| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 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 |
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| E 015 SS=F | Subsistence Needs for Staff and Patients<br>CFR(s): 483.73(b)(1)<br><br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for | E 015 | | 2/13/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/10/2023

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| E 015 | Continued From page 1<br>hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility failed to have subsistence food available to meet the needs for residents and staff as identified in the emergency preparedness plan. This had the potential to affect all residents in the facility.<br><br>Findings included:<br><br>The facility's Emergency Preparedness Manual contained a sample of a 7-day disaster menu prepared by the facility's food supplier.<br><br>A tour of the dry storage area in the kitchen on 1/26/23 at 3:00 PM revealed there was not an area for emergency preparedness food storage and foods on the sample 7-day disaster menu were not available in the facility.<br><br>An interview with the Dietary Manager (DM) on 1/26/23 at 3:10 PM revealed that the DM had been in the position since August 2022. The DM stated the facility did not have an emergency food | E 015 | 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 Correction is submitted as a written allegation of compliance. NorthChase Nursing and Rehabilitation Center 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 Center 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. | |

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| E 015 | Continued From page 2<br>supply on hand for the residents and staff and the items on the sample disaster menu were not available in the facility. The DM revealed that in the event of an emergency she did not know what she would serve.<br><br>An interview was conducted with the Administrator on 1/26/23 at 3:20 PM. The Administrator stated in the event of an emergency, the facility would serve whatever food happened to be on hand. The Administrator further stated the facility would probably serve soup and sandwiches or potato chips during an emergency. The Administrator revealed there was no emergency food supply on hand to meet the needs of the residents and staff. The Administrator stated that the facility should have an emergency menu with an inventoried emergency food supply with all items on the menu on hand. | E 015 | E-015 (F) Subsistence Needs for Staff and Patients CFR(s): 483.73 (B)(1)<br>There were no events in the past 90 days requiring the facility to use emergency food supply. No residents were affected.<br><br>On 2/6/2023, the facility initiated a designated storage area for emergency food supply.<br><br>On 2/6/2023, the Administrator and Dietary Manager completed an inventory of all current food supply to ensure the facility had adequate provision of food and water per facility protocol for emergency preparedness. The Dietary manager ordered an additional 3-day supply of nonperishable food items. The facility will maintain a minimal of a 3-day supply of food available on a regular basis designated as emergency food supply.<br><br>On 2/6/2023, the Administrator educated the Dietary Manager regarding Emergency Preparedness with emphasis on ensuring the facility maintained a minimal of 3-day provision of food and water designated as emergency food supply.<br><br>On 2/6/2023, the Dietary Manager educated kitchen staff regarding Emergency Food Supply with emphasis on ensuring emergency food items are stored appropriately and monitored for expiration dates.<br>Nursing Home Administrator/Assistant Nursing Home Administrator will complete | |

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| E 015 | Continued From page 3 | E 015 | weekly audit of emergency food supply weekly times 4 weeks then monthly times 1 month to ensure enough supplies for both residents and staff are on hand and stored in designated area. The Administrator and/or Assistant Administrator will address all concerns identified during the audit to include ordering food when indicated and re-education of staff.<br><br>Administrator will forward the audits of emergency food supply to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will review audits monthly x 2 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.<br><br>Corrective action completed 2/13/23 | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation was conducted from 01/23/23 through 01/26/23.<br>Event ID # 4JUM11.<br>The following intakes were investigated: NC00196875, NC00194737, NC00194366, NC00192193, and NC00195091.<br>3 out of 14 complaint allegations were substantiated with deficiencies. | F 000 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, | F 584 | | 2/13/23 |

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| F 584 | Continued From page 4 | F 584 | | |

