	-	ND HUMAN SERVICES MEDICAID SERVICES			FOI	RM APPROVED NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		TE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED	
		345557	B. WING		C 10/28/2015		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2010	
				3800 INDEPENDENCE BOULEVARD			
AZALEA F	IEALTH & REHAB CEN	ER		WILMINGTON, NC 28412			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)	
PREFIX TAG	· ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE	
F 000		3	F 00	00			
		e cited as a result of the on conducted on October 28,					
	2015. Event ID #CD						
F 278	483.20(g) - (j) ASSE	SSMENT	F 27	78		11/20/15	
SS=D	ACCURACY/COORI	DINATION/CERTIFIED					
	The assessment mus resident's status.	st accurately reflect the					
	A registered nurse m each assessment wit participation of healt						
	A registered nurse m assessment is comp	ust sign and certify that the leted.					
		completes a portion of the In and certify the accuracy of sessment.					
	willfully and knowing false statement in a subject to a civil mon \$1,000 for each asse willfully and knowing to certify a material a	Medicaid, an individual who y certifies a material and resident assessment is ey penalty of not more than essment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each					
	Clinical disagreemen material and false sta	t does not constitute a atement.					
	This REQUIREMEN by:	Γ is not met as evidenced					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE	
Electroni	cally Signed					11/20/2015	

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.

			(VO) 1			<u>VO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
			A. BOILDING			С
		345557	B. WING		1	0/28/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
A7AI EA 1	IEALTH & REHAB CEN	red		3800 INDEPENDENCE BOULEVARE)	
	IEAEITH & REHAD CEN	IER		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 278	Continued From pag	e 1	F 27	78		
		d staff interview, the facility	1 21	1. A correction for the MD	S codina of	
		nimum Data Set (MDS)		behavioral symptoms for F		
	assessment accurate	ely for the behavioral		be submitted on 11/20/15.		
		sampled resident. (Resident				
	# 41)			2. Residents with behavior		
	Findings Included:			are at risk for this alleged practice. All MDS assess		
				residents with behavioral		
	Resident # 41 was a	dmitted to the facility on		been reviewed to identify a		
	3/27/2015 with multip	ble diagnoses including		errors in coding behaviora	l symptoms.	
		a, Depression and anxiety.				
		ssessment dated 10/2/2015		3.MDS nurses have been	•	
	symptoms.	t did not have any behavioral		the regional MDS nurse co coding of behavioral symp	•	
	Symptoms.			to the RAI manual to inclu		
	The resident's record	review for the months of		the areas of the resident of	•	
	September 2015 and	October 2015 revealed the		interviewing staff when ap	propriate for the	
		havioral symptoms daily		assessment. The MDS nu		
	ranging from refusing			and document the review		
		sing to take her daily meal		for accuracy concerning the behavioral symptoms prior		
	supplements from the	e nurses' at the facility.		for the next 12 weeks.	to submission	
	On 10/27/2015 at 9:0	00 AM, the unit nurse was				
		aled the resident exhibited		4.The MDS nurses will pre	esent the results	
		s daily. He also reported the		of the review monthly to the		
		rent medication to help with		committee for review and		
	the behavioral sympt	ioms.		recommendations for the		
	0n 10/27/2015 at 11	:00 AM, the MDS nurse was		review process and outline	eu above.	
		nowledged that resident's		5.Allegation of compliance	e for this plan is	
		should have been coded on		11/20/2015		
	the MDS but was mis	ssed. She also added that				
		will review the resident 's				
	MDS to make sure the also reflects the resid	ne coding is accurate and dent's current status.				
	On 10/28/2015 at 10	:00 AM, the Director of				
		nterviewed. She reported				
	Resident # 41 exhibit					

If continuation sheet Page 2 of 149

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/201 MAPPROVE D. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY	
		345557	B. WING			C 10/28/2015		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP 3800 INDEPENDENCE BOULEVARI		TREET ADDRESS, CITY, STATE, ZIP CODE 300 INDEPENDENCE BOULEVARD			
AZALEA H	IEALTH & REHAB CENT	ER	WILMINGTON, NC 28412		/ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 278	Continued From page		F	278				
	· ·	xpectation was that the MDS ded accurately reflecting the ymptoms.						
F 309 SS=D	309 483.25 PROVIDE CARE/SERVICES FOR		F	309			11/20/15	
		Γ is not met as evidenced						
	by: Based on observations, staff, physician and resident interviews and record review, the facility failed to provide evidence of communication with the dialysis clinic. The facility also failed to monitor the condition of a resident after dialysis treatment and implement safety precautions for a dialysis access site for 1 of 1 (Resident #193) reviewed for dialysis. Findings included:				1. Information concerning resident #19 treatment on 10/27/15 by the dialysis center was gathered by the Director of Nursing and documented in the resider chart. Staff was notified of restrictions for vital signs and assessment was completed for the resident. The kardex located on the inside of the resident's closet has been updated to state the	nt's or		
Resident #193 was admitted on 10/10/15 with a diagnosis of end stage renal disease (ERSD) requiring dialysis. The admission Minimum Data Set (MDS) dated 10/17/15 still in progress indicated Resident #193 was cognitively intact and extensive assistance with his activities of daily living except for eating which required supervision. Resident #193 was care planned for dialysis Tuesday, Thursday and Saturday with interventions to include monitoring the				 limitations due to the presence of the shunt/ fistula. The resident assessmen was completed. Residents receiving hemodialysis are risk for these issues. Each resident on hemodialysis has an assessment every shift of the shunt/ fistula/ port that is use for the dialysis. The assessment is located on the MAR. The kardex for hemodialysis residents is kept on the 	e at			
	shunt/vascular/cathet	ter access for sign and g or infection, assessment of			inside of the closet door for referral by a nursing staff indicating that the resident			

Facility ID: 100671

If continuation sheet Page 3 of 149

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		MPLETED	
						С	
		345557	B. WING	· · · · · · · · · · · · · · · · · · ·	1	0/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		CODE		
AZALEA H	IEALTH & REHAB CENT	ER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 309	Continued From page	e 3	F 30	09			
		thrill or bruit as ordered.		on dialysis treatment and t	he location of		
		ds for edema, vital signs as		the shunt/ fistula/ port that			
	ordered and commur	nication with the dialysis staff		dialysis. There will be a cl	ear statement		
	and physician as per	routine.		concerning limitations for t			
				fistula. Dialysis communic			
	-	tal stay for Resident #193 arterial/vascular fistula		Pass CP1697 is now being			
		e 2015 in preparation for		communication between the dialysis center with each	-		
		itted to the hospital on		resident will be assessed p			
	-	I failure and had a Permcath		discharge using the Saber			
	(intravenous access	used for dialysis) placed.		Return from dialysis Asses			
	During his first dialys	is treatment, Resident #193		Click Care. The resident v	vill be assessed		
		est with cardio-pulmonary		upon return using the Sab			
		given. He was admitted to		Return from Dialysis Asses			
	-	5 with orders for dialysis 3		information will also be pla			
	times weekly.			CP1697. Any change of c during either pre or post di			
	In an interview on 10	/26/15 at 11:00 AM, Resident		assessments will be called	•		
		i fistula in his right lower arm		physician.			
		d the Permcath to his right		3. The nursing staff has b	een in-serviced		
	chest was temporary	. He stated the facility had		concerning the above info	mation by the		
	-	ince his admission and he		Director of Nursing or Unit	-		
		ke is blood pressure in his		kardex for all hemodialysis			
		ne thought the staff would		been verified for complete			
	constricting his right a	couldn ' t have anything		New admissions on hemo have the kardex verified du			
		ann.		admission process by the	•		
	In an interview on 10	/27/15 at 9:00 AM, Nurse		nursing or designee. The			
		issess his vital signs and		forms used for dialysis from			
	look at the catheter to	o make sure it was intact		day will be brought to the r	next at risk		
	-	d with him. She stated she		meeting for review. The c			
		#193 had a fistula to his right		checked for the completion			
		have any blood draws from		Departure/ Return assess			
	that arm.			information missing will be documented. The nurse re	-		
	On 10/27/15 at 9:30 /	AM, Resident #193 left the		identified for follow-up.			
		treatment. In his closet was		4.The Director of Nursing	will document		
		tions for caring for a resident		this process each At Risk i			
		Resident #193 's room.		weeks, 3x a week for 4 we			

