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 12/09/2022

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
E 000	Initial Comments An unannounced recertification survey was conducted on 12/5/22 through 12/9/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #H0W11111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 12/5/22 through 12/9/22. Event #H0W111. The following intakes were investigated: NC 00195712, NC 00193255 and NC00195734. 2 of the 7 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		1/4/23

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

Electronically Signed | 12/30/2022

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 12/09/2022

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 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to provide a resident with privacy when Resident #50 was observed lying in bed with her buttock and lower body exposed with the door to the hallway open, the blinds to the window open, and the privacy curtain not pulled around the bed in a semi-private room. In addition, the facility failed to provide a privacy curtain for a resident who resided in a semi-private room with a roommate (Resident #20). The deficient practice affected 2 of 2 residents reviewed for privacy. The reasonable person concept was applied to example 1 as residents have an expectation of privacy in their home environment. The findings included: 1. Resident #50 was admitted to the facility on 3/20/21 with medical diagnoses which included in part advanced dementia with behaviors. Resident's 10/19/22 quarterly Minimum Data Set (MDS) assessment revealed that resident had severe cognitive impairment and exhibited no	F 583	A privacy curtain and curtain track were ordered for resident #50. She was moved to a room with a privacy curtain until curtain and track were obtained. 100% room audit was conducted by the Environmental Services Director on 12/12/2022 to determine current status of privacy curtain integrity and to note those rooms lacking a privacy curtain. Missing curtains were replaced by 12/30/2022. Education will be provided to the department head staff by the administrator, by 1/3/2023, on the process for noting curtains that need attention during concierge rounds. The DON or designee will educate all clinical staff by January 3, 2023 on ensuring privacy curtains are functioning and used appropriately, to ensure blinds are closed during times of care and for residents that disrobe and that the curtains are being used between residents. Any staff member that is not educated by January 3, 2023 will be educated prior to working their next scheduled shift.	

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 12/09/2022

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 583	Continued From page 2 behaviors. Resident was always incontinent of bowel and bladder and required extensive assistance with bed mobility, transfers, and toileting. Observation on 12/05/22 at 4:34 PM revealed Resident #50 was lying in bed dressed only in a shirt with no incontinence brief or clothing on lower body. The privacy curtain was not pulled around resident's bed, the blinds were open facing a grassy area at the front of the building adjacent to the parking lot and the door to the hallway was open. Resident #50 was in a semiprivate room and her roommate was present. Interview on 12/5/22 at 4:40 PM with Nurse #4 revealed that Resident #50's family requested that resident not wear incontinence briefs and they had supplied cloth pads for the bed. Observation on 12/06/22 at 09:59 AM revealed Resident #50 was lying in bed dressed in a shirt only with a blanket wrapped around her upper body. Resident #50 was turned on her side facing the window with the blinds open, and the privacy curtain was not pulled around her bed and the door to the hallway was open. Resident's buttock was exposed. Resident's roommate was in the room. Observation on 12/06/22 at 10:25 AM revealed Resident #50 was lying in bed on her back dressed in a shirt only with nothing on her lower body and with no sheet or blanket covering her. Resident #50's lower body was exposed. The privacy curtain was not pulled around the bed, the blinds were open and the door to the hallway was open. Resident #50's roommate was in the room.	F 583	Administrator or designee will audit 5 random rooms weekly for 12 weeks to ensure privacy curtains are present and functioning properly and that privacy is being maintained with use of blinds and center curtains. Audits will be reviewed in Resident Review meeting weekly and monthly in the facility Quality Assurance Performance Improvement meeting. Quality Assurance team may change the plan of action or extend audits if necessary to ensure ongoing compliance.	

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 12/09/2022

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 583	Continued From page 3	F 583		

Interview on 12/06/22 at 4:27 PM with Nurse #2 revealed Resident #50 was incontinent of bowel and bladder and her family did not want her to wear a brief. Nurse #2 stated that resident #50 used cloth pads provided by the family for incontinence.

Observation on 12/7/22 at 11:45 AM revealed Resident #50 was lying in bed uncovered with a top on only. The privacy curtain was not pulled around the bed, the blinds were open and the door to the hallway was open. Resident #50's buttock was exposed.

Interview on 12/08/22 at 9:10 AM with Nurse #1 revealed that Resident #50 had incontinence of bowel and bladder and family requested that resident not wear briefs, so she just laid on the cloth pads. Nurse #1 stated that Resident #50 was a high fall risk, so the door and privacy curtain were kept open. Nurse #1 did not know why the Nursing Aides did not dress Resident #50 in a gown to maintain privacy.

Interview on 12/8/22 at 9:30 AM with Nursing Aide (NA) #1 revealed that Resident #50 had incontinence and used pads that family provided. NA #1 revealed that Resident #50 doesn't wear clothes because they kept her on the pads and had to change them frequently. NA #1 stated she tried to keep Resident #50 covered but she was restless and picked and pulled at things. NA #1 stated the door was kept open and the privacy curtain was not pulled due to Resident #50's high fall risk. NA #1 stated when she provided care to Resident #50, she closed the door and the blinds

Follow up interview on 12/09/22 at 9:30 AM with

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 12/09/2022

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 583	Continued From page 4	F 583		

NA #1 revealed that she did not dress Resident #50's lower body when in bed due to family's request to use pads only on the bed so she left her clothes off. If she got Resident #50 up in the chair, NA #1 stated she put pants on her. NA #1 stated she tried to keep covers on Resident #50, but she was restless and took them off. NA #1 stated she checked Resident #50 frequently and put the covers back on.

Interview on 12/09/22 at 9:40 AM with Nurse #4 revealed that staff checked on Resident #50 frequently. Nurse #4 stated that the NAs got Resident #50 up if she was restless. The NAs didn't put pants on Resident #50 when she was in bed because she did not wear a brief. She indicated they can't close the door or the curtain because she was a high fall risk.

Interview on 12/09/22 at 11:45 AM with the Social Worker (SW) revealed that she had a care plan meeting with Resident #50's daughter in November at which time resident's daughter stated that she felt that resident would be more comfortable dressed in a gown and requested that resident remain in bed as much as possible. SW stated that staff got resident up occasionally as tolerated. SW revealed that Resident #50's daughter preferred that resident not wear a brief and used cloth pads instead for incontinence. SW stated that residents should not be exposed. SW stated that residents should be covered and dressed in clothing that did not leave them exposed. SW stated that staff should be aware that residents should not be exposed.

Interview on 12/09/22 at 12:30 PM with the Director of Nursing (DON) revealed that residents should not be exposed. The DON stated that

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 12/09/2022

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 583	Continued From page 5	F 583		

residents should be dressed in clothing that kept them covered. The DON revealed that Resident #50 sometimes removed her clothing, but she should not be left exposed.

Interview on 12/8/22 at 4:30 PM with the Administrator revealed that he expected that residents would not be exposed, and their privacy would be maintained. The Administrator further stated that privacy curtains were to be utilized and blinds closed to prevent residents being exposed to other residents, staff, or visitors.

2. Resident #20 was admitted to the facility on 7/30/21 with diagnoses which included in part stroke and dementia.

Resident #20's 9/30/22 quarterly Minimum Data Set (MDS) assessment indicated resident had mild cognitive impairment.

An observation was conducted of Resident #20's room on 12/5/22 at 11:20 AM. This was a semi-private room where Resident #20 resided with a roommate (Resident # 30). There was no privacy curtain available for Resident #20.

Interview on 12/5/22 at 12:05 PM with Resident #20 revealed that she did not feel like she had privacy. Resident #20 stated that the privacy curtain around her bed had been down for months, that she had reported it to staff and was told it would be put up, but they had not done so.

