STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING ______ B. WING ______	C 03/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Physician Assistant interviews, the facility failed to follow the physicians order and complete the daily dressing change for 1 of 5 sampled residents (Resident #5). Findings Included: Resident #5 was admitted to the facility on 3/4/19 with diagnoses that included; Fracture of left lower leg with external fixator placement, Muscle Weakness, Heart Disease, Diabetes, and Polyneuropathy. The most recent Minimum Data Set (MDS) dated 3/11/19 and coded as an admission assessment indicated resident was cognitively intact. He required extensive one-person assistance with mobility, transfers, and ADL ' s (activities of daily living). A review of the physician progress notes dated 3/5/19 documented that Resident #5 underwent closed reduction and manipulation with application of external fixator to left ankle with debridement at open fracture site on 2/28/19. A review of the physicians ' order dated 3/5/19 documented an order in place for Xeroform Petrolatum Gauze 5%, to apply to left lower	F 658	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purpose of general liability, professional malpractice or any other court proceeding. #1 Resident #5 no longer resides at the facility. #2 Residents with wounds are at risk for this issue. The Director of Nursing reviewed the Point Click Care Treatment Administration Record audit to identify any other resident with wounds that treatments were not documented as completed on 3/17/19. Those residents identified had their wounds assessed on 3/20/19 to identify any deterioration in the wound. There was no evidence of deterioration. #3 To prevent this from recurring, the Director of Nursing or designee will reeducate the licensed nurses concerning the expectation that treatments be completed per provider orders and documented in the Treatment Administration Record. #4 To monitor and maintain ongoing	4/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/11/2019

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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F 658	Continued From page 1 extremity every day shift for wound care, to clean site with wound cleanser (avoid pin sites) and apply Xeroform to cover the blistered and opened areas and wrap with gauze. A review of the physician orders dated 3/5/19 documented an order in place to provide pin care to left lower extremity with a 1:1 concentration of Normal Saline and Peroxide and rub sites with soaked Qtip every day shift and every evening shift. A review of the physician order dated 3/13/19 documented an order in place to apply Xeroform Petrolatum Gauze 5% to left heel topically every day shift for wound care, and clean with wound cleaner or normal saline, and apply dressing and wrap with gauze. A review of the Treatment Administration Record (TAR) on 3/20/19 showed no documentation that the Xeroform dressing change to left lower extremity was completed on 3/17/19. A phone interview was conducted on 3/20/19 at 5:30 PM with Nurse #1 who was the primary care nurse for Resident #5 from 7:00 AM through 7:00 PM on Sunday 3/17/19. She stated she did the dressing change and cleaned the pin sites to wounds once on Saturday 3/16/19 and stated she did not complete the day shift dressing change or cleanse pin sites per physician order on Sunday 3/17/19. An interview was conducted with the wound treatment nurse on 3/21/19 at 9:30 AM. She stated the residents primary care nurse would be responsible for wound treatments on weekends, and stated the residents dressing changes were	F 658	compliance, the Director of Nursing or designee will run the Point Click Care Treatment Administration Record Audit Report, choosing the missing documentation choice, to identify medications and treatments that were not documented as being completed. This will be reviewed during each morning clinical meeting. A follow up list will be created to investigate the situation and either get the nurse to correct documentation or council the nurse responsible. This review will be documented in the morning clinical meeting with each meeting for 12 weeks. The Director of Nursing or designee will validate that the dressings have been changed by validating the appropriate dates are documented on the dressing per orders. This will be documented 5 dressings per day, 3 times weekly for 12 weeks The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 658	Continued From page 2 ordered to be changed each day shift and the pin sites cleaned twice each day to reduce the risk of infection. An interview was conducted with the facility physician assistant on 3/20/19 at 4:00 PM. She stated the resident had orders in place for wound care to affected areas and pin sites cleaned each day shift and her expectation was that wound care was performed per orders. An interview was conducted on 3/22/19 at 7:00 AM with the Director of Nursing. She stated her expectation was that the residents wound treatments should have been completed on 3/17/19 per the physicians ' order.	F 658		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		4/15/19

