STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345667	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to provide a sanitary environment by failing to clean a dirty wheelchair for 1 of 1 sampled resident (Resident #17) and failing to clean tube feeding formula from an oxygen concentrator for 1 of 1 sampled resident (Resident #5). The findings included: 1. Resident #17 was admitted to the facility on 9/4/13 with multiple diagnose including Dementia. On 11/18/2014 at 12:48 PM Resident #17 ' s wheelchair was observed on the left inside area beneath the arm rest a 2 inch long by 1/4 inch wide and a 3 inch long by 1/4 inch wide stream of dried light tan substance. Observed on the right hand side of the resident ' s arm rest was a dime size area of light pink dried substance. Also observed on the cushion of the resident's wheelchair were 4 stained areas ranging from quarter to 1/2 dollar size of dried light tan substance. On 11/18/2014 3:22 PM Resident #17 ' s wheelchair was observed on the left inside area beneath the arm rest a 2 inch long by 1/4 inch wide and a 3 inch long by 1/4 inch wide stream of dried light tan substance. Observed on the right	F 253	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **F253 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – Resident #17 was transferred into a clean wheelchair with a clean cushion, and the wheelchair belonging to resident # 17 was cleaned on	11/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Schazee F. Majeed	Administrator	11.25.14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346667	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 253	Continued From page 1 hand side of the resident ' s arm rest was a dime size area of light pink dried substance. Also observed on the cushion of the resident's wheelchair were 4 stained areas ranging from quarter to 1/2 dollar size of dried light tan substance. On 11/19/2014 9:43 AM Resident #17 ' s wheelchair was observed on the left inside area beneath the arm rest a 2 inch long by 1/4 inch wide and a 3 inch long by 1/4 inch wide stream of dried light tan substance. Observed on the right hand side of the resident ' s arm rest was a dime size area of light pink dried substance. Also observed on the cushion of the resident's wheelchair were 4 stained areas ranging from quarter to 1/2 dollar size of dried light tan substance. Observed on the wheelchair spilled in the crease of the entire right hand side of the cushion were particles of dried light tan colored substance. On 11/19/14 at 10:05 AM the Unit Manager for the 100 hall stated that when the wheelchairs were dirty, staff were supposed to take them into the soiled utility room. When the housekeeping staff came in the next morning they would clean the wheelchairs. On 11/19/2014 10:20 AM the Housekeeping Manager stated that the Nursing Assistants on 3rd shift were supposed to inspect the wheelchairs that were in use every night. If they were dirty they were to take them to the shower and clean them. If a cushion was dirty the gel cushion could be unzipped and the cover removed and washed. On 11/19/2014 10:43 AM the Director of Nursing	F 253	11/19/14. The oxygen concentrator in the room of resident #5 was cleaned on 11/19/14. Completion date 11/19/14. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – All patient wheelchairs inspected by the Unit Managers and DON on 11/20/14. No other dirty chairs were found. Resident rooms who have tube feeding were inspected for spilled formula on November 20, 2014 by the DON. No other areas of concern were noted. Completion date 11/20/14. **Measures to be put in place or systemic changes made to ensure practice will not re-occur** – All leadership team members have room rounding assignments. In case there is an open position, a back-up person has been assigned. Education has been provided to the team	11/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 253	Continued From page 2 (DON) stated the facility did not have a cleaning policy for wheelchairs. The DON stated when staff identify a dirty wheelchair they took it to the soiled utility room and the housekeeper cleaned it that day. On 11/19/14 at 2:40 PM the Administrator and Director of Nursing stated they did have a monitoring tool to do rounds daily and check for spills and cleanliness of residents ' equipment. The Administrator stated that the Director of Social Services should have been the one to have checked the room but she had not been trained and no one had monitored 103 for dirty wheelchairs. 2. Resident #5 was admitted to the facility on 10/25/14 with diagnoses including Dysphagia and was receiving Jevity continuoulsy via a gastrostomy tube. He also had an order for Oxygen at 2liters per minute via nasal cannula as needed. During an observation on 11/17/14 at 11:10am the oxygen concentrator was observed to have dried, light brown matter on the left, top area of the concentrator. During an observation on 11/18/14 at 8:45am the oxygen concentrator was observed to have dried, light brown matter on the top left sided area of the concentrator. During an observation on 11/18/14 at 11:55am the oxygen concentrator was observed to have dried, light brown matter on the top left sided area of the concentrator. During an observation on 11/19/14 at 8:40am the	F 253	on monitoring wheelchairs and other equipment for cleanliness. Staff will be re-in-serviced on wheelchair and cushion cleaning by the DON/Designee. Staff will be re-in-serviced on cleaning up spilled tube feeding by the DON/Designee. Completion date 11/26/14. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** Wheelchair and cushion cleanliness will be audited 3 times per week for 4 weeks then PRN by the Department Head rounding tool. Results will be presented to the QA committee and any issues or concerns noted will be reported immediately to the Administrator or DON. Equipment cleanliness will be audited 3 times per week for 4 weeks then PRN by the Department Head rounding tool. Results will be presented to the QA committee and any issues or	11/26/14 11/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345657	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 253	Continued From page 3 oxygen concentrator was observed to have dried, light brown matter on the top left sided area of the concentrator and on the right top, running down the concentrator on the front side. During an observation of the oxygen concentrator with the Unit Manager on 11/19/14 at 8:48am and interview she stated that housekeeping was responsible for wiping down any equipment in the resident ' s room to remove the tube feeding matter off of the concentrator. During an interview with Housekeeping Aide #1 on 11/19/14 at 8:50am he stated that housekeeping is responsible for the daily room cleaning and this included equipment. He further stated that he was not sure why this was missed in the room. During an interview with the Administrator on 11/19/14 at 10:10am she stated that it would be expected that if nursing saw the dried tube feed on the concentrator or spilled the tube feed that they would clean it; however, ultimately it is the housekeeping department ' s responsibility to clean equipment in the room. During a follow up Quality Assurance interview with the Administrator and Director of Nursing on 11/19/14 at 2:40pm it was stated that the action plan for monitoring and cleaning tube feeding from resident equipment had been driven by the plan of correction the facility had developed as a result of the previous survey. She further stated the monitoring tool included daily rounds of resident rooms to check for spills and cleanliness of resident equipment. She stated the activities assistant should have checked Resident #5 ' s room but she resigned and the facility had no one	F 253	concerns noted will be reported immediately to the Administrator or DON.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345667	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 253	Continued From page 4 monitoring the room	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F272 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – Resident #193 was admitted on 10/31/14. Hospital discharge orders did not indicate a fluid restriction. The facility's medical director did not write orders for a fluid restriction upon assessment of the patient. Registered dietitian did not place patient on a fluid restriction due to lab values. Resident #193 discharged from facility to home on 11/20/14. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – When a patient is admitted to facility receiving dialysis, communication between the	11/20/14 11/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 272	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to comprehensively assess a dialysis resident by failing to coordinate the resident ' s care with the dialysis center to identify a resident was on fluid restrictions for 1 of 1 dialysis resident (Resident #193). The findings included: Resident #193 was admitted to the facility on 10/31/14 and had diagnoses that included End Stage Renal Disease (ESRD) with Hemodialysis. A review of the Care Area Assessment (CAA) Summary for Nutritional Status dated 11/6/14 revealed the resident received a regular diet. The assessment included no information to reveal the resident was on fluid restrictions. The resident ' s Care Plan with entries dated 11/1/14 to 11/13/14 revealed no information the resident was on fluid restrictions. Review of the Admission Minimum Data Set (MDS) Assessment dated 11/7/14 revealed the resident was cognitively intact and received dialysis while a resident in the facility. On 11/18/14 at 12:52 PM, Resident 193 stated in an interview that she was on fluid restrictions. NA (nursing assistant) #1 entered the room during the interview and when asked if the resident was on fluid restrictions, the NA stated she was not aware of any fluid restrictions for the resident.	F 272	dialysis center and facility will include discussion regarding specific recommendations from dialysis on fluid restrictions. Unit manager will be responsible for communicating with dialysis center. Completion 11/20/14. **Measures to be put in place or systemic changes made to ensure practice will not re-occur** - When a patient is admitted to facility receiving dialysis, communication between the dialysis center and facility will include discussion regarding specific recommendations from dialysis on fluid restrictions. Unit manager will be responsible for contacting dialysis center. Completion 11/20/14. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur**- The unit manager will clarify orders on all patients admitted into the facility with the dialysis center to include recommendations for fluid	11/20/14 11/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 272	Continued From page 6 The Dietary Manager stated in an interview on 11/18/14 at 2:49 PM that he had spoken with the resident several times and the resident did not say anything about being on fluid restrictions. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 11/18/14 at 4:17 PM. The MDS Nurses stated they were not aware the resident was supposed to be on fluid restrictions. The Nurses stated they had not spoken with the staff at the dialysis unit regarding the resident ' s care. Review of the hospital discharge orders dated 10/31/14 and facility physician ' s orders revealed no orders regarding fluid restrictions for the resident. An interview was conducted with a nurse at the dialysis center where the resident received dialysis. The Nurse stated the resident was on a fluid restriction of no more than 32 ounces of fluids per day. On 11/19/14 at 11:34 the facility ' s Dietician stated in an interview she was not aware the resident was on fluid restrictions. On 11/19/14 at 2:58 PM the Director of Nursing (DON) stated in an interview that the facility had not communicated with the Dialysis Center or the Center ' s physician concerning Resident #193 ' s fluid restrictions. The DON further stated that she was not aware that the comprehensive assessment would include communicating with the Dialysis Center.	F 272	restrictions. Any issues or concerns will be immediately addressed and discussed in the weekly QA risk meetings and monthly QA meetings. Completion 11/24/14. **F372 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – Dumpster area cleaned of all garbage on 11/19/14. 11/19/14 **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – Dumpster area will be monitored daily by the Director of Environmental Services or designee. If any trash is on the ground, it will be disposed of properly in the garbage receptacle. All housekeeping and dietary staff in-serviced on proper disposal of trash and garbage and that trash and garbage must be placed in the proper receptacle if seen on the ground. An audit will be 11/20/14	
