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 10/18/2018

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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow its abuse and neglect policy by failing to report misappropriation of property for 2 of 3 sampled residents (Resident #6 and Resident #10) to the Health Care Personnel Registry (HCPR). Findings included: A review of the Abuse Policy and Procedure dated March 10, 2017 (revised) in the reporting/response section #3, page 3, revealed, in part, "The Administrator was responsible to ensure that incidents as indicated are reported to the appropriate local/state/federal agencies including the state Nurse Aide Registry. For all allegations that do not involve abuse or result in serious bodily injury, the Administrator will ensure the Division of Health Service Regulation, Health Care Personnel Section and other appropriate agencies are notified no later than 24 hours. A written report must be sent to Health Service Regulation, Health Care Personnel Section within	F 607	NorthChase Nursing and Rehabilitation 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 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.	11/14/18

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

Electronically Signed | 11/08/2018

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F 607	Continued From page 1 five (5) working days from the date the facility becomes aware of the alleged incident." 1) Resident #6 was admitted to the facility on 02/18/18. The Minimum Data Set (MDS) quarterly assessment dated 07/27/18 revealed the resident was cognitively aware. A review of the 24-hour initial report revealed on 05/10/18, Resident #6 alleged her money was missing in the amount of $38.00. The 24-hour report was sent via facsimile (fax) to the HCPR. The fax sheet confirmed the report was received on 05/11/18 at 6:21 PM. A review of the 5-day investigation report was completed, but there was no fax sheet to confirm the report was sent to the HCPR. 2) Resident #10 was admitted to the facility on 04/18/18. The MDS dated 04/25/18 5-day assessment revealed the resident was cognitively aware. A review of the 24-hour initial report was completed and sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/16/18 at 5:56 PM, however, the fax log for the facility indicated there was an error which read Error 346* and to try again. There was no fax confirming the receipt of the 5-day investigation report. An interview was conducted with the Administrator on 10/17/18 at 5:45 PM. The Administrator stated he was sure the 5-day investigation reports for Resident #6 and Resident #10 were sent to the HCPR via a fax	F 607	The process that led to this deficiency was the facility failed to follow its abuse and neglect policy by failing to report misappropriation of property for 2 of 3 sampled residents (resident #6 and resident #10) to the Health Care Personnel Registry. (HCPR) 100% audit of all resident HCPR reportable events to include resident # 6 and resident #10 x 90 days was initiated on 10/18/18 by the Administrator and Director of Nursing (DON) to ensure all investigative folders are complete to include a 24 hour report and 5 day report with written summary of investigation and proof of fax confirmation, police report when applicable, statements from staff and other documentation as indicated All areas of concern will be immediately addressed by the Administrator/DON to include faxing 24 hour/5 day report and obtaining confirmation of fax completion and completion of investigation Audit was completed on 10/19/2018. 100% in-service was completed by the Facility Nurse Consultant with the Administrator, DON, Social Worker on 10/18/18 in regards to HCPR Reportable Investigation Folders to include: The facility must initiate an investigative folder for all required HCPR reportable events to include but is not limited to the following: 1. Completion of a 24 hour report timely. The 24 hour report should be faxed to HCPR upon completion and the facility must retain fax confirmation records as proof report was faxed per HCPR requirements	

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F 607	Continued From page 2 and asked to notify the HCPR office to verify if it was received. A phone interview was conducted with the Complaint Intake Department (CID) for the State of North Carolina (NC) on 10/18/18 at 9:18 AM. The CID reported they were unable to find any facility reported incidents for Resident #6 and Resident #10. The CID stated unless the 24-hour report and the 5-day investigation report were both submitted to the HCPR, the investigation would be incomplete and would not appear as reported. The CID forwarded the call to the HCPR Representative to see if they would have a record of the reportable incidents. The HCPR representative was unable to find any reportable incidents for 2017 and 2018 for Resident #6 and Resident #10. An interview was conducted with the Administrator on 10/18/18 at 9:45 AM. The Administrator stated he was unable to provide a fax confirming the 5-day investigation reports were faxed. The Administrator understood that each component of the process (24-hour report and 5-day investigation report) needed to be completed in its entirety in order to be a completed reported investigation.	F 607	2. Completion of a 5 day report with summary of investigation. 5 day report, summary of investigation and supporting documents should be faxed to HCPR upon completion and the facility must retain fax confirmation records as proof report was faxed per HCPR requirements 3. Statements from staff or witnesses 4. In-services related to event 5. Police report if indicated 6. All other documents as related to the investigation If at any time the facility is unable to fax the 24hr or 5 day report or have issues with fax being received by HCPR, the facility must continue to attempt to fax reports daily until completed and show proof of each attempt. If the facility is unsure if report was received, the Administrator should contact HCPR to confirm and document the call in the investigative folder. 100% Audit of all resident HCPR reportable events will be completed by the Social Worker/ADON utilizing the HCPR Investigation Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all investigative folders are complete to include a 24 hour report and 5 day report with written summary of investigation and proof of fax confirmation, police report when applicable, statements from staff and other documentation as indicated All areas of concern will be immediately addressed by the Administrator/DON to include faxing 24 hour/5 day report and obtaining confirmation of fax completion and/or completion of investigation The Quality Assurance Nurse (QA) will	

