consult Aud Tool weekly x 4 weeks then monthly x month to ensure all concerns are addressed. The DON will present the findings of the Consult Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee mont for 2 months for review to determine trends and/or issues that may need further interventions put into place and determine the need for further frequent of monitoring.	ess t to en e aff. it c 1 the thly d to	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345119	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER	040110		STREET ADDRESS, CITY, STATE, ZIP CODE	05/17/2024
				3015 ENTERPRISE DRIVE	
NORTHC	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 745	Continued From page	e 52	F 745		
		ated the NP that evaluated uary no longer worked at the			
F 760 SS=E	PM with the Administ stated Resident #22 I December regarding mammogram and the was that administratic Administrator stated s appointment would be written, and 5 months obtain an appointmer she did not know why the process to obtain mammogram followin Residents are Free o	e resolution of the grievance on would follow up. The she expected the e made when an order was s was too long to wait to nt. The Administrator stated / there was a breakdown in the appointment for the	F 760		6/24/24
	medication errors. This REQUIREMENT by: Based on record rev Consultant, and Nurs facility failed to 1a.) a antihypertensive med prescribed to lower b diabetic medication T blood sugar , a phosp medication prescribed phosphorus in the blo and Cymbalta prescri hemodialysis residen treatments. This resu	T is not met as evidenced iew, and staff, Pharmacy e Practitioner interviews the dminister the lication Metoprolol lood pressure, the oral tradjenta prescribed to lower obtate binder Sevelamer (a d to lower the amount of bod when receiving dialysis), ibed for neuropathy to a t after returning from dialysis		F 760 Free of Significant Med Errors On 6/12/24, the unit manager assessed Resident #17 and reviewed the electronic medication administration record (eMAR) to ensure the resident was administered medication per physician orders. The uni manager updated the provider on resider assessment and reviewed the eMAR/missing doses with the provider and adjusted medication times with dialysis days to ensure the resident receives medications per physician) t

Event ID: R0B411

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						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	PLE CONSTRUCTION		E SURVEY IPLETED
			A. BUILDIN	IG		С
		345119	B. WING		04	5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		, 11/2024
				3015 ENTERPRISE DRIVE		
NORTHC	HASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETIC DATE
		,			IENCY)	
F 760		- 50				
F 700			F 7			
	Sevelamer, and 8 dos	of Tradjenta, 15 doses of ses of Cymbalta. 1b.) urse of the oral antifungal		orders. The Director of updated the eMAR.	Nursing (DON)	
		or treatment of vaginitis		On 6/13/24, the unit ma	naders initiated an	
		sicians order (Resident #17).		audit of all residents rec		
		he 3 doses of Diflucan not		This audit is to ensure r		
		curred for 1 of 5 resident		administration times are		
		ion administration (Resident		accommodate dialysis of	-	
	#17).			medications are admini	-	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			physician's order. The u		
				DON will address all co	-	
	Findings included.			during the audit to inclu		
				resident, verifying with t	-	
	1a.) Resident #17 wa	is admitted to the facility on		administration times to		
		ses including hypertension,		dialysis days and educa		
	diabetes, end stage r			audit will be completed		
	neuropathy.					
				On 6/13/24, the unit ma	nager, nurse	
	A physician's order da	ated 03/26/24 for Resident		supervisor, and Quality		
	#17 revealed Hemodi			initiated an audit of all e		
	Thursday, Saturday a			medications were admin	nistered per	
				physician order to inclue	-	
	A physician's order da	ated 04/02/24 for Resident		receiving dialysis and/o		
		olol Succinate extended		antibiotic therapy. The u		
		(mgs). Give one tablet by		and/or the Director of N	•	
	mouth daily for hyper			all concerns identified d	-	
				include assessment of t	-	
	Review of Resident #	17's Medication		notification of the provid	ler if medications	
	Administration Record	d (MAR) dated April 2024		not administered or not		
	revealed Metoprolol S	Succinate extended release		administer per physicial	n order for further	
	50 milligrams was scl	heduled for administration		recommendations with	documentation in	
	daily at 8:00 AM. The	MAR had chart code "3"		the electronic record. The	he audit will be	
	documented on the fo	ollowing dates indicating the		completed by 6/24/24.		
	medication was not a	dministered due to Resident				
	#17 was out of the fac	cility.		On 6/12/24, the Directo	r of Nursing (DON)	
				and the Assistant Direct	tor of Nursing	
	04/02/24 (Tuesday) 8	8:00 AM: out of the facility.		(ADON) initiated an aud	lit of all	
	04/04/24 (Thursday)	8:00 AM: out of the facility.		medications listed as "n	ot available" to	
	04/06/24 (Saturday) 8	3:00 AM: out of the facility.		administer from 5/9/24-	6/9/24 This audit	

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		TE SURVEY	
			A. BOILDING			С	
		345119	B. WING)5/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
		HABILITATION CENTER		3015 ENTERPRISE DRIVE			
NORTHER	ASE NORSING AND RE	HABILITATION CENTER		WILMINGTON, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 760	Continued From page	e 54	F 76	in l			
		8:00 AM: out of the facility.		is to ensure medications are	available and		
		8:00 AM: out of the facility.		administered per physician o			
		8:00 AM: out of the facility.		DON will address all concern			
		8:00 AM: out of the facility.		during the audit to include ob			
		8:00 AM: out of the facility.		medications from pharmacy			
		8:00 AM: out of the facility.		notification of the physician f			
	· ····································			recommendations when med			
	Review of Resident #	17's Medication		cannot be obtained. The aud	lit will be		
	Administration Recor	d (MAR) dated May 2024		completed by 6/24/24.			
		Succinate extended release					
		heduled for administration		On 6/13/24, the Staff Facilita	tor initiated		
		MAR had chart code "3"		an in-service with all nurses	regarding		
	documented on the fo	ollowing dates indicating the		Following Physician's Orders	s with		
	medication was not a	dministered due to Resident		emphasis on (1) ordering me	dications		
	#17 was out of the fa	cility.		timely to ensure medication a	available to		
				administer per physician orde	er, (2)		
		8:00 AM: out of the facility.		obtaining medications from e	Kit or back		
		8:00 AM: out of the facility.		up pharmacy when not imme			
		8:00 AM: out of the facility.		available (3) notification of th			
		8:00 AM: out of the facility.		when medications to include			
		8:00 AM: out of the facility.		cannot be obtained for furthe	er instructions		
	05/16/24 (Thursday)	8:00 AM: out of the facility.		and/or alternative medication			
				medication times for resident			
		ated 04/04/24 for Resident		receive dialysis to ensure me			
		ta 5 milligrams. Give one		administered per physician o			
	tablet once daily for d	liabetes.		completing the full course of			
				therapy unless otherwise ord	•		
	Review of Resident #			physician. The in-service will	ii de		
		d (MAR) dated April 2024		completed by 6/24/24.			
		mgs give one tablet once		After 6/24/24 any purpo who	has not		
	daily for diabetes was	t 8:00 AM. The MAR had		After 6/24/24, any nurse who worked or received the in-se			
		nented on the following dates		complete it upon the next scl			
		tion was not administered		shift. All newly hired nurses v			
	-	was out of the facility.		in-serviced during orientation			
		the out of the lability.		Following Physician's Orders			
	04/04/24 (Thursday)	8:00 AM: out of the facility.		The Unit Managers, Assistar			
		8:00 AM: out of the facility.		Nursing (ADON), and/or Nur			
		8:00 AM: out of the facility.		will review the Orders Listing			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 06/25/202 FORM APPROVE OMB NO. 0938-039			
TATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY PLETED		
		345119	B. WING			C / 17/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		11/2024		
				3015 ENTERPRISE DRIVE				
NORTHC	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 760	Continued From pag	e 55	F 76	30				
	10	8:00 AM: out of the facility.	170	medications not administer	ad ta includa			
		8:00 AM: out of the facility.		antibiotics 5 times a week x				
		8:00 AM: out of the facility.		monthly x 1 month. This au				
		8:00 AM: out of the facility.		medications were available				
		8:00 AM: out of the facility.		administered per physician				
		8:00 AM: out of the facility.		antibiotics were administered				
		-		complete course prescribed	and/or the			
	Review of Resident #	417's Medication		physician notified if medicat	tions could not			
	Administration Recor	d (MAR) dated May 2024		be administered for further				
		mgs give one tablet once		recommendations with docu				
	daily for diabetes wa			the electronic record. The L				
		at 8:00 AM. The MAR had		ADON and/or Nurse Superv				
		nented on the following dates		address all concerns identif	•			
	-	ation was not administered		audit to include obtaining m				
		was out of the facility.		when indicated, notification				
	05/02/24 (Thursday)	8:00 AM: out of the facility.		physician when medications obtained for further instruct				
		8:00 AM: out of the facility.		documentation in the electro				
		8:00 AM: out of the facility.		and/or re-training of staff. T				
		8:00 AM: out of the facility.		Nursing (DON) will review t				
		8:00 AM: out of the facility.		Listing Report weekly x 4 w				
		8:00 AM: out of the facility.		monthly x 1 month to ensur				
				are addressed.				
		ated 04/02/24 for Resident		The Quality Assurance (QA	·			
		mer 800 milligrams. Give 2		Nurse Supervisor will audit	•			
	ladiels inree times a	day for Hypophosphatemia.		admitted/readmitted resider dialysis weekly x 4 weeks th	•			
	Review of Resident #	t17's Medication		1 month utilizing the Dialysi	•			
		d (MAR) dated April 2024		This audit is to ensure med				
		800 mgs. Give 2 tablets		administration times are ad				
		Hypophosphatemia was		accommodate dialysis days	,			
	-	stration three times a day at		medications are administer				
		and 4:00 PM. The 8:00 AM		physician's order. The QA	•			
	dose had chart code	"3" documented on the		the Nurse Supervisor will a				
	-	ating the medication was not		concerns identified during the				
		Resident #17 was out of the		include assessing the resid				
	-	/ and 4:00 PM doses were		with the physician administr				
	signed as administer	ed.		accommodate dialysis days	and			