Facility ID: 100671

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345557	B. WING _				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
A741 EA 1				38	00 INDEPENDENCE BOULEVARD		
	IEALTH & REHAB CENT	ER		W	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 309	manager #1 stated th assessment form that each dialysis treatment produce a form dated PM with vital signs do in the shift. Unit many no documentation of a dialysis clinic and the dialysis treatments. Uf only way anyone would dialysis treatments of #193 or called the dial In an interview on 10/ assistant (NA) #1 state facility for 2 and one h familiar with Resident was not aware of any after his treatments of Resident #193 had a stated the residents h care in their closets In another interview of Nurse #1 stated she w and one half years and responsible for putting precautions on each of Resident #193 had no closet directing the state In an interview on 10/ medical director state communication with the treatment and he sho	27/15 at 2:00 PM, unit ere was a communication is should be completed after int but she was only able to 10/27/15 created at 1:10 boumented as taken earlier ager #1 also stated she had communication between the facility regarding any of his init manager #1 stated the ild know anything about his uid be if she asked Resident ilysis clinic. 27/15 at 2; 10 PM nursing ted she had worked at the half years and she was #193. NA #1 stated she need to obtain vital signs r was she aware that fistula in his right arm. She had instructions about their on 10/27/15 at 2:30 PM, worked at the facility for two ind the nurses were g the kardex forms with resident closet. She verified o information inside his aff in care precautions. 27/15 at 2:40 PM, the d the facility should be in he dialysis clinic if there was esident #193 during his uld be thoroughly assessed	F 3	809	weekly x 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the monitoring process. 5.Allegation of compliance is 11/20/15.		
	any problems with Re treatment and he sho	sident #193 during his					

Facility ID: 100671

If continuation sheet Page 5 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING				C 28/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AZALEA H	IEALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	since his had a histor associated with his di medical director further that the facility know for required when caring In an interview on 10/ stated she had worked one half years and she #193 today. She stated before he went to his morning. She stated for from dialysis around 2 did not obtain his vita went straight to theray normally does not get on second shift. NA # that Resident #193 ha and not aware his blo obtained in his right a In an interview on 10/ #193 stated nobody for since yesterday or as back from dialysis too straight to therapy the really tired. In an interview on 10/ administrator, director consultant stated the procedure for caring for nurse consultant also communication betwee dialysis clinic.	to ensure he was stable y of a recent cardiac arrest alysis treatment. The er stated his expectation the proper precautions for a dialysis resident. (27/15 at 2:50 PM, NA #2 ed at the facility for two and he was assigned Resident ed she took his vital signs dialysis treatment this Resident #193 arrived back 2:45 PM. NA #2 stated she I signs on his return and he py. NA #2 also stated he t back on her shift but rather e2 stated she was unaware ad a fistula in his right arm hod pressure should not be irm. (27/15 at 3:40 PM, Resident had obtained his vital signs sessed him since he got day. He stated she went en to bed because he felt (27/15 at 4:00 PM, r of nursing and nurse facility had no policy or for dialysis residents. The	F	309	Skip to content Using Gmail with screen readers Kathy		

If continuation sheet Page 6 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/23/2015 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345557	B. WING					C 28/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	E, ZIP CODE	_	
AZALEA	HEALTH & REHAB CENT	ER			3800 INDEPENDENCE BOUL			
					WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	6	F	309	9			
	from therapy. She sta	when she after he got back ted she started her did not obtain his vital signs						
	In an another intervie Resident #193 stated yesterday and they pri informing staff not to pressure in his right a his permission before felt a lot better knowin Permcath was obserview with tape. In an interview on 10/ rehabilitation director straight to therapy yes minutes before tiring. assess his vital signs In an interview 10/28/ consultant and the ad expectation would be how to adequately ca include access safety	w on 10/28/15 at 8:30 AM, they got his vital signs at up a sign in his room do lab draws or blood irm. He stated they asked putting up the sign and he ng it was up there. The yed with the caps secured 28/15 at 10:40 AM, the stated Resident #193 came sterday and stood for 6 She stated therapy did not or access prior to therapy. 15 at 11:40 AM the nurse ministrator stated their for the facility staff know re for a dialysis resident to and precautions, clinical e communication with the						

If continuation sheet Page 7 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 APPROVED D: 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345557	B. WING			C 10/28/2015			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
AZALEA H	IEALTH & REHAB CENT	ER			10 INDEPENDENCE BOULEVARD LMINGTON, NC 28412				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE CO TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 309	Continued From page	2.7	F3	309					

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 8 of 149

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		IMENT OF HEALTH AN RS FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 11/23/2015 M APPROVED D. 0938-0391		
345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE COMF	E SURVEY PLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			345557	B. WING _					
AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF F	PROVIDER OR SUPPLIER				•			
	AZALEA	AZALEA HEALTH & REHAB CENTER							
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE		FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PF			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CC TAG CROSS-REFERENCED TO THE APPROPRIATE CC				
F 309 Continued From page 8 F 309	F 309	Continued From page	2.8	F3					

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 9 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 APPROVED D: 0938-0391		
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345557	B. WING	B. WING 10/28/201					
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
		ED		38	300 INDEPENDENCE BOULEVARD				
	IEALTH & REHAB CENT	ER		W	/ILMINGTON, NC 28412				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE		
F 309	Continued From page	9	F	309	Search				

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 10 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING		C 10/28/2015		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			20/2010
AZALEA H	IEALTH & REHAB CENT	ER					
		ATEMENT OF DEFICIENCIES	ID	~~~	VILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	2 10	F	309	Error checking mail for kathyrightathome@bellsouth.net. Deta Dismiss	ills	
					COMPOSE		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 11 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345557	B. WING _			C 10/28/2015		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
AZALEA H	IEALTH & REHAB CENT	ER						
				W	ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From page	9 11	F 3	809				
					Labels			
					Inbox (6,439)			
					Starred			
					Important			
					Sent Mail			
					Drafts (6)			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 12 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING				C 28/2015
NAME OF F	ROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	
AZALEA	HEALTH & REHAB CENT	ER					
		ATEMENT OF DEFICIENCIES	ID	v	VILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 12	F	309	[Imap]/Drafts		
					Personal		
					Travel		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 13 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING _			(10/:	C 28/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CENT	ER			00 INDEPENDENCE BOULEVARD ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	9 13	F 3	309			
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Facility ID: 100671

If continuation sheet Page 14 of 149

		D HUMAN SERVICES MEDICAID SERVICES			F	NTED: 11/23/2015 FORM APPROVED B NO. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
		345557	B. WING _			C 10/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From page	e 14	F	309			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 15 of 149

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 VILMINGTON, NC 28412			ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/23/2015 MAPPROVED O. 0938-0391	
345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 WILMINGTON, NC 28412 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVO (EACH CORRECTIVE ACTION SHOULD BE COMPLETIO DATE (X5) COMPLETIO DATE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATI COM	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			345557	B. WING _				
AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIO DATE	NAME OF P	ROVIDER OR SUPPLIER		1		- · ·		
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATECOMPLETIO DATE	AZALEA I	HEALTH & REHAB CENT	ER					
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION	
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Facility ID: 100671

If continuation sheet Page 16 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 11/23/2015 APPROVED 0: 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	ATE SURVEY DMPLETED	
		345557	B. WING				C 28/2015	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	IEALTH & REHAB CENT	FR		3	300 INDEPENDENCE BOULEVARD			
				N	/ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 17 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391	
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	345557	B. WING		C 10/28/2015	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA HEALTH & REHAB CENTER	1		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 309 Continued From page 1	7	F 3			

Facility ID: 100671

If continuation sheet Page 18 of 149

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345557	B. WING		C 10/28/2015	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA HEALTH & REHAB CENTER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 309 Continued From page 18	F 30			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 19 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 11/23/2015 RM APPROVED NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTI		(X3) DA	(X3) DATE SURVEY COMPLETED	
		345557	B. WING				C 10/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE	•		
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPEN WILMINGTON	IDENCE BOULEVARD N, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
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Facility ID: 100671

If continuation sheet Page 20 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING			C 10/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IEALTH & REHAB CENT	ED		38	800 INDEPENDENCE BOULEVARD		
				N	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	20	F	309	More		
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 21 of 149

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412			D HUMAN SERVICES MEDICAID SERVICES			F	NO. 0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DATE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) E	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREGULATORY OR LSC IDENTIFYING INFORMATION)			345557	B. WING _				
AZALEA HEALTH & REHAB CENTER 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) COMPLETIC COMPLETIC DATE	NAME OF P	ROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE	AZALEA I	IEALTH & REHAB CENT	ER			2D		
F 309 Continued From page 21 F 309	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	COMPLETION	
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 22 of 149

DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MEI				FORM	D: 11/23/2015 MAPPROVED D. 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345557	B. WING _			C 28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA HEALTH & REHAB CENTER			3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309 Continued From page 22		F 3			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 23 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345557					C
NAME OF P	ROVIDER OR SUPPLIER	545557			TREET ADDRESS, CITY, STATE, ZIP CODE	10/	28/2015
					300 INDEPENDENCE BOULEVARD		
	IEALTH & REHAB CENT	ER	WILMINGTON, NC 28412				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	309		ΛΤΕ	DATE

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 24 of 149

		ID HUMAN SERVICES				FORM	D: 11/23/2015
STATEMENT O	5 FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
	CONTRECTION		A. BUILDIN	NG			C
		345557	B. WING				28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2			
	IEALTH & REHAB CENT	ER) INDEPENDENCE BOULEVARD		
				WIL	MINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
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		D HUMAN SERVICES					APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU		CONSTRUCTION	(X3) DATE	0.0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							C
		345557	B. WING			10/2	28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CENT	ER			300 INDEPENDENCE BOULEVARD		
				N	/ILMINGTON, NC 28412		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
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Facility ID: 100671

If continuation sheet Page 26 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345557	B. WING		C 10/28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/28/2013
	IEALTH & REHAB CENT	ED		3800 INDEPENDENCE BOULEVARD	
	IEALTH & REHAD CENT	EK		WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
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		D HUMAN SERVICES				1 APPROVED
		MEDICAID SERVICES				0.0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	LETED
		345557	B. WING _			C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	IEALTH & REHAB CENT	FR		38	300 INDEPENDENCE BOULEVARD	
				W	ILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 28 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 11/23/2015 APPROVED 0: 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345557	B. WING				C 28/2015		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
	IEALTH & REHAB CENT	ED		3					
	IEALIN & REHAD CENT	ER		WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 29 of 149

		ID HUMAN SERVICES			FORM AP	
		MEDICAID SERVICES			OMB NO. 09	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUR COMPLETE	VEY D
		345557	B. WING		C 10/28/2	015
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH & REHAB CENT	ED		3800 INDEPENDENCE BOULEVARD		
	IEALTH & REHAD CENT	ER		WILMINGTON, NC 28412		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		MPLETION DATE
IAG				DEFICIENCY)		
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Facility ID: 100671

If continuation sheet Page 30 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		20/2010
AZALEA H	IEALTH & REHAB CENT	ER					
				W	LMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 31 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 APPROVED
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345557	B. WING				C 28/2015
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/.	20/2015
	OVIDER OR SOFFLIER						
AZALEA H	EALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
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					Not starred		
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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 11/23/2015 MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345557	B. WING _				C 28/2015	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
AZALEA H	IEALTH & REHAB CENT	ER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL F		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE COMPLETION HE APPROPRIATE DATE		
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 33 of 149

		D HUMAN SERVICES				M APPROVED
						0.0938-0391
STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		345557	B. WING			C / 28/2015
NAME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	LTH & REHAB CENT	P		3800 INDEPENDENCE BOULEVARD		
		-N		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/23/2015 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	E SURVEY PLETED
		345557	B. WING			C /28/2015
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH & REHAB CENT	ED		3800 INDEPENDENCE BOULEVARD		
	IEALTH & REHAD CENT	ER		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
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				Not starred		
				Not starred		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 35 of 149

		D HUMAN SERVICES					APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:					LETED
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		345557	B. WING	≩			28/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	IEALTH & REHAB CENT	FR		3	800 INDEPENDENCE BOULEVARD		
				v	VILMINGTON, NC 28412		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	IC		PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 36 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING			(10/:	C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
	IEALTH & REHAB CENT			38	300 INDEPENDENCE BOULEVARD		
	IEALIN & RENAD CENT	ER		w	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 37 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 // APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345557					C 28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2010	
	IEALTH & REHAB CENT	ED		3	800 INDEPENDENCE BOULEVARD			
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If continuation sheet Page 38 of 149

		ID HUMAN SERVICES				FORM): 11/23/2015 APPROVED
STATEMENT O	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OMB NO. 0938-0397 (X3) DATE SURVEY COMPLETED	
		345557	B. WING				C 28/2015
	ROVIDER OR SUPPLIER	0.0001			REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER						
AZALEA H	IEALTH & REHAB CENT	ER					
				vv	ILMINGTON, NC 28412		
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		ID HUMAN SERVICES					APPROVED
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	CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345557	B. WING			10/	28/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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If continuation sheet Page 40 of 149

CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0383-039 AND PLAN OF CORRECTION (1) IPROVINCE VALUE (2) MULTIPLE CONSTRUCTION	DEPARTMENT OF HEALTH AND HUMAN SERVICES								
C Invalue or provider or surprise STREET ADDRESS, CITV, STATE, ZIP CODE 3800 MOEPPONENCE BOULEVARD 3000 MOEPPONENCE BOULEVARD 30000 MOEPPONENCE BOULEVARD 3000 MOEPPONENCE BOULEVAR	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DA	ATE SURVEY		
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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER D PROVIDER OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION OREFIX CAMPLETED OD PROVIDER OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CARECTION NUST BE PRECEDED BY FULL TAG PROVIDER'S PLAN OF CORRECTION COMPLETED CONTINUED (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FA 309 CONTINUE FOR page 41 F 309			ND HUMAN SERVICES				
Image: Name of provider or supplier 345557 B. WING Image: Street Address, city, state, zip code AZALEA HEALTH & REHAB CENTER STREET Address, city, state, zip code 3800 INDEPENDENCE BOULEVARD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X5) COMPLETION DATE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
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Event ID: CD4H11

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If continuation sheet Page 42 of 149

		ID HUMAN SERVICES MEDICAID SERVICES			0	FORM APPROVED OMB NO. 0938-0391		
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(3) DATE SURVEY COMPLETED		
		345557	B. WING			C 10/28/2015		
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATI 3800 INDEPENDENCE BOULE WILMINGTON, NC 28412		10/20/2013		
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		D HUMAN SERVICES MEDICAID SERVICES				FORM	11/23/2015 APPROVED 0.0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345557	B. WING			(10/:) 28/2015			
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
	IEALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD					
/				WILMINGTON, NC 28412						
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 44 of 149

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938- STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	IEALTH AND HUMAN SERVICES DICARE & MEDICAID SERVICES		
345557 B. WING 10/28/2015	ES (X1) PROVIDER/SUPPLIER/CLIA	STATEMENT O	
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AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	EHAB CENTER	AZALEA HI	
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 45 of 149

	DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03									
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345557	B. WING	i			C 28/2015			
NAME OF PI	ROVIDER OR SUPPLIER			_	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2015			
					800 INDEPENDENCE BOULEVARD					
AZALEA H	IEALTH & REHAB CENT	ER			VILMINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRE TA	ΞIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557					C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
A741 E A 1	IEALTH & REHAB CENT	FD		3	300 INDEPENDENCE BOULEVARD		
	IEALIN & RENAD CENT	ER		v	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 47 of 149

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345557	B. WING				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CENT	ER			00 INDEPENDENCE BOULEVARD ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 309	Continued From page	2 47	F3	309	From: Valerie delCid Sent: Tuesday, November 17, 2015 8:5 PM To: Kathleen Stierwalt <kathleen stierwalt@saberhealth.com=""> Susan Mai <susan.mai@saberhealth.com> Subject: PoC Please read this very closely! Let me know what you think.</susan.mai@saberhealth.com></kathleen>		
					Omnicare should be able to get the formulary easily.		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 48 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING _				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
AZALEA H	IEALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD /ILMINGTON, NC 28412		
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F 309	Continued From page	2 48	F3	309	Valerie del Cid, RN BSN Regional Director of Clinical Services NC/VA/FL Saber HealthCare Cell 216- 645-8468 This email and any files transmitted wit are confidential and intended solely for use of the individual or entity to whom they are addressed. If you have receive this email in error please notify the sys manager. This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should r disseminate, distribute or copy this e-m	the ed tem d e not	
					3 Attachments		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 49 of 149