An interview on 12/7/22 at 5:18 PM with the Maintenance Director revealed he was responsible for the housekeeping and laundry services in the facility. The Maintenance Director revealed he was new to the facility and had only

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 12/09/2022

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 583	Continued From page 6 been in the position for a few months and the housekeeping staff were also new. The Maintenance Director said he was aware that there were some privacy curtains missing from resident rooms, including Resident #20's room, and he was working on replacing them. The Maintenance Director stated that privacy curtains were to be available to provide full privacy for each resident in all rooms. Interview on 12/8/22 at 4:28 PM with the facility administrator revealed that his expectation was for all resident rooms to have privacy curtains available. Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) indicated that each room should have privacy curtains clean and available for each resident in the room. The DON stated that she expected the nursing staff would inform the Maintenance Director if a room did not have a privacy curtain available or if the curtain did not provide full privacy of the resident in the room.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		1/4/23

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 12/09/2022

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 584	Continued From page 7 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to maintain a clean and sanitary living environment by 1) not providing housekeeping services for 100, 200 and 300 halls 2) not replacing soiled privacy curtains in resident rooms (Rooms 101, 104, 106, 107, and 112); and 3) not eliminating a strong odor in Room 102. This deficient practice affected 3 of 3 halls observed.	F 584	Privacy curtains in rooms 101,104, 106, 107 and 112 were cleaned and replaced. On December 9, 2022, Environmental Services Director inspected each room and provided housekeeping services as needed to ensure clean, sanitary environment with no odor. The housekeeping director was educated by the administrator on December 27,	

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 12/09/2022

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 584	Continued From page 8 Findings included. 1). An observation conducted on 12/07/22 at 9:15 AM revealed no housekeeping staff on the 200 hallway, the floors in some of the resident rooms were littered with trash including napkins, food crumbs, and straws on the floor. Continuous observations conducted on 12/07/22 from 9:15 AM through 11:30 AM revealed no housekeeping staff or cleaning carts were observed on any of the halls in the facility. Continuous observations conducted on 12/07/22 from 12:00 PM through 12:30 PM revealed no housekeeping staff or cleaning carts on the halls. During an interview conducted on 12/07/22 at 1:00 PM Nurse aide #10 stated her assignment included rooms 111 - 121 she indicated she had not seen housekeeping staff on the floor today. During an interview conducted on 12/07/22 at 1:30 PM with Nurse aide #2 she indicated she had not seen housekeeping staff on the 200 or 300 halls today. Continuous observations conducted on 12/07/22 from 2:00 - 3:00 PM revealed no housekeeping staff on the halls. Multiple interviews conducted with alert and oriented residents on 12/07/22 from 2:00 -3:00 PM on the 100. 200, and 300 halls revealed housekeeping had not cleaned their rooms today. An interview was conducted on 12/07/22 at 3:40 PM with the Maintenance Director along with the	F 584	2022, as to the requirement to have housekeeping daily in each room and resident area. The housekeeping director educated the housekeeping staff on December 28, 2022, on the requirement to have housekeeping daily in each resident room and communal areas, to include ensuring privacy curtains are clean and facility is free from odors. The Administrator or designee will conduct 10 random room audits weekly for 12 weeks to ensure housekeeping occurs daily in all resident rooms, privacy curtains are clean, and odors are being controlled. Audits will be reviewed in resident review meeting weekly and monthly in QA meeting. Audits may be changed or extended to ensure ongoing compliance.	

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 12/09/2022

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 584	Continued From page 9	F 584		

Administrator. The Maintenance Director stated he was also the Housekeeping Supervisor. The Maintenance Director stated he was the reason housekeeping staff were not on the floor this morning. He stated he asked the housekeeping staff to stay out of the way since the survey was in progress and there was so much going on but stated he didn't realize the staff had not cleaned the resident rooms when he asked them to leave the hall. He stated the housekeeping staff had already left for the day and they were expected to clean resident rooms daily including sweeping, mopping, wiping down high touch surfaces and stated there was a checklist used to guide them.

An interview was conducted on 12/08/22 at 1:43 PM with Housekeeping Aide #1. She stated she worked from 6:00 AM - 2:00 PM daily and left at 12:00 PM yesterday on 12/07/22 for an appointment. She stated after being asked to leave the floor yesterday morning on 12/07/22 she stocked the housekeeping room and cleaned the break rooms. She stated she typically cleaned every room on her assigned hall which included wiping down all surfaces and mopping floors including the activities room. She stated she usually cleaned resident rooms until breakfast, then continued cleaning after breakfast and cleaned until lunchtime, then will do spot checks later in day. She stated there were usually 2-4 housekeeping staff with two staff members on each hall. She stated she had about half of the rooms on the 200-hall cleaned yesterday and then she was asked to start cleaning other areas and had not completed cleaning her rooms.

During the interview conducted on 12/07/22 at 3:40 PM the Administrator stated he expected housekeeping staff to clean the rooms daily. He

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 12/09/2022

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 584	Continued From page 10	F 584		

indicated the rooms should have been checked before housekeeping staff left for the day.

2). Initial observations on 12/5/22 at 11:30 AM revealed the privacy curtains in Rooms 101, 104, 106, 107 and 112 were soiled with scattered dark colored stains and dirt noted on the lower half of the curtains.
Further observations on tour of the facility on 12/5/22 at 11:45 AM revealed a strong urine odor at the threshold of Room 102. Once in the room, the odor was stronger and more pungent. There was an open laundry hamper filled with soiled cloth incontinence pads present in the room in front of the closet.

Observation on 12/5/22 at 4:34 PM revealed a strong odor of urine in and around Room 102. The open laundry hamper filled to the top with soiled incontinence pads was noted in front of the closet.
Interview on 12/5/22 at 4:40 PM with Nurse #4 revealed that one of the occupants of Room 102, Resident #50, was incontinent and family requested that resident not wear briefs. Resident #50 instead used cloth incontinence pads on the bed which the family provided and laundered. Nurse #4 stated the soiled pads were placed in the open laundry hamper in resident's room for the family to pick up twice per week.

Observation on 12/06/22 at 9:59 AM revealed a strong urine odor in Room 102.

Interview on 12/06/22 at 4:27 PM with Nurse #2

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 12/09/2022

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 584	Continued From page 11	F 584		

revealed that she had observed the strong urine odor in Room 102 for a while, and she was not aware of anything being done to eliminate the odor.

Observation on 12/7/22 at 1145 AM revealed a strong odor present in Room 102 and the hallway outside the room.

Interview on 12/07/22 at 5:21 PM with the Maintenance Director revealed he was responsible for the housekeeping and laundry services in the facility. The Maintenance Director revealed he was new to the facility and had only been in the position for a few months and the housekeeping staff were also new. The Maintenance Director stated the odor in Room 102 and the hallway around that room had been reported to him. The Maintenance Director stated he had replaced Resident #50's mattress but the room continued to have an odor. The Maintenance Director stated he ordered a new product to eliminate odor, but he had not received it. The Maintenance Director further revealed that he was aware of several privacy curtains being dirty and he was working on laundering or replacing them. He stated the privacy curtains were to be cleaned monthly and as needed.

Interview on 12/08/22 at 9:10 AM with Nurse #1 revealed that there was a strong urine odor in Room 102 but the resident in that room, Resident #50, used cloth pads for incontinence per the family request and there wasn't much the facility could do about the odor.

Interview on 12/8/22 at 9:30 AM with Nursing Aide (NA)#1 revealed that Room 102 had a urine odor since the cloth pads were started about a month

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 12/09/2022

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 584	Continued From page 12 ago for Resident #50 for incontinence. NA #1 stated the urine odor in Room 102 is from the pads and the mattress. Interview on 12/8/22 at 4:30 PM with the Administrator revealed that he expected that residents would have a clean, comfortable odor free environment including clean privacy curtains in each room. Interview on 12/09/22 at 11:45 AM with the Social Worker (SW) revealed that she had met with Resident #50's family member for a care plan meeting recently. Resident #50's family member requested that resident not wear a brief and instead use cloth pads for incontinence. SW stated that residents should have a pleasant odor free environment. SW stated that the soiled pads in the room should be double bagged and then placed in the laundry hamper to reduce the odor. Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) revealed that she expected that resident rooms would be free from urine odor and that the soiled cloth incontinence pads used in Room 102 would be bagged prior to being placed in the laundry hamper.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		1/4/23

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 12/09/2022

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 657	Continued From page 13 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update the comprehensive care plan to include the use of antipsychotic medications for 1 of 21 residents reviewed for care plans (Resident # 24). The findings included: Resident #24 was admitted to the facility on 5/3/13 with diagnoses to include Moyamoya disease (a rare, progressive cerebrovascular disorder caused by blocked arteries at the base of the brain) and vascular dementia with behavioral disturbance and bipolar disorder. Review of the electronic medical record (EMR) for Resident #24 revealed a physician's order dated 8/23/2022 for Zyprexa (an antipsychotic	F 657	The care plan was updated for resident #24 by the MDS nurse on 12/9/2022 to reflect antipsychotic use. On 12/12/2022 the MDS nurses audited all care plans for residents that were currently receiving antipsychotic medications to ensure care plan accuracy. The Director of Nursing will re-educate the MDS nurses on ensuring care plan accuracy and updating the care plans during the Clinical Morning Meeting by 12/30/2022. Order listing report will be reviewed by the DON 5x week for 12 weeks in the clinical morning meeting to identify resident with new antipsychotic orders and to verify that the care plans are being updated timely. Audits will be reviewed in the resident	