Facility ID: 923038

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						NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	ATE SURVEY OMPLETED
						С
		345119				05/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	e 56	F 76	0		
	04/02/24 (Tuesday) 04/04/24 (Thursday) 04/06/24 (Saturday) 04/09/24 (Tuesday) 04/11/24 (Thursday) 04/16/24 (Tuesday) 04/16/24 (Tuesday) 04/23/24 (Tuesday) 04/25/24 (Thursday) 04/25/24 (Thursday) 04/25/24 (Thursday) 04/25/24 (Thursday) 04/25/24 (Thursday) 04/25/24 (Thursday) 04/25/24 (Thursday) 05/02/24 (Thursday) 05/02/24 (Thursday) 05/02/24 (Thursday) 05/02/24 (Thursday) 05/03/24 (Thursday) 05/11/24 (Saturday) 05/11/24 (Saturday) 05/14/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday)	 8:00 AM: out of the facility. 8:00 AM:		 re-training of staff. The DON will the Dialysis Audit Tool weekly x 4 then monthly x 1 month to ensure areas of concern are addressed. The Director of Nursing will forwa Orders Listing Report, and Dialys Tool to the Quality Assurance and Performance Improvement (QAP Committee monthly for two (2) mreview and to determine trends a issues that may need further interput into place and to determine the for further and / or frequency of monitoring. 	weeks all and the sis Audit d l) onths for nd / or rventions	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP		
		345119	B. WING				17/2024	
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	-	
NORTHC	ASE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	neuropathy was sche 9:00 AM daily. The M documented on the for medication was not a #17 was out of the fac 04/25/24 (Thursday) 04/30/24 (Tuesday) 04/30/24 (Tuesday) Review of Resident # Administration Record revealed Cymbalta 60 release. Give 30 mgs neuropathy was sche 9:00 AM daily. The M documented on the for medication was not a #17 was out of the fac 05/02/24 (Thursday) 05/07/24 (Tuesday) 05/07/24 (Tuesday) 05/01/24 (Tuesday) 05/11/24 (Saturday) 05/11/24 (Tuesday) 05/16/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday) 05/16/24 (Thursday) The Minimum Data S assessment dated 04 #17 had moderately in no rejection of care an A progress note docu Practitioner dated 05/ Resident #17 was ale place, and time. She wheelchair at the nursi	duled for administration at AR had chart code "3" ollowing dates indicating the dministered due to Resident cility. 9:00 AM: out of the facility. 9:00 AM: out of the facility. 17's Medication d (MAR) dated May 2024 0 mgs oral capsules delayed by mouth in the morning for duled for administration at AR had chart code "3" ollowing dates indicating the dministered due to Resident cility. 9:00 AM: out of the facility. 9:00 AM:	F	760				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/25/2024 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION			LETED
		345119	B. WING			(05/	」 17/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	TE, ZIP CODE	_	
NORTHC	ASE NURSING AND RE	HABILITATION CENTER		8015 ENTERPRISE DRIVE WILMINGTON, NC 28405	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 760	was 144 mg/dl (milligi cardiovascular exam at her baseline. Neuro (bilateral below knee right hand were minin During an interview of Medication Aide #1 st #17 was at dialysis sh indicating Resident # the time the medication once she documented of the facility the med again on the MAR. Sh were not given once F dialysis because it did needing to be administ During an interview of Director of Nursing st who documented Res facility for the dates th administered in April a available for interview away on vacation and to contact Nurse #5 a She stated the Medication adjusted to administe returned from dialysis During a phone interview the Nurse Practitioner evaluated Resident # 05/15/24. She indicator	r minute. Her blood sugar rams per deciliter). The indicated Resident #17 was opathic pain of stumps amputation) to thighs and hal. She had no tremors. In 05/17/24 at 1:00 PM ated on the days Resident he documented code "3" 17 was out of the facility at ons were due. She stated d that the resident was out ication would not show up he stated the medications Resident #17 returned from d not show on the MAR as stered. In 05/17/24 at 2:00 PM the ated Nurse #4 and Nurse #5 sident #17 was out of the he medication was not and May 2024 were not v. She stated Nurse #4 was d she made attempts today nd there was no response. al Director was unavailable family emergency. She times should have been r to Resident #17 after she and that was not done.	F 760				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345119	B. WING				C / 17/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHC	ASE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SHOULD BE COMPLI		
F 760	Metoprolol was presc control high blood pre pressure reading on ((systolic/diastolic). Sh pressures have been Tradjenta was presch additional protection f received sliding scale blood sugars were sta Cymbalta was presch there had been no rej adverse symptoms. S prescribed to Residen dialysis and was a ph indicated her phosphe normal limits and no a had been reported fro Resident #17 was ale her wheelchair throug there had been no rej change of condition a should have been adj dialysis. She indicate exhibited any significa receiving the Metopro Sevelamer daily. 1b.) A physician's ord Resident #17 reveale Give one tablet by mo other day for vaginitis Review of the Medica (MAR) dated May 202 Diflucan 150 milligram	ribed to Resident #17 to essure and her blood 05/15/24 was 116/76 he indicated her blood okay. She stated the bloed to Resident #17 for for diabetes and she also insulin. She stated her able. She indicated the ibed for neuropathy and ports of increased pain or she stated Sevelamer was nt #17 due to being on osphate binder. She porus levels were within abnormal phosphorus levels om dialysis staff. She stated ert, oriented, and typically in shout the day. She stated ports to her regarding a nd the medication times usted to account for d Resident #17 had not ant outcome from not blol, Tradjenta, Cymbalta, or er dated 04/30/24 for d Diflucan 150 milligrams. buth in the morning every 	F	760				