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F 607	Continued From page 3	F 607	review and initial the HCPR Investigation Audit Tool weekly x 4 weeks then monthly x 1 month to assure all areas of concern have been addressed. The QA nurse will forward HCPR Investigation Audit Tool to Executive QA committee monthly x 3 months to determine trends and / or issues that may require further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		11/14/18

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F 609	Continued From page 4 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to complete facility reportable incidents to the Health Care Personnel Registry (HCPR) by not submitting the 5-day investigation report for 2 of 3 residents (Resident #6 and Resident #10) observed for misappropriation of property. Findings included: 1) Resident #6 was admitted to the facility on 02/18/18. The Minimum Data Set (MDS) quarterly assessment dated 07/27/18 revealed the resident was cognitively aware. A review of the 24-hour report revealed on 05/10/18, Resident #6 alleged her money was missing in the amount of $38.00. The 24-hour report was sent via facsimile (fax) to the HCPR. The fax sheet confirmed the report was received on 05/11/18 at 6:21 PM. A review of the 5-day investigation report was completed, but there was no fax sheet to confirm the report was sent to the HCPR. A review of the 5-day investigation report completed by the facility revealed an allegation was made by Resident #6 that money was taken from a cell phone case in her room. The report indicated this incident was reported and an investigation was immediately initiated. The report indicated a search was conducted in the resident ' s room and in the laundry area. The	F 609	NorthChase Nursing and Rehabilitation 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 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 was the facility failed to follow its abuse and neglect policy by failing to report misappropriation of property for 2 of 3 sampled residents (resident #6 and resident #10) to the Health Care Personnel Registry. (HCPR) 100% audit of all resident HCPR reportable events to include resident # 6 and resident #10 x 90 days was initiated	

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F 609	Continued From page 5 local sheriff ' s department was notified of the allegation and came to the facility to make a report. The deputy ' s report stated no further action was taken based on the lack of information. The 5-day investigation report stated, based on the investigation, the allegation could not be substantiated and interviews with staff did not yield additional information regarding the whereabouts of money. The report stated a thorough search was conducted throughout the physical area and the money could not be located. As part of the investigation, the report stated other residents in the area were interviewed and no other incidents of missing items were noted and no other identifying information regarding the allegation was provided. The report stated the resident ' s family member (FM) was obtaining money from the cell phone case when the discovery was made and may have inadvertently obtained the money. The money that was allegedly taken were funds that were part of the facility ' s activities fund. The report stated the money was returned to the resident and the resident provided the funds to the Activities Director. An interview was conducted with Resident #6 on 10/17/18 at 12:15 PM. The resident reported the money was missing but the facility never determined how and indicated that the money was returned and she gave the money to the Activities Director. 2) Resident #10 was admitted to the facility on 04/18/18. The MDS dated 04/25/18 5-day assessment revealed the resident was cognitively aware. A review of a facility grievance form written on	F 609	on 10/18/18 by the Administrator and Director of Nursing (DON) to ensure all investigative folders are complete to include a 24 hour report and 5 day report with written summary of investigation and proof of fax confirmation, police report when applicable, statements from staff and other documentation as indicated All areas of concern will be immediately addressed by the Administrator/DON to include faxing 24 hour/5 day report and obtaining confirmation of fax completion and completion of investigation Audit was completed on 10/19/18. 100% in-service was completed by the Facility Nurse Consultant with the Administrator, DON, Social Worker on 10/18/18 in regards to HCPR Reportable Investigation Folders to include: The facility must initiate an investigative folder for all required HCPR reportable events to include but is not limited to the following: 1. Completion of a 24 hour report timely. The 24 hour report should be faxed to HCPR upon completion and the facility must retain fax confirmation records as proof report was faxed per HCPR requirements 2. Completion of a 5 day report with summary of investigation. 5 day report, summary of investigation and supporting documents should be faxed to HCPR upon completion and the facility must retain fax confirmation records as proof report was faxed per HCPR requirements 3. Statements from staff or witnesses 4. In-services related to event 5. Police report if indicated	