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 VILMINGTON, 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 COMPLETIC DATE (X5) COMPLETIC DATE		MENT OF HEALTH AN					FORM): 11/23/2015 1 APPROVED). 0938-0391	
345557 B. WING 10/28/2015 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 REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE (X5) COMPLETIC DATE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	COMPLETED		
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AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE	NAME OF P	PROVIDER OR SUPPLIER							
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 50 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU		CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		345557	B. WING				C 28/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	FREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH & REHAB CENT	ED		38	300 INDEPENDENCE BOULEVARD		
	IEALIN & RENAD CENT	ER		W	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	≥ 50	F	309	Preview attachment Azalea Annual F 356.docx		
					Azalea Annual F 356.docx		
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: CD)4H11	Fac	ility ID: 100671 If continu	ation sheet	Page 51 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 APPROVED 0. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING	i			C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	EALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD		
					/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
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					Azalea Annual F278.docx		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 52 of 149

VEFICIENCIES VRRECTION VIDER OR SUPPLIER ALTH & REHAB CENTE SUMMARY STA (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDING	E CONSTRUCTION	BE COMPLETION
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	ER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	10/28/2015 N (X5) BE COMPLETION
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	N (X5) BE COMPLETION
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
(EACH DEFICIENCY REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
ontinued From page	52	F 309	9	
			Click here to Reply or Forward	
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			Terms - Privacy	
			Last account activity: 8 days ago Details	
2-{				Manage Terms - Privacy Last account activity: 8 days ago

Facility ID: 100671

If continuation sheet Page 53 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557					C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		FD		38	00 INDEPENDENCE BOULEVARD		
	IEALTH & REHAB CENT	ER		W	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	2 53		309	DEFICIENCY)		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 54 of 149

DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & ME				FORM APPROVED OMB NO. 0938-0391			
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
	345557	B. WING		C 10/28/2015			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
AZALEA HEALTH & REHAB CENTER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412					
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
F 309 Continued From page 54		F 3					

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 55 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391		
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED		
		345557	B. WING _			(10//	C 28/2015		
NAME OF PROVID	DER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
AZALEA HEAL	TH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 309 Co	ntinued From page	55	F	309					

Facility ID: 100671

If continuation sheet Page 56 of 149

		D HUMAN SERVICES					APPROVED
			(X2) MI			(X3) DATE	0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
			7				2
		345557	B. WIN	G			- 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH & REHAB CENT	ED		3	800 INDEPENDENCE BOULEVARD		
	TEALTH & REHAD CENT	ER		v	/ILMINGTON, NC 28412		
(X4) ID		ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRE TA		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 309	Continued From page	: 56	F	- 309			
					1.		
					¿ Information concerning the Resident	s	
					treatment on 10-27-15 by the dialysis		
					center was		
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: CD4	H11	Fac	cility ID: 100671 If continua	ation sheet I	Page 57 of 149

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		3	COMPLETED
		245557	B. WING		С
		345557		STREET ADDRESS, CITY, STATE, ZIP CODE	10/28/2015
NAME OF PI	ROVIDER OR SUPPLIER			3800 INDEPENDENCE BOULEVARD	
AZALEA H	IEALTH & REHAB CENT	[ER		WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 309	Continued From page	e 57	F 30	9	
				gathered by the Director of Nurs documented in the resident⊡s cl	-
			¿ Staff was notified of restrictions signs and assessment was comp the		
			resident. The kardex located on inside of the resident⊟s closet has updated to		
				state the limitations due to the proof the shunt/fistula.	resence
				¿ The resident assessment was completed.	
				2. Residents receiving hemodialysis are at risk for these	e issues.
				¿ Each resident on hemodialysis assessment every shift of the shunt/fistula/port	has an
				that is used for the dialysis. The assessment is located on the MA	AR.
				¿ The kardex for hemodialysis re kept on the inside of the closet d referral	
				by all nursing staff indicating that resident is on dialysis treatment location of	
				the shunt/fistula/port that is used dialysis. There will be a clear sta concerning	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 58 of 149

TATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
	CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING	3	C	
		345557	B. WING		10/28/2015	5
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CEN	TER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE	ETION
F 309	Continued From pag	ge 58	F 30	9		
				limitations for the limb with the	fistula.	
				¿ Dialysis communication form CP1687 is now being used for communication	Med Pass	
				between the building and the d center with each visit. The resi assessed		
				prior to discharge using the Sa Departure/Return from Dialysis Assessment in Point		
				Click Care. The resident will be upon return using the Saber Departure/Return	e assessed	
				from Dialysis Assessment and information will also be placed CP1687. Any		
				change of condition noticed du pre or post dialysis assessmen called	•	
				to the physician.		
				3.		
				¿ The nursing staff has been ir concerning the above informat Director		
				of Nursing or Unit Manager.		
				¿ The kardex for all hemodialy residents have been verified for		

Facility ID: 100671

If continuation sheet Page 59 of 149

				E CONSTRUCTION	OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 ,		(X3) DATE SURVEY COMPLETED
			1		с
		345557	B. WING		10/28/2015
NAME OF PI	ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	
	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD	
				WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 309	Continued From page	e 59	F 309		
	1.0			information.	
				New admissions on hemodialysis we have the kardex verified during the admission	
				process by the Director of Nursing designee.	or
				¿ The communication forms used dialysis from the previous will be b to the next	
				At Risk meeting for review. The ch be checked for the completion of th Saber	
				Departure/Return assessment. Ar information missing will be gathere	
				documented. The nurse responsib identified for follow up.	le
				4.	
				The Director of Nursing will docum process each At Risk meeting for 4 weeks, 3x	
				a week for 4 weeks, and then wee weeks.	kly x8
				The Director of Nursing will report findings of the monitoring to the mo QAPI	
				committee for review and recommendations for the duration monitoring process.	of the

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 60 of 149

	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVEI 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		345557	B. WING		C 10/2	8/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		0/2013
				3800 INDEPENDENCE BOULE	VARD	
AZALEA H	EALTH & REHAB CENT	EK		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page	e 60	F 30	09		
				5.		
				Allegation of complian	nce is 11-20-2015	
				Page 1 of 1		
				1.		
				¿ Information concern treatment on 10-27-15 center was		
				gathered by the Direct documented in the res		
				¿ Staff was notified of signs and assessment the		
				resident. The kardex l of the resident⊡s clos to		
				state the limitations du of the shunt/fistula.	ue to the presence	
				ز The resident assess completed.	sment was	
				2. Residents receiving risk for these issues.) hemodialysis are at	
				¿ Each resident on he assessment every shi		

If continuation sheet Page 61 of 149

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245557			С	
		345557	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	10/28/2015	
NAME OF F	ROVIDER OR SUPPLIER					
AZALEA	HEALTH & REHAB CENT	TER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 309	Continued From page	e 61	F 309		dents is r for e d the r nent la. d Pass is will be	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 62 of 149

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING MAME OF PROVIDER OR SUPPLIER 345557 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X3) DATE SURVEY COMPLETED C 10/28/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	-
AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRO	
AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	
WILMINGTON, NC 28412 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	
	D BE COMPLETION
F 309 Continued From page 62 F 309	
change of condition noticed during e pre or post dialysis assessments wi called	
to the physician.	
3.	
¿ The nursing staff has been in service concerning the above information by Director	
of Nursing or Unit Manager.	
¿ The kardex for all hemodialysis residents have been verified for con information.	nplete
New admissions on hemodialysis w have the kardex verified during the admission	ill
process by the Director of Nursing of designee.	r
خ The communication forms used for dialysis from the previous will be bro to the next	
At Risk meeting for review. The cha be checked for the completion of the Saber	
Departure/Return assessment. Any information missing will be gathered	and
documented. The nurse responsible identified for follow up.	,

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 63 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 11/23/201 APPROVE . 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	SURVEY LETED
		345557	B. WING			10/2	<i>,</i> 28/2015
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
Δ7ΔΙ ΕΔ Η	EALTH & REHAB CENT	FR		38	800 INDEPENDENCE BOULEVARD		
				N	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From page	63	Í -	200			
1 309	Continued From page	: 05	F	309	4.		
					The Director of Nursing will document process each At Risk meeting for 4 weeks, 3x	this	
					a week for 4 weeks, and then weekly weeks.	x8	
					The Director of Nursing will report the findings of the monitoring to the month QAPI	ıly	
					committee for review and recommendations for the duration of the monitoring process.	he	
					5.		
					Allegation of compliance is 11-20-201	5	
	7(02-99) Previous Versions Obs	olete Event ID: CD			ility ID: 100671 If continu	ation sheet F	