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 12/09/2022

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 657	Continued From page 14 medication) 5mg tablet, give 1 tablet by mouth at bedtime for dementia with behaviors, bipolar. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/10/2022 revealed Resident #24 was moderately cognitively impaired and was coded as having delusions, verbal and other behaviors 4-6 days per week. Resident #24 was assessed to be receiving antipsychotic medication 7 days a week. Review of the comprehensive care plan for Resident #24 updated 10/7/2022 did not reveal a plan of care for Resident #24 receiving antipsychotic medication. An interview was completed the MDS Coordinator #1 on 12/9/2022 at 10:40 AM. She stated that Resident #24 should have been care planned for receiving antipsychotic medication. The MDS Coordinator #1 further stated that it must have been overlooked when updating the care plan. An interview was completed with the Director of Nursing (DON) on 12/9/22 at 3:35 PM. The DON stated that she expected the care plans to be updated and new information added, and old information deleted as necessary.	F 657	review meeting weekly and monthly in the facility Quality Assurance Performance Improvement meeting. QAPI team may change the plan of action or extend the audits to ensure ongoing compliance.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		1/4/23

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 12/09/2022

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 684	Continued From page 15	F 684		

practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff, and Physician Assistant (PA) interviews, the facility failed to complete a neurological assessment to include a) current vital signs with each neurological assessment recorded and b) assessment of hand grasps and observation of changes in behavior for 1 of 1 resident reviewed for falls (Resident #50) .

Findings:
Resident #50 was admitted to the facility on 3/20/21 with medical diagnoses which included in part advanced dementia with behaviors.

Resident's 10/19/22 quarterly Minimum Data Set (MDS) assessment revealed that resident had severe cognitive impairment, exhibited no behaviors and had history of falls.

A review of an incident report documented by Nurse #1 on 11/2/22 at 6:00 PM revealed that the Nursing Assistant (NA) observed Resident #50 lying on the floor beside her bed with bleeding from the right side of the head above the temple region. As a result of the incident Resident #50 sustained skin tears to the left lower arm, the right knee, and the top of her scalp.
Review of Resident #50's November 2022 physician orders revealed resident did not receive an anticoagulant (blood thinning) medication.

A). Review of the Neurological (Neuro) check assessments for Resident #50 beginning on 11/2/22 at 6:00 PM which were recorded in the computer system revealed on 11/2/22 at 6:10 PM

On 12/29/2022 a neuro assessment was completed for resident #50 to include current vital signs, assessment of hand grasps and behaviors. No negative findings.
Neuro checks and vital signs were reviewed on 12/29/2022 for all falls that occurred after 12/9/2022. Any residents with missing or incomplete neuro checks were assessed by the DON. There were no negative findings.
The Director of Nursing will educate all nurses on assessment accuracy and obtaining vital signs per assessment schedule by 1/3/2022. All nurses that do not receive the education will be re-educated prior to working their next scheduled shift.
Neuro check assessments will be audited 5x a week for 12 weeks to ensure accuracy and completion. Any inaccurate documentation will result in resident re-assessment and one on one education with the assigned nurse. Audits will be reviewed in the resident review meeting weekly and monthly in the facility Quality Assurance Performance Improvement meeting. QAPI team may change the plan of action or extend the audits to ensure ongoing compliance.

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 12/09/2022

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 684	Continued From page 16	F 684		

the vital signs (VS) were recorded as blood pressure (BP) 130/68, respiratory rate 18, pulse rate 80 beats per minute. Neuro check assessments were documented in the computer system as every 15 minutes for 1 hour at 6:00 PM, 6;15 PM, 6:30 PM and 7:15 PM. The neuro check assessments were documented for every 30 minutes at 7:45 PM and 8:15 PM. Every hour neuro checks were documented at 10:45 PM, 11:45 PM, 12:00 midnight and on 11/3/22 at 12: 45 AM. Every 4-hour neuro checks were recorded on 11/3/22 at 4:45 AM, 8:45 AM, 12:45 PM and 4:45 PM. Every 8-hour neuro checks were recorded on 11/4/22 at 12:45 AM, 8:45 AM, and on 11/5/22 at 12:45 AM and 8:45 AM. Each vital sign recording on these assessments were recorded as BP 130/68, respiratory rate 18, pulse rate 80 beats per minute with the date listed as 11/2/22 and the time of 6:10 PM.

An interview was conducted on 12/7/22 at 9:30 AM with Nurse #1 who completed the incident report regarding Resident #50's fall on 11/2/22. Nurse #1 completed the neuro check assessments for Resident #50 on 11/2/22 and on 11/3/22. Nurse #1 stated new VS should have been obtained with every neuro check assessment.

An interview was conducted on 12/9/22 at 12:05 PM with Nurse # 6 who completed the neuro check assessments on 11/4/22 revealed she did not always obtain VS when she completed neuro checks and the previous VS that were recorded auto populated in the computer system. Nurse # 6 stated part of doing neuro check assessments was to obtain current VS with each assessment.

An interview was conducted on 12/9/22 at 12:15

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 12/09/2022

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 684	Continued From page 17	F 684		

PM with Nurse #3 who completed neuro checks for Resident #50 on 11/5/22 revealed that whenever a resident had an unwitnessed fall neuro check including a new set of vital signs with each assessment were required. Nurse #3 stated vital signs were not always taken with each neuro check, but they were supposed to be done.

Interview on 12/9/22 at 12:20 PM with the PA revealed that she expected that vital signs would be taken with each neuro check assessment following a fall.

Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) revealed that neuro checks were to be initiated at the time of a fall and best practice was to obtain vital signs with each neuro check assessment. DON stated the nurses could improve on this process.

B). Review of Neurological (Neuro) check assessments for Resident #50 beginning on 11/2/22 at 6:00 PM which were recorded in the computer revealed the following parts of the neuro assessment were not recorded:

1. 11/2/22 6:00 PM hand grasps and changes in behavior
2. 11/2/22 6:15 PM hand grasps and changes in behavior
3. 11/2/22 6:30 PM hand grasps and changes in behavior
4. 11/2/22 7:15 PM hand grasps and changes in behavior
5. 11/2/22 7:45 PM hand grasps and changes in behavior
6. 11/2/22 at 8:15 PM hand grasps and changes in behavior
7. 11/2/22 at 10:45 PM hand grasps, and changes in behavior

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 12/09/2022

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 684	Continued From page 18 8. 11/2/22 at 11:45 PM changes in behavior 9. 11/3/22 at 12:00 AM level of consciousness mental status, hand grasps, reflexes, and changes in behavior 10. 11/3/22 at 12:45 AM ability to communicate and changes in behavior 11. 11/3/22 at4:45 AM ability to communicate and changes in behavior 12. 11/3/22 at 8:45 AM ability to communicate, hand grasps, reflexes, and changes in behavior 13. 11/3/22 at 12:45 PM ability to communicate, hand grasps, and changes in behavior Interview on 12/7/22 at 9:30 AM with Nurse #1 revealed that neuro checks were to be performed for residents that sustained a witnessed or unwitnessed fall with suspected head injury. Nurse #1 stated that neuro checks consisted of an assessment of level of consciousness, hand grasps, changes in behavior and vital signs. Interview on 12/9/22 at 12:20 PM with the PA revealed that she expected that level of consciousness, changes in behavior and hand grasps as well as current vital signs would be assessed when neuro checks were performed. PA stated it was important to complete the assessment of a resident's neuro status following a fall. Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) revealed that she expected that the nurses would complete neuro checks including an assessment of the resident's level of consciousness, hand grasps and changes in behavior.	F 684		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		1/4/23

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 12/09/2022

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 692	Continued From page 19 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Registered Dietician, and Physician Assistant interviews the facility failed to obtain and record accurate weights and to identify and verify the accuracy of weights for 5 of 21 residents (Resident #26, #41, #52, #33, #58) reviewed for significant weight change. Findings included. 1). Resident #26 was admitted to the facility on 02/27/20 with diagnoses of congestive heart failure (CHF), diabetes, and chronic kidney disease.	F 692	On 12/29/2022 weights were obtained for residents 26, 52 and 33. Residents 41 and 58 are no longer in the facility. On 12/29/2022 the Director of Nursing reviewed each electronic medical record to ensure each resident had an appropriate weight order and that there were no recorded weights requiring follow up per facility policy. All nursing staff will be re-educated by the Director of Nursing on the facility weight policy and following physicians orders by 1/3/2023. The Director of Nursing will review all recorded weights weekly for 12 weeks to	

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 12/09/2022

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 692	Continued From page 20	F 692		

The Minimum Data Set (MDS) quarterly assessment dated 11/12/22 revealed Resident #26 required extensive assistance with activities of daily living. Resident #26 had weight loss and received a therapeutic diet.