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F 609	Continued From page 6 05/10/18 revealed Resident #10 stated when a FM came to get him the morning of 05/10/18 at 10:00 AM, Resident #10 went to grab an envelope out of his bureau drawer and the money was gone from the envelope. Resident #10 reported that he and the FM were going on an outing to a grocery store. Resident #10 stated a FM had come by on 05/09/18 at 2:00 PM and had given him $44.00 in cash (2 20 ' s and 4 1 ' s) in a white envelope for him to use. Resident #10 stated when another FM came to get him at 10:00 AM, he went to grab the money from the envelope out of the bureau drawer and the money was gone from the envelope. Resident #10 stated he saw the money 05/09/18 at around 5:00 PM. The grievance report stated the room was searched and no money was found. The grievance report added Resident #10 ' s FM who provided the money was notified and she stated that she had come out 05/09/18 around 2:00 PM and gave Resident #10 the money in a white envelope. A record review revealed the 24-hour initial report was completed and sent via fax to the HCPR on 05/10/18 at 2:11 PM. The 5-day investigation report was completed and signed and attempted to be sent via fax to the HCPR on 05/16/18 at 5:56 PM, however, the fax log for the facility indicated there was an error which read Error 346* and to try again. There was no fax confirming the receipt of the 5-day investigation report. The 5-day investigation report indicated a full investigation was completed by interviewing all staff that had contact with Resident #10 and interviewable residents that were in proximity to Resident #10 ' s room. There were no further	F 609	6. All other documents as related to the investigation If at any time the facility is unable to fax the 24hr or 5 day report or have issues with fax being received by HCPR, the facility must continue to attempt to fax reports daily until completed and show proof of each attempt. If the facility is unsure if report was received, the Administrator should contact HCPR to confirm and document the call in the investigative folder. 100% Audit of all resident HCPR reportable events will be completed by the Social Worker/ADON utilizing the HCPR Investigation Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all investigative folders are complete to include a 24 hour report and 5 day report with written summary of investigation and proof of fax confirmation, police report when applicable, statements from staff and other documentation as indicated All areas of concern will be immediately addressed by the Administrator/DON to include faxing 24 hour/5 day report and obtaining confirmation of fax completion and/or completion of investigation The Quality Assurance Nurse (QA) will review and initial the HCPR Investigation Audit Tool weekly x 4 weeks then monthly x 1 month to assure all areas of concern have been addressed. The QA nurse will forward HCPR Investigation Audit Tool to Executive QA committee monthly x 3 months to determine trends and / or issues that may require further interventions put into place and to determine the need for further and	

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F 609	Continued From page 7	F 609		

reports of missing items. The deputy from the local sheriff ' s department made a report, but indicated there was not enough information to investigate a crime. The report indicated, based on the investigation, no allegation of abuse regarding the whereabouts of the money could be substantiated and the money was replaced to Resident #10 as a courtesy.

An interview was conducted with Resident #10 on 10/17/18 at 4:30 PM. Resident #10 was alert and oriented and reported $44.00 was taken from his bureau drawer which was in a white envelope. Resident #10 stated the facility never recovered the money and they had the police come and investigate it. Resident #10 stated they searched the room and were unable to locate the money. Resident #10 reported he was asked by the facility staff to keep his money locked up at the front office, but he refused and wanted to keep it on his person at all times.

An interview was conducted with the Administrator on 10/17/18 at 5:45 PM. The Administrator stated he was sure the 5-day investigation reports for Resident #6 and Resident #10 were sent to the HCPR via a fax and asked to notify the HCPR office to verify if it was received.

A phone interview was conducted with the Complaint Intake Department (CID) for the State of North Carolina (NC) on 10/18/18 at 9:18 AM. The CID reported they were unable to find any facility reported incidents for Resident #6 and Resident #10. The CID stated unless the 24-hour report and the 5-day investigation report were both submitted to the HCPR, the investigation would be incomplete and would not appear as

/ or frequency of monitoring.

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F 609	Continued From page 8 reported. The CID forwarded the call to the HCPR Representative to see if they would have a record of the reportable incidents. The HCPR representative was unable to find any reportable incidents for 2017 and 2018 for Resident #6 and Resident #10. An interview was conducted with the Administrator on 10/18/18 at 9:45 AM. The Administrator stated he was unable to provide a fax confirming the 5-day investigation reports were faxed. The Administrator understood that each component of the process (24-hour report and 5-day investigation report) needed to be completed in its entirety in order to be a completed reported investigation.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow physician orders by not obtaining ordered blood work (labs) and a Urine Analysis for 1 of 3 residents (Resident #2) sampled. Findings included:	F 684	The process that led to this deficiency was the facility failed to follow physician orders by not obtaining ordered blood work (labs) and a Urine Analysis for 1 of 3 residents (resident #2) sampled. 100% audit of all physician lab (MD) orders, discharge summaries and admissions lab orders to include resident	11/14/18