Facility ID: 100671

If continuation sheet Page 64 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 11/23/20 FORM APPROVE OMB NO. 0938-039	ΞD
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345557	B. WING			C 10/28/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CI		10/20/2015	
				3800 INDEPENDENC			
AZALEA	IEALTH & REHAB CENT	ER		WILMINGTON, NC			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		IDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX (EACH CO	ORRECTIVE ACTION SHOULD E	COMPLETION	N
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	G CROSS-RE	FERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE	
					DEFICIENCY)		
F 200		- 04	_				
F 309	Continued From page	e 64	F	309			
				1 of 1			
				1 of 1			
FORM CMS-256	 67(02-99) Previous Versions Obs	solete Event ID:CD)4H11	Facility ID: 100671	If continu	ation sheet Page 65 of 1	149

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	11/23/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPLI	URVEY ETED
	345557	B. WING		C 10/2	8/2015
NAME OF PROVIDER OR SUPPLIER					
AZALEA HEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 Continued From page	e 65	F 3			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 66 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345557	B. WING		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER				•
AZALEA HEALTH & REHAB CENTER	R		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 309 Continued From page 6	56	F 3		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 67 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT OF D AND PLAN OF CO	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING _				C 28/2015
NAME OF PROV	IDER OR SUPPLIER	DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
AZALEA HEA	LTH & REHAB CENTE	ER			00 INDEPENDENCE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 C	ontinued From page	67	F 3	309			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 68 of 149

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M				FORM): 11/23/2015 1 APPROVED). 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
	345557	B. WING		10/2	C 28/2015
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
AZALEA HEALTH & REHAB CENTI	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 Continued From page	68	F 30			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 69 of 149

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/23/2015 M APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	E SURVEY PLETED
		345557	B. WING _			C / 28/2015
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD		
				WILMINGTON, NC 28412		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	Continued From page	9 69	F 3	09		
				Azalea Annual F 309.docx		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 70 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING _			(10/:	C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
AZALEA H	IEALTH & REHAB CENT	ER			300 INDEPENDENCE BOULEVARD /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	2 70	F	309			
					Open		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 71 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345557	B. WING _				C /28/2015
NAME OF PI	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE	•	
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDEN WILMINGTON, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From page	2 71	F	09			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 72 of 149

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 345557 B. WING 10/28/201	EY ,
345557 B. WING 10/28/201	45
	15
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(X5) PLETION DATE
F 309 Continued From page 72 F 309	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 73 of 149

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOR	D: 11/23/2015 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	345557	B. WING			C / 28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA HEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309 Continued From page	₽ 73	F 3			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 74 of 149

		ID HUMAN SERVICES MEDICAID SERVICES			FC	NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345557	B. WING _			C 10/28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From page	2 74	F3	309		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 75 of 149

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF CORRECTION 345557 B. WING C C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD 10/28/2015 AZALEA HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETI DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETI DATE F 309 Continued From page 75 F 309 F 309 ID ID		MENT OF HEALTH AN				FORM APPRO OMB NO. 0938-0	VED
Image: Name of provider or supplier Street address, city, state, zip code AZALEA HEALTH & REHAB CENTER STREET Address, city, state, zip code (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X5) COMPLETI DATE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)			345557	B. WING			
AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE	NAME OF F	PROVIDER OR SUPPLIER				•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETI DATE	AZALEA	HEALTH & REHAB CENT	ER				
F 309 Continued From page 75 F 309	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLET	TION
Conversation opened. 1 unread message.	F 309	Continued From page	2 75	F 30		sage.	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 76 of 149

		D HUMAN SERVICES				FORM	D: 11/23/2015 MAPPROVED
STATEMENT O	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			PLETED
		345557	B. WING				C /28/2015
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	976	F	309			
					Skip to content Using Gmail with screen readers		
					Kathy		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 77 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	B. WING _		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AZALEA HEALTH & REHAB CENTE	R		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 309 Continued From page	77	F 3		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 78 of 149

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)	B NO. 0938-0391 DATE SURVEY COMPLETED C 10/28/2015
345557 B. WING	10/20/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
F 309 Continued From page 78 F 309	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 79 of 149

STATEMENT OF DEFICIENCIES (x1) PROVIDERSUPPLIERCLIA (x2) MULTIPLE CONSTRUCTION (x3) DATE SURVEY AND PLAN OF CORRECTION 345557 B. WING C C NAME OF PROVIDER OR SUPPLIER 345557 B. WING C 10/28/2015 AALEA HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 INDEPENDENCE BOULEVARD C 10/28/2015 VILINING IN, DE CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER OR SUPPLIER COMPLETION VA1 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER OR SPLAN OF CORRECTION SHOULD BE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER APROPRIATE COMPLETION TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER CORRECTION SHOULD BE COMPLETION F 309 Continued From page 79 F 309 F 309 F 309 ID ID			ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED IB NO. 0938-0391
Image: Name of provider or supplier 345557 B. WING	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				B) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			345557	B. WING _			
AZALEA HEALTH & REHAB CENTER 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) COMPLETION DATE	NAME OF P	ROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	AZALEA H	IEALTH & REHAB CENT	ER			ARD	
F 309 Continued From page 79 F 309 Image: Provide From page 79 F 309	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION
	F 309	Continued From page	9 79	F3			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 80 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING _				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER		- I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH & REHAB CENT	ED		38	00 INDEPENDENCE BOULEVARD		
	IEALIN & RENAD CENT	ER		W	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	80	FS	309			
					Search		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 81 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPI F	CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							C
		345557	B. WING			10/:	28/2015
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	EALTH & REHAB CENT	ER					
				vv	ILMINGTON, NC 28412		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
			•		,		
F 309	Continued From page	81	Fa	309			
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					Dismiss		
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 82 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345557	B. WING			C / 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		120/2010
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
F 309	Continued From page	2 82	F 30	9		
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				Important		
				Sent Mail		
				Drafts (6)		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 83 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING	i			C 28/2015
	ROVIDER OR SUPPLIER		I	38	IREET ADDRESS, CITY, STATE, ZIP CODE 300 INDEPENDENCE BOULEVARD VILMINGTON, NC 28412	1 10,	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREI TAG	ΞIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	83	F	309			
					[Imap]/Drafts		
					Personal		
					Travel		
					More		
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:CC)4H11	Far	iliity ID: 100671 If continu	ation sheet	Page 84 of 149

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOR	D: 11/23/2015 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	345557	B. WING			C / 28/2015
NAME OF PROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA HEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENC)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309 Continued From page	2.84	F 3			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 85 of 149

DEPARTMENT OF HEA CENTERS FOR MEDIC						FORM	D: 11/23/2015 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING	B. WING			C 28/2015
NAME OF PROVIDER OR SUPPL	LIER		I		TREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA HEALTH & REHA	B CENTI	ER			800 INDEPENDENCE BOULEVARD /ILMINGTON, NC 28412		
PREFIX (EACH DE				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 309 Continued Fro	m page	85	F	309			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 86 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345557	B. WING		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
AZALEA HEALTH & REHAB CENTE	R		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 309 Continued From page 8	36	F 3		

Facility ID: 100671

If continuation sheet Page 87 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING	B. WING			C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	IEALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD		
				\ \	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 309				309			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 88 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345557	B. WING		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AZALEA HEALTH & REHAB CENTE	R		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 309 Continued From page 8	38	F 3		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 89 of 149

CENTERS FOR MEDICARE & MEI	IUMAN SERVICES			FORM APPRO OMB NO. 0938-0	
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	345557	B. WING		C 10/28/2015	
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA HEALTH & REHAB CENTER			3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENCY MU			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 309 Continued From page 89		F 3			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 90 of 149

		D HUMAN SERVICES					APPROVED
CENTERS FOR MEDIC							0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING				C 28/2015
NAME OF PROVIDER OR SUP	PLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	
				38	800 INDEPENDENCE BOULEVARD		
AZALEA HEALTH & REH		2R		N	/ILMINGTON, NC 28412		
PREFIX (EACH [DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309 Continued Fr				309			
					More		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 91 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345557	B. WING _	B. WING			C 28/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	IEALTH & REHAB CENT	ED		38	800 INDEPENDENCE BOULEVARD			
	IEALIN & RENAD CENT	ER		W	/ILMINGTON, NC 28412			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	D BE COMPLETION			
F 309	Continued From page	91	FS	309				
					1 of 7,255			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 92 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME				FORM	: 11/23/2015 APPROVED 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
	345557	B. WING _		C 10/2	8/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA HEALTH & REHAB CENTER	2		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENCY M			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 Continued From page 9	22	F 3			