Facility ID: 923038

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/25/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345119	B. WING					C 17/2024
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, Z	IP CODE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER			8015 ENTERPRISE DRIVE WILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BI		(X5) COMPLETION DATE
F 760	beginning 05/01/24. T code "10" documente indicating the medicar MAR read as follows: 05/01/24 9:00 AM "10 05/03/24 9:00 AM "10 05/05/24 9:00 AM "10 Nesident #17 was eva infection. She was al place, and time. She wheelchair at the nurs She was positive for u would start Gentamyo (intramuscular) daily f During a phone interv the Consultant Pharm Diflucan was received 04/30/24 at 7:00 PM. tablets on 05/01/24. She also kept in the e-kit (containing extra dose use) in the facility. He Diflucan were availab the facility. She report the full course of the n administration on 05/0 was not aware of any Resident #17 not received treatment.	The medication had chart d on the following dates tion was not available. The " medication not available. " medication not available. " medication not available. " medication was signed as " mented by the Nurse 15/24 revealed in part; aluated for urinary tract ert and oriented to person, was sitting in her ses station in no distress. urinary tract infection and tin 80 mgs IM for 7 days. The Pharmacy dispensed 3 She stated the order for a at the Pharmacy on The Pharmacy dispensed 3 She stated Diflucan was kit located in the facility s of medications for backup r record showed 6 doses of le on 05/01/24 in the e-kit at ted they should have had medication available for 01/24. She indicated she	F	760				

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FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	345119	B. WING		C 05/17/2024
OVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP (
ASE NURSING AND RE	HABILITATION CENTER			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
Continued From page	e 61	F 76	n	
Director of Nursing st who documented the available on 05/01/24 available for interview #4 was away on vaca attempts today to cor no response. During a phone intervi- the Nurse Practitione that Resident #17 did Diflucan. She stated in and one dose (150 m sufficient. She stated effectively clear her s evaluated Resident # symptoms of urinary prescribed Gentamyous treatment. She indication	ated Nurse #4 and Nurse #5 medication was not and 05/03/24 were not w. She reported that Nurse ation, and she had made ntact Nurse #5 and there was view on 05/17/24 at 3:30 PM r stated she was not aware I not get the 3 doses of it was prescribed for vaginitis rgs) of Diflucan could be she prescribed 3 doses to ymptoms. She stated she i17 on 05/15/24 for tract infection (UTI) and cin IM (intramuscular) for UTI tted although Resident #17 ry tract infection it was not			
During an interview o Director of Nursing (D MAR indicated the m She stated the Nurse kit while waiting for th the Pharmacy. She ir was available the MA account for the misse education had alread medication administra was made aware of th	n 05/17/24 at 4:00 PM the DON) stated "10" on the edication was not available. should have checked the e- ne medication to come from indicated once the medication R was not adjusted to ed doses. She stated y been started on ation last night when she he concern with Diflucan.			
	S FOR MEDICARE & DEFICIENCIES CORRECTION OVIDER OR SUPPLIER ASE NURSING AND RE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page Director of Nursing st who documented the available for interview #4 was away on vaca attempts today to cor no response. During a phone interv the Nurse Practitione that Resident #17 did Diflucan. She stated and one dose (150 m sufficient. She stated effectively clear her s evaluated Resident # symptoms of urinary prescribed Gentamyce treatment. She indica was positive for urina necessarily a direct re course of Diflucan for During an interview of Director of Nursing (I MAR indicated the m She stated the Nurse kit while waiting for th the Pharmacy. She ir was available the MA account for the misse education had alread medication administra was made aware of the	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345119 OVIDER OR SUPPLIER ASE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 Director of Nursing stated Nurse #4 and Nurse #5 who documented the medication was not available on 05/01/24 and 05/03/24 were not available for interview. She reported that Nurse #4 was away on vacation, and she had made attempts today to contact Nurse #5 and there was no response. During a phone interview on 05/17/24 at 3:30 PM the Nurse Practitioner stated she was not aware that Resident #17 did not get the 3 doses of Diflucan. She stated it was prescribed for vaginitis and one dose (150 mgs) of Diflucan could be sufficient. She stated she prescribed 3 doses to effectively clear her symptoms. She stated she evaluated Resident #17 on 05/15/24 for symptoms of urinary tract infection (UTI) and prescribed Gentamycin IM (intramuscular) for UTI treatment. She indicated although Resident #17 was positive for urinary tract infection it was not necessarily a direct result from not getting the full course of Diflucan for vaginitis. During an interview on 05/17/24 at 4:00 PM the Director of Nursing (DON) stated "10" on the MAR indicated the medication was not available. She stated the Nurse should have checked the e- kit while waiting for the medication to come from the Pharmacy. She indicated once the medication was available the MAR was not adjusted to account for the missed doses. She stated education had already been started on medication administration last	EDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING 345119 B. WING OVIDER OR SUPPLIER 345119 ASE NURSING AND REHABILITATION CENTER ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 61 F 760 Director of Nursing stated Nurse #4 and Nurse #5 who documented the medication was not available on 05/01/24 and 05/03/24 were not available on 05/01/24 at 3:30 PM the Nurse Practitioner stated she was not aware that Resident #17 did not get the 3 doses of Diflucan. She stated it was prescribed for vaginitis and one dose (150 mgs) of Diflucan could be sufficient. She stated she prescribed 3 doses to effectively clear her symptoms. She stated she evaluated Resident #17 on 05/15/24 for symptoms of urinary tract infection (UTI) and prescribed Gentamycin IM (intramuscular) for UTI treatment. She indicated although Resident #17 was positive for urinary tract infection it was not necessarily a direct result from not getting the full course of Diflucan for vaginitis. During an interview on 05/17/24 at 4:00 PM the Director of Nursing (DON) stated "10" on the MAR indicated the medication was not available. She stated the Nurse should have checked the e- kit while waiting for the medication to come from the Pharmacy. She indicated once the medication was available the MAR was not adjusted to account for the missed doses. She stated education had already been stated on medication administration last night when she <td>FOR MEDICARE & MEDICAID SERVICES "DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 346119 STREET ADDRESS, CITY, STATE, ZP G STREET ADDRESS, CITY, STATE, ZP G CONTINUE AT CITY, STATE, ZP G STREET ADDRESS, CITY, STATE, ZP G STREET ADDRESS, CITY, STATE, ZP G STREET ADDRESS, STREET STREET ADDRESS, STREET STREET ADDRESS, STREET ADDRESS, STREET ADDRESS, STREET ADDRESS, STREET ADDRESS, STREET ADDRESS, STREET ADDRESS, STREET</td>	FOR MEDICARE & MEDICAID SERVICES "DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 346119 STREET ADDRESS, CITY, STATE, ZP G STREET ADDRESS, CITY, STATE, ZP G CONTINUE AT CITY, STATE, ZP G STREET ADDRESS, CITY, STATE, ZP G STREET ADDRESS, CITY, STATE, ZP G STREET ADDRESS, STREET STREET ADDRESS, STREET STREET ADDRESS, STREET ADDRESS, STREET

Facility ID: 923038

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/25/2024 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345119	B. WING				C 17/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
NORTHCH	ASE NURSING AND REI	HABILITATION CENTER			015 ENTERPRISE DRIVE /ILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls, personnel to have acco §483.45(h)(2) The faci locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to secure left unattended and un lock while the cart wa resident rooms. This was	1)(2) of Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. Fility must provide separately affixed compartments for drugs listed in Schedule II of brug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can f is not met as evidenced and staff interviews the e a medication cart that was nlocked with the keys in the s in the hallway near was observed for 1 of 4 ewed for medication storage.	F	761	F 761 Label/Store Drugs and Biologic On 5/13/24, the Director of Nursing (D verbally educated Nurse #3 regarding Medication Storage with emphasis on ensuring the medication cart is locked when not directly supervised by the assigned nurse. The medication cart w immediately secured by the hall nurse	ON) vas	