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F 684	Continued From page 9 Resident #2 was admitted to the facility on 03/15/18 with a readmit of 10/04/18 after being hospitalized on 09/29/18. Diagnoses included, in part, dementia, pain, weakness, hypothyroidism and high blood pressure. The Minimum Data Set (MDS) dated 08/28/18 quarterly assessment revealed Resident #2 was severely cognitively impaired. Resident #2 did not exhibit any mood or behaviors, required extensive assistance with one staff assistance with all activities of daily living (ADLs), had no impairments and used a walker and wheelchair. Resident #2 was frequently incontinent of bladder and always continent of bowel. A review of the care plan updated on 07/18/18 revealed a plan of care was in place for complications due to hypothyroidism. The interventions included to monitor lab values, monitor for signs and symptoms such as excessive weakness, fatigue, sleepiness and mental status changes and notify physician of changes. A review of a progress note written by the Nurse Practioner (NP) on 09/27/18 revealed the NP was evaluating the resident due to lethargy (fatigue) and tremors. The NP stated in her progress note she would obtain a CBC (complete blood count), BMP (Basal Metabolic Panel), TSH Thyroid Stimulating Hormone), urinalysis (U/A), and urine C & S (Culture and Sensitivity) to evaluate for a reversible cause. A review of the physician orders dated 09/27/18 revealed an order for CBC, BMP, TSH, Magnesium and Phosphorous level, a U/A and Urine C & S.	F 684	#2 x 30 days was initiated on 10/17/18 by the Director of Nursing (DON), Quality Assurance Nurse (QA) and clinical team to ensure all labs were drawn per MD order. All areas of concern will be immediately addressed by the DON to include assessment of resident, notification of MD of any missed labs to obtain new orders, completion of labs per MD order, notification of MD and resident representative (RR) of lab results with documentation in electronic record. Audit was completed on 10/17/2018. On 10/1/2018 MD was notified by the Unit Supervisor that facility failed to obtain labs per MD order for resident #2 with no new orders due to labs being completed at the local emergency room. 100% in-service of all nurses was initiated by the Staff Facilitator on 10/18/18 in regards to Lab Orders to include: 1. Nursing staff are responsible to ensure that the admitting physician is alerted to all lab recommendations per discharge summaries for all new admissions. 2. Nursing staff are responsible to ensure all standing admission lab orders are completed as ordered with notification of MD/RR of lab results. 3. Nursing staff must notify the physician of any refusal of lab draw or failure to obtain labs and obtain new orders, as appropriate, with documentation in electronic record. 4. Nursing staff must notify RR of any refusal of lab attempts and document in electronic record. 5. All labs orders will be written on the	

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F 684	Continued From page 10 A review of the medical record revealed there were no results for blood work or a U/A obtained on 09/27/18. An interview with the evening Nurse Supervisor (NS) at 3:30 PM on 10/16/18 revealed he could not recall any blood work or a urinalysis being ordered on 09/27/18. The NS stated, the process of ordering lab work was to fill out a lab slip of what was ordered and place the slip in the lab book at the nurse ' s station under the numbered date the labs were to be drawn. The NS stated the labs were also put into their computer system. The NS stated when the technicians from the lab company arrived, they would go to the lab book for that specific day and pull the slip of what was needed to be drawn. The NS stated if they were ordered, they would have been in the lab book. The NS reported no labs were put in the system for 09/27/18 and he was unable to find the lab slip that was placed in the book. The NS stated if there was an order for U/A, then the facility would have obtained the urine to do the U/A the day the order was written which would have been 09/27/18. The NS confirmed there was no U/A completed on 09/27/18 and there were no orders put in the system on 09/27/18 to have the blood work drawn. An interview was conducted with Nurse #2 on 10/17/18 at 9:45 AM. Nurse #2 reported if the physician wrote an order for a U/A then that should have been done on 09/27/18. Nurse #2 confirmed there were no results of a U/A and no orders for blood work were put in the computer system or lab book on 09/27/18 for Resident #2. An interview with the NP on 10/18/18 at 9:45 AM	F 684	appropriate lab log for the appropriate date to be drawn. 6. Once labs are drawn, the lab order will be dated and initial as complete in the lab log. 7. Once lab results are received, the lab order will be highlighted in the lab log. 8. Nurses must document in electronic record utilizing the Phlebotomist Note under PCC progress notes and include: a. All lab attempts whether successful or not b. Refusal of labs c. Response to lab attempt/draw d. Condition of site after lab draw e. Notification of MD of any refusals or inability to obtain lab as ordered. f. A follow up note that MD/RR were notified of lab results. RR should be notified of all lab results both normal and abnormal 9. All lab results will be reviewed during Cardinal IDT. 10. The lab log will be reviewed daily during Cardinal IDT to ensure all labs are marked as obtained and orders received. Any labs not marked as complete will be followed up on by the Clinical Coordinator. 11. Procedure for Initiating lab orders: a. All orders for labs will be obtained on the next scheduled lab day unless ordered as STAT or for same day draw b. All orders for Urinalysis or Urine culture will be obtained the same day as ordered on the shift it is ordered. Notify MD if unable to obtain. In-service will be completed by 10/22/2018. After 10/22/2018 no nurse will	

