DEPARTMENT OF HEALTH AND HUMAN SERVICES.

JUN 0.2 2014.

PRINTED: 05/23/2014

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO, 0938-03
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345557	B. WING		C 05/15/2014
NAME OF PE	ROVIDER OR SUPPLIER		- 1	TREET ADDRESS, CITY, STATE, ZIP CODE	
	· · · · · · · · · · · · · · · · · · ·		. : :	800 INDEPENDENCE BOULEVARD	
AZALEA H	EALTH & REHAB CENT	ER	1	NILMINGTON, NC 28412	
(X4) ID PREFIX TAG	· (EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	·			The standard has	
			·	This plan of correction is prepared be	
F 309	1	ARE/SERVICES FOR	F 309	required by State and Federal law an	
SS=G	HIGHEST WELL BE	ING		because Azalea Health and Rehabilit	
1			1 .	Center agrees with the allegations ar	
	Each resident must r	eceive and the facility must		on this Statement of Deficiencies . As	
		ry care and services to attain		Health and Rehabilitation Center doe	
		est practicable physical,		any deficiency is present. Further the	
٠.	mental, and psychos		1	submission of a Plan of Correction ar	
-		comprehensive assessment		changes in any policy, procedure or	activity is
	and plan of care.	grander of the series of the series		not an admission of a deficiency.	- 11.
	,		1		
				This plan of correction shall operate	as Azalea
	This DEOLIDEMEN	T is not met as evidenced		Health and Rehab written credible all	egation of
	by:	I is not met as evidences		compliance effective 5/30/14	
	Based on record re-	view and staff interviews the ire that staff reported an			1 1
	incident when a resi	dent's leg was caught under	1	At the time of the complaint	euruau Rae
		nsfer resulting in delayed	F309		
1.0	treatment for a fract	ured leg for 1 (Resident #1) of		# 1 had already received treatment	or me injury
	3 sampled residents	reviewed for transfers and		Facility had conducted thorough inv	
	fall related injuries.	TOTIONOU TOT TOTIONOU WITE		starting on 5-2-14. Internal investiga	ATION
	ion related injunes.			determined a C.N.A used an inappr	opriate
• :	The findings include	d:		transfer and failed to report to the ne	irse. The
	mienigo monas			C.N.A was terminated 5-6-14	
	Resident #1 was ad	mitted to the facility on	1	In-service to nursing staff on require	
		ses that included a history of		report immediately any incident or u	nusual
	Polio, Paralysis, Dia	betes and Coronary Artery		5-30-14	
	Disease.		,	CNA's were re-educated via their jo	b description
	-:		1	on reporting all changes in resident	s condition,
		ited 3/21/14 revealed the		incident and accidents via the Stop	
	resident was to be t	ransferred with the assist of		(Interact) 8/20/14	
	one to two persons.			DON will audit 24 ° risk report and r	eview all
				Stop and Watch Tool as indicated for	
	The Admission Min	mum Data Set (MDS)		and PRN.	
		4/1/14 revealed the resident		24° Reports and the Stop & Watch	lools will be
1	had short and long	term memory loss and was	'	taken to QA/QI for review and with	
		ely impaired. The MDS		variances the plan of correction will	
	royooled the reside	nt required extensive		variances the plan of correction will	De reviseu.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

revealed that with surface to surface transfers the

revealed the resident required extensive assistance of one person for transfers. The MDS