Event ID: R0B411

Facility ID: 923038

If continuation sheet Page 63 of 84

			()(0)			NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED		
						С		
		345119	B. WING			05/17/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE		
F 761	Continued From page	e 63	F 76	51				
	During an observatio	n on 05/13/24 at 03:10 PM		On 6/11/24, the administra	ator completed			
		n the 400 hallway was		an audit of all medication				
		l and unlocked with the cart		is to ensure all medication				
		The nurse was not in site of		locked when not directly s	• •			
		s standing 3 feet away from The nurse was observed		assigned nurse. No addit were noted.				
		ent's room from down the		were noted.				
	hallway approximatel			On 5/13/24 by the admini	strator with all			
	5 11	,		nurses and medication aid				
	÷	on 05/13/24 at 3:15 PM		Medication Storage with e				
		got distracted when she was		removing keys and securi				
		dent. She acknowledged she		cart when not directly sup	•			
	-	e medication cart and left the the cart unlocked. She stated		assigned nurse/medicatio				
	it was done in error.	the cart unlocked. One stated		After 6/24/24, any nurse of	-			
				aide who has not worked				
	During an interview o	on 05/17/24 at 11:43 AM the		in-service will complete it	upon the next			
		tated Nurse #3 reported to		scheduled work shift. All r	•			
		ne stated Nurse #3 was		nurses or medication aide				
		's room in a hurry and left the		in-service during orientation				
		dicated education would be		Medication Storage. All ne	-			
	provided.			nurses and medication aid in-serviced during orienta				
				Medication Storage.	lon regarding			
				The unit managers and Q				
				(QA) Nurse will audit all m				
				twice weekly x 4 weeks, the month utilizing the Medica	•			
				This audit is to ensure all				
				were locked and keys ren				
				under direct supervision c	of the nurse. The			
				nurse and/or medication a				
				immediately re-trained by				
				Manager, QA nurse, and				
				for any identified areas of DON will review the Medie				
				for completion and to ens				

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ATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>1</i>	CONSTRUCTION	(X3) DA	<u>NO. 0938-03</u> TE SURVEY MPLETED
		345119	B. WING			С
	ROVIDER OR SUPPLIER	545119		TREET ADDRESS, CITY, STATE, ZIP CODE	0	5/17/2024
	KONDER OR SOLT EIER			015 ENTERPRISE DRIVE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		VILMINGTON, 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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 761	Continued From page	9 64	F 761	4 weeks, then monthly x 1 mon	ith.	
				The Director of Nursing will for Medication Audit Tool to the Qu Assurance and Performance Improvement (QAPI) Committe for two (2) months for review and determine trends and / or issue need further interventions put in and to determine the need for f / or frequency of monitoring.	ward the iality e monthly nd to is that may nto place	
F 804 SS=E	CFR(s): 483.60(d)(1) §483.60(d) Food and		F 804			6/24/24
	§483.60(d)(1) Food p conserve nutritive val §483.60(d)(2) Food a attractive, and at a sa temperature. This REQUIREMENT	repared by methods that ue, flavor, and appearance; nd drink that is palatable,				
	and staff interview, th food was palatable ar temperature for 4 of 8 palatability and tempe #116, and #107) and members in attendan	n, record review, resident e facility failed to ensure nd served at an appetizing b residents reviewed for food erature (Residents #22, 5 of 5 Resident Council ce at a Resident Council 23, #119, #14, #75 and		F 804 Nutritive Value/Appear, Palatable/Prefer Temp On 6/13/24, the administrator of meal delivery for Resident #22, #107, and Resident #116. Durin observation, the meal trays we for resident preference and the verbalized the meal was served appropriate temperature and w to taste.	, Resident ng the re accurate resident d at the	
	-					

Event ID: R0B411

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		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	ATE SURVEY
		345119	B. WING			C
	ROVIDER OR SUPPLIER	040110		STREET ADDRESS, CITY, STATE, ZIP CODI		05/17/2024
	CONDERVOIR OR OUT FIELD			3015 ENTERPRISE DRIVE	-	
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 804	Continued From page	<u>- 65</u>	F 80	л		
1 001		is which included diabetes.	F 00		ducated	
				food preference survey and ea Resident #116 and Resident #		
	Resident #22's quarte	erly Minimum Data Set		regarding meal alternatives to		
		indicated the resident was		to request an alternative meal		
	cognitively intact.			preferences will be updated.		
	An interview was con	ducted with Resident #22 on		On 6/15/24, the Staff Facilitate	or completed	
	5/13/24 at 12:00 PM.	Resident #22 revealed the		a food preference survey and		
		t appetizing or cooked well.		Resident #22 regarding meal		
		she wished she could make		to include how to request an a		
	a choice about what	she received to eat.		meal. Any new preferences w updated.	ill be	
	Meal observation of F	Resident #22's lunch tray on				
		revealed resident received 2		On 6/13/24, the administrator	and Director	
		oop of potato salad and a		of Nursing (DON) initiated an		
		nd cheese. Resident refused		meal preparation to ensure for		
		he macaroni and cheese		prepared in a manner to be w		
	Resident #22 reques	ken tenders were hard.		and palatable to taste per reci administrator addressed all co	•	
		nt received 1 grilled cheese		identified during the audit to in		
	sandwich.			education of the cook when in		
				audit will be completed by 6/2		
	An interview was con	ducted on 5/14/24 at 9:12				
		2. Resident #22 indicated		On 6/13/24, the Admissions D		
		tly not hot when it was		Social Worker, Activities, Staf		
		ot palatable. Resident #22		and Activity Director initiated r		
	did not look or taste	ved cold food and food that		questionnaires regarding Mea with all alert and oriented resid	•	
				Questionnaires included (1) a		
	An interview was con	ducted on 5/17/24 at 9:50		served at an appetizing tempe		
		Manager. The Dietary		foods served hot/cold foods se	•	
	-	was not aware that Resident		not, do staff offer another tray		
		nplaints. The Dietary		food when indicated? (2) Is fo		
		esident #22 preferred grilled		seasoned to your liking, if not		
		dinner recently and the n per resident's preference.		provide salt/pepper/sugar whe requested? (3) are your food	*11	
		n per residents preierence.		preferences/dislikes honored?	lf not	
	An interview was con	ducted on 5/17/24 at 12:20		please explain and (4) Is food		
		rator. The Administrator		fully, tender and easy to const		