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F 684	Continued From page 11 was conducted via phone. The NP stated she recalled seeing Resident #2 on 09/27/18 and she was noted to have tremors and increased lethargy. The NP stated the resident was alert and awake at the time of her assessment. The NP reported after assessing her, she ordered blood work to include a CBC, BMP, TSH, Magnesium and Phosphorous level, a U/A and Urine C & S to determine if there was a reversible cause based on the lab results. The NP stated she would have expected the U/A to be completed on 09/27/18 and for the remainder of the labs requested to be ordered for the next lab draw. An interview with the Director of Nursing (DON) on 10/18/18 at 10:30 AM revealed her expectation of the nursing staff was to ensure they obtained a urine to complete an analysis on the day it was ordered and any orders for blood work were put in the system and ordered.	F 684	be allowed to work until in-service has been completed. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Lab Orders to include: 1. Nursing staff are responsible to ensure that the admitting physician is alerted to all lab recommendations per discharge summaries for all new admissions. 2. Nursing staff are responsible to ensure all standing admission lab orders are completed as ordered with notification of MD/RR of lab results. 3. Nursing staff must notify the physician of any refusal of lab draw or failure to obtain labs and obtain new orders, as appropriate, with documentation in electronic record. 4. Nursing staff must notify RR of any refusal of lab attempts and document in electronic record. 5. All labs orders will be written on the appropriate lab log for the appropriate date to be drawn. 6. Once labs are drawn, the lab order will be dated and initial as complete in the lab log. 7. Once lab results are received, the lab order will be highlighted in the lab log. 8. Nurses must document in electronic record utilizing the Phlebotomist Note under PCC progress notes and include: a. All lab attempts whether successful or not b. Refusal of labs c. Response to lab attempt/draw d. Condition of site after lab draw e. Notification of MD of any refusals or	

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F 684	Continued From page 12	F 684		

inability to obtain lab as ordered.
f. A follow up note that MD/RR were notified of lab results. RR should be notified of all lab results both normal and abnormal
9. All lab results will be reviewed during Cardinal IDT.
10. The lab log will be reviewed daily during Cardinal IDT to ensure all labs are marked as obtained and orders received. Any labs not marked as complete will be followed up on by the Clinical Coordinator.
11. Procedure for Initiating lab orders:
a. All orders for labs will be obtained on the next scheduled lab day unless ordered as STAT or for same day draw
b. All orders for Urinalysis or Urine culture will be obtained the same day as ordered on the shift it is ordered. Notify MD if unable to obtain.

100% in- service of all nurses was initiated on 11/8/2018 in regards to Lab Draws with Quest Laboratory to include:
1. Nursing staff are responsible to provide the requisition in the lab system for lab orders. If nurse is unable to complete the requisition in the lab system, the nurse then must complete a hand written requisition and place in the lab book.
2. If an order for a UA C&S is received, the nurse that receives the order must obtain the specimen by the end of the shift. If the specimen is unable to be obtained by the nurse, the MD must be

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F 684	Continued From page 13	F 684	notified and a note documented in Point Click Care. 3. STAT lab orders must be obtained immediately upon receiving the order. All STAT labs will be transported to New Hanover Regional Medical Center Lab by designated courier. 4. Quest phlebotomist will obtain labs per lab logs 3 days a week on scheduled lab day. 5. If Quest is unable to obtain labs for any reason the assigned staff nurse must sign the requisition form and notify the on call supervisor by the end of shift to include MD notification. In-service will be completed by 11/14/2018. After 11/14/2018 no nurse will be allowed to work until in-service has been completed An In-Service provided to Quest Laboratory Services manager on 11/07/2018 in regards to the process for phlebotomist on scheduled lab days at the facility. 1. Nursing staff are responsible to provide the requisition in the lab system for lab orders. If nurse is unable to complete the requisition in the lab system, the nurse then must complete a hand written requisition and place in the lab book. 2. Quest phlebotomist will obtain labs per lab logs 3 days a week on scheduled lab day. 3. If Quest is unable to obtain labs for any reason the assigned staff nurse must sign the requisition form.	

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F 684	Continued From page 14	F 684	4. Quest is responsible for communicating with nursing staff if unable to obtain any labs as ordered. Requisition form must be signed by nursing staff regarding lab refusals, inability to obtain lab as scheduled. 100% Audit of all MD lab orders, discharge summaries and admissions lab orders to include resident #2 will be completed by the nurse supervisor, hall nurses, and Clinical Coordinators utilizing the Lab Audit Tool 5 times a week x 4 weeks, weekly x 4 weeks then monthly x 1 month to ensure all labs are drawn as per MD order with MD/RR notification of lab results. All areas of concern will be immediately addressed by the nurse supervisor, hall nurses, and Clinical Coordinators to include re-education of staff, assessment of resident, notification of MD of any missed labs to obtain new orders, completion of labs per MD order, notification of MD and resident representative (RR) of lab results with documentation in electronic record. DON/ADON/Administrator will review and initial the Lab Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed and labs are completed per MD order. The QA nurse will forward Lab Audit Tool to Executive QI committee monthly x 3 months to determine trends and / or issues that may require further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 692	Continued From page 15	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, nurse practitioner interview, resident interview, staff interview, and record review the facility failed to provide food items requested by the family and documented on the resident's meal tray slips for 1 of 3 sampled residents (Resident #9) reviewed for significant weight loss. In addition, the facility failed to provide the nurse practitioner (NP) with nutrition intervention recommendations made by the registered dietitian (RD) for consideration in addressing Resident #9's continued weight loss. Findings included:	F 692	The process that led to this deficiency was the facility failed to provide food items requested by the family and documented on the resident's meal tray slips for 1 of 3 sampled residents (resident #9) reviewed for significant weight loss. In addition, the facility failed to provide the nurse practitioner (NP) with nutrition intervention recommendations made by the registered dietitian (RD) for consideration in addressing resident #9 continued weight loss. 100% audit of all meal tray cards to	11/14/18

