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 06/10/2022

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

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E 000	Initial Comments An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted on 06/06/20 through 06/10/20. The facility was found to be in compliance with 42 CFR 483.73 related to E0024 (b) (6), Subpart-B Requirements for long term care facilities. Event ID# YOOH11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 06/06/22 through 06/10/22. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The following intakes were investigated: NC00186757, NC00186887, NC00187425, NC00187634, NC00187820, NC00187876, NC00188106, NC00188536, NC00188150, NC00188755, NC00189448, and NC00189054. 4 of 34 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced	F 624		7/8/22

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

Electronically Signed | 06/30/2022

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F 624	Continued From page 1 by: Based on record review and staff interviews and home healthcare agency interview the facility failed to refer Resident #8 to home healthcare as ordered by the physician, as care planned when discharged from the facility. This was for 1 of 1 sampled resident (Resident #8) reviewed for discharge. The findings included: A review of the medical record revealed Resident #8 was admitted to the facility on 12/06/21 with acute and chronic respiratory failure, tracheostomy, depression, anxiety, gastrostomy, toxic encephalopathy, hypertension, and diabetes. Resident #8's Minimum Data Set dated 03/04/22 revealed resident had no cognitive impairments. Resident needed limited assistance with bed mobility, transfers, eating, toilet use, dressing, personal hygiene, and bathing. She utilized a rollator and had no impairment with range of motion. Resident #8 was receiving occupational therapy (OT) and physical therapy (PT). Resident #8's care plan included the focus area of her desire to be discharged home upon completion of rehabilitation and skilled nursing services. This area was initiated on 12/10/21 and the goal was for Resident #8 to be prepared for discharge on target date of 04/08/22. The interventions, all initiated on 12/10/21, included: Encourage resident to discuss feeling and concerns with impending discharge, and observe for and address episodes of anxiety, fear, and for distress. MD evaluation of resident discharge potential and resident needs as indicated.	F 624	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. F624 Preparation for Safe/Orderly Transfer/Discharge Resident #8 no longer resides in the facility. On 3/6/22, the Social Worker completed and faxed a referral for home healthcare, physical therapy, occupational therapy, nursing (RN), social worker (SW), nursing assistant (NA), and wound care per physician recommendation. On 3/7/22, an initial home visit and evaluation was completed by the Home Health Agency.	

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F 624	Continued From page 2 Prepare and give resident contact information for all community referrals. Provide the resident with written instructions and visual aids as required to ensure care continuity post discharge. A physician's order for Resident #8 dated 03/02/22 indicated a referral for home healthcare, PT, OT, nursing (RN), social worker (SW), nursing assistant (NA), and wound care. A social service progress note dated 03/02/22 completed by the SW indicated when she and the assistant social worker/discharge planner (ASW) went to speak with Resident #8 to confirm her discharge on 03/04/22. SW indicated she would be setting up for the resident a proper discharge with durable medical equipment (DME) and home health (HH) services. The nursing home notice of transfer/discharge dated 03/03/22 indicated Resident #8's health has improved sufficiently so that the resident no longer needed the services provided by the facility. An interview was conducted with Nurse #4 on 06/09/22 at 10:15 AM. She stated that she called and spoke with Resident #8 on 03/06/22 during a routine phone call made to discharged residents. She stated Resident #8 reported no concerns, but made the comment that no home healthcare nurse or aide showed up at her house on the day of discharge as they were supposed to do, and 2 to 3 days later they have yet to show up at her home for a visit. Nurse #4 said after the phone call she immediately let the SW know Resident #8 had not had a home healthcare visit. Nurse #4 stated Resident #8 was able to communicate with staff, was alert and oriented and had been	F 624	On 6/28/2022, the Administrator initiated an audit of all discharges to the community for the past 14 days. This audit is to ensure a referral to home health was completed per physician order prior to discharge when indicated. The Social Worker will address all concerns identified during the audit. Audit will be completed by 7/8/2022. On 6/28/2022, the Administrator initiated an in-service with the Social Workers on Discharge Referrals for Home Health. Emphasis is placed on completion a referral for home health services are completed prior to resident discharge from facility per physician order to ensure safe and orderly transfer or discharge from the facility. In-service will be completed by 7/8/2022. All newly hired Social Workers will be in-serviced during orientation regarding Discharge Referrals for Home Health. The Assistant Administrator will audit all discharges to the community weekly x 4 weeks then monthly x 1 month utilizing the Discharge Audit Tool. This audit is to ensure a referral to home health was completed per physician order prior to discharge when indicated. The Discharge Planner and/or Social Worker will address all concerns identified during the audit to include but not limited to initiation of referral for home health services per physician order/recommendation. The Administrator will review the Discharge Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were	