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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| F 584 | Continued From page 5<br>Based on observations and staff interviews the facility failed to: 1a) repair drywall wall damage in 6 of 7 resident rooms (302, 309, 506, 508, 514, and 612), 1b) failed to remove the black greenish substance from the commode base caulking in 4 of 13 resident rooms (506, 508, 510, and 615), 1c) failed to ensure the ceiling light cover was free from damage in 1 of 4 shower rooms (300 hall), 1d) failed to ensure the florescent ceiling light cover was free from damage in 1 of 3 nursing stations (over exit door by Pelican nursing station).<br><br>Findings included:<br><br>1a. An observation on 01/23/23 at 11:40 AM revealed drywall wall damage in 6 of 7 resident rooms (302, 309, 506, 508, 514, and 612).<br><br>1b. An observation on 01/23/23 at 11:40 AM revealed black greenish substance from the commode base caulking in 4 of 13 resident rooms (506, 508, 510, and 615).<br><br>1c. An observation on 01/23/23 at 11:40 AM revealed a shower ceiling light cover was damaged and hanging free in 1 of 4 shower rooms (300 hall).<br><br>1d. An observation on 01/23/23 at 11:40 AM revealed a florescent ceiling light cover was damaged in 1 of 3 nursing stations (over exit door by Pelican nursing station).<br><br>An interview and facilty tour of the facility was conducted with the Maintenance Director (MD) and Assistant Administrator on 01/25/23 at 1:15 PM. The MD Assistant Administrator stated there were multiple areas in the facility that still needed | F 584 | Drywall damage in resident rooms 302, 309, 506, 508, 514, 612 was repaired by the maintenance staff and Hill Co by 2/7/2023.<br><br>Removal of Black greenish substance around toilet base in rooms 506, 508, 510, 615 was repaired by the maintenance staff 2/7/2023.<br><br>Shower room ceiling light in 300 hall shower room was repaired by the maintenance staff on 2/7/2023.<br><br>Fluorescent light in pelican hall over exit door was repaired by maintenance on 2/7/2023.<br><br>100% observation of the facility to include resident rooms 302, 309, 506, 508, 510, 514, 612, 615, 300 hall shower room, and over exit doors to ensure rooms or other areas were in good repair. The Maintenance staff will address all concerns identified during the audit to include placing work orders when indicated. Audit was completed on 2/3/2022<br><br>Nursing Home Administrator educated maintenance director and assistant maintenance regarding Homelike Environment with emphasis on ensuring rooms remain in good repair and reviewing TELS at least 5 days per week to ensure all maintenance items identified are addressed timely. Education completed on 2/6/2022 | |

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| F 584 | Continued From page 6<br>to be addressed, replaced, or repaired. MD stated he had had an assistant and was able to keep up with most of the faclity's repairs. He said he did not know what the black greenish substance actually was around some of the commodes and did not know about the leaking commodes. MD said housekeeping was responsible for cleaning bathrooms, and that maintenance was responsible for repairing or replacing items in the facility. The Assistant Administrator identified additional areas of concern she observed during the tour of the facility, shower rooms, and resident rooms. She said their current Quality Assurance and Performance Improvement Action (QAPI) Plan was not working, and was not specific enough to address all of the residents physical environment needs in the facility.<br><br>An interview was conducted with the Administrator on 01/26/23 at 6:03 PM revealed they were making progress and were improving residents living environment to make it more home like. She said there were still areas in the facility that still needed to be addressed and they would be putting a plan in place, through QAPI, to address those areas identified. She said her additional concerns included: repair and paint needed in resident rooms/bathrooms, repair or replace of commodes, and repair or replace of any other identified physical plant concerns that needed to be addressed. The administrator stated it was her expectation for all the residents to have a safe and homelike environment that was clean and in good repair. | F 584 | Staff Development Coordinator initiated inservice with all staff on placing work orders in TELS to ensure proper notification of maintenance regarding needed repairs. In-service will be completed by 2/13/23. After 2/13/23, any staff who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired employees will be in serviced during orientation.<br><br>Administrator and/or assistant administrator will audit all areas of facility to include resident rooms 302, 309, 506, 508, 510, 514, 612, 615, 300 hall shower rooms and areas over exit doors weekly x4 weeks then monthly x1 month to ensure rooms are in good repair. Audit will be completed utilizing the Home-Like Environment Audit Tool. Work order will be placed in TELS and maintenance will correct any issues identified during the audit.<br><br>Assistant Administrator will present finding of Home-Like Environment Audit Tool to QAPI monthly for 2 months. QAPI committee will review Home-Like Environment Audit Tool to determine trends and or issues that may need further interventions and to determine the need for further monitoring. | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) | F 804 | | 2/13/23 |