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F 692	Continued From page 16 Record review revealed Resident #9 was admitted to the facility on 02/23/15 and readmitted to the facility on 05/18/18. The resident's documented diagnoses included dementia without behavioral disturbance, atrial fibrillation, congestive heart failure, hyperlipidemia, and constipation. The resident's Weight Summary documented on 01/09/18 she weighed 117.7 pounds, on 02/14/18 and 02/16/18 she weighed 119.8 pounds, on 03/09/18 she weighed 117 pounds, on 04/06/18 she weighed 115.5 pounds, on 05/09/18 she weighed 111 pounds, on 06/06/18 she weighed 109 pounds, on 07/08/18 she weighed 107.5 pounds, and on 08/08/18 she weighed 101.8 pounds. Resident #9's 08/22/18 quarterly minimum data set (MDS) documented her cognition was moderately impaired, she was independent in eating requiring set-up assistance only, she was 63 inches tall and weighed 99 pounds, and she experienced a significant weight loss. A 08/28/18 RD progress note documented the resident's current body weight was 98.6 pounds, the resident experienced a significant weight loss of 5.3% x 30 days and 15% x 180 days, and the resident's meal intake varied from 0 - 75%. During discussion with the nurse the nurse reported she thought the resident would better tolerate her supplement if it was provided with the evening medications. The RD's recommendations included moving the resident's Resource 2.0 to the evening medication pass 90 cubic centimeters (cc) to aid with energy intake and compliance, enriched meal program (EMP) with all meals, and an evening snack to aid with	F 692	include resident #9 was completed on 10/18/18 by the Dietary Manager to ensure that all food preference items requested by the resident or resident representative were provided on the meal tray. All areas of concern were immediately addressed by the Dietary Manager to include obtaining requested items during meal, modification of meal tray card and/or re-education of staff. 100 % Audit of all Register Dietician Recommendations (RD) to include resident #9 x 90 days was initiated on 10/18/18 by the Dietary Consultant and Director of Nursing to ensure all RD recommendations had been reviewed by the physician (MD) and that any recommendations approved had been implemented per MD order. All areas of concern will be immediately addressed by the Director of Nursing (DON), Assistant Director of nursing (ADON), and clinical coordinators to include notification of MD of RD recommendations, obtaining new orders as indicated, notifying Resident Representative (RR) of new orders/interventions, and assessment of resident to include weight. Audit will be completed by 11/14/2018. 100% audit of all weights was completed on 11/7/18 to include resident #9 X 30 days by the Quality Improvement Nurse. To ensure all residents with significant weight loss/gain was assessed for cause of weight change, referrals to MD/RD completed for significant weight change, therapy referral completed as indicated, RR notified of significant weight change, appropriate interventions were initiated	

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F 692	Continued From page 17 energy intake. The resident's care plan, last updated on 09/04/18, identified "State of nourishment: Resident is at risk for weight loss (due to) poor intake (by mouth). She has had significant weight loss" as a problem. Interventions to this problem included providing the diet as ordered, providing protein supplementation, referral to dietitian for evaluation/recommendations, and taking weights per facility protocol. The resident's Weight Summary documented on 09/07/18 Resident #9 weighed 97.7 pounds. A 09/11/18 progress note documented the resident's current body weight was 97.7 pounds, she was on a regular diet, her meal intake varied from 0 - 25%, and the family refused a feeding tube. A 09/25/18 RD progress note documented the resident's current body weight was 97.7 pounds, her meal intake varied between 25 - 75%, she continued to refuse supplements although staff were still encouraging her to eat/drink them, and she ate better when fed by family. The RD's recommendations included moving the resident's Resource 2.0 to the evening medication pass 90 cubic centimeters (cc) to aid with energy intake and compliance, enriched meal program (EMP) with all meals, and an evening snack to aid with energy intake. The resident's Weight Summary documented on 10/10/18 she weighed 96.5 pounds. On 10/16/18 at 12:50 PM Resident #9 was eating lunch in her bed. She received stew beef,	F 692	and care plan/ care guide was updated. All areas of concern will be immediately addressed by the DON to include assessment of resident, MD/RD/therapy referrals as indicated, notification of RR of weight change and initiation of appropriate interventions. On 10/23/2018 resident #9 was assessed by nursing staff and referred to the MD/RD by the Dietary Manger for continued weight loss with the following new orders/interventions Enriched Meal Plan, ice cream, whole milk twice a day with meals resident reported distaste from mashed potatoes, food preference provided to family. Resident Representative is aware of weight, weight monitoring and interventions by nursing staff. 100% in-service of all nurses was initiated on 10/18/18 by the Staff Facilitator in regards to RD Recommendations to include: 1. Notification of MD of all RD recommendations 2. Documentation that MD has reviewed RD recommendation with approval/new orders received or reason recommendation was not initiated. This documentation will be linked to the RD Progress note. 3. Implementing new orders 4. Notification of RR of all new orders/interventions 5. MD must initial RD recommendation and return to DON. In-service will be completed by 10/22/18. After 10/22/18no nurse will be allowed to	