Resident #26's care plan dated 11/14/22 revealed a risk for nutritional decline, dehydration, and weight fluctuations related to diagnoses of chronic kidney disease, vitamin deficiency, cardiac disease, and the need for a therapeutic diet with variable oral intake, diuretic use, significant weight loss, and history of malnutrition. The goal of care was for Resident #26 to maintain adequate nutrition and hydration status through the next review. Interventions included in part; Registered Dietician (RD) to evaluate and make diet change recommendations as needed, serve diet as ordered, and obtain weights per physician order.

A review of Resident 26's weights recorded in the medical record were as follows:

11/25/22 221.6 lbs.
11/28/22 221.6 lbs.
11/29/22 222.6 lbs.
11/29/22 222.6 lbs.
11/30/22 195.8 lbs.
12/03/22 195.8 lbs.
12/04/22 195.8 lbs.
12/05/22 198.8 lbs.
12/06/22 198.8 lbs.

Review of Resident 26's progress note dated 12/01/22 revealed a note from the Registered Dietician regarding weight change which documented Resident #26 had recent weight loss of 26 lbs. over 1 day. Lasix was increased for

ensure staff are obtaining weights per physician order and following facility weight policy. Any issues identified during the audits will be reported to the MD, the resident will be weighed and the nurse will received additional education. Audits will be reviewed in the resident review meeting weekly and monthly in the facility Quality Assurance Performance Improvement meeting. QAPI team may change the plan of action or extend the audits to ensure ongoing compliance.

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 12/09/2022

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 692	Continued From page 21	F 692		

bilateral lower extremity edema. He appears to be eating well at 50-100% of most meals. Some weight loss is anticipated given increase in diuretics. Continue with frequent weights. Continues with salt-restricted diet to reduce fluid retention. Monitor weights.

An interview was conducted on 12/07/22 at 2:40 PM with the Registered Dietician. She stated Resident #26 was reviewed in the IDT meeting, and the resident's intake was consistent, and it was determined the diuretic use contributed to his weight loss. She stated Resident #26 had a history of weight fluctuations, received frequent weight checks, and received nutritional supplements. She stated weight inconsistencies were reviewed in interdisciplinary team (IDT) meetings and the team would discuss if there were any nutritional issues and reason for substantial weight gain or loss and they had a nurse aide who consistently checked weights. She stated she reviewed the weight variance report weekly which triggered standard weight changes, and she communicated with staff through IDT meetings regarding interventions to be implemented. She stated Resident #26 had a diagnoses of heart failure and it would be significant that weights were recorded accurately. She indicated Resident #26's weight loss on 11/30/22 of 27 lbs. was not accurate.

An interview was conducted on 12/07/22 at 3:18 PM with Nurse Aide #5. She stated she was not the only nurse aide responsible for obtaining weights, and stated inconsistencies were due to residents being weighed in wheelchairs and staff not using the same scale or the leg rest may not have been on the chair at the time and the last weight obtained the resident could have been

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 12/09/2022

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 692	Continued From page 22	F 692		

weighed with both leg rests on the chair. She stated wheelchairs have two leg rests and a chair pad so those things not being included would make weights inaccurate causing wheelchair weights to vary. She stated she reviewed weights with the Director of Nursing (DON) daily and weekly and the DON lets her know who needs to be weighed. Nurse Aide #5 stated she reported weight changes to the nurse and the DON and then was instructed if a reweigh was needed.

An interview was conducted on 12/08/22 at 3:00 PM with the Physician Assistant (PA). She stated residents with significant weight change should be reweighed right away for accuracy and if it's a true weight change the PA or Physician should be notified. She stated Resident #26 had weight fluctuations and stated the weight loss on 11/30/22 of 28 lbs. over one day was inaccurate and a reweigh should have occurred that day.

An interview was conducted on 12/09/22 at 12:00 PM with the Director of Nursing along with the Administrator. They both stated weights should be accurate and that a reweigh should be obtained as soon as possible if there was a significant weight change.

2). Resident #41 was admitted to the facility on 10/08/19 with diagnoses to include congestive heart disease (CHF), cerebral vascular accident (CVA), diabetes, and vitamin deficiency.

The Minimum Data Set (MDS) annual assessment dated 10/10/22 revealed Resident #41 was cognitively intact and required extensive assistance with activities of daily living and supervision with eating. She had weigh gain and

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 12/09/2022

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 692	Continued From page 23	F 692		

received a therapeutic diet.

Resident 41's care plan dated 10/18/22 revealed a risk for nutritional decline related to history of CVA, vitamin deficiency, diabetes, and history of malnutrition and venous ulcers. The goal of care was to not continue to gain a significant amount of weight through the next review. Interventions included in part; Registered Dietician to evaluate and make diet change recommendations as needed, serve diet as ordered, and obtain weights per physician order.

A review of Resident 41's weights recorded in the medical record were as follows:

07/11/22 212.4 lbs.
07/11/22 202.6 lbs.
08/02/22 193.2 lbs.
08/08/22 194.6 lbs.
09/05/22 239.4 lbs.
10/11/22 240.6 lbs.
10/18/22 238.6 lbs.
11/07/22 228.6 lbs.

Review of Resident #41's progress note dated 08/04/22 revealed a note from the Registered Dietician regarding the weight change. The dietician documented she questioned the accuracy of 1 month weight loss as resident with two different weights on 07/11/22 recorded as 212.4# and 202.6#. The note documented a weight loss of 9.4 lbs. or 4.6% over 1 month based on 202# weight which is near significant. Resident #41's weight has ranged between 187-215 lbs. over 3 months. Receives a low concentrated sweets diet with regular/thin

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 12/09/2022

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 692	Continued From page 24	F 692		

consistencies. Resident #41's oral intake was mostly good. No edema per 07/16/22 and 06/11/22 nursing notes. Resident without significant changes in edema or oral intake to account for weight changes. Monitor weights closely.

An interview was conducted on 12/07/22 at 2:16 PM with the Registered Dietician. She stated Resident #41 did not appear to have any reason for weight fluctuations and believed the residents weight fluctuations were due to inconsistencies in obtaining weights.

An interview was conducted on 12/07/22 at 3:18 PM with Nurse Aide #5. She stated she was not the only nurse aide responsible for obtaining weights, and stated inconsistencies were due to residents being weighed in wheelchairs and staff not using the same scale or the leg rest may not have been on the chair at the time and the last weight obtained the resident could have been weighed with both leg rests on the chair. She stated wheelchairs have two leg rests and a chair pad so those things not being included would make weights inaccurate causing wheelchair weights to vary. She stated she reviewed weights with the Director of Nursing (DON) daily and weekly and the DON lets her know who needs to be weighed. Nurse Aide #5 stated she reported weight changes to the nurse and the DON and then was instructed if a reweigh was needed.

An interview was conducted on 12/08/22 at 3:00 PM with the Physician Assistant (PA). She stated residents with significant weight change should be reweighed right away for accuracy and if it's a true weight change the PA or Physician should be notified. She stated Resident #41 should have

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 12/09/2022

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 692	Continued From page 25	F 692		

been reweighed for accuracy.

An interview was conducted on 12/09/22 at 12:00 PM with the Director of Nursing along with the Administrator. They both stated weights should be accurate and that a reweigh should be obtained as soon as possible if there was a significant weight change.

3). Resident #52 was admitted to the facility on 06/16/21 with diagnoses of left below knee amputation, anemia, and renal insufficiency.

The Minimum Data Set (MDS) Quarterly assessment dated 09/22/22 revealed Resident #52 was cognitively intact and required extensive assistance with activities of daily living (ADLs). She received a regular diet with thin consistency and had no weight loss or gain.

Resident #52's care plan dated 09/22/22 revealed a risk for nutritional decline, dehydration, and weight fluctuations related to recent infection, chronic kidney disease, diuretic use, and history of weight loss. The goal of care was to remain adequately nourished and hydrated. Interventions included in part; to encourage adequate fluid intake, monitor weight per protocol and provide diet as ordered.

Review of Resident #52's progress note dated 12/07/22 revealed a Registered Dietician note indicating resident triggers for significant weight loss of 40 pounds (lbs.) or 15.8% over 6 months related to above knee amputation in June. Resident most recently triggers for significant weight loss of 12.2 lbs. or 5.4% over 1 week.

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 12/09/2022

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 692	Continued From page 26	F 692		

Resident has been pursuing weight loss as she would like to have fitting for prosthetic. Continue to monitor weights.