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| F 804 | Continued From page 7<br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident and staff interview and test tray evaluation, the facility failed to ensure food was palatable and served at an appetizing temperature for 3 of 24 residents reviewed on the 100, 400 and 700 halls for food palatability and temperature (Resident #332, Resident #18, and Resident #81).<br><br>Findings:<br><br>a. Resident # 332 was admitted to the facility on 1/11/23.<br><br>Resident #332s 1/17/23 admission Minimum Data Set (MDS) assessment revealed resident was cognitively intact.<br><br>Interview on 1/23/23 at 12:18 PM with Resident #332 revealed meals were served cold all the time. Resident #332 indicated the food was the biggest problem since she was admitted to the facility due to receiving cold food and food that did not taste good. Resident #332 stated if she couldn't eat what was served, she ate snacks that her visitors brought her.<br><br>b. Resident #18 was admitted to the facility on 11/22/22. | F 804 | Resident #332 no longer resides at facility.<br>Residents #18 and #81 continue to reside at the facility in stable condition.<br><br>On 2/9/2023, the Administrator/Assistant Administrator completed an audit of resident meal trays for breakfast, lunch, and dinner to include residents #18 and #81 to ensure all meal trays served are palatable and at a preferred temperature. The Administrator will address all concerns identified during the audit.<br><br>Staff Development Coordinator initiated in services with nurses and nursing assistants (NA) regarding timely passing of meal trays to ensure the resident meals are served palatable and at preferred temperatures. Inservice will be completed 2/13/2023. After 2/13/23, any nurse or nursing assistant who has not worked or received the in-service will receive upon next scheduled work shift. All newly hired nursing and nurse aides will be educated during orientation.<br><br>Unit managers (UM), Quality Assurance | |

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| F 804 | Continued From page 8<br><br>Resident #18's admission Minimum Data Set (MDS) assessment on 12/28/22 indicated resident was cognitively intact.<br><br>Interview on 1/23/23 at 4:10 PM with Resident #18 revealed that she received cold meals all the time. Resident #18 stated her meals were always cold, meals were not reheated, and she often could not eat it because of this. Resident #18 stated her family brought her snacks that she ate if she did not eat the meal.<br><br>c. Resident #81 was admitted to the facility on 10/24/22.<br><br>Resident #81's admission MDS on 10/31/22 indicated resident was cognitively intact.<br><br>Interview on 1/24/23 at 1:23 PM with Resident #81 revealed resident's breakfast was always served cold and the other meals were frequently served cold.<br><br>Observation of breakfast and interview with Resident #81 on 1/25/23 at 9:26 AM revealed resident was served eggs, bacon, and an English muffin. The bacon was not crisp as resident preferred, the English muffin was not toasted and did not have butter or jelly on the tray and the eggs, the resident stated, were cold. Resident #81 stated she ate food that her family member brought instead.<br><br>Observation on 1/26/23 at 8:30 AM of the breakfast meal served on 100 hall revealed all meals were served from an open, non-insulated metal cart. The test tray was taken off the cart after the last meal was served. The test tray was | F 804 | (QA) nurse, Assistant Administrator will complete 10 observations of meal delivery weekly x 4 weeks then monthly times 1 month to include all mealtimes and meal delivery on weekends utilizing a Meal Service Audit Tool. Audit is to ensure meal trays are passed timely and resident meals are served palatable and at preferred temperature. UM, QA nurse and Assistant Administrator will address all concerns identified during the audit.<br><br>Assistant Administrator will present finding of Meal Service Audit Tool to Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. QAPI committee will review Meal Service Audit Tool to determine trends and or issues that may need further interventions and to determine the need for further monitoring. | |

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| F 804 | Continued From page 9<br>tasted for palatability with the Administrator present. When the dome lid was removed from the plate there was no steam coming off the plate. The meal was tasted by the surveyor and noted the scrambled eggs and pancake were cold, and the link sausage was lukewarm.<br><br>Interview on 1/26/23 at 11:09 AM with the Dietary Manager (DM) revealed that she was not aware of resident concerns regarding cold food and the facility had some insulated meal carts, but not enough to deliver meals to all the halls.<br><br>Interview on 1/26/23 at 5:35 PM with the Administrator revealed that she expected that food would be palatable and served at appropriate temperatures per resident preference. The Administrator further stated that she expected that food would be reheated as necessary. | F 804 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents | F 812 | | 2/13/23 |