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		ATE SURVEY OMPLETED
						С
		345119	B. WING			05/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
NORTHCI	HASE NURSING AND RE	HABILITATION CENTER		3015 ENTERPRISE DRIVE WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 804	Continued From page	e 66	F 80)4		
		ware of Resident #22 having	1 00	please explain. The Administ	ator Social	
	any concerns about of	6		Worker, and Dietary Manager		
	,			all concerns identified during		
		nt #116's 3/19/24 quarterly		include updating food prefere	nces,	
		ADS) assessment revealed		offering additional meal tray/s	•	
	resident was cognitiv	ely intact.		when indicated and education		
				The questionnaires will be co	mpleted by	
		at 1:47 PM with Resident od often does not look or		6/24/14.		
		t #116 stated she frequently		On 6/13/24, the social worker	admissions	
	-	applement provided by her		director, and/or activity director		
		ng due to the meals being		resident food preference surv		
	-	e. Resident #116 stated her		alert and oriented residents.	•	
		old, not reheated and she		to ensure identify resident for	d	
	often could not eat it	because of this.		preferences and to ensure the		
				card reflects food preferences		
	Meal observation on			administrator will address all		
		116 had her lunch meal tray		identified during the audit to in		
		consisted of chicken and		updating food preferences wh		
		nd mashed potatoes and		indicated. The surveys will be	completed	
	few bites of her meal	6 indicated she had tried a		by 6/24/14. On 6/13/24, the staff facilitato	r (SE)	
		I the meal did not look		initiated an in-service with the		
		ot taste good. Resident was		assistants (NA) and nurses re	-	
		nutritional supplement that		Meal Delivery with emphasis		
	she received on her i	meal tray. Resident #116		ensuring meal tray is accurate	e for the	
	indicated she was dri	inking her supplement		meal tray card to include sup		
		could not eat the meal that		and resident preferences (2)		
		nt #116 stated she could ask		notifying the dietary departme		
		t was usually a peanut butter		meal tray is not accurate to in		
	since she had diabet	nd she could not eat that		resident preferences, tray is r an appetizing temperature to		
				or resident requests an altern		
	An interview was cor	nducted with the Registered		and (3) offering resident addit		
		5/24 at 11:15 AM. The RD		seasoning to include but not l		
		e position at the facility for 5		salt/pepper/sugar/butter to en		
	months. The RD sta	ted she was not aware of		palatable.		
	-	ood that was served. The				
	RD stated she was n	ot involved with the menu or		The in-service will be comple	ed by	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE C	ONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,				IPLETED
							С
		345119	B. WING			05	5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
NORTHC	ASE NURSING AND RE	HABILITATION CENTER			5 ENTERPRISE DRIVE		
				WI	LMINGTON, 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 804	Continued From page	e 67	F 8	04			
		ted her main role was to		-	6/24/14. After 6/24/14, any nurse or		
		ew of the resident's record			nursing assistant who has not comple	eted	
	1	ve interview of the resident			the in-service will complete it upon the		
		meals. The RD stated			next scheduled work shift. All newly h		
		gnificant weight loss. The			nurses or NAs will be in-service during		
		ot aware Resident #116 was			orientation regarding Meal Delivery.	5	
		due to concerns with the			On $6/13/24$, the administrator and sta	ff	
	•	d palatability. The RD did			facilitator (SF) initiated an in-service v		
		would follow up with the			the dietary staff regarding Preparing N		
	Dietary Manager.	·			Trays with emphasis on ensuring the		
					tray is accurate with the meal tray car		
	3. Resident #107 was	3. Resident #107 was admitted on 10/5/22.			per physician's order to include and p resident preference.		
	Review of Resident #			The in-service also includes the dieta	rv		
	record revealed a Nu			staff must complete test trays for	i y		
	note which indicated			temperature monitoring prior to sendi	na		
		ncerns that resident's			trays out to the units to ensure trays a		
		d resident was not eating the			served at preferable temperatures. The		
		note indicated Resident			in-service will be completed by 6/24/1		
	1 0	urse Practitioner that the			After 6/24/14, any dietary staff who ha		
		he progress note further			not completed the in-service will com		
	•	ad a poor appetite with a			it upon the next scheduled work shift.		
		s. The progress note did not			newly hired dietary staff will be in-service		
	-	was receiving end of life			during orientation regarding Preparing		
	care.	5			Meal Trays.	,	
					The activity director, admissions		
	Interview with Reside	ent #107 on 5/13/24 at 11:07			coordinator, dietary manager, and/or	the	
	AM revealed the food	l was not good. Resident			social worker will complete 5 resident		
	-	snacks in her room that her			questionnaires weekly x 4 weeks, the	n	
		ident #107 stated the food			monthly x 1 month regarding Meal		
		ot or palatable. Resident			Delivery with all alert and oriented		
		aff were aware she did not			residents. These questionnaires are t	0	
		y added the extra items that			identify any concerns related to meal		
		ved and sometimes she did			delivery and to ensure food was palat		
	not.				served at an appetizing temperature a	and	
					per resident preference. The Social		
		nch meal on 5/13/24 at			Worker and Dietary Manager will add		
		esident #107's meal tray			all concerns identified during the audi	t to	
	ticket indicated reside	ent was to receive a regular			include updating food preferences,		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY COMPLETED		
		345119	B. WING		C 05/17/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
NORTHCH	ASE NURSING AND REI	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE		
F 804	jelly sandwich, and a supplement. Observa meal tray revealed re- container which conta scoop of potato salad and cheese. Residen the meal that was pro container with food th that she was eating. #107 indicated the ch and the macaroni and Observation of Reside on 5/14/24 at 12:40 P received two bowls of jelly sandwich and a f contained chicken and mashed potatoes and An interview was con- on 5/14/24 at 12:40 P the meal she received palatable. Resident # dumplings looked slop chicken ground up an An interview was con- on 5/15/24 at 12:45 P she ate a peanut butte lunch. Resident #107 she should eat peanu every day because sh	m diet with double of soup, a peanut butter and sugar free milk shake tion of Resident #107's sident received a Styrofoam ained 2 chicken tenders, a , and a scoop of macaroni at was observed not eating wided. Resident had a at her family had provided Interview with Resident icken was cold and hard d cheese was cold and dry. ent #107's lunch meal tray 'M revealed resident f soup, a peanut butter and foam container which d dumplings, carrots and I gravy. ducted with Resident #107 M. Resident #107 stated d was not hot and not 107 stated the chicken and ppy and messy with the	F 804	 offering additional meal tray/season when indicated and re-training of s The Administrator will review the requestionnaires weekly x 4 weeks, to monthly x 1 month, to ensure all co- are addressed. The administrator and/or the dietar manager will complete meal temper audits 3 times a week to include all x 4 weeks then monthly x 1 month the Meal Temperature Audit Tool. T audit is to ensure meals are served appetizing temperature per regulate The administrator and/or the dietar manager will address all concerns identified during the audit to include providing additional meal tray wher indicated and re-training of staff. The Administrator will review the Meal Temperature Audit Tool 3 times a w 4 weeks then monthly x 1 month to ensure all concerns are addressed The Administrator will forward the M Temperature Audit Tool and the Me Delivery Questionnaires to the Qua Assurance and Performance Improvement (QAPI) Committee m for two (2) months for review and to determine trends and / or issues th need further interventions put into p and to determine the need for furth / or frequency of monitoring. 	taff. sident hen oncerns y rature meals utilizing his l at an ions. y e n he y kek x y Meal sal ulity onthly o at may place		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/25/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		345119	B. WING		_		C 17/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
			3	015 ENTERPRISE DRIVE			
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER	v	VILMINGTON, NC 2840	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From page revealed the following		F 804				
	thrown on trays and n grievance follow up in educated by the man and food temperature						
	indicated staff were to	work on delivering the food ropriate temperatures on					
	follow up indicated the	red mushy. The grievance e Dietary Manager explained sometimes mushy due to					
	hot when served in St were repeated freque up indicated foam cor recent dishwasher fire	voiced that food was not yrofoam trays and meals ntly. The grievance follow ntainers were used due to a and they would resume once the new dishwasher is					
	was held on 5/14/24 a attended by the Resid (Resident #23) and a intact residents (Resid #41). The sample of Council meeting state discussed in the Resi months and they cont The sampled resident meals that were not p	lent Council President sample of other cognitively dent #119, #14, #75 and residents in the Resident d the food had been dent Council meetings for inued to receive cold food. s stated they received alatable and food that did . The residents stated the					

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						FORM	APPROVED
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345119	B. WING			COMPLETED C 05/17/2024 CITY, STATE, ZIP CODE E DRIVE IC 28405 OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE	
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		-
NORTHCH	IASE NURSING AND RE	HABILITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 804	ARTMENT OF HEALTH AND HUMAN SERVICES F ITERS FOR MEDICARE & MEDICAID SERVICES OME MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) G AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) G 345119 B. WING						
	PM with the Director of DON stated the facilit system for residents t and to ensure the residents t and meal delivery wa investigated more clo An interview was con AM with the Dietary M Manager stated she w residents had any foo Manager stated she w grievances filed regar Manager stated that s hard to get them train how the meals were s Manager indicated sh staff and was constar Dietary Manager furth insulated meal carts, the meals. The Dieta obtained likes and dis admission but did not update these or recei food. The Dietary Ma by the Administrator t food temperatures, bu was anything she cou An interview was con PM with the Administrator stated she expected t palatable and served	of Nursing (DON). The y needed to work on a to receive an alternate meal idents received a hot, DON indicated food service is an area that needed to be sely. ducted on 5/17/24 at 9:50 Manager. The Dietary vas not aware that the of complaints. The Dietary vas not informed of any rding the food. The Dietary she had new staff, and it was ed and to pay attention to served. The Dietary he had a high turnover of ntly training staff. The her stated she had some but not enough to deliver all ry Manager indicated she slikes from the residents on make routine rounds to ve feedback regarding the anager stated she was told o improve the food and the ut she did not think there ild do. ducted on 5/17/24 at 12:20 rator. The Administrator hat the food would be					
		stated she expected that nate meals if a resident did					