A review of Resident 52's weights recorded in the medical record were as follows:

06/06/22 252.8 lbs.
07/05/22 232.2 lbs.
08/03/22 225.0 lbs.
09/08/22 224.6 lbs.
10/12/22 225.6 lbs.
11/07/22 222.6 lbs.
11/29/22 224.8 lbs.
12/06/22 212.6 lbs.

An interview was conducted on 12/07/22 at 2:19 PM with the Registered Dietician. She stated Resident #52 had significant weight loss over 6 months ago due to having surgery for a below knee amputation and is on a weight loss regimen program at this time. She stated a 12 lb. weight loss was recorded in the electronic medical record on 12/06/22 which she thought was most likely a discrepancy and although she was on a weight loss program, she expected weights to be recorded accurately. She stated if it was a true weight loss there should have been a reweigh and a report to the nurse.

An interview was conducted on 12/07/22 at 3:18 PM with Nurse Aide #5. She stated she was not the only nurse aide responsible for obtaining weights, and stated inconsistencies were due to residents being weighed in wheelchairs and staff not using the same scale or the leg rest may not have been on the chair at the time and the last weight obtained the resident could have been

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 12/09/2022

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 692	Continued From page 27	F 692		

weighed with both leg rests on the chair. She stated wheelchairs have two leg rests and a chair pad so those things not being included would make weights inaccurate causing wheelchair weights to vary. She stated she reviewed weights with the Director of Nursing (DON) daily and weekly and the DON lets her know who needs to be weighed. Nurse Aide #5 stated she reported weight changes to the nurse and the DON and then was instructed if a reweigh was needed.

An interview was conducted on 12/08/22 at 3:00 PM with the Physician Assistant (PA). She stated residents with significant weight change should be reweighed right away for accuracy and if it's a true weight change the PA or Physician should be notified. She stated Resident #52 should have been reweighed for accuracy.

An interview was conducted on 12/09/22 at 12:00 PM with the Director of Nursing along with the Administrator. They both stated weights should be accurate and that a reweigh should be obtained as soon as possible if there was a significant weight change.

4). Resident #33 was admitted to the facility on 12/4/20 with diagnoses which included in part neurocognitive disorder with Lewy Bodies, Alzheimer's Disease, depression, and anxiety.

Resident #33's 10/12/22 Annual Minimum Data Set (MDS) assessment revealed resident was severely cognitively impaired, received a regular diet, had no weight loss or gain with a weight of

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 12/09/2022

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 692	Continued From page 28	F 692		

147#.

Resident #33's 10/13/22 care plan indicated a focus of increased risk for poor nutrition and included a goal of resident will maintain adequate nutrition and will be free from significant weight changes every month. Interventions included diet as ordered and monitor weight per protocol.

Review of Resident #33's progress notes revealed a 11/10/22 Registered Dietician (RD) note regarding weight loss and indicated to continue to monitor resident's weight.

Resident #33's wheelchair weights were recorded in the medical record as:
10/22/22 148.6 pounds (lbs.)
11/07/22 142.6 lbs.
11/29/22 189.8 lbs.
12/5/22 186.6 lbs.

Interview on 12/7/22 at 2:03 PM with Registered Dietician (RD) revealed a reweigh should have been completed when the first weight change was noted. RD stated there was no medical reason for the weight change recorded for Resident #33. RD stated she questioned the accuracy of the weights. RD stated there have been frequent fluctuations in residents' weights due to issues with the consistency of obtaining weights and one of the scales not functioning. RD further stated that weight inconsistencies were reviewed at a weekly interdisciplinary team meeting and the team discussed any nutritional issues or reason for substantial weight gain.

Interview on 12/7/22 at 2:57 PM with Nursing Aide (NA) #5 revealed that she was not always responsible for obtaining resident weights. NA #5

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 12/09/2022

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 692	Continued From page 29	F 692		

stated the Director of Nursing (DON) informed her who to obtain weights on for daily, weekly, and monthly weights. NA #5 stated the nursing aides on the floor do their own weights if she wasn't scheduled to do weights. NA #5 stated she reported weight changes to the nurse and DON and then was instructed if a reweigh was needed.

Interview on 12/7/22 at 3:44 PM with the Maintenance Director revealed the facility had a contract with a new company to service and calibrate the scales. The Maintenance Director indicated that one scale was not working, and he was waiting for a part to repair it. The Maintenance Director stated the scales were calibrated monthly.

Interview on 12/8/22 at 2:05 PM with PA revealed that residents with significant weight changes, gain or loss, should be reweighed right away. PA stated that accurate weights were essential to monitoring a resident's medical status. PA stated that most likely the weights recorded on 11/29/22 and 12/5/22 for Resident #33 were inaccurate.

Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) revealed she expected weights would be accurate and that a reweigh would be obtained as soon as possible if there was a weight loss or gain.

5). Resident #58 was admitted to the facility on 11/18/2022 with diagnoses to include

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 12/09/2022

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 692	Continued From page 30	F 692		

Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease), traumatic subarachnoid hemorrhage (traumatic brain injury), aphasia (difficulty with speech), and dysphagia (difficulty swallowing), and unspecified protein-calorie malnutrition. Resident #58 was discharged home with wife and outpatient therapy services on 12/6/2022.

Review of the EMR for Resident #58 included the following dates and weights:
1. 11/18/2022 at 4:56 PM the resident's weight was 188.0 pounds (lbs.) wheelchair scale obtained by Nurse #3
2. 11/22/2022 at 2:59 PM the resident's weight was 178.6 lbs. mechanical lift scale obtained by Restorative Aide

Review of the admission Minimum Data Set (MDS) assessment dated 11/24/2022 indicated that Resident #58 was severely cognitively impaired and required extensive assistance with eating.

Review of Resident #58's care plan dated 11/18/2022 revealed a plan of care for risk for nutritional decline, dehydration, and weight fluctuations related to ALS, aphasia, dysphagia, malnutrition, recent traumatic subarachnoid hemorrhage, variable oral intake, requires assistance with eating. Interventions included in part: monitor dietary intake; provide diet per order, monitor weight per protocol.

An interview was completed with the Restorative Aide on 12/7/2022 at 09:25 AM. The Restorative Aide stated that there were 3 ways to obtain weights on residents. She further stated that the mechanical lift was used to obtain weights for residents confined to their beds, wheelchair

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 12/09/2022

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 692	Continued From page 31	F 692		

weights for residents that cannot stand and standing weights for residents that can stand on the scale. The Restorative Aide further stated that she was not the only person that does the weights in the facility and there is no consistency for how the weights are obtained. The Restorative Aide indicated that she could see the previous weights for residents in the Point of Care documentation. The Restorative Aid stated that she was aware that the weight she obtained for Resident #59 was 10 lbs. less than his admission weight. She stated that she must have forgotten to reweigh Resident #58. She stated that if the residents with heart failure gained or lost more than 5 pounds, she would inform the nurse or the Director of Nursing (DON). The Restorative Aid further stated that if the weight was 10 pounds or more different from the previous weight, she would reweigh the resident.

An interview with the Physician occurred on 12/7/2022 at 11:50 AM. The Physician stated that if she had seen the weights, she would have asked for a reweigh to see if the weight was accurate. She further stated that weights were important especially if the resident has heart failure or malnutrition.

An interview was completed with Nurse #3 on 12/8/2022 at 12:27 PM. Nurse #3 stated that she was the nurse that admitted Resident #58 to the facility. She further stated that she had not weighed Resident #58 when he was admitted. Nurse #3 indicated that she had documented the weight listed on Resident # 58's hospital discharge papers as a "place holder" weight, until an admission weight was obtained. She stated that she had meant to strike out that weight when she obtained his weight, but she forgot.