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| F 812 | Continued From page 10<br>from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to maintain the final rinse cycle temperature of the high temperature sanitizing dish machine at or above 180 degrees Fahrenheit per manufacturers recommendations and failed to routinely monitor and record the dish machine wash and rinse cycle temperatures for 1 of 1 dish machines observed. 2) failed to obtain food temperatures prior to serving and failed to maintain consistent food temperature logs during 1 of 2 observations. 3). failed to label and date leftover food and ensure the nourishment room refrigerator was free from debris for 1 of 2 nourishment rooms (200 Hall nourishment room). This practice had the potential to affect the food served to the residents.<br><br>Findings included.<br><br>1.) An observation was made on 01/23/23 at 1:27 PM of the wash and rinse sanitizing cycles of dishware placed in the high temperature sanitizing dish machine by Dietary Aide #1. The loaded dish rack placed in the dish machine was observed to have a wash cycle temp of 160 degrees Fahrenheit and a final rinse cycle temperature of 170 degrees Fahrenheit. A second loaded dish rack was placed in the dish machine and reached a wash temperature of 160 degrees and final rinse temperature of 177 degrees Fahrenheit. | F 812 | On 1/25/23, a contracted vendor evaluated dish machine and ordered replacement part to ensure adequate temperature is obtained during rinse cycle. The facility manually washed/rinsed dishes and utensils. Repair was completed on 1/27/23 and temperature ranges noted to be at or above 180 degrees during rinse cycle. Proactively the facility ordered a new dish machine on 1/25/23.<br><br>On 1/24/23, the dietary staff completed temperature checks on food held on the steam table with no identified concerns.<br><br>200 hall nutrition room refrigerators was cleaned, and all unlabeled or expired items were disposed of on 1/26/2023.<br><br>On 1/27/2023, Dietary Manager completed an audit of all nutrition room refrigerators to ensure all items were dated appropriately when opened and not expired and that refrigerators were clean. The Dietary Manager will address all concerns identified during the audit to include removing all items not properly dated when opened, items that are expired and/or cleaning refrigerator when indicated. Audit will be completed by 2/13/23. | |

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| F 812 | Continued From page 11<br>During an interview on 01/23/23 at 1:30 PM with Dietary Aide #1 he stated the dish machine did not always reach a final rinse temperature of 180 degrees. He stated the dish machine was old and after several cycles of washing dishware the rinse cycle would eventually reach the final rinse temperature of 180 degrees but not consistently. He stated the issue had been ongoing for a few months.<br><br>On 01/23/23 at 1:35 PM a review of the temperature log for the high temperature dish machine dated January 2023 revealed many dates with no wash and rinse temperatures recorded. The temperature log revealed:<br><br>01/02/23 the wash cycle temperature was recorded at 164 degrees Fahrenheit with a final rinse cycle reading of 167 degrees Fahrenheit.<br><br>01/03/23 the wash cycle temperature was recorded at 153 degrees Fahrenheit with a final rinse cycle reading of 140 degrees Fahrenheit.<br><br>01/04/23 the wash cycle temperature was recorded at 175 degrees Fahrenheit with a final rinse cycle reading of 170 degrees Fahrenheit.<br><br>01/05/23 the wash cycle temperature was recorded at 141 degrees Fahrenheit and no final rinse cycle reading was recorded for this cycle.<br><br>There were no dish machine temperatures recorded on 01/13/23, 01/14/23, 01/15/23, 01/16/23, 01/18/23, 01/22/23, or 01/23/23.<br><br>Review of the manufacturer's guidelines revealed the final rinse minimum temperature of 180 degrees Fahrenheit on the dish machine must be | F 812 | 1/26/2023, the Assistant Administrator initiated an in-service with the Dietary Manager and dietary staff regarding (1) Monitoring Dish Machine Temperatures with emphasis on ensuring temperatures during wash/rinse cycle are at or above 180 degrees and that temperatures are logged per facility protocol and (2) Monitoring Food Temperature with emphasis on monitoring and recording food temperatures prior to severing to ensure meals are served at appropriate temperature with documentation on temperature log each meal.<br><br>Unit Manager(s) will audit nutrition room refrigerators weekly x 4 weeks then monthly x 1 month utilizing the Nourishment Room Audit Tool to ensure refrigerators are clean and all items are dated when opened and items are not expired. Expired and undated items will be discarded immediately, and the refrigerator cleaned when indicated. Staff will be re-educated for all concerns identified. The Assistant Administrator will review the Nourishment Room Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.<br><br>Dietary Manager and/or Dietary Assistant Manager will complete 10 meal preparations observations and audit temperature logs weekly x 4 weeks then monthly x 1 month to include all mealtimes utilizing the Kitchen Audit Tool. This audit is to ensure dietary staff monitor food temperatures prior to | |