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F 692	Continued From page 18 mashed potatoes and gravy, carrots, a roll, and a cookie. Her tray slip documented Standing Orders: deli turkey sandwich with two ounces of meat and two slices of whole wheat bread, bag of chips, and soup. None of the standing order foods were on the resident's meal tray. On 10/17/18 at 12:43 PM Resident #9 was eating lunch in her bed. She received chicken, mixed vegetables, and mashed potatoes and gravy. Her tray slip documented Standing Orders: deli turkey sandwich with two ounces of meat and two slices of whole wheat bread, bag of chips, and soup. None of the standing order foods were on the resident's meal tray. On 10/17/18 at 1:56 PM Resident #9 stated what the facility provided her to eat was fine, and she would eat what she wanted and leave the rest on her plate. She commented her appetite was not always good, but she was never hungry in the facility. On 10/17/18 at 3:08 PM the Kitchen Manager stated the enriched food item at lunch on 10/16/18 and 10/17/18 was soup. She reported that standing order foods were foods added daily to Resident #9's standard meal trays. On 10/17/18 at 3:17 PM the Dietary Manager (DM) provided a list of residents on the EMP program, and Resident #9 was not on that list. On 10/17/18 at 3:36 PM the DM stated Resident #9's family suggested the resident get two of her favorite foods at lunch, deli sandwiches and chef salads. However, the DM reported she talked the family into adding these two foods to the resident's standard meal trays, adding the chef	F 692	work until in-service has been completed. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to RD Recommendations to include: 1. Notification of MD of all RD recommendations 2. Documentation that MD has reviewed RD recommendation with approval/new orders received or reason recommendation was not initiated. This documentation will be linked to the RD Progress note. 3. Implementing new orders 4. Notification of RR of all new orders/interventions 5. MD must initial RD recommendation and return to DON. 100% in-service was initiated on 11/2/18 by the Staff Development Coordinator with all nurses in regards to Significant Weight Loss/Gain to include: 1. Nursing staff will obtain weights on admission and re-admission to the facility then weekly until weight stable x 4 weeks 2. All residents will be weighed monthly by the 10th of each month 3. Any resident who triggers for +/- 5% or +/- 10% weight change will be immediately re-weighed to verify weight change. If significant weight change is noted then resident will be weighed weekly until weight is stable x 4 weeks. 4. MD must be notified of all significant weight loss/gain with documentation in the electronic medical record 5. RD referrals should be submitted for all admissions, re-admissions and	

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F 692	Continued From page 19 salads twice a week and adding the deli sandwiches the other five days at lunch. In addition, the DM commented she and the family wanted Resident #9 to get soup with each lunch meal. On 10/17/18 at 4:35 PM, during a telephone interview, the facility's RD stated she was in the building weekly, and provided copies of her nutrition recommendations to the Director of Nursing (DON) who was responsible for obtaining a physician order to put them in place. According to the RD, the facility's NP was very receptive to her recommendations and expertise as a RD, and usually wrote orders quickly to support her recommendations. The RD commented that it was important to discontinue ineffective nutrition interventions and put new ones in place for residents who continued to experience weight loss. On 10/17/18 at 5:24 PM the DON stated the RD was supposed to make copies of her progress notes after each visit and provide them to herself and the DM. However, the DON commented she did not receive any copies of progress notes from the RD's 09/25/18 visit until 10/02/18, and then there were no recommendations for Resident #9 included in her copies. On 10/18/18 at 11:03 AM the Kitchen Manager stated she knew Resident #9 did not eat a lot of the chef salad and deli sandwiches in the past, but if the items still appeared on the resident's meal tray slips, then the resident should continue to receive them at her lunch meals. The Kitchen Manager provided a list of resident's receiving evening snacks via physician order, and Resident #9 did not appear on the list.	F 692	residents with significant weight loss/gain 6. Nursing staff should submit therapy referral as appropriate with weight loss or concerns related to resident ability to fed self or swallow. 7. Weight loss interventions should be initiated with any significant weight loss. 8. Nursing staff should notify Resident Representative of any significant weight change to include any new orders or interventions with documentation in the electronic medical record. In-service will be completed by 11/14/18. After 11/14/18 no nurse will be allowed to work until in-service has been completed. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Significant Weight Loss/Gain to include: 1. Nursing staff will obtain weights on admission and re-admission to the facility then weekly until weight stable x 4 weeks 2. All residents will be weighed monthly by the 10th of each month 3. Any resident who triggers for +/- 5% or +/- 10% weight change will be immediately re-weighed to verify weight change. If significant weight change is noted then resident will be weighed weekly until weight is stable x 4 weeks. 4. MD must be notified of all significant weight loss/gain with documentation in the electronic medical record 5. RD referrals should be submitted for all admissions, re-admissions and residents with significant weight loss/gain 6. Nursing staff should submit therapy	