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STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	D. 0938-039 SURVEY PLETED	
		345119	B. WING				C / 17/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	1	301	REET ADDRESS, CITY, STATE, ZIP CODE 15 ENTERPRISE DRIVE LMINGTON, NC 28405	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	to the kitchen to be re Resident Allergies, Pi CFR(s): 483.60(d)(4) §483.60(d) Food and Each resident receive §483.60(d)(4) Food th allergies, intolerances §483.60(d)(5) Appeal nutritive value to resid food that is initially se different meal choice This REQUIREMENT by: Based on observatio and resident interview provide alternative m reviewed for nutrition #21, Resident #22, R #107, and Resident # Findings included: 1a. Resident #7 was 04/20/23. Review of a quarterly Assessment dated 03 documented he had i In an interview with R 12:08 PM he stated w cold, dried out and ha	 ved and would take the meal eheated if it was cold. references, Substitutes (5) drink as and the facility provides- hat accommodates resident s, and preferences; ling options of similar dents who choose not to eat erved or who request a is not met as evidenced ns, record review and staff vs, the facility failed to eals for 6 out of 8 residents (Resident # 7, Resident esident # 116, Resident # 116, Resident # 119). admitted to the facility on Minimum Data Set 8/15/24 for Resident #7 ntact cognition. Resident #21 on 05/16/24 at when he gets his food it's ard. He stated he was not or an alternate meal if he did 		804	F 806 Resident Allergies, Preferences Substitutes On 6/13/24, the Staff Facilitator initiater food preference survey and educated Resident #7, Resident #21, Resident #116, and Resident #107 regarding me alternatives to include how to request a alternative meal. Any new preferences be updated. On 6/15/24, the Staff Facilitator comple a food preference survey and educated Resident #22 and Resident #19 regard meal alternatives to include how to request an alternative meal. Any new preferences will be updated. On 6/13/24, the administrator observed meal delivery for Resident #7, Residen 21, Resident #22, Resident #19, Resid #107 and Resident #119. During the	da eal an will eted d ing d t#	6/24/24	

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			0.00			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	TE SURVEY
			A. BUILDING	G		С
		345119	B. WING)5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (5/11/2024
				3015 ENTERPRISE DRIVE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		WILMINGTON, NC 28405		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETIO DATE
F 806	Continued From page	e 72	F 80	06		
				observation the meal tray		
		s admitted to the facility on		for resident preference and		
	10/12/23.			appetizing temperature. Th		
	Bovious of a guartaria	MDS apparent datad		were provided with an alte	rnative meal	
		MDS assessment dated		when requested.		
	cognition.	a Resident #21 had intact		On 6/13/24, the Social Wo	rker activity	
	cognition.			director, admissions coord		
	An observation of the	lunch meal served to		dietary manager initiated r		
F	Resident #21 include			questionnaires regarding A		
		·		Meals with all alert and original		
	In an interview with R	Resident #21 on 05/13/24 at		Questionnaires included (1	1) Do staff offer	
	2:00 PM she stated s	he did not eat anything that		you an alternative meal wh	nen requested?	
		n, and she was not going to		(2) Are you aware of what		
		s served. She stated she		available as an alternative	()	
		bout the seafood dislike, but		you given a choice of food		
		d not eat eggs or sausage		And (4) What three items w		
		vas served both. She		to see on the alternative m		
	reported that she had			Administrator, Social Work Manager will address all co		
	-	ad brought in for her and that d on eating. She stated she		identified during the questi		
	-	ternative. She noted that in		include education of reside		
	the past a staff memb			The questionnaires will be		
		or the week and asked her to		6/24/14.	completed by	
		he preferred. She stated that				
		and after that no one had		On 6/13/24, a resident cou	incil meeting	
		her an alternate meal		was held with the dietician	•	
	choice. She noted sh	ne ate food brought in a lot		and Director of Nursing an	d alert and	
		e the food she was served		oriented residents regardir	-	
		or it was cold when it was		Meal Process to include (1	•	
	served to her.			preferences (2) select mea		
	- · · ·			how to request alternate m		
		cumentation for resident		(4) 3 resident preference of		
		eviewed. For the week of		alternative. Any alert and o		
		tion showed that residents		who did not attend residen		
	were asked which me	eginning on Wednesday,		meeting will be educated 1 worker. Education will be c		
	04/17/24. Residents			6/24/14. The dietary mana		
		on 04/15/24 or 04/16/24 of		the alternative meal option		

Facility ID: 923038

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	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION	T T	<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· /	MPLETED
				_			С
		345119	B. WING			0	5/17/2024
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	015 ENTERPRISE DRIVE		
NORTHC	HASE NURSING AND RE	HABILITATION CENTER		W	/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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 806	Continued From page	e 73	F 80	06			
	that week. The week	of 5/13/24 documentation			indicated per resident council		
	showed that resident	s were asked which meal or			preferences.		
	alternate was preferr	ed each day beginning on					
	Thursday, 05/16/24.				On 6/13/24, the staff facilitator (SF)		
		g the menu on 05/13/24,			initiated an in-service with the nursing		
	05/14/24, or 05/15/24	1 the week of 05/13/24.			assistants (NA) and nurses regarding		
	la sa istomistrutith ti	he Administrator on OE/17/24			Meal Delivery with emphasis on (1)		
		he Administrator on 05/17/24 ed she did expect the			ensuring meal tray is accurate for the meal tray card to include resident		
		hoice for meal preferences.			preferences (2) immediately notifying t	he	
		id not know why residents			dietary department when the meal tray		
		this week on 05/13/24,			not accurate to include resident		
	05/14/24 or 05/15/24	regarding meal choices and			preferences, tray is not served at an		
	were not interviewed	on 04/15/14 and 04/16/14			appetizing temperature to be reheated		
		o/24. She stated the evening			resident requests an alternative meal a		
		n a menu for the week. She			(3) offering resident additional seasoni	ng	
		each resident who was able			to include but not limited to		
		bbtain meal preferences. She			salt/pepper/sugar/butter to ensure mea	alis	
	-	tarted in April 2024. Prior to on each unit and the aides			palatable. The in-service will be completed by 6/24/14. After 6/24/14, a	nv	
		y and ask each resident			nurse or nursing assistant who has not	-	
	-	She explained that process			completed the in-service will complete		
		des didn't have time to do			upon the next scheduled work shift. All		
	that and complete the	eir other duties.			newly hired nurses or NAs will be		
					in-service during orientation regarding		
		Receptionist #3 on 05/17/24			Meal Delivery.		
		ed she had only gone around			On 6/17/24, the administrator complete		
		nterviewed residents for			an in-service with the Dietary Manager	-	
		e time and that was this			regarding Select Meal Process with	with	
	-	plained because she wasn't Wednesday, she could only			emphasis on completing an interview v all alert and oriented residents regarding		
	interview for preferen				meal preference/alternative meal and	чy	
	Thursday's menu (05				ensuring resident preference for meal honored.	is	
		Receptionist #1 on 05/17/24					
		ed she had in the past went			The Social Worker and/or the assistan	t	
		sidents what meal they			administrator will complete 5 resident		
		a time. It used to be that a			questionnaires weekly x 4 weeks, then		
	list of residents was r	made and if any resident			monthly x 1 month with alert and orien	ted	