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| F 812 | Continued From page 12<br>maintained and corrective measures should be taken immediately to maintain the temperatures. The temperature displays must be checked repeatedly whenever the washer is running to make sure the proper temperatures were being maintained.<br><br>A second observation was conducted on 01/24/23 at 12:28 PM of the high temperature dish machine with the Regional Dietary Consultant along with the Dietary Manager. The Regional Dietary Consultant placed a portable thermometer in the dish rack and cycled it through the dish machine. The portable thermometer reading registered at approximately 160 degrees after the cycle was completed.<br><br>During an interview with the Dietary Manager on 01/24/23 at 12:45 PM she stated when she had problems with the dish machine, she usually just notified the Assistant Maintenance Director, and he would come in and try to resolve the problem with the temperatures and then the issue would start again, and she would just continue to notify him. She stated she did not always place a work order for the dish machine.<br><br>An interview was conducted on 1/25/23 at 2:00 PM with the Maintenance Director. He stated he was not made aware that the dish machine was not reaching the final rinse temperatures of 180 degrees. He stated he relied on staff to place work orders on equipment in need of repair and he had not received a work order from the kitchen regarding the dish machine. He stated a new dish machine was approved for order and the order would be placed today and the plan was to repair the old machine while waiting on the new machine. | F 812 | serving, meals are served at appropriate temperatures per facility protocol and that staff document temperature monitoring on logs each meal. The Dietary Manager and/or Dietary Assistant Manager will address all concerns identified during the audit to include but not limited to re-education of staff. The Administrator will review the Kitchen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.<br><br>Dietary Manager will review dish machine temperature monitoring logs and observe dish machine wash/ rinse cycles 10 times a week x 4 weeks then monthly x 1 month to include all mealtimes utilizing the Kitchen Audit Tool. This audit to ensure temperature of dish machine wash/rinse cycle is at or above 180 degrees and that dietary staff are monitoring temperatures of wash/rinse cycle per facility protocol with documentation on the temperature logs each meal. The Dietary Manager will address all concerns identified during the audit. The Assistant Administrator will review the Kitchen Audit tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.<br><br>Assistant Administrator will present finding of the Nourishment Room Audit Tool and the Kitchen Audit Tool to Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. QAPI committee will review Nourishment Room Audit Tool and the Kitchen Audit Tool to determine trends and or issues that may need further interventions and to | |

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| F 812 | Continued From page 13<br><br>A follow up interview was conducted on 01/26/23 at 11:09 AM with the Dietary Manger along with the Regional Dietary Consultant. The Dietary Manager stated the dish machine not reaching the required temperatures had been an ongoing problem. She acknowledged that the staff were not consistently checking and recording the dish machine temperature logs and stated staff had been trained to do so. The Regional Dietary Consultant stated staff should be consistently recording and maintaining temperature logs on the dish machine. The Dietary Manager stated the dish machine was taken out of service until the repairs could be made.<br><br>In an interview on 01/26/23 at 4:00 PM with the Administrator she stated a new dish machine was ordered. She stated she expected the dietary staff to consistently monitor and record the temperatures on the dish machine to ensure the machine was working properly.<br><br>2.) During the initial tour of the kitchen on 01/23/23 at 11:30 PM food was observed being held on the steam table to be served for the lunch meal and included fried pork chops, cabbage, rice, gravy, cornbread, and fruit cobbler.<br><br>Further observation on 01/23/23 at 12:30 PM of the food held on the steam table revealed food plates were being prepared and trays were observed on the tray carts ready to be delivered to residents.<br><br>In an interview on 01/23/23 at 12:30 PM with the Cook #1 she stated she checked the food temperatures of the foods currently held on the steam table and the food plated on the tray carts | F 812 | determine the need for further monitoring. | |

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while the food was still on the stovetop and prior to the food being placed on the steam table and stated the temperatures were recorded on the temperature log. She acknowledged the food had been on the steam table since approximately 11:30 AM before being plated. She stated she did not check the food temperatures for the lunch meal while the food was held on the steam table.