Facility ID: 100671

If continuation sheet Page 93 of 149

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345557	B. WING		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
AZALEA HEALTH & REHAB CEN	TER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENC			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 309 Continued From pag	e 93	F 3		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 94 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	C	X2) MULTIPLE	CONSTRUCTION		
	CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
							С
		345557	B	3. WING		10	/28/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CENT	ER			300 INDEPENDENCE BOULEVARD		
		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
(X4) ID PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETION DATE	
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FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: Cl	D4H11	Fac	iliity ID: 100671 If cont	inuation sheet	Page 95 of 149
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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING			(10/	C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER		- I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA HEALTH & REHAB CENTER			380	00 INDEPENDENCE BOULEVARD			
	IEALTH & REHAD CENT	ER		WI	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
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					Not starred		
					Not starred		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 96 of 149

		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
				_			C
		345557	B. WING			10/28/2015	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IEALTH & REHAB CENT	FR			300 INDEPENDENCE BOULEVARD		
				N	/ILMINGTON, NC 28412		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
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					Not starred		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 97 of 149

		ID HUMAN SERVICES				M APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	D. 0938-0391 E SURVEY PLETED
		345557	B. WING			C / 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	-CTION	(X5)
PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 98 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345557				C 10/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2010
	IEALTH & REHAB CENT	ED		3800 INDEPENDENCE BOULEVARD			
	IEALIN & RENAD CENT	ER		W	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIZ TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 99 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	SURVEY LETED
		345557	B. WING	G		C 10/2) 28/2015
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0,2010
	IEALTH & REHAB CENT	FR			300 INDEPENDENCE BOULEVARD		
				N	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IE PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	99	F	- 309			
					Not starred		
					Not starred		
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:CI)4H11	Fac	sility ID: 100671 If continuat	ion sheet Pa	age 100 of 149

		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING _				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	S	REET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA H	IEALTH & REHAB CENT	ER			000 INDEPENDENCE BOULEVARD		
				W	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 101 of 149

		ID HUMAN SERVICES			FORM	D: 11/23/2015
STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	0. 0938-0391 SURVEY ILETED
		345557	B. WING			C 28/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/	20/2015
NAME OF F	ROVIDER OR SUPPLIER					
AZALEA	HEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD		
				WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	Continued From page	e 101	F 30			
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CENTERS FOR MEDICARE & MEDICAID SERVICES		()NAD NO. 0020 0204
		OMB NO. 0938-0391
	(2) MULTIPLE CONSTRUCTION . BUILDING	(X3) DATE SURVEY COMPLETED
345557 В	. WING	C 10/28/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD	
AZALEA HEALIN & RENAD CENTER	WILMINGTON, NC 28412	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 309 Continued From page 102	F 309 Not starred Not starred	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 103 of 149

		D HUMAN SERVICES				APPROVED
						. 0938-0391
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	ETED
		345557	B. WING		10/2	; 28/2015
NAME OF PROVID	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	TH & REHAB CENT	P		3800 INDEPENDENCE BOULEVARD		
		-N		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309 Col	ntinued From page	103	F 309			
FORM CMS-2567/02-0	99) Previous Versions Obso	olete Event ID:CD4	H11 =	acility ID: 100671 If cr	ontinuation sheet Pa	age 104 of 140

		ID HUMAN SERVICES				APPROVED	
	5 FOR MEDICARE & I	MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE S	. 0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:			COMPL		
					c	;	
		345557	B. WING		10/2	8/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE	
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 105 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 // APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345557	B. WING				C 28/2015	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE				
	IEALTH & REHAB CENT	ER			800 INDEPENDENCE BOULEVARD			
				V	VILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 309	Continued From page	2 105	F	309	Not starred			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 106 of 149

		ID HUMAN SERVICES					APPROVED	
		MEDICAID SERVICES					0.0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED	
		345557	B. WING _				C 28/2015	
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE				
	IEALTH & REHAB CENT	ED		38	00 INDEPENDENCE BOULEVARD			
	IEALIN & RENAD CENT	ER		W	ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD R			(X5) COMPLETION DATE	
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					Not starred			
					Not starred			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 107 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	
AZALEA H	IEALTH & REHAB CENT	ER			300 INDEPENDENCE BOULEVARD /ILMINGTON, NC 28412		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG				
F 309	Continued From page	2 107	F	309	Not starred		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 108 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 11/23/2015 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345557	B. WING) 28/2015
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	20/2015
	CONDER OR SOFFLIER						
AZALEA H	EALTH & REHAB CENT	ER			300 INDEPENDENCE BOULEVARD /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
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					Not starred		
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:CC)4H11	Fac	Not starred	ion sheet P:	age 109 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345557	B. WING _				C 28/2015	
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
AZALEA H	AZALEA HEALTH & REHAB CENTER			3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 309	Continued From page	- 109	F 3	N	ot starred			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 110 of 149

		ID HUMAN SERVICES			FC	TED: 11/23/2015 ORM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	NO. 0938-0391 ATE SURVEY DMPLETED
		345557	B. WING			С
		345557	D. WING			10/28/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
	HEALTH & REHAB CENT	FR		3800 INDEPENDENCE BOUL	EVARD	
				WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
TAG F 309		· · · ·	F 3	DE		DATE
FORM CMS-25	37(02-99) Previous Versions Obs	solete Event ID: CD4H1	1	Facility ID: 100671	If continuation she	et Page 111 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345557	B. WING			C 10/28/2015		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 10/		
		ED		3800 INDEPENDENCE BOULEVARD				
	AZALEA HEALTH & REHAB CENTER			W	/ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From page	e 111	F	309	Not starred			
					Not starred			
					Not starred			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 112 of 149

		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING	G		C 10/28/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 .0.	
AZALEA H	IEALTH & REHAB CENT	ER			300 INDEPENDENCE BOULEVARD		
		ATEMENT OF DEFICIENCIES			/ILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRE TA	FIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	COMPLETION DATE
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 113 of 149

		ID HUMAN SERVICES				APPROVED			
STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	0. 0938-0391 SURVEY LETED			
		345557	B. WING			C 28/2015			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD					
				WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	χ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE			
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				Not starred					
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				Not starred					

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 114 of 149

	MENT OF HEALTH AN						APPROVED			
		MEDICAID SERVICES					0. 0938-0391			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED			
		345557	B. WING				C 28/2015			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
	IEALTH & REHAB CENT	FR		3800 INDEPENDENCE BOULEVARD						
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				N	VILMINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE			
F 309	Continued From page	2 114	F	309	Not starred					

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 115 of 149

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I				FORM	APPROVED 0938-0391				
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY ETED				
	345557	B. WING		C 10/2	8/2015				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•					
AZALEA HEALTH & REHAB CENTER			3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412						
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO						
F 309 Continued From page	- 115	F 3							

Facility ID: 100671

If continuation sheet Page 116 of 149

		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		345557	B. WING _				C 28/2015			
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE					
AZALEA I	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412						
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
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Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 117 of 149

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345557	B. WING _				C 28/2015	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
		FD		38	300 INDEPENDENCE BOULEVARD			
	IEALTH & REHAB CENT	ER		W	ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From page	: 117	F3	309	Kathleen Stierwalt			
					Kathleen Stierwalt Attachments12:30 PM (9 minutes ago)			
					to me			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 118 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345557	B. WING				C 28/2015
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AZALEA H	IEALTH & REHAB CENT	ER					
0(0)15					PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 309			F3	309	From: Valerie delCid Sent: Tuesday, November 17, 2015 8:5 PM To: Kathleen Stierwalt <kathleen.stierwalt@saberhealth.com> Susan Mai</kathleen.stierwalt@saberhealth.com>		
					<susan.mai@saberhealth.com> Subject: PoC</susan.mai@saberhealth.com>		
					Please read this very closely! Let me know what you think.		
					Omnicare should be able to get the formulary easily.		