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 12/09/2022

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 692	Continued From page 32 An interview was conducted with the Administrator on 12/8/2022 at 4:35 PM. The Administrator stated that he expected the weights to be correct for the residents. An interview was conducted with the DON on 12/8/2022 5:05 PM. The DON stated that she expected the residents' weights to be obtained within 24 hours upon admission and then weekly times 4.	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		1/4/23

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 12/09/2022

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 761	Continued From page 33 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to: 1) remove expired insulins from 1 of 2 medication storage rooms (200/300 hall) and 2) keep unattended medications stored in a locked compartment for 1 of 1 resident observed with medications at the bedside (Resident #49). Findings included. 1). An observation was conducted with Unit Manger #1 on 12/08/22 at 1:00 PM of the 200/300 hall medication storage room. The observation revealed two opened Novolin 70/30 (70 % intermediate acting/30 % short acting) insulin flex pens found in the medication storage refrigerator with handwritten opened dates of 10/14/22 on insulin pen #1 and 10/03/22 on insulin pen #2. A review of the manufacturer's storage instructions for Novolin 70/30 flex pen insulin revealed to discard 28 days after opening. An interview was conducted on 12/08/22 at 1:00 PM with Unit Manager #1. She acknowledged the insulin pens had expired and stated she thought she had discarded all of the expired medications in the medication room including the expired insulin pens in the refrigerator. She stated the insulin pens were for the same resident who did not require insulin injections very often. She stated the medication storage room including the refrigerators were checked at least weekly to discard any expired medications. She stated it was an oversight and she discarded the insulin pens immediately.	F 761	The cup of pills were removed from the room by the nurse on 12/7/2022. Expired medication was removed by the Director of Nursing on 12/9/2022. DON or designee will check the expiration dates and open dates of each medication on each medication cart by 12/30/2022. Any expired medications or undated multidose items will be removed from the cart and reordered. The DON/designee will educate each nurse using the Omnicare Medication Storage education and on ensuring each resident takes his or her medications prior to the nurse leaving the room by 1/3/2023. A copy of the Omnicare Medication Storage will be placed on each med cart for reference. DON/designee will audit each medication cart weekly for 12 weeks to ensure ongoing compliance. The DON/designee will observe 3 med passes weekly to ensure medications are being given per order and not left unattended at the bedside. Audits will be reviewed in the resident review meeting weekly and monthly in the facility Quality Assurance Performance Improvement meeting. QAPI team may change the plan of action or extend the audits to ensure ongoing compliance.	

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 12/09/2022

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 761	Continued From page 34	F 761		

An interview was conducted on 12/09/22 at 2:00 PM with the Director of Nursing (DON). She stated the expired insulin pens should have been discarded by the expiration dates.

2). Resident #49 was admitted on 12/16/20 with diagnoses which included in part: osteoporosis, dementia, chronic kidney disease and hypertension.

Review of Resident #49's 10/14/22 annual Minimum Data Set assessment revealed resident was cognitively intact.
Review of Resident #49's medication administration record (MAR) revealed resident received medications at 8:00 AM, 12:00, 4:00 PM and 6:00 PM daily.

Observation and interview on 12/8/22 at 9:10 AM of an unattended plastic medication cup with pudding with white and colored particles visible with a spoon in it on Resident #49's bedside table. Nurse #1, the nurse assigned to Resident #49 for the 7:00 AM to 3:00 PM shift on 12/8/22, verified that the plastic medication cup contained crushed medications mixed with pudding. Nurse # 1 stated that the plastic cup of medications must have been left from a prior shift medication pass and that she had not noticed it earlier when she was in Resident #49's room. Nurse #1 stated she had given Resident #49 her medications that morning and she did not recall having left medication on the bedside table. Nurse #1 stated medication should not be left at the bedside and that residents should be observed swallowing the medication before leaving the room. Nurse #1 placed the plastic medication cup in the trash can

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 12/09/2022

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 761	Continued From page 35 in Resident #49's room. Interview on 12/8/22 at 9:20 AM with Resident #49 revealed she did not remember when the medication cup was left on her bedside table but that one of the nurses must have left it for her to take. Interview on 12/8/22 at 9:30 AM with Nursing Aide (NA) #1 revealed that she had delivered Resident #49's breakfast tray earlier that morning and could not say for sure if the medication cup was on the bedside table at that time. NA #1 stated that if it had been there, it was probably because the nurse had left it for the resident to take. Interview on 12/08/22 at 03:25 PM with Nurse #2, the nurse assigned to Resident #49 for the 3:00 PM -11:00 PM shift on 12/7/22, revealed that she administered all of resident's medications crushed. Nurse #2 stated that she administered Resident #49's scheduled 4:00 PM and 6:00 PM medications crushed mixed in pudding on 12/7/22 and did not recall any problem or that she had left the medication cup with the crushed medications on resident's bedside table. Nurse #2 stated she usually handed Resident #49 the spoon with the pudding and crushed medications for the resident to take herself. Interview on 12/09/22 at 12:30 PM with the Director of Nursing (DON) revealed that she expected that medications would not be left at the bedside. DON stated that she expected that medications be administered when prepared and that the resident would be observed taking and swallowing the medications.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		1/4/23

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 12/09/2022

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 804	Continued From page 36 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations and staff and residents interviews the facility failed to provide foods at a temperature according to residents' preferences and to maintain palatability for 4 of 8 residents reviewed for food palatability (Resident #59, Resident 215, Resident #6, and Resident #3). Findings included: Review of the Resident Council Meeting Minutes revealed the following information: - A meeting conducted on 9/29/22 indicated the food was cold and residents wanted different kinds of snacks. - A meeting conducted on 10/31/2022 indicated the new Dietary Manager met with residents to talk about the trays not getting passed out when meal carts are delivered to the halls. - A meeting dated 11/16/2022 indicated the food was still cold. An observation and interview of Nurse Assistant (NA) #9 passing trays on the 200 long hall occurred on 12/6/2022 at 12:30 PM. NA #9 was the only staff member observed passing trays on	F 804	Repairs were made on the pellet warmer and was heating properly prior to survey exit. Food committee meeting was scheduled for January 3 to discuss food palatability and food concerns. A select menu program was implemented to allow residents greater flexibility in food selection on December 12, 2002. Dietary manager was educated on December 29, 2022 by the Regional Dietician on the importance of preparing foods that is well seasoned and acceptable to the residents stressing the menus and recipes provided. The dietary staff will be educated by 1/3/23 by dietary manager on the service of hot and cold food. The nursing staff will be educated by 1/3/2023 on providing meal trays timely to ensure meals are served warm and on the process of safety reheating food. The Admin Team will be educated by the Administrator on All Hands On Deck Program by 1/3/2023. The dietary manager or designee will temperature check 5 test trays a week for	

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 12/09/2022

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 804	Continued From page 37	F 804		

long hall from an insulated meal cart and it took her 23 minutes to deliver trays to 19 residents. NA #9 stated there were 3 NAs working on the 200 hall today. She further stated that 1 NA was assisting residents eating in the dining room, and 1 NA was passing trays on the short hall and she was passing meal trays on the long hall. NA #9 indicated that it usually took at least 20 minutes to pass out the meal trays.

Observation on 12/07/22 of the lunch meal served on 100 hall revealed the enclosed meal cart for rooms 111-101 arrived on the hall at 12:45 PM. The last tray was served at 1:05 PM. The test tray was tasted for palatability with the Dietary Manager present. When the dome lid was removed from the plate there was no steam coming off the plate. The cabbage was hard and had a bitter taste, the potatoes were salty, and the kielbasa was cold.

A test tray was sampled on 12/7/2022 at 12:30 PM. The food was barely warm, the cooked cabbage was crunchy and not cooked all the way through, the potatoes were mashed with skins on and were very salty.

An observation of NA #7 passing meal trays to 18 residents on the 200 long hall occurred on 12/8/22 at 12:25 PM. NA #7 was observed serving the last meal tray at 12:47 PM.

An interview was completed with the Dietary Manager (DM) and the Regional Registered Dietician (RD) on 12/7/2022 at 3:45 PM. The DM stated she was the 6th Dietary Manager the facility had hired since the DM that was a chef retired in April. She stated that she was trying to improve the quality of the food and the meal cart

12 weeks to ensure food is served at appropriate temperature. The dietary manger or designee will also interview five alert and oriented residents weekly for 12 weeks for acceptance of meal palatability. Audits will be reviewed in resident review meeting weekly and monthly in QA meeting. Plan may be changed or extended to ensure ongoing compliance.

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 12/09/2022

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 804	Continued From page 38	F 804		

delivery process so the food would not be cold when it was served.

Resident #59's 11/15/22 Minimum Data Set (MDS) assessment indicated resident was cognitively intact.

Interview on 12/5/22 at 10:50 AM with Resident #59 revealed he was not feeling well this morning because he was nauseated. He further stated that the nurse had given him medication for the nausea. Resident #59 stated he was glad he was going home on 12/9/2022 because the food was horrible here. Resident #59 indicated that the food was always cold and usually not the meal he ordered.