A follow up observation conducted on 01/24/23 at 12:30 PM revealed staff checking the food temperatures of the food held on the steam table. The food was held at the appropriate temperatures.

A review of the temperature log from the prior day (01/23/23) dinner meal revealed no food temperatures were recorded. Further review of the food temperature logs from September 2022 through January 2023 revealed many dates without food temperatures recorded.

In an interview with the Dietary Manager on 01/24/23 at 12:45 PM she stated the kitchen staff failed to obtain and record temperatures for the dinner meal on 01/23/23. She stated the food temperature logs were not being maintained consistently. She stated the dietary staff had been educated on checking and recording food temperatures and maintaining temperature logs.

A follow up interview was conducted on 01/26/23 at 11:09 AM with the Dietary Manger along with the Regional Dietary Consultant. The Dietary Manager stated food temperature logs should be consistently maintained. The Regional Dietary Consultant stated staff should be consistently recording and maintaining food temperature to ensure food reached the appropriate

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temperatures and to ensure food was being held on the steam table at the appropriate temperature.

In an interview on 01/26/23 at 4:00 PM with the Administrator she stated dietary staff should being checking and recording food temperatures consistently to ensure foods were being held at the appropriate temperatures.

3). Observation of the 200-hall nourishment room on 01/24/23 at 1:23 PM revealed the following:

1.plastic bag which contained plastic food storage containers of green beans, chicken, mashed potatoes and rolls. The outside of the plastic bag was labeled 12/25/22

2.plastic bag which contained food including a jar of mayonnaise, a microwave sandwich that was to be stored in the freezer, and a package of deli sliced turkey. The outside of the plastic bag was dated 12/24/22

3.plastic bag which contained a bowl of potato salad which was visibly spoiled. No name or date was on the plastic bag or the bowl.

4. plastic container with a pork chop meal with no date.

5. plastic container with mashed potatoes, chicken and green beans labeled with a date of 1/13/23

6. a bottle of Ranch salad dressing labeled with a date of 11/9/22.

7. a bowl containing rice labeled with a date 1/17/23.

8. an open carton of Oat Milk with no opened date and no name.

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9. a soda and a water bottle in the freezer with no name or date.

The nourishment room refrigerator was visibly dirty with dried, sticky substances on the inside front panel and shelves.

Interview on 01/26/23 at 10:15 AM with Nurse #7 revealed dietary staff cleaned and stocked the refrigerator. Nursing staff were to label and date food brought in by families for the residents. Nurse #7 stated she was not sure how long food was kept in the refrigerator before it was discarded.

Interview on 01/26/23 at a10:33 AM with Nurse #1 revealed dietary cleaned the nourishment room refrigerator and discarded expired food. Nurse #1 further stated when families brought in food the nursing staff they labelled and dated it before placing it in the refrigerator. Dietary discarded items when they cleaned out the refrigerator.

Interview on 01/26/23 t 10:39 AM with nursing assistant (NA) #7 revealed when a family brought in food, nursing staff labelled and dated it before putting it in the nourishment room refrigerator. NA #7 stated she thought food items could stay in the refrigerator 5-10 days before they were thrown away. NA #7 further stated she was not exactly sure how long food was stored in the refrigerator. NA #7 stated dietary discarded foods that were expired and was responsible for cleaning out the nourishment room refrigerator.