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F 624	Continued From page 3 decannulated, and no longer required use of gastric feeding tube prior to discharge. Nurse #4 stated education was provided to Resident #8 for stoma and g-tube site dressing changes. An interview was conducted with the SW and ASW on 06/09/22 at 3:10 PM. SW stated Resident #8 was discharged from the facility on 03/04/22 and the ASW was assigned to complete her healthcare referral. She reported that on 03/06/22 Resident #8 contacted her by phone and indicated that she had not heard from the home healthcare provider. She revealed that she reached out to the home healthcare provider and they stated that they had not received a referral for Resident #8. The SW stated that they completed the referral that day and faxed it to the provider and the provider sent out a nurse the next day on 03/07/22 to complete the initial home health visit. She indicated she thought the ASW completed the referral on 03/02/22, but there was no documented evidence of the referral being sent or approved by the provider. The SW added when she learned of the delay in home healthcare services for Resident #8, she was not in fear of any harm or negative consequences due to her ability to complete most of her activity of daily living (ADL) care independently. SW and ASW indicated they thought the referral was made and the error was on their part and not the home healthcare agency. A phone interview was conducted with the home healthcare agency's risk manager (RM) on 06/09/22 at 1:20 PM. She revealed they received Resident #8's home healthcare referral from the facility's SW and ASW on 03/06/22 at 3:24 PM. RM said as soon as the agency received resident's referral on 03/06/22 they immediately	F 624	addressed. The DON will forward the results of the Discharge Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Discharge Audit Tool 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.	

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F 624	Continued From page 4 sent out a nurse to visit Resident #8 the next day on 03/07/22. During an interview with the Administrator on 06/09/22 at 3:30 PM she stated she expected referrals for home healthcare services and/or other referrals related to discharge to be completed prior to the resident discharging from the facility.	F 624		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer an antibiotic 6 times per the physician order for 1 of 3 residents (Resident #2) observed for medication errors. Findings included: Resident #2 was admitted to the facility on 01/21/22 and discharged home on 05/28/22. Resident #2 had a diagnosis, in part, of stroke and clostridium difficile (C-Diff an intestinal infection). The Minimum Data Set quarterly assessment dated 04/30/22 revealed the resident was severely cognitively impaired and received 7 days of an antibiotic during this look back period. A physician ' s order written on 03/03/22 at 9:00 AM revealed give one Vancocin (Vancomycin HCL) 250 milligrams (mg) capsule by mouth two	F 760	F760 Residents are Free of Significant Med Errors Resident #2 no longer resides in the facility On 6/28/2022, the Director of Nursing initiated an audit of all newly prescribed medication orders to include antibiotics along with the Medication Administration Records (MARs) from 6/1/22 to 6/30/22. This audit is to ensure orders were transcribed accurately to the MAR and administered per physician order. The Assistant Director of Nursing and Unit Managers will address all concerns identified during the audit to include but not limited to assessment of the resident, initiating orders when indicated, notification of physician when medication not administered and/or not available for further recommendations and/or	7/8/22

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F 760	Continued From page 5 times per day for C-Diff for 14 days. This order was discontinued on 03/06/22 at 12:05 PM. A review of the Medication Administration Record (MAR) from 03/03/22 to 03/06/22 revealed Resident #2 had received the Vancocin medication as ordered for 7 doses (3.5 days) as evidenced by the nursing initials and check marks. A physician ' s order written on 03/06/22 at 8:00 PM revealed Vancomycin 50 mg give 5 milliliters (ml) per milligram (mg) via Percutaneous Endo Gastric tube (PEG, a tube inserted in the abdomen) two times a day for C-DIFF for 10 days. A review of the MAR on 03/06/22 at 8:00 PM revealed the nursing initials by Nurse #1 for the 8:00 PM dose with a #5 recorded. Per the MAR, #5 indicated to "hold and see nursing note." A nursing note on 03/06/22 written by Nurse #1 revealed "the medication was not given, waiting for it to arrive from pharmacy." The MAR on 03/07/22 revealed the nursing initials by Nurse #2 for the 8:00 AM dose with a #10 recorded. Per the MAR, the #10 meant the medication was not available. Review of a physician progress note written on 03/07/22 revealed, in part, the medication administration record was reviewed, and the resident did not receive the ordered 250mg (5 ml per mg/ml) twice daily {for ten days} and changed the order to Vancomycin 125 mg four times daily to complete 14-day course.	F 760	education of the nurse. Audit will be completed by 7/8/2022. On 6/28/2022, the Director of Nursing initiated an in-service with all nurses and medication aides regarding Following Physician's Orders. Emphasis is on transcribing orders to the MAR upon receiving, documenting medication administration on MAR and notification of physician for further instructions if medication is not available or there is a delay in receiving medication from pharmacy. In-service will be completed by 7/8/2022. All newly hired nurses and/or medication aide will be in-serviced during orientation regarding Following Physician Orders. The IDT team to include Director of Nursing (DON), Assistant Director of Nursing (ADON), Minimum Data Set Nurse (MDS), Treatment Nurse and Unit Managers will review all newly written physician orders to include but not limited to newly written orders for antibiotics utilizing the Orders Listing Report 5 times a week x 8 weeks. This audit is to ensure all orders were transcribed accurately to the MAR/TAR, medications were available and administered per physician order. The ADON, MDS nurse, Treatment nurse and/or Unit Managers will address all concerns identified during the audit. The DON will review the Orders Listing Report 5 times a week x 8 weeks to ensure all concerns were addressed. The ADON and Unit Managers will review	