F 372	483.35(i)(3) DISPOSE GARBAGE & REFUSE	F 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 372 SS=E	Continued From page 7 PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure the area surrounding the dumper was free of debris for 1 of 1 dumpsters observed. The findings included. During the initial kitchen tour on 11/17/14 at 10:00 AM the dumpster area was observed with the Certified Dietary Manager (CDM). A single disposable glove was observed on the ground to the right, one disposable glove was behind and one disposable glove was observed on the ground on the left side of the dumpster. Assorted papers and a clear plastic bag were observed on the ground surrounding the dumpster. A second observation of the dumpster area on 11/18/14 at 7:54 AM revealed one disposable glove was observed on the ground to the right, one disposable glove was behind and one disposable glove was observed on the left side of the dumpster. Assorted papers and a clear plastic bag were observed on the ground surrounding the dumpster. A third observation of the dumpster area on 11/19/14 at 8:24 AM revealed one disposable glove was behind and two disposable gloves were observed on the ground on the left side of the dumpster. Assorted papers, straw papers	F 372	conducted at various times throughout the day 3 times per week for 4 weeks by the Director of Environmental Services. **Measures to be put in place or systemic changes made to ensure practice will not re-occur** - Dumpster area will be monitored daily by the Director of Environmental Services or designee. If any trash is on the ground, it will be disposed of properly in the garbage receptacle. All housekeeping and dietary staff in-serviced on proper disposal of trash and garbage and that trash and garbage must be placed in the proper receptacle if seen on the ground. An audit will be conducted at various times throughout the day 3 times per week for 4 weeks by the Director of Environmental Services. Checking of the dumpster area for trash and/or debris will be added to the job duties of the Director of Environmental Services, or in	12/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 372	Continued From page 8 and a clear plastic bag were observed on the ground surrounding the dumpster. During an interview with the CDM on 11/19/14 at 9:59 AM he stated that the kitchen shared responsibility with housekeeping and maintenance staff to keep the dumpster area clean. During an interview with the Environmental Supervisor on 11/19/14 at 10:02 AM he stated that staff checked the area daily and are suppose to clean and sweep the dumpster area daily. He indicated staff would be out to clean the area.	F 372	his absence, a designee may be appointed. Completion date 11/24/14. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** Monitoring the area surrounding the dumpster will be done daily by the Director of Environmental Services or designee. Any issues will be reported during morning stand-up meeting and discussed during QA meetings.	11/24/14
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**F431 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – The undated Vials of Fluvirin were immediately discarded. Completion date 11/19/14. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – Medication Carts and Medication rooms, to include medication refrigerators,	11/19/14 11/21/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 431	Continued From page 9 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to place an open date on 3 of 4 opened vials of Fluvirin vaccine. The findings included: During an observation of hall 100 medication room refrigerator on 11/19/14 at 10:10am two of two opened vials of Fluvirin had no open date. During an interview with Nurse #2 on 11/19/14 at 10:15am she stated that the nurses are supposed to put an open date on each vial when opened. She then stated that most of the flu shots have been done unless there is a new admission from the hospital or a staff person requested the flu vaccine. During an observation of hall 200 medication room refrigerator on 11/19/14 at 10:20am one of two opened vials of Fluvirin vaccine had no open date. During an interview with Nurse #1 on 11/19/14 at	F 431	were inspected by the Unit Managers and no other undated vials were noted. Completion date 11/21/14. **Measures to be put in place or systemic changes made to ensure practice will not re-occur** – In-service with nurses to be done on dating Fluvirin vials when they are opened. This will be audited 3 times a week for 4 weeks by the DON/Designee and PRN thereafter. Any issues will be addressed immediately and brought to the QA meeting. Completion date 11/26/14 **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur**- Unit managers will conduct inspections routinely to check for undated Fluvirin bottles. Any issues noted will be corrected immediately and brought to the facility's QA meeting. Training on dating of Fluvirin once opened will also	11/26/14 11/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 431	Continued From page 10 10:30am she stated that when a vial is opened an open date should be placed on the box or vial. During an interview with the Director of Nursing on 11/19/14 at 10:35am she stated that it is expected that all Flu vaccine vials be dated when opened.	F 431	be incorporated into the orientation for new nurses. Completion 11/26/14.	
