DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE								
							D. 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 03/14/2017			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
AZALEA HEALTH & REHAB CENTER				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 PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO TH DEFICIENCY		ON SHOULD BECOMPLETIONIE APPROPRIATEDATE		
F 000	INITIAL COMMENTS		F	000				
		encies as a result of the on of 3/14/17, Event 55LQ11.						
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE	
Electronically Signed 0							03/16/2017	

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.

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