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F 760	Continued From page 6 A physician ' s order written on 03/07/22 at 11:50 AM revealed the order for Vancomycin 50 mg, give 5 milliliters (ml) via PEG tube two times a day for C-DIFF for 10 days was discontinued on 03/07/22 at 11:50 AM. A physician ' s order written on 03/09/22 at 6:00 PM revealed give 125 mg/ml Vancomycin HCl Suspension via PEG tube every 6 hours for 14 days for C-DIFF. This order was discontinued on 03/11/22 at 12:27 PM. The MAR on 03/09/22 at 6:00 PM revealed the medication was given at 6:00 PM as evidenced by nursing initials from Nurse #3 with a check mark. The MAR on 03/10/22 revealed an "X" for the Midnight dose, 6:00 AM dose, 12:00 PM dose and 6:00 PM dose indicating these four doses were not administered on 03/10/22 by Nurse #1 and Nurse #3 as ordered on 03/09/22. The MAR on 03/11/22 revealed an "X" for the Midnight dose and the 6:00 AM dose indicating two doses by Nurse #1 were not administered on 03/11/22 as ordered on 03/09/22. A physician ' s order written on 03/11/22 at 2:00 PM revealed give 125 mg/ml Vancomycin HCl Suspension via PEG tube every 6 hours for 14 days for C-DIFF until 03/23/22. The MAR from 03/11/22 at 2:00 PM until 03/23/22 at 8:00 PM revealed the resident received the ordered doses as evidenced by nursing initials and check marks. An interview was conducted with Nurse #1 via phone at 3:00 PM on 06/10/22. Nurse #1 reported when documenting on the MAR, the nurses ' initials were typed in and a check mark	F 760	Medication Audit Report 5 days a week x 8 weeks to ensure the nurse and/or medication aide documented medication administration per physician order and/or documented resident refusal and physician notification when indicated. The ADON and/or Unit Managers will address all concerns identified during the audit to include but not limited to assessment of the resident, notification of physician of missed medication administration for further recommendations and/or re-education of the nurse/medication aide. The DON will review the MAR Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Medication Audit Report and the Orders Listing Report to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Medication Audit Report and the Orders Listing Report 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.	

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F 760	Continued From page 7	F 760		

indicated the medication was given. Nurse #1 stated the #5 indicated to "hold the medication and see nursing note." Nurse #1 stated on 03/06/22 she recorded #5 on the MAR with a nursing note indicating they were waiting for medication, Vancomycin suspension, from the pharmacy. She stated there was a lapse in treatment because it took a day and half for the medication to be sent to the facility. Nurse #1 stated she could not remember if she notified the physician on the night of 03/06/22 via phone regarding the medication not being available or to see if the physician wanted to continue to administer the oral Vancomycin while waiting for the suspension Vancomycin, but that she wrote a note in the physician book. Nurse #1 reported on 03/10/22 and 03/11/22 if she administered the Vancomycin at Midnight and 6:00 AM she would have recorded that on the MAR with her initials and a check mark. She stated if there was an "X" than she did not administer the medication but could not recall why she did not administer it. She stated, "That was back in March."

An interview was conducted with Nurse #2 via phone at 3:30 PM on 06/10/22. Nurse #2 revealed when documenting on the MAR she recorded the #10 on 03/07/22 which meant the medication was not available and we were waiting for it to come from pharmacy. She stated she notified the physician but did not get orders to administer the oral Vancomycin while waiting for the suspension Vancomycin. She stated the order was discontinued until the medication came in from pharmacy.

Nurse #3 was an agency nurse and no longer worked at the facility and was unable to be interviewed regarding the medication

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administration of the Vancomycin suspension on 03/10/22 for the 12:00 PM and 6:00 PM dose. The phone number that was provided indicated the number was no longer in service. The facility was not able to provide an alternate number.

An interview was conducted with the current Director of Nursing (DON). The DON reported she was not the DON at the time of these orders. The DON confirmed that there was a break in the treatment while waiting for the suspension Vancomycin, but the order was discontinued on 03/07/22 and then rewritten on 03/09/22. The DON confirmed the order written on 03/09/22 and discontinued on 03/11/22 revealed that 6 doses of the Vancomycin were not administered as ordered. The DON stated the order was rewritten at 2:00 PM on 03/11/22 to administer every 6 hours until 03/23/22 and Resident #2 received 14 days of the antibiotic. The DON stated her expectation was for the nurses to administer the medication as ordered.