An observation and interview were completed with Resident #59 on 12/7/2022 at 5:00 PM. Resident #59 was sitting up on the side of his bed eating dinner and his Responsible Party (RP) was standing beside him. Resident #59 stated that his RP brought him a "home cooked" meal for dinner. He further stated that the RP would usually bring him dinner because he didn't like the food he's served at the facility. Resident #59 indicated that the food didn't taste good, and it was usually cold. Resident #59 stated that he would usually eat his breakfast because it tasted good.
An observation and interview were conducted with Resident #59 on 12/8/2022 at 1:00 PM. Resident #59 was sitting up in his wheelchair and his lunch tray was still on the overbed table. Observation of the meal tray revealed 1 bite out of the bar-be-que sandwich, the cottage cheese was untouched, and the bowl of broccoli cheese soup had a small amount consumed. Resident #59 stated that the bar-be-que sandwich had no taste to it, he didn't like cottage cheese, and the

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 12/09/2022

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 804	Continued From page 39	F 804		

soup was cold.

An interview with the Administrator was conducted on 12/8/2022 at 4:40 PM. He stated that his expectation was for the meal trays to get passed out in a timely manner, so the food was not cold when received by the residents and the taste of the food was palatable.

Resident #215 was admitted to the facility on 12/1/2022.

An interview was conducted with Resident #215 on 12/7/2022 at 12:30 PM. Resident #215 stated that for lunch she had ordered the pizza, a salad, and a crispy rice treat. Resident #215 further stated that the pizza was black around the edges and the crust was too hard to bite into, but the salad was good and so was the crispy rice treat.

An interview with the Administrator was conducted on 12/8/2022 at 4:40 PM. He stated that his expectation was for the meal trays to get passed out in a timely manner, so the food was not cold when received by the residents and the taste of the food was palatable.

Resident #6 was admitted to the facility on 7/19/18.

Resident #6's 11/9/22 quarterly Minimum Data Set (MDS) assessment revealed resident had mild cognitive impairment.

A meal observation and interview on 12/7/22 at 1:15 PM with Resident #6 revealed that she had received kielbasa, potatoes, and cabbage for lunch. Resident #6 stated her lunch was "so so."

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 12/09/2022

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 804	Continued From page 40	F 804		

Resident #6 indicated that the cabbage was not good and most of the time the food was cold.

Interview on 12/7/22 at 1:20 PM with Resident #3 revealed that her lunch of kielbasa, potatoes and cabbage was okay stating the potatoes tased salty. Observation of Resident #3's meal tray revealed she had consumed a small amount of the potatoes and cabbage and a few bites of kielbasa. Resident #3 stated she got cold food all the time and if she couldn't eat it, she ate snacks her family provided.

Interview on 12/08/22 at 3:45 PM with the Dietary Manager (DM) revealed that she was new to the facility and was in the dietary manager position since October 2022. DM indicated that she was aware of resident concerns regarding cold food, and she tried to address individually with each resident. DM stated that she was trying to improve the quality of the food and the meal cart delivery process so the food would not be served cold.

Interview on 12/08/22 at 4:35 PM with the Administrator revealed that he expected that food would be palatable and served at appropriate temperatures per resident preference. The Administrator further stated that he expected that food would be reheated as necessary.

Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) revealed that she expected that food would be served at temperatures according to resident preferences. DON stated that she expected that hot foods would be served hot and cold foods would be served cold.

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 12/09/2022

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 804	Continued From page 41	F 804		

Resident #3 was admitted to the facility on 9/25/13.

Resident #3's 9/29/22 annual Minimum Data Set (MDS) assessment indicated resident was cognitively intact.

Interview on 12/8/22 at 9:00 AM with Resident #3 revealed that she had not eaten her eggs because they were cold when she received her tray.

Interview on 12/07/22 at 3:15 PM with the Regional Registered Dietician revealed food temperatures were checked when the meals left the tray line and were within range. Regional RD stated food should be palatable and at an appropriate temperature per the resident preferences when it was served. Regional RD stated it was a problem if the residents stated the food was cold.

Interview on 12/08/22 at 3:45 PM with the Dietary Manager (DM) revealed that she was new to the facility and was in the dietary manager position since October 2022. DM indicated that she was aware of resident concerns regarding cold food, and she tried to address individually with each resident. DM stated that she was trying to improve the quality of the food and the meal cart delivery process so the food would not be served cold.

Interview on 12/08/22 at 4:35 PM with the Administrator revealed that he expected that food would be palatable and served at appropriate temperatures per resident preference. The Administrator further stated that he expected that

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 12/09/2022

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 804	Continued From page 42 food would be reheated as necessary. Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) revealed that she expected that food would be served at temperatures according to resident preferences. DON stated that she expected that hot foods would be served hot and cold foods would be served cold.	F 804		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to honor food preferences for 3 of 5 residents (Resident #34, #59, #215) reviewed for food preferences. Findings included. 1). Resident #34 was admitted to the facility on 06/28/19 with diagnoses to include hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, and diabetes.	F 806	On 12/30/2022 the dietary manager completed a Dietary History and Preference for resident 34. Residents 59 and 215 are no longer in the facility. Food Committee meeting was scheduled for 1/3/2023 to discuss Dietary Preferences with residents that choose to attend. The dietary manager was educated on 12/29/2022 by the regional dietary manager on obtaining the dietary history and preference on admission, quarterly and as needed to meet the needs of the residents. The dietary manager will	1/4/23

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 12/09/2022

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 806	Continued From page 43 A physician order dated 12/07/20 revealed Resident #34 was to receive a low concentrated sweets (LCS) diet, with Regular texture, Thin consistency. A care plan dated 04/1/21 revealed Resident #34 was at risk for nutritional decline, dehydration, and weight fluctuations related to history of stroke, congestive heart failure, diabetes, the need for a therapeutic diet, and edema status. The goal of care included in part to be free of significant weight changes. Interventions included in part; to encourage adequate fluid intake, monitor dietary intake and provide diet as order. The Minimum Data Set (MDS) quarterly assessment dated 10/14/22 revealed Resident #34 was cognitively intact. She had no rejection of care and required extensive assistance with activities of daily living and was independent with set up assistance for eating. She had impaired range of motion on one side and received a therapeutic diet. A meal observation conducted on 12/07/22 at 1:30 PM revealed Resident #34 was served potatoes, sausage, and cabbage. When asked if she enjoyed her lunch, she stated they served her cabbage and stated she I didn't like cabbage and it was on her meal ticket that she disliked cabbage. A review of her meal slip revealed her dislikes included fish and cabbage. She stated this was not the first time she had been served cabbage on her meal tray. An interview was conducted with the Dietary Manager on 12/08/22 at 2:00 PM. She stated she had been the dietary manager since October	F 806	educate the dietary staff prior to 1/3/2023 on the importance of following the preference list on the resident meal tickets. Dietary manager or designee will conduct 5 tray card audits 5x week for 12 weeks to ensure resident preferences are honored. Any issues identified will be corrected immediately. Audits will be reviewed in the weekly resident review meeting and monthly in QAPI meeting for 3 months. QA team may change the plan or extend the audits to ensure ongoing compliance.	

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 12/09/2022

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 806	Continued From page 44	F 806		

2022. She stated there were two fairly new dietary aides working yesterday on 12/07/22 and stated they didn't pay attention to the dislikes on the resident's meal ticket. She stated she would have to provide education again on ensuring food preferences were honored which included looking at the meal tickets when plating the food.

During an interview conducted with the Director of Nursing (DON) along with the Administrator on 12/09/22 at 3:00 PM. They both stated they expected resident food preferences to be honored and Resident #34 should not have been served foods on her dislike list.

2. Resident #59 was admitted to the facility on 11/9/2022 and most recently readmitted to the facility on 11/28/2022.
Review of the admission Minimum Data Set (MDS) assessment dated 11/15/2022 revealed Resident #59 was cognitively intact.

An interview was completed with Resident #59 on 12/8/2022 at 1:00 PM. Resident #59 stated that he had not received a menu yesterday so he could order his lunch for today. Resident #59 indicated that no one had ever explained to him why he didn't receive the meal he requested. He explained this had been a problem for him previously that he requested a meal from the menu but was served a different meal.

An interview was completed with Resident #59 on 12/9/2022 at 11:35 AM. Resident #59 stated that he had ordered a hamburger with lettuce and tomato, potato chips, and chocolate ice cream for dinner last night and he was served chicken

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 12/09/2022

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 806	Continued From page 45	F 806		

goulash, cheese puffs, and fruit cocktail. Resident #59 stated that he was really looking forward to the chocolate ice cream last night but had to eat fruit cocktail because he didn't like anything else that was served. Resident #59 further stated that he had not asked the staff for chocolate ice cream. He indicated that he did not like to complain.