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F 692	Continued From page 20 On 10/18/18 at 11:10 AM the DON stated the facility relied on the expertise and recommendations of the RD to keep residents from losing weight, and she expected the kitchen to supply all the foods that were listed on resident tray slips at meals. On 10/18/18 at 11:18 AM, during a telephone conversation with the facility's NP, she stated she was not aware of any recent nutrition recommendations for Resident #9. She reported when she was made aware of new RD recommendations, she immediately took the time to write orders to implement the recommendations. She commented she was not sure how effective Resource supplement with the evening medication pass would be for Resident #9 because the resident had a history of refusing most supplement products. However, the NP stated the EMP program and a bed time snack might be effective. According to the NP, Resident #9 had many food dislikes, but the resident's family did not want to resort to a feeding tube to keep the resident nourished. The NP reported it was important to keep trying new nutrition interventions for Resident #9 in order to find something the resident was receptive to that might halt her weight loss.	F 692	referral as appropriate with weight loss or concerns related to resident ability to fed self or swallow. 7. Weight loss interventions should be initiated with any significant weight loss. 8. Nursing staff should notify Resident Representative of any significant weight change to include any new orders or interventions with documentation in the electronic medical record. 100% in-service was initiated on 11/2/18 by the Dietary Manger with all Dietary staff in regards to Tray Card Accuracy Protocol to include: 1. Upon admission and PRN dietary manger or assistant dietary manger will speak to resident/family about preferences. 2. Preferences will be added to tray card in PCC by dietary manger or assistant dietary manger. 3. Dietary staff will read tray card during meal service and honor preferences on tray card. 4. Dietary aide that caps the meal tray will do final inspections of meal tray to assure all preferences are correct. 5. Preferences will be upgraded per resident/family request. In-service will be completed by 11/8/18. After 11/8/18, no dietary staff will be allowed to work until in-service has been completed. 100% audit of RD recommendations to include resident #9 will be completed by the ADON and Clinical Coordinators	

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 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 21	F 692	weekly x 8 weeks then monthly x 1 month utilizing the RD Recommendation Audit Tool to ensure all RD recommendations have been reviewed by the MD and that any recommendations approved had been implemented per MD order. All areas of concern will be immediately addressed by the ADON and Clinical Coordinators to include notification of MD of RD recommendations, obtaining new orders as indicated, notifying RR of new orders/interventions, assessment of resident to include weight. The DON/Administrator will review the RD Recommendation Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed. 10% Audit of meal tray cards to include resident #9 will be completed by the Dietary Manger and or Assistant Dietary Manger utilizing the Meal Card Audit Tool 3 times a day 5 times a week x 4 weeks, 3 times a day weekly x 4 weeks then 3 times a day monthly x 1 month to ensure all resident/resident representative food preference items are provided as requested. All areas of concern will be immediately addressed by the Dietary Manager to include providing appropriate food items as requested, correction of meal tray cards and/or re-education of staff. The Administrator will review and initial the Meal Card Audit Tool weekly x 8 weeks then monthly x 1 month. 25% Audit of all weights to include resident #9 will be completed by the Unit Supervisor, Quality Improvement Nurse, Staff Development Coordinator, Minimum	

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F 692	Continued From page 22	F 692	Data Set Nurse, utilizing the Weight Audit Tool 3 times a week x 4 weeks, then weekly x 4 weeks then monthly x 1 month to ensure all residents with significant weight loss/gain was assessed for cause of weight change, referrals to MD/RD completed for significant weight change, therapy referral completed as indicated, RR notified of significant weight change, appropriate interventions were initiated and care plan/ care guide was updated . All areas of concern will be immediately addressed by the ADON, Quality Assurance nurse (QA) and clinical nursing staff to include assessment of resident, MD/RD/therapy referrals as indicated, notification of RR of weight loss and initiation of appropriate weight loss interventions. The DON will review the Weight Audit Tool weekly x 8 weeks to ensure all areas of concern have been addressed. The Quality Assurance Nurse (QA) will forward all RD Recommendation Audit Tools, Meal Card Audit Tool and the Weight Audit Tool to Executive QA committee monthly x 3 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.	