Interview and observation of the 200 Hall nourishment room refrigerator with the Dietary Manager (DM) was conducted on 01/26/23 at

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| F 812 | Continued From page 17<br>3:30 PM. DM observed the expired food items in the plastic bags in the refrigerator and stated she did not know why the expired items were in the nourishment room refrigerator and that they should have been discarded. DM stated that dietary staff checked the nourishment room refrigerators daily and made sure they were clean and stocked them with items such as juice and soda for the residents.<br><br>Interview with the Administrator on 01/26/23 at 4:32 PM revealed that her expectation was that the dietary department ensured that there were no expired items in the nourishment room refrigerators and that all food was labelled and dated properly. The Administrator further stated that she expected that all out of date items would be discarded immediately. | F 812 | | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. | F 867 | | 2/13/23 |

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| F 867 | Continued From page 18<br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or | F 867 | | |

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safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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| F 867 | Continued From page 20<br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations and staff interviews the facility's Quality Assessment and Assurance (QAA) program failed to maintain implemented procedures and monitor interventions the committee put in place following the complaint survey conducted on 8/13/21. This was for two recited deficiencies on the current recertification and complaint survey in the areas of Resident Rights (F584) and Food and Nutrition Services (F804). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.<br><br>Findings included.<br><br>This tag is cross-referenced to:<br><br>F584: Based on observations and staff interviews, the facility failed to 1a). repair drywall wall damage in 6 of 7 resident rooms (302, 309, 506, 508, 514 and 612), 1b); failed to remove the black greenish substance from the commode | F 867 | On 2/3/2023, the Clinical Consultant reviewed all previous citations and action plans related to F584 and F804 from 8/13/21 to present to identify system failure to maintain and monitor interventions that were put into place. The clinical consultant will address all concerns identified during the audit. Audit will be completed by 2/13/23.<br><br>On 2/9/2023, the Clinical Consultant initiated an in-service with the Administrator, Assistant Administrator, Director of Nursing (DON), QA Nurse, and QA committee regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice. In-service also included identifying issues that warrant development and establishing a system to | |

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| F 867 | Continued From page 21<br>base caulking in 4 of 13 resident rooms (506, 508, 510, and 615), 1c); failed to ensure the ceiling light cover was free from damage in 1 of 4 shower rooms (300 hall), 1d); and failed to ensure the fluorescent ceiling light cover was free from damage in 1 of 3 nursing stations (over exit door by Pelican nursing station).<br><br>During the complaint survey of 08/13/21 the facility was cited for failing to remove a black greenish substance from ceiling vents, remove the black greenish substance from the commode base caulking, ensure the ceilings were free from damaged drywall, replace the broken or missing toilet paper dispensers in resident rooms, repair overhead lights that were either non-functioning, missing a light cover, or had broken covers, repair leaking commode bases and unclog a resident's bathroom commode.<br><br>F804: Based on observation, record review, resident and staff interview and test tray evaluation, the facility failed to ensure food was palatable and served at an appetizing temperature for 3 of 24 residents reviewed on the 100, 400 and 700 halls for food palatability and temperature (Resident #332, Resident #18, and Resident #81).<br><br>During the complaint survey of 08/13/21, the facility was cited for failing to serve food that was palatable and at a preferable temperature during a lunch meal.<br><br>An interview on 01/26/23 at 5:25 PM with the Administrator indicated that she had been the Administrator at the facility for 9-months and it was a large building. She said the facility had made progress and would continue to work | F 867 | monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 2/13/23. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process.<br><br>The Administrator will be responsible for ensuring that the finding of this survey and other issues identified through audits are reported to QAPI committee and addressed appropriately in accordance with regulatory guidelines.<br><br>The Administrator/Assistant Administrator will complete monthly review of all finding identified on Meal Service Audit Tool, Home-Like Environment QI Audit Tool, and Kitchen Audit Tool related to tags F-584 and F-804 to ensure appropriate follow up and interventions are in place.<br><br>Nursing Home Administrator/Assistant Administrator will report results to the QAPI committee and the Clinical Consultant monthly times 3 months for review and recommendations and/or determine the need for further monitoring. | |

| 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 01/26/2023 |

| 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 867 | Continued From page 22<br>toward making more progress. She stated she felt having two full-time Maintenance Staff was sufficient and they had a system in place that monitored and tracked work orders; but they would continue to work toward making more progress.<br><br>A follow up interview on 01/26/23 at 6:00 PM with the Administrator revealed she was unaware that there were issues with food palatability. She further stated that there were new staff members in the dietary department and more training and monitoring was needed for food preparation. | F 867 | | |