Facility ID: 100671

If continuation sheet Page 119 of 149

		D HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED
		345557	B. WING _				C 28/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH & REHAB CENT	FR		38	00 INDEPENDENCE BOULEVARD		
				W	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	9 119	F 3	09	DEFICIENCY) Valerie del Cid, RN BSN Regional Director of Clinical Services NC/VA/FL Saber HealthCare Cell 216- 645-8468 This email and any files transmitted wit are confidential and intended solely for use of the individual or entity to whom they are addressed. If you have receive this email in error please notify the sys manager. This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should r disseminate, distribute or copy this e-m 3 Attachments	the ed tem d e not	

Facility ID: 100671

If continuation sheet Page 120 of 149

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345557	B. WING		C 10/28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				3800 INDEPENDENCE BOULEVARD	
AZALEA H	IEALTH & REHAB CEN	TER		WILMINGTON, NC 28412	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	
PREFIX TAG		CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	
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				Preview attachment Azalea Annu 309.docx	ial F
				Azalea Annual F 309.docx	

		MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345557	B. WING		C 10/28/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2010
	IEALTH & REHAB CENT	rep.		3800 INDEPENDENCE BOULEVARD	
	IEALIN & RENAB CENT	IER		WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
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If continuation sheet Page 122 of 149

		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 11/23/2015 I APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING		(C 28/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		20/2013
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From page	€ 122	F 30			
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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345557	B. WING				C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH & REHAB CENT	ED		38	300 INDEPENDENCE BOULEVARD		
				W	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 123	F	309			
					Click here to Reply or Forward		
					1.04 GB (6%) of 15 GB used		
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					Terms - Privacy		
					Last account activity: 8 days ago Details		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 124 of 149

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					IPLETED
							С
		345557	E	B. WING		10	/28/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA I	HEALTH & REHAB CENT	ER			00 INDEPENDENCE BOULEVARD		
	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC		(X5)
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F 309	Continued From page	2 124		F 309	Kathleen Stierwalt kathleen.stierwalt@saberhealth.co	om	
					Show details		
FORM CMS-256	37(02-99) Previous Versions Obs	olete Event ID:Cl	D4H11	Fac	ility ID: 100671 If cor	tinuation sheet	Page 125 of 149

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
A. DUILDING	
345557 B. WING	C 10/28/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE,	, ZIP CODE
AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEV WILMINGTON, NC 28412	VARD
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVI CROSS-REFERENCED TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED	AN OF CORRECTION (X5) TE ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 309 Continued From page 125 F 309 Image: Continued From page 125 F 309	

Facility ID: 100671

If continuation sheet Page 126 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345557	B. WING		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •
AZALEA HEALTH & REHAB CENTE	R		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 309 Continued From page	126	F 3		

Facility ID: 100671

If continuation sheet Page 127 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345557	B. WING _			C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2013
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD		
				WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	Continued From page	2 127	F 3		alysis ing and	
				¿ Staff was notified of restriction signs and assessment was com		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 128 of 149

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0 (X3) DATE SU	RVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLET	ED
		345557	B. WING		C	0045
NAME OF PI	ROVIDER OR SUPPLIER	040001		STREET ADDRESS, CITY, STATE, ZIP C	0DE 10/28/	2015
				3800 INDEPENDENCE BOULEVARD		
AZALEA F	IEALTH & REHAB CENT	ER		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE	(X5) OMPLETION DATE
F 309	Continued From page	e 128	F 309			
				the		
				resident. The kardex locate inside of the resident⊡s clo updated to		
				state the limitations due to t of the shunt/fistula.	the presence	
				¿ The resident assessment completed.	was	
				2. Residents receivi hemodialysis are at risk for		
				¿ Each resident on hemodia assessment every shift of th shunt/fistula/port		
				that is used for the dialysis. assessment is located on th		
				¿ The kardex for hemodialy kept on the inside of the clo referral		
				by all nursing staff indicating resident is on dialysis treatron location of		
				the shunt/fistula/port that is dialysis. There will be a clear concerning		
				limitations for the limb with	the fistula.	
				¿ Dialysis communication fo CP1687 is now being used communication		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 129 of 149

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/23/201 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		345557	B. WING		C 10/28/2015	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA H	EALTH & REHAB CENT	ER		8800 INDEPENDENCE BOULEVARD		
				WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 309	Continued From page	9 129	F 309			
				between the building and the dial center with each visit. The resider assessed	-	
				prior to discharge using the Sabe Departure/Return from Dialysis Assessment in Point	r	
				Click Care. The resident will be a upon return using the Saber Departure/Return	ssessed	
				from Dialysis Assessment and the information will also be placed on CP1687. Any		
				change of condition noticed durin pre or post dialysis assessments called		
				to the physician.		
				3.		
				¿ The nursing staff has been in se concerning the above information Director		
				of Nursing or Unit Manager.		
				¿ The kardex for all hemodialysis residents have been verified for c information.		
				New admissions on hemodialysis have the kardex verified during th admission		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 130 of 149

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 345557 B. WING 10/28/201 NAME OF PROVIDER OR SUPPLIER AZALEA HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED C C C C C C C C C C C C C C C C C C C		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/23/2015 APPROVED 0. 0938-0391
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ZAZLEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 (Y4) [D] PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILST REPREZEDB DB VPLIL REGULATORY OR LSC IDENTIFYING INFORMATION) DD PREFIX TAG PREFIX CONSERSERBERED TO THE APPROPRIATE DEFICIENCY) COMPOSE (EACH DEFICIENT WILST BE PRECEDED BY VPLIL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX CONSERSERBERED TO THE APPROPRIATE DEFICIENCY) COMPOSE (EACH DEFICIENT WILST BE PRECEDED BY VPLIL DEFICIENCY) PROCESS BY the Director of Nursing or designee. Compose (CONSERSERBERED TO THE APPROPRIATE DEFICIENCY) COMPOSE (CONSERSERSERCED TO THE APPROPRIATE DEFICIENCY) COMPOSE (CONSERSERSERCED TO THE APPROPRIATE DEFICIENCY) CONSERSERSERCED TO THE APPROPRIATE DEFICIENCY CONSERSERSERCED TO THE APPROPRIATE DEFICIENCY CONSERSERSERSERCED THE APPROPRIATE DEFICIENCY C	NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
PREFIX TXG (ECCH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TXG Continued CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMM F 309 Continued From page 130 F 309 process by the Director of Nursing or designee. ; The communication forms used for dialysis from the previous will be brought to the next ; The communication forms used for dialysis from the previous will be brought Departure/Return assessment. Any information missing will be gathered and documented. The nurse responsible identified for follow up. 4. The Director of Nursing will document this process each At Risk meeting for 4 weeks. 3x a week for 4 weeks, and then weekly x8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the	AZALEA H	IEALTH & REHAB CENT	ER					
process by the Director of Nursing or designee. ¿ The communication forms used for dialysis from the previous will be brought to the next At Risk meeting for review. The chart will be checked for the completion of the Saber Departure/Return assessment. Any information missing will be gathered and documented. The nurse responsible identified for follow up. 4. The Director of Nursing will document this process each At Risk meeting for 4 weeks, 3x a week for 4 weeks, and then weekly x8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		(X5) COMPLETION DATE
	F 309	Continued From page	≥ 130	F	309	 process by the Director of Nursing or designee. ¿ The communication forms used for dialysis from the previous will be broug to the next At Risk meeting for review. The chart of be checked for the completion of the Saber Departure/Return assessment. Any information missing will be gathered and documented. The nurse responsible identified for follow up. 4. The Director of Nursing will document of process each At Risk meeting for 4 weeks, 3x a week for 4 weeks, and then weekly x weeks. The Director of Nursing will report the findings of the monitoring to the month QAP1 committee for review and 	will nd this :8	
5. Allegation of compliance is 11-20-2015						5.	5	

Facility ID: 100671

If continuation sheet Page 131 of 149

STATEMENT AND PLAN O NAME OF F	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AZALEA (X4) ID PREFIX	ROVIDER OR SUPPLIER				COMPLETED
AZALEA (X4) ID PREFIX	ROVIDER OR SUPPLIER	345557	B. WING		10/28/2015
(X4) ID PREFIX				STREET ADDRESS, CITY, STATE, ZIP CODE	
PREFIX	HEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 309	Continued From page	e 131	F 30	9	
				 Page 1 of 1 1. ¿ Information concerning the Resider treatment on 10-27-15 by the dialysic center was gathered by the Director of Nursing a documented in the resident s chart. ¿ Staff was notified of restrictions for signs and assessment was completed the resident. The kardex located on the of the resident s closet has been up to state the limitations due to the prese of the shunt/fistula. ¿ The resident assessment was completed. 2. Residents receiving hemodialysis 	s and r vital ed for inside odated
				 risk for these issues. ¿ Each resident on hemodialysis has assessment every shift of the shunt/fistula/port that is used for the dialysis. The assessment is located on the MAR. ¿ The kardex for hemodialysis reside 	s an