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a written agreement for services provided by an outside entity for 1 of 1 resident receiving dialysis services (Resident #193). The findings included: There was one resident in the facility receiving	F 500	**F500 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – Da Vita dialysis center was contacted immediately to request an agreement, and on 11/20/14, we received a draft of an agreement. The agreement between Azalea Health and Rehab and Da Vita Dialysis was signed by the Administrator of Azalea on 11/20/14. The agreement became fully executed on 11/24/14. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – Resident #193 discharged on 11/20/14. When new dialysis residents are scheduled to be admitted into the facility, it will first be verified by the administrator that	11/24/14 11/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 500	Continued From page 11 outside dialysis services at the time of the survey. On 11/19/14 at 9:00 AM the Administrator stated in an interview there was not a dialysis contract in the book and did not know what the previous administrator did with the contract.	F 500	there is an active agreement in place between the facility and the dialysis center. Completion date: 11/24/14.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff	F 520	**Measures to be put in place or systemic changes made to ensure practice will not re-occur** – For new dialysis residents scheduled to be admitted into the facility, it will first be verified that there is an active agreement in place between the facility and the dialysis center. Completion date: 11/24/14. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** When a dialysis resident is admitted into the facility, it will be verified by the administrator that an active and executed agreement is in place between the healthcare facility and the dialysis center. **F520 - How corrective action will be accomplished for each resident found to have been affected by the deficient**	11/24/14 11/24/14 11/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3600 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 520	Continued From page 12 interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in December 7, 2013. This was for one recited deficiency which were originally cited in December 7, 2014 on a complaint and recertification survey and on the current complaint and recertification survey. The deficiency was in the area of Housekeeping and Maintenance Services. The continued failure of the facility during two complaint and recertification surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F-253: Housekeeping and Environment: Based on observations, record review and interviews the facility failed to provide a sanitary environment by failing to clean a dirty wheelchair for 1 of 1 sampled resident (Resident #17) and failing to clean tube feeding formula from an oxygen concentrator for 1 of 1 sampled resident (Resident #5). During a recertification and complaint survey of December 7, 2014 the facility was cited for failing to clean the tube feeding formula from the feeding tube pole. On the current recertification and complaint survey the facility was recited for F-253 for failing to clean a dirty wheelchair and tube feeding formula from an oxygen concentrator. During an interview on 11/19/14 at 2:40 PM the	F 520	**practice** – Resident #17 was transferred into a clean wheelchair with a clean cushion, and the wheelchair belonging to resident # 17 was cleaned on 11/19/14. The oxygen concentrator in the room of resident #5 was cleaned on 11/19/14. Completion date 11/19/14. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – All patient wheelchairs inspected by the Unit Managers and DON on 11/20/14. No other dirty chairs were found. Resident rooms who have tube feeding were inspected for spilled formula on November 20, 2014 by the DON. No other areas of concern were noted. Completion date 11/20/14. **Measures to be put in place or systemic changes made to ensure practice will not re-occur** – All leadership team members have room rounding	11/20/14 11/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(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 520	Continued From page 13 Administrator and the Director of Nursing stated the frequency of Quality Assessment and Assurance Committee meetings were monthly. The Administrator stated that she had not been at the facility during the December 7, 2013 recertification and complaint investigation survey but the facility did have a process to monitor cleanliness of residents' rooms and equipment. She further stated she had recently hired a new Director of Social Services and she should have monitored Resident #17's room, but she had not been trained and no one had checked Resident #17's room. The Administrator further stated the Activities Assistant should have checked Resident #5's room but she resigned with no notice and no one was monitoring Resident #5's room.	F 520	assignments. In case there is an open position, a back-up person has been assigned. Education has been provided to the team on monitoring wheelchairs and other equipment for cleanliness. Staff will be re-in-serviced on wheelchair and cushion cleaning by the DON/Designee. Staff will be re-in-serviced on cleaning up spilled tube feeding by the DON/Designee. Completion date 11/26/14. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** Wheelchair and cushion cleanliness will be audited 3 times per week for 4 weeks then PRN by the Department Head rounding tool. Results will be presented to the QA committee and any issues or concerns noted will be reported immediately to the Administrator or DON. Equipment cleanliness will be audited 3 times per week for 4 weeks then PRN by the Department Head rounding tool. Results will be presented to the QA committee and any issues or concerns noted will be reported immediately to the Administrator or DON	11/26/14