An interview was completed with Nurse Assistant #8 on 12/7/2022 at 9:15 AM. NA #8 stated that the Dietary staff brought the menus for the residents and left them in a designated basket at the nurses' stations around 3:00 PM every day. She further stated the NAs were responsible for assisting the residents with filling out the menus for the next day. NA #8 indicated that there were times in the last few months that the menus did not get delivered to the nurses' stations, but she thought it was getting better.

An interview was completed with the Dietary Manager (DM) and the Regional Registered Dietician (RD) on 12/7/2022 at 3:45 PM. The Regional RD stated they were initiating a new system for the residents to order their meals today. The Regional RD further stated that a new dietary menu sheet would be delivered tonight to the residents that just required the NA to circle the residents' choice for meals instead of writing out each item separately. The DM stated that the new system was being implemented because residents had been complaining they were not getting the meals they preferred.

An interview with the Administrator was conducted on 12/8/2022 at 4:40 PM. He stated that his expectation was for Dietary to honor the resident's food preferences, likes, and dislikes.

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 12/09/2022

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 806	Continued From page 46	F 806		

3. Resident #215 was admitted to the facility on 12/1/2022.

An interview and observation of Resident #215 was completed on 12/7/2022 at 08:54 AM. Resident #215 was sitting up on the side of the bed with her breakfast tray on the overbed table. Resident #215 was alert and oriented to person, place, and time and was able to communicate her needs. Resident #215's breakfast tray was observed to have scrambled eggs, toast, and orange juice and coffee. Resident #215 stated she was hoping she would have pancakes (pancakes were available) for breakfast today. She further stated that she was receiving a sugar substitute instead of real sugar and she didn't like it. Resident #215 indicated that no one had asked her what she wanted to eat for meals, and she had never seen a menu or filled one out.

An interview was conducted with Dietary Manager (DM) on 12/7/2022 at 09:07 AM. The DM stated it was the nurse assistants'(NA) responsibility to get the residents' menus filled out the day before and turned back into dietary. She further stated that she had not had a chance to talk to Resident #215 yet about her preferences, likes, and dislikes but she would this morning.

An interview was conducted with the DM and the Regional Registered Dietician (RD) on 12/7/2022 at 3:45 PM. The DM stated that she was the 6th DM the facility had hired since the DM that was a chef retired in April and that she had only been the DM for 1 month. The Regional RD stated that newly admitted residents should have their Dietary assessment for food preferences, likes, and dislikes completed within 48 hours of

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 12/09/2022

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 806	Continued From page 47 admission. The DM stated that she had been so busy, and she had not had a chance to see Resident #215 and complete the Dietary assessment until today. An interview was completed with the Administrator on 12/8/2022 at 4:40 PM. The Administrator stated that his expectation was for Dietary to serve meals that honors the resident's preferences, likes, and dislikes.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired items from 1 of 1 dry goods storage area, failed to label and date items in 1 of 1 reach-in coolers, 1 of 1 walk-in	F 812	All foods that were found to be undated were removed and discarded. On 12/26/2022 all refrigerators and dry food storage areas were checked by the	1/4/23

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 12/09/2022

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 812	Continued From page 48 refrigerators, 1 of 1 walk-in freezers and 1 of 2 nourishment rooms. This practice had the potential to affect the food served to the residents. The findings included: 1. Initial observation of the kitchen reach in cooler on 12/5/22 at 10:50 AM revealed items which were opened with no use by label: - a container of nectar thick apple juice - a container of nectar thick water - a container of nectar thick iced tea - a container of nectar thick cranberry juice - a container of honey thick water - a container of honey thick iced tea - a container of honey thick cranberry juice 2. Initial observation of the dry storage on 12/5/22 at 10:55 AM revealed: - a plastic bag filled with packets of instant thickened coffee with an expiration date of 9/17/22 3. Initial observation of the walk-in refrigerator on 12/5/22 at 11:05 AM revealed the following items with a date not specified as opened or discard date: - An opened plastic bag of salad mix with a date of 11/11/22 written on the plastic bag. - An opened plastic bag of sliced deli turkey with a date of 11/11/22 written on the plastic bag. - An opened plastic bag of sliced deli ham with a date of 11/27/22 written on the plastic bag. - An opened package of shredded cheese with a date of 11/11/22 written on the plastic bag. 4. Initial observation of the walk-in freezer on 12/5/22 at 11:10 AM revealed the following items	F 812	Dietary Manager and any opened undated foods were discarded. The Dietary Manager was educated by the Regional Dietary Manager on 12/29/2022 concerning the importance of proper food storage and labeling. The Dietary Manager will education the dietary staff by 1/3/2023 on the importance of discarding out of date foods and proper food storage. All nursing staff will be educated by the DON or designee on the importance of labeling all resident food items in the nourishment rooms and proper food storage. All food storage areas will be audited 5x week for 12 weeks to ensure foods are stored and labeled properly and that expired foods have been removed. Any opened and undated foods as well as expired foods found during the audits will be removed. Audits will be reviewed in the weekly resident review meeting and monthly in QA for 3 months. Plan may be changed or extended to ensure ongoing compliance.	

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 12/09/2022

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 812	Continued From page 49	F 812		

with no opened or discard date:
- an opened package of hamburger patties
- an opened box of biscuits

Interview on 12/5/22 at 11:20 AM with Cook #1 revealed that he was new to the position at the facility. Cook #1 stated he thought the procedure for labelling foods was to record a date 7 days from the day it was opened and that was the discard date. Cook #1 further stated the dietary staff had been working on checking the dates on food items for any expired items.

Interview with the Dietary Manager on 12/05/22 at 04:25 PM revealed that she was new to the position as of about a month ago. DM further stated the procedure for labelling food to store once opened it was that it was to be wrapped in plastic and labelled with an opened and a discard date. DM further stated she had new employees in the dietary department that required education regarding the process of labelling food items and to check the expiration dates frequently.

5. Observation of the 100-hall nourishment room on 12/06/22 at 10:20 AM revealed the following:
- An opened container of honey thick tea dated 11/22/22.
- An opened bottle of nectar thick tea dated 10/8/22.
- An opened container of strawberry ice cream with no name or date.
- A plastic container of cantaloupe with no name and a date of 12/1/22.

A sign was observed on the refrigerator which stated: Daily checks. All food must have a name and date. Any unmarked items or opened food older than 3 days will be discarded.

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 12/09/2022

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 812	Continued From page 50 Interview with the Administrator on 12/08/22 at 4:32 PM revealed that his expectation was that the dietary department ensured that there were no expired items served and that all food would be labelled and documented properly. The Administrator further stated that he expected that all out of date items would be discarded immediately. He stated that there had been turn over in the dietary department and that a process for checking items in all areas of the kitchen was needed as well as education of all dietary staff on the procedure for labelling and dating foods.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation surveys of 9/23/21. This was for 1 deficiency cited in the area of label and store drugs and biologicals (F761) cited on the current recertification and complaint investigation survey of 12/9/22. The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	For the cited deficiency F761 the cup of pills were removed from the room by the nurse on 12/7/2022. And the expired medication were removed by the Director of Nursing on 12/9/2022. The facility has changed the monitoring of implemented interventions by the QAPI committee to monitoring results weekly. All residents have the potential to be affected by this deficient practice, therefore moving forward, the findings from the audits will be reviewed weekly by the QAPI committee to ensure compliance with implemented measures for F761.	1/4/23

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 12/09/2022

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 867	Continued From page 51 Findings included: This tag is cross referenced to: F761 Based on observations, and staff interviews the facility failed to: 1) remove expired insulins from 1 of 2 medication storage rooms (200/300 hall) and 2) keep unattended medications stored in a locked compartment for 1 of 1 resident observed with medications at the bedside (Resident #49). During the recertification and complaint survey completed on 9/23/21 the facility failed to discard expired medications, keep medication cart drawers free of loose medications and discard expired medication in medication storage rooms. Interview on 12/9/22 at 12:30 PM with the Director of Nursing (DON) revealed that there was room for improvement and education in the area of medication storage. Interview on 12/9/22 at 2:20 PM with the Administrator revealed that the QAPI meeting was held monthly, and Quality Assurance (QA) activities and outcomes were discussed. He indicated housekeeping and dietary were two areas that the QA program prioritized for improvement and ongoing education. He indicated medication storage had not been a focus area for their QA program.	F 867	Education was provided to the IDT by the Regional Director of Clinical Services on the federal regulation of QAPI on 1/3/2023. Starting the week of 1/2/2023, a QAPI meeting (Resident Review) form will be completed each week to show compliance data for the plan of correctio for F761 for 12 weeks. The results of the audits will be forwarded to the facility QAPI committee weekly for further review and recommendations. The facility Administrator is responsible for compliance.	