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 132 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345557	B. WING		C 10/28/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
AZALEA H	EALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD	
				WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 309	Continued From page	122	F 3	00	
1 000	Continued From page	5 102		kept on the inside of the clo referral	oset door for
				by all nursing staff indicatin resident is on dialysis treat location of	
				the shunt/fistula/port that is dialysis. There will be a cle concerning	
				limitations for the limb with	the fistula.
				¿ Dialysis communication f CP1687 is now being used communication	
				between the building and th center with each visit. The assessed	
				prior to discharge using the Departure/Return from Dial Assessment in Point	
				Click Care. The resident wi upon return using the Sabe Departure/Return	
				from Dialysis Assessment a information will also be plac CP1687. Any	
				change of condition noticed pre or post dialysis assessi called	
				to the physician.	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 133 of 149

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 1 APPROVED) <u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		345557	B. WING	B. WING		C 10/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA H	IEALTH & REHAB CENT	ER					
				W	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From page	: 133	F	309			
					3.		
					¿ The nursing staff has been in servic concerning the above information by t Director		
					of Nursing or Unit Manager.		
					¿ The kardex for all hemodialysis residents have been verified for comp information.	lete	
					New admissions on hemodialysis will have the kardex verified during the admission		
					process by the Director of Nursing or designee.		
					¿ The communication forms used for dialysis from the previous will be brou to the next	ght	
					At Risk meeting for review. The chart be checked for the completion of the Saber	will	
					Departure/Return assessment. Any information missing will be gathered a	nd	
					documented. The nurse responsible identified for follow up.		
					4.		
					The Director of Nursing will document process each At Risk meeting for 4 weeks, 3x	this	

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 134 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: FORM OMB NO.	APPROVED
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPLE	JRVEY
		345557	B. WING			C	3/2015
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
AZALEA H	EALTH & REHAB CENT	ER			300 INDEPENDENCE BOULEVARD		
				W	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	Continued From page	124					
F 309	Continued From page	2 134	F	309	a week for 4 weeks, and then weekly weeks.	« 8	
					The Director of Nursing will report the findings of the monitoring to the month QAPI	ıly	
					committee for review and recommendations for the duration of the monitoring process.	ne	
					5.		
					Allegation of compliance is 11-20-201	5	
	7(02-99) Previous Versions Obs	olete Event ID: CD			ility ID: 100671 If continua	tion sheet Pag	

Facility ID: 100671

If continuation sheet Page 135 of 149

		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	IPI F	CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
							C
		345557	B. WING			10/	28/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 300 INDEPENDENCE BOULEVARD		
AZALEA H	IEALTH & REHAB CENT	ER			/ILMINGTON, NC 28412		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
IAG		,			DEFICIENCY)		
F 309	Continued From page	e 135	F	309			
					4 - 5 4		
					1 of 1		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 136 of 149

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345557 B. WING TO/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 INDEPENDENCE BOULEVARD 10/28/2015 AZALEA HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S PUAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD ACTION SHOULD ACTION SHOULD ACTION SHOULD ACTI			ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 I APPROVED . 0938-0391
345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD AZALEA HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) Image: Complex of the properties of the propertie	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMPI	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 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			345557	B. WING _				
AZALEA HEALTH & REHAB CENTER 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	NAME OF P	ROVIDER OR SUPPLIER					•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	AZALEA I	HEALTH & REHAB CENT	ER					
F 309 Continued From page 136 F 309 Image: state	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH COR	RECTIVE ACTION SHOULD B		COMPLETION
	F 309	Continued From page	2 136	F				

Facility ID: 100671

If continuation sheet Page 137 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				FORM APPROVED OMB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	B. WING _		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
AZALEA HEALTH & REHAB CENTE	R		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 309 Continued From page	137	F 3		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 138 of 149

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETE C	RVEY IED
	10045
345557 B. WING 10/28/2	/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AZALEA HEALTH & REHAB CENTER 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 Continued From page 138 F 309	

Facility ID: 100671

If continuation sheet Page 139 of 149

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME				PRINTED: 11/23/2015 FORM APPROVED OMB NO. 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345557	B. WING		C 10/28/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
AZALEA HEALTH & REHAB CENTER			3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 309 Continued From page 13	39	F 30		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 140 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		O. 0938-0391 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
						С
		345557	B. WING		10	/28/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD		
AZALEA H	IEALTH & REHAB CENT	ER		WILMINGTON, NC 28412		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETION DATE
IAG		,	1/10	DEFICIENCY)		
F 309	Continued From page	e 140	F 3	09		
				Azalea Annual F 309.docx		
				Open		

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 141 of 149

CENTERS FOR MEDICARE & MEDIC	IAN SERVICES AID SERVICES			FORM APPROV OMB NO. 0938-03	
STATEMENT OF DEFICIENCIES (X1) PR	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345557	B. WING		C 10/28/2015	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AZALEA HEALTH & REHAB CENTER			3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDEN	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ON
F 309 Continued From page 141		F 3			

Facility ID: 100671

If continuation sheet Page 142 of 149

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED A. BUILDING			ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/23/2015 M APPROVED D. 0938-0391
345557 B. WING 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMF	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD			345557	B. WING _				
I 3800 INDEPENDENCE BOULEVARD	NAME OF PI	ROVIDER OR SUPPLIER					•	
AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412	AZALEA H	IEALTH & REHAB CENT	ER					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 309 Continued From page 142 F 309	F 309	Continued From page	e 142	F	609			

Facility ID: 100671

If continuation sheet Page 143 of 149

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)	OMB NO. 0938-0391 IULTIPLE CONSTRUCTION (X3) DATE SURVEY
	ILDING COMPLETED
345557 B. W	NG 10/28/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE DEFICIENCY) DATE
F 309 Continued From page 143	F 309

Facility ID: 100671

If continuation sheet Page 144 of 149

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COM	D. 0938-0391 E SURVEY PLETED			
		345557	B. WING			C / 28/2015			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
AZALEA	HEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412					
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION COM FIX (EACH CORRECTIVE ACTION SHOULD BE COM G CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 309	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F3						

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 145 of 149

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) E	NO. 0938-0391 DATE SURVEY OMPLETED	
		345557	B. WING _			C 10/28/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DDE		
AZALEA H	IEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CON CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 309	Continued From page	e 145	F3	309			

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 146 of 149

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/23/201 MAPPROVEI O. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
345557			B. WING		C 10/28/2015		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
AZALEA H	HEALTH & REHAB CENT	ER		3800 INDEPENDENCE BOULEVARD			
				vv	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 146	F	309			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.		F :	356	1.Information concerning Resident #19 treatment on 10/27/15 by the dialysis center was gathered by the Director of Nursing and documented in the resident chart. Staff was notified of restrictions vital signs and assessment was completed for the resident. The karder located on the inside of the resident's closet has been updated to state the limitations due to the presence of the shunt/ fistula. The resident assessment	nt's for K	11/20/15

Event ID: CD4H11

Facility ID: 100671

If continuation sheet Page 147 of 149

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345557			B. WING			C 10/28/2015		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/		
				3	800 INDEPENDENCE BOULEVARD			
AZALEA I	IEALTH & REHAB CENT	ER		١	WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE		
F 356	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	TAG CROSS-REFERENCED TO THE APPROP		nd the ced e, ked dent ed to		

Facility ID: 100671

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/23/2015 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345557		B. WING		C 10/28/2015		
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
		50		38	800 INDEPENDENCE BOULEVARD		
	IEALTH & REHAB CENT	ER		w	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 356	Continued From page	≥ 148	F	356			
	include the resident c			550	report the findings to the monthly QAP		
	On 10/27/15 at 8:00 /	AM, the posting of daily			committee for review and recommendations for the duration of th	0	
		otal actual hours worked by			monitoring.	6	
	all licensed nurse (RN	and LPN) by shift. The			5. The Allegation of Compliance Date for	or	
		parately the actual hours			this plan is 11/20/15.		
	include the resident c	PN. The daily staffing did not ensus.					
		AM, the posting of daily					
		otal actual hours worked by J and I PN) by shift The					
	all licensed nurse (RN and LPN) by shift. The posting did not list separately the actual hours						
	worked by RN and LF include the resident c	N. The daily staffing did not ensus.					
	at 9:45 AM revealed t	ector of Nursing on 10/28/15 hat she followed the same at was completed in the					
	9:50 AM revealed that form did not list the ad registered nurse sepa	ninistrator on 10/28/15 at t she was not aware that the ctual hours worked by the arate from the licensed					
	further stated that goi sure the form is revise	worked. The Administrator ng forth she would make ed and it captures the daily he actual hours worked by					
		arate from the hours worked					

Facility ID: 100671

If continuation sheet Page 149 of 149