STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING ______ B. WING ______	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiences were cited as a result of the complaint investigation conducted in conjunction with the recertification survey, Event ID#V0D611, Exit Date 11/29/18.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately document the correct discharge destination for the most recent Medicare stay for 1 of 3 residents whose closed records were reviewed (Resident #130). Record review revealed that Resident #130 had been admitted to the facility on 08/13/18 and discharged on 09/05/18. Diagnoses included gastrointestinal hemorrhage, hypertension, Parkinson's disease, Type II Diabetes Mellitus, cerebrovascular disease, acute kidney failure and abnormal posture. Review of the Minimum Data Set (MDS) Discharge assessment dated 09/05/18 documented in Section A: Line A2100-a discharge status of acute hospital. Review of the nursing note documented by Nurse #1 on 09/05/18 at 2:26 PM read: "Resident transferred to her personal w/c by mechanical lift and 2 staff. Went over the instructions of medications with her daughter. Scripts for her medication given to daughter. Who at this time	F 641	NorthChase Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. NorthChase Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, NorthChase Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that led to this deficiency	12/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/21/2018

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

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F 641	Continued From page 1 stated, "The home agency people will go over this with me". Resident in stable condition at time of transfer. Personal belongings packed up by daughter. Transported by van to home." In an interview conducted with Nurse #2, MDS, on 11/29/18 at 10:30 AM she stated that the assessment was coded in error. She said that the resident went home with her daughter and not to the hospital. She commented that she was going to modify the assessment to accurately document the resident's discharge destination. In an interview conducted with the Interim Director of Nursing on 11/29/18 at 1:15 PM she stated that she expected the MDS assessments to be coded with the correct discharge destination.	F 641	was determined to be an error in following the guidelines set in the RAI manual concerning coding discharged resident's status. On 11/29/18 resident #130 the status was correctly changed on the MDS to reflect that the resident discharged home. On 12/17/18, 100% Audit of all discharged residents to home was conducted to include resident 130 by the MDS nurse to ensure that the coding was accurate. No areas of concern were identified. On 12/17/18, an in-service was initiated by the SDC for all MDS nurses to ensure residents discharge destination is coded correctly. This includes coding for discharge to the community, hospital, acute hospital, psychiatric hospital, inpatient rehabilitation facility, ID/DD facility, hospice, long term care hospital, deceased or other. The in-service was completed by 12/18/18. 100 % of all discharged residents will be reviewed by the DON for 4 weeks, then monthly for 2 months, utilizing a Resident Discharge Destination Tool to ensure that all coding for discharged residents is accurate. Any areas of concern identified during the review will be immediately addressed by the DON to include accurately coding the discharge destination of the resident. The DON will present the findings of the	

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F 641	Continued From page 2	F 641	Resident Discharge Destination Tool to the Executive QI committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the Discharge Destination Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to obtain a physician's order for an indwelling urinary catheter for 1 of 5 residents (Resident #380) observed for catheter care. Findings included: Resident #380 was admitted to the facility on 11/22/18. Diagnoses included, in part, muscle weakness, renal insufficiency, urinary retention due to enlarged prostate and metastatic cancer. There was no Minimum Data Set (MDS)	F 658	NorthChase Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. NorthChase Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement	12/24/18

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F 658 Continued From page 3
information completed at this time.

A review of the discharge summary report dated 11/22/18 from the hospital revealed the resident was to continue with the Foley catheter.

A review of the baseline care plan dated 11/22/18 revealed a plan of care for an indwelling urinary catheter.

A review of a progress note written on 11/22/18 by the facility physician revealed Resident #380 was admitted to the facility post hospitalization with acute renal insufficiency and urinary retention with placement of a Foley catheter. The note further indicated Resident #380 was followed by an urologist (a doctor specializing in the urinary system) at the hospital.

A review of the admitting physician orders from 11/22/18 revealed there was no order for an indwelling urinary catheter.

A review of the Treatment Administration Record (TAR) for November, 2018, revealed there was an order to secure the catheter to the resident ' s leg as well as an order to flush the catheter as needed written on 11/22/18. The TAR was noted to be signed off by nursing as evidenced by their initials.

An observation of Resident #380 on 11/28/18 at 3:30 PM revealed the resident had an indwelling Foley catheter in place. The catheter was noted to be draining clear amber colored urine, had a privacy bag in place and was positioned low on the side of the bed. The catheter tubing was noted to be secured to Resident #380's left leg.

F 658

with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, NorthChase Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

The process that led to this deficiency was determined to be a failure in the admissions review checklist

On 11/28/18 resident #380 an order was obtained from the physician for an order for an indwelling urinary catheter.

On 11/28/18, 100% Audit of all residents with Foley catheters was completed by the Unit Manager to include resident #380 to ensure all orders for indwelling urinary catheters were complete to include appropriate diagnosis, size of catheter and parameters for changing the urinary catheters present in chart and MAR. No areas of concern were identified.

On 12/18/18, an in-service was initiated by the SDC for all nurses to ensure residents with indwelling catheters have complete orders to include:
1. Diagnosis for catheter use
2. Size of catheter
3. Parameters for when to change the urinary catheters.
4. Notifying the physician to clarify any that do not contain appropriate diagnosis,

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F 658	Continued From page 4 An interview was conducted with Nurse #4 on 11/28/18 at 3:30 PM. Nurse #4 reported Resident #380 had an indwelling urinary catheter, but she was not sure of the size. Nurse #4 stated when a resident was admitted to the facility with a Foley catheter, we were to obtain orders for the indwelling catheter indicating the size of the catheter, the amount of saline to inflate the balloon to secure the catheter and a diagnosis to have a Foley Catheter. An interview was conducted with the Unit Manager (UM) on 11/29/18 at 3:50 PM. The UM reported all orders should be transcribed within 24 hours of an admission. The UM reviewed the admitting orders and all additional orders written after 11/22/18 and confirmed there was no order for Resident #380 to have an indwelling urinary catheter. An interview was conducted with the Director of Nursing (DON) on 11/29/18 at 5:00 PM. The DON reported her expectation of the nurses was to ensure there was an order to have an indwelling urinary catheter.	F 658	size and instructions on when to change indwelling urinary catheters. The in-service will be completed by 12/24/18. All newly hired nurses will be in-serviced by the SDC during orientation to ensure all orders for indwelling urinary catheters are complete to include: 1. Diagnosis for catheter use 2. Size of catheter 3. Parameters for when to change the urinary catheters. 4. Notifying the physician to clarify any that do not contain appropriate diagnosis, size and instructions on when to change indwelling urinary catheters. 100% of residents with indwelling catheters with will be reviewed by the DON or unit Coordinators weekly for 4 weeks, then monthly for 2 month, utilizing a Foley Audit Tool to ensure there is no signs\symptoms of urinary tract infection and that all orders for indwelling urinary catheters are clarified to address parameters for changing the catheters, orders are transcribed correctly to the MAR, and documentation is completed on the MAR when the indwelling urinary catheter is changed per the physician orders. Any areas of concern identified during the review will be immediately addressed by the DON to include obtaining an order clarification, notification of attending physician assessment of the	

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F 658	Continued From page 5	F 658	resident and/or providing additional staff training. The DON will present the findings of the Catheter Monitoring tools to the Executive QI committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the Catheter Monitoring tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	