Facility ID: 923038

If continuation sheet Page 74 of 84

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · · ·	TE SURVEY
			A. BUILDING	<u> </u>		
		245440	B WINC			С
		345119	B. WING		0	5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		3015 ENTERPRISE DRIVE		
				WILMINGTON, NC 28405		
(X4) ID			ID	PROVIDER'S PLAN OF COR		(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
F 806	Continued From page	e 74	F 80	06		
	wanted something di	fferent that day it would be		residents regarding Alternative	Meals.	
		en to the kitchen. She stated		This questionnaire is to ensure		
	-	lone weekly. She explained		are offered a select meal option		
	the last time she did			provided an alternative meal se		
		preferred to eat each day		when requested. The Social W		
		ong to interview and circle		Dietary Manager will address a		
		enu. She said she was		identified during the questionna		
		lert and oriented residents		include providing an appropriat		
		es were, but she could not		when indicated and retraining s		
	get to everyone. She explained after the residents were interviewed the menus would then			Administrator will review the re-		
				questionnaires to ensure that a are addressed.	li concerns	
	-	en so that meal preferences ch day. She explained the		ale addressed.		
		around with the weekly		The dietary manager will review	v the Select	
	-	y do Wednesday through		Menu Interviews weekly x 4 we		
		menu for the week wasn't		monthly x 1 month to ensure th		
	given to her until Tue			residents are offered meal		
	5	, 3		options/alternative meals option	ns per	
	In an interview with F	Receptionist #2 on 5/17/24 at		preference. The assistant admi		
	2:48 PM she stated t	he process currently in place		will address all concerns identif	fied during	
	was to obtain menu p	preferences for a week at a		the audit to include re-training of	of Dietary	
		is process had been in place		Manager. The Administrator wi		
		ior to that she would go to		the Select Menu Interviews we		
		nurses which residents were		weeks then monthly x 1 month	to ensure	
		d those were the residents		all concerns are addressed.		
		and review the menu with		The Administrator will forward t	ha	
		le the resident's choices and he kitchen. Usually on		The Administrator will forward t Alternative Meal Questionnaire		
		mes Tuesdays no choice		Select Menu Interviews to the (
	-	the receptionist would not		Assurance and Performance	zaanty	
	get the menu in time			Improvement (QAPI) Committe	e monthlv	
		vent around to inquire about		for two (2) months for review a		
		he following day, not that		determine trends and / or issue		
		had been employed since		need further interventions put in		
	-	ompleted choice menus		and to determine the need for f	•	
		e noted that recently the		/ or frequency of monitoring.		
		ught it took too much time				
	away from the recept	tionist answering the phone				
	and had talked to the	Dietary Manager about				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/25/2024 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345119	B. WING _					C 17/2024
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZI	IP CODE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER			15 ENTERPRISE DRIVE /ILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	K	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE		(X5) COMPLETION DATE
F 806	residents. In an interview with th 05/17/24 at 10:31 AM at the facility for 2 yea process was for the re- and interview residen When the kitchen rec- ticket would be adjust something other than this process had beer She noted the main m 300, 500, and 700. St choices are not poste resident who did not g the residents were no went around to ask. St responsible for provid menu each week. Sh week of 5/13/24 that n what they wanted to e and 05/15/24 or for th 04/15/24 and 04/16/2 out. She stated she w was not working but th progress." She stated from the "everyday m following choices: ch cut sandwich, grilled of choice. All entrees ep with chips and the very	go around and interview the the Dietary Manager on I she stated she had worked ars. She explained the eceptionists to go around ts for meal preferences. eived the menus each meal ted for residents who wanted the main meal. She stated in place for about a month. menus were posted on halls me explained alternate menu d. She noted that any get a choice was because tt in their rooms when staff She reported that she was ling the receptionist with the me did not know why for the residents were not asked eat on 05/13/24, 05/14/24, we week of 4/15/24 for 4 because the menu was wasn't sure why the process hat it was a "work in d alternates were available enu" that included the eeseburger, chef salad, cold cheese, or the chef's daily weept the chef's salad came	F	306	DEFICI	ENCY)		
	-	erly Minimum Data Set indicated the resident was						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/25/2024 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345119	B. WING		_		C 17/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
NORTHCH	IASE NURSING AND REI	HABILITATION CENTER		3015 ENTERPRISE DRIVE WILMINGTON, NC 2840			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 806	Continued From page	276	F 80	5			
	5/13/24 at 12:00 PM. wished she could mal received to eat. An interview was com AM with Resident #22 only thing she was off grilled cheese sandwi A meal observation co 12:26 PM revealed Re the head of the bed e pasta take out meal. ordered take out as si did not want a grilled Resident #22 stated t orders for the meals a alternate prior to the r doing that for a long ti An interview was cone AM with the Dietary M Manager stated she w #22 having any food of	onducted on 5/16/24 at esident #22 was in bed with levated feeding herself a Resident stated she he did not like the lunch and cheese sandwich again. he staff used to take the and offer the meal or an meal but they had not been ime. ducted on 5/17/24 at 9:50 Manager. The Dietary vas not aware of Resident complaints. The Dietary nad items available for Dietary Manager indicated of the residents about					
	PM with the Administr further stated she exp be honored, residents	ferences and alternate					

Facility ID: 923038

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345119	B. WING				U /17/2024
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHC	ASE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 806	 d. Resident #116 wat 1/22/24 with diagnosi chronic obstructive pudiabetes. Review of Resident # record revealed a phy for a consistent carbor Review of Resident # Minimum Data Set (N resident was cognitive Interview on 5/13/24 a #116 indicated the foo good and she was no other than a peanut b Resident #116 stated nutritional supplement instead of eating. Meal observation on a revealed Resident #116 had no Resident #116 had no Resident #116 had no Resident #116 revealed Resident #116 revealed Resident #116 had no Resident instead of a list of alter stated she knew that butter and jelly sandw that since she was a fe. Resident #107 was 	s admitted to the facility on s which included in part almonary disease and 116's electronic health visician order dated 1/22/24 whydrate diet. 116's 3/19/24 quarterly IDS) assessment revealed ely intact. at 1:47 PM with Resident bd often did not look or taste t aware of an alternate meal utter and jelly sandwich. she frequently drank a t provided by her family 5/14/24 at 12:45 PM 16 was sitting on the side of n tray in front of her. of eaten any of the lunch. ed drinking her nutritional f eating the meal. Resident ot like the meal and was not mate meals. Resident #116 she could get a peanut <i>v</i> ich, but she could not eat	F	806	5		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345119	B. WING				C 17/2024
NAME OF PF	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER			015 ENTERPRISE DRIVE VILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 806	Continued From page	978	F	806			
	AM revealed the food mostly ate snacks sup	nt #107 on 5/13/24 at 11:07 was not good and she oplied by her family. ot aware of alternate options					
	head of the bed eleva front of her. Resident the meal tray but inste	07's was in bed with the ated with her meal tray in t #107 had not eaten from					
	on 5/14/24 at 12:40 P the meal she received	ducted with Resident #107 M. Resident #107 stated d was not hot and not s not offered an alternate.					
	on 5/15/24 at 12:45 P she ate a peanut butt lunch. Resident #107 what you get for your stated she did not like jelly sandwiches ever diabetic. Resident #1	ducted with Resident #107 M. Resident #107 stated er and jelly sandwich for 7 stated she was told you get meals. Resident #107 e to eat peanut butter and y day because she was 07 stated the food was not could not eat it and was not heal.					
		admitted to the facility on sis which included diabetes					
		19's 4/11/24 quarterly IDS) assessment indicated ely intact.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		LETED
		345119	B. WING				C 17/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER			015 ENTERPRISE DRIVE VILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 806 F 880 SS=D	Interview with Reside PM revealed she coul that was served as it Resident #19 stated as did not have an altern An interview was com AM with Nurse #1. N used to give copies of residents if they want but it had not been do An interview was com PM with the Administr stated she expected t alternate meals. The not know what the brea alternate meals. Infection Prevention & CFR(s): 483.80(a)(1)(§483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and trar diseases and infection program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syster reporting, investigatin	nt #19 on $5/14/24$ at $12:45$ Id not eat the lunch meal was not appetizing. sometimes staff stated they hate meal available. ducted on $5/17/24$ at $9:35$ urse #1 stated the facility f the menu and asked the ed the meal or an alternate, one for a while. ducted on $5/17/24$ at $1:50$ rator. The Administrator the residents to receive Administrator stated she did eakdown was with the a Control (2)(4)(e)(f) htrol blish and maintain an nd control program a safe, sanitary and hent and to help prevent the asmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at		806			6/24/24