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F 842	Continued From page 3 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 4 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to document the administration of the prescribed pain and fever reducing medication Tylenol (Acetaminophen) and the anti-nausea medication Zofran (Ondansetron) on the residents Medication Administration Record (MAR) for 1 of 5 sampled residents that were reviewed (Resident #5). Findings Included: Resident #5 was admitted to the facility on 3/4/19 with diagnoses that included; Fracture of left lower leg with external fixator placement, Muscle Weakness, Heart Disease, Diabetes, and Polyneuropathy. The most recent Minimum Data Set (MDS) dated 3/11/19 and coded as an admission assessment indicated Resident #5 was cognitively intact. He required extensive one-person assistance with mobility, transfers, and ADL ' s (activities of daily living). A review of the physician progress notes dated 3/5/19 documented that Resident #5 underwent closed reduction and manipulation with application of external fixator to left ankle with debridement at the open fracture site on 2/28/19 with orders written for wound care treatments.	F 842	#1 Resident #5 is no longer resides in the facility. #2 To identify other residents that have the potential to be affected, the Director of Nursing will run the Point Click care Medication Admin Audit Report, choosing the missing documentation choice, to identify medications and treatments that were not documented as being completed on 3/21/19. Any issues identified will be followed up with the responsible nurse for clarification as to whether the medication was given or not. The responsible nurse will either correct the documentation or write a statement as to why the medication was not given. #3 To prevent this from recurring, the Director of Nursing or designee will reeducate licensed nurses concerning medication administration policy including the requirement to document the administration of medications at the time that the medications are given. #4 To monitor and maintain ongoing compliance, the Director of Nursing or designee will run the Point Click Care Medication Admin Audit Report, choosing the missing documentation choice, to	

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F 842

Continued From page 5

A review of the nursing note dated 3/16/19 at 9:00 AM documented resident had a fever of 102.3 and was noted to be shaking and vomited. The on-call physician assistant was notified, and orders were received for Tylenol (Acetaminophen) 500 milligrams (mg) - give two tablets by mouth every six hours and as needed and start Tylenol 500mgs by mouth every four hours as needed for fever and pain. An order was received on 3/16/19 for Zofran (Ondansetron) 4 mg- give one tablet by mouth every six hours as needed for nausea and vomiting.

A review of the medical record on 3/20/19 documented that on 3/16/19 at 9:00 AM resident #5 had a fever of 102.3 and on 3/17/19 residents ' fever was documented at 102 degrees.

A review of the Medication Administration Record (MAR) on 3/20/19 showed that only one dose of the prescribed Tylenol (Acetaminophen) 500mg was administered which was given at 11:30 PM on 3/16/19. No Tylenol doses were documented as being administered on 3/16/19 prior to the 11:30 PM dose and no doses were documented as being administered on 3/17/19. No documentation was recorded that Zofran (Ondansetron) had been administered on 3/16/19 or 3/17/19.

An interview was conducted on 3/20/19 at 3:30 PM with Nurse #1 who stated she was the residents primary care nurse on 3/16/19 and 3/17/19 from 7:00 AM through 7:00 PM each day. She stated Resident #5 had vomiting and shaking on Saturday 3/16/19 and his temperature was 102.3 She called the on- call Physician Assistant and received orders for Tylenol 500mg every 4 hours for pain and fever and to start Bactrim

F 842

identify medications and treatments that were not documented as being completed. This will be reviewed during each morning clinical meeting. A follow up list will be created to investigate the situation and either get the nurse to correct documentation or council the nurse responsible. This review will be documented in the morning clinical meeting for 12 weeks.

The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.

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F 842	Continued From page 6 (antibiotic) by mouth for 7 days and stated he had Zofran ordered as needed for nausea and vomiting. She stated on Saturday 3/16/19 she gave him two doses of Zofran for vomiting and two doses of Tylenol 500mg for his fever, and stated she gave two doses of Tylenol 500mg on 3/17/19 prior to him being transported by EMS (Emergency medical services) to the hospital. She stated when EMS arrived his temperature was 105 degrees. A review of the nursing progress note dated 3/17/19 documented Resident #5 was sent out to hospital for fever of 102.8, when EMS (Emergency medical services) arrived at the facility at 7:15 PM the resident ' s fever was 105 degrees. A follow up interview was conducted on 3/21/19 at 9:55 AM with Nurse #1. She stated Resident #5 received two doses of Tylenol 500mg on Saturday morning 3/16/19 and one evening dose of Tylenol 500mg on 3/16/19, and stated she failed to document the morning and evening dose that she administered. She stated he received two doses of Tylenol 500mg on Sunday 3/17/19 and stated she also failed to document the doses. She stated she administered two doses of Zofran by mouth on Saturday 3/16/19 and one dose on Sunday 3/17/19, and stated she also failed to document the Zofran doses on the residents Medication Administration Record. An interview was conducted on 3/22/19 at 7:00 AM with the Director of Nursing. She stated her expectation was that the nurses are documenting all medications administered on the resident ' s medication administration record.	F 842		