Facility ID: 923038

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/25/2024 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345119	B. WING				C 17/2024
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE,	ZIP CODE		
NORTHCH	ASE NURSING AND RE	HABILITATION CENTER		015 ENTERPRISE DRIVE VILMINGTON, NC 28405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 880	providing services una arrangement based u conducted according accepted national stat §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement tha least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact will transmit th (vi)The hand hygiene by staff involved in dir	ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify de diseases or can spread to other in possible incidents of the or infections should be assission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct to or their food, if direct ne disease; and procedures to be followed rect resident contact.	F 880				
	reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fat	asmission-based precautions ent spread of infections; plation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct or their food, if direct he disease; and procedures to be followed rect resident contact.					

Facility ID: 923038

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY DMPLETED
		345119	B. WING _				C 05/17/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		0,11/2024
				30	15 ENTERPRISE DRIVE		
NORTHCH	ASE 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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	§483.80(e) Linens. Personnel must hanc	e 81 Ile, store, process, and s to prevent the spread of	F	380			
	IPCP and update the This REQUIREMENT by: Based on observation resident, and the Nur the facility failed to im Barrier Precautions (donning Personal Pro- include donning glove contact resident care were observed provid an indwelling central dialysis and who rece lower extremity and w	view. act an annual review of its ir program, as necessary. F is not met as evidenced ons, record review, and staff, rese Practitioner interviews hplement the Enhanced EBP) policy regarding betective Equipment (PPE) to les and gown during high activities. Two Nurse Aides ding care to a resident with venous catheter used for leived wound care to the right were not wearing a gown curred for 1 of 5 resident			F 880 Infection Prevention & Contr CFR(s): 483.80(a)(1)(2)(4)(e)(f) On 5/15/24, the Director of Nursing in serviced nursing assistant (NA) # NA #4 and regarding Enhanced Bat Precautions (EBP) to include the us personal protective equipment (PPE while providing care, linen change, services in rooms identified as required Enhanced Barrier Precautions.	(DON) 3 and rier e of 5) and	
	Findings included. The facility's Enhance updated on 04/01/24 Precautions were use Standard Precautions multidrug resistant or transmission during h	high contact resident care			On 6/13/24, the nurse supervisors initiated 15 random resident care observations with all staff to include shifts. This audit is to ensure staff w utilizing appropriate use of PPE who rooms designated as requiring isola precautions to include but not limite EBP. The nurse supervisors and/or DON will address all concerns ident during the audit to include education	vere en in tion d to the tified n of	
	and gown. Enhanced be in place for the du or until resolution of a an indwelling medica	ed the use of both gloves I Barrier Precautions are to ration of the residents stay a wound or discontinuation of I device. n on 05/14/24 at 9:45 AM a			staff. The observations will be comp by 6/24/14. On 5/15/24, the infection prevention Quality Assurance (QA) Nurse initia in-service with all nurses, medicatio aides, nursing assistants, housekee	iist/ ted an n	

Event ID: R0B411

Facility ID: 923038

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		MEDICAID SERVICES				0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	E SURVEY PLETED
			A. BUILDING	G		
		345119	B. WING			С
		545119	B. WING			/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
NORTHC	HASE 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 82	F 88	30		
		Resident #82's room door		staff and therapy staff re	aardina	
		anced Barrier Precautions.		Enhanced Barrier Preca		
		lust wear gloves and a gown		emphasis on donning/do		
		-contact resident care		providing direct patient c	•	
	activities: dressing, b			and/or changing linens for		
	-	g linens, providing hygiene,		identified as requiring EE		
		ce care or use of a central		be completed by 6/24/14		
	line, urinary catheters, feeding tubes, and wo			any staff who has not wo		
care.	-		the in-service will comple	ete it upon the		
				next scheduled work shi	ft. All newly hired	
	During an observation on 05/14/24 at 9:45 AM Nurse Aide #3 was observed in Resident #82's	n on 05/14/24 at 9:45 AM		nurses, medication aides	s, nursing	
			assistants, housekeepin	-		
		ed linens. Resident #82 was		therapy staff will be in-se	-	
	-	in her wheelchair. Nurse		orientation regarding En		
	-	s when changing the bed		Precautions with empha		
	-	A cart with PPE (personal		donning/doffing PPE whi		
	protective equipment	/ II		patient care, treatments,		
		e Aide #3 stated she had a		linens for residents ident		
	•	ansferred Resident #82 to		EBP. All newly hired nur		
		ook it off before changing tated she knew Resident #3		aides, nursing assistants staff and therapy staff wi		
	was on Enhanced Ba			during orientation by the		
		ne should wear a gown and		and/or infection prevention		
		g direct care including		regarding Enhanced Bar		
		She indicated she had				
	received training on E			The Infection Prevention	ist/QA Nurse	
	•	ted it was done in error.		and/or Staff Facilitator w		
				Resident Care Audits we	-	
	During an interview o	n 05/14/24 at 9:45 AM		then monthly x 1 month.		
	-	ert and oriented to person,		ensure staff utilize appro		
	place, and time. She			in rooms designated as i		
		e of her dialysis port, and		precautions to include bu		
		her leg. She stated she had		EBP. The Infection Prev		
		Precautions for a while due		address all concerns ide		
		difficile - a bacteria that		audit to include re-trainir		
	causes infection of th	e colon).		Director of Nursing (DON		
				Resident Care Audits we	-	
	-	on 05/14/24 at 10:00 AM the		then monthly for 1 month		
	INURSE Practitioner sta	ated Resident #82 was no		identified areas of conce	m nave been	1

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	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345119	B. WING		0	C 5/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHCI	ASE 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 880	longer on Contact Pre 05/13/24 and was now Precautions due to ha device and receiving v During an observation Nurse Aide #4 was ob room providing incont observed wearing glo she had the gown on then started with inco replacing her gown. S training on Enhanced stated it was a mistak a gown on before pro During an interview of Infection Control Nurs was on Enhanced Ba having a dialysis acce She stated Resident # Precautions for C. diff now on Enhanced Ba indicated the nurse ai Enhanced Barrier Pre worn a gown along w direct care. During an interview of Director of Nursing (D wear the appropriate care to residents on E	ecautions for C. difficile as of w on Enhanced Barrier aving a dialysis access wound care. In on 05/15/24 at 2:10 PM oserved in Resident #82's tinence care. She was ves but no gown. She stated at first then discarded it ntinence care without she stated she had received Barrier Precautions. She te and she should have put viding incontinence care. In 05/17/24 at 09:30 AM the se indicated Resident #82 rrier Precautions due to ass device and wound care. #82 came off of Contact ficile on 05/13/24 and was rrier Precautions. She des had been trained on ecautions and should have ith gloves when providing	F 88	addressed. The Director of Nursing will forversults of the Resident Care Au Quality Assurance and Perform Improvement (QAPI) Committe x 2 months for review and to deterneds and / or issues that may further interventions put into plate determine the need for further a frequency of monitoring.	dits to the ance e monthly etermine need ace and to	

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