(X8) DATE

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

5/31/14

PRINTED: 05/23/2014 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WNG 05/15/2014 345557 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3800 INDEPENDENCE BOULEVARD AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) F309 At the time of the complaint survey, Res. F 309 Continued From page 1 F 309 # 1 had already received treatment for his injury . resident was not steady and only able to stabilize Facility had conducted thorough investigation with staff assistance. The MDS revealed the starting on 5-2-14. Internal investigation resident used a wheelchair for mobility and had determined a C.N.A used an inappropriate experienced no recent falls. transfer and failed to report to the nurse. The The Care Area Assessment (CAA) for Falls dated C.N.A was terminated 5-6-14 4/2/14 revealed the resident did not attempt to get In-service to nursing staff on requirement to out of bed, had a long history of Polio with report immediately any incident or unusual Paralytic Syndrome and had been bed bound for many years. CNA's were re-educated via their job description on reporting all changes in resident's condition, A Witness Statement of Incident/Accident or incident and accidents via the Stop & Watch tool Injury of Unknown Orlgin by the Administrator (Interact) 8/20/14 dated 5/2/14 revealed the RP for Resident #1 DON will audit 24 ° risk report and review all came to the administrator 's office on the Stop and Watch Tool as indicated for 4 weeks morning of 5/2/14 saying the staff had broken the and PRN. resident's foot. The statement revealed the RP stated the resident told her his foot got caught in 24° Reports and the Stop & Watch tools will be the wheelchair and the NAs did not stop to taken to QA/QI for review and with any dislodge it but kept pulling until his foot was free. variances the plan of correction will be revised. The statement revealed the RP stated she told 5/31/14

A nursing progress note dated 5/2/14 at 10:23 AM revealed at 8:30 that morning the resident 's Responsible Party (RP) reported that Resident #1 had swelling and pain in the left foot that increased with movement. The Nurse documented the resident had pain of the left lower extremity at a level of 4 on a pain scale of 0-10, 0 being no pain and 10 being unbearable pain. The progress note revealed the administrator and the physician's assistant (PA)

the nurse last night on the 3PM-11PM shift. The statement revealed the RP was accompanied to the nurse 's station by the administrator and the resident 's nurse was questioned about an incident with the resident 's foot but the nurse

was not aware of such an incident.

NAME OF PROVIDER OR SUPPLIER 34857 AZALEA HEALTH & REHAB CENTER SITREET ADDRESS, CITY, STATE, ZIP CODE 3500 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 WILMINGTON, NC 28412 PREFX REGULATORY OR LSC IDENTIFYING INFORMATION) FOR JO CONTINUED FROM THE STATE OF CONTINUED IN PROVIDER PLANDER P		F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DEPARTA	MENT OF HEALTH AN	ID HUMAN SERVICES			Leading to the transfer of the		FORM	: 05/23/2014 I APPROVED : 0938-0391
STATEMENT O	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345557	B, WING	, .			1	0 15/2014
NAME OF PE	OVIDER OR SUPPLIER			· st	REET ADDRESS, CITY, STATE, Z	IP CODE		, ,
NAME OF FR	TOVIDER OR SOFT MEN			38	00 INDEPENDENCE BOULEVA	RD		
AZALEA H	EALTH & REHAB CENT	ER			ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix .	PROVIDER'S PLAN (EACH CORRECTIVE CROSS REFERENCED DEFICE	ACTION SHOULD TO THE APPROPR	BE .	(X6) COMPLETION DATE
						· · ·		
F 309	Continued From pag	e 3	- F	309				
	fracture of the left tib	ia. The note revealed repeat	1			-		
	x-rays were done du	ring the visit that showed a						
	non-displaced fractu	re with excellent alignment.				.*.	7.	
	,		:	ı				
	On 5/14/14 at 2:35 P	M an interview was		- 1		٠.		1
. ,		urse assigned to Resident	-	. [
	#1 on 5/1/14 on the	3PM to 11PM shift. Nurse #1	1					
	stated the resident	s RP frequently asked for		:		100		."
		he resident. The Nurse		- 1		- '		
		uld assess the resident for	-]					
	pain he would say he	e had no pain or would not						
	say anything. The N	urse stated on 5/1/14 the RP				•		
		's ankle was swollen and		- 1	*. * · · .		1	
	asked if he could ha	ve anything for pain. The	1			· · · · .	100	
	Nurse stated there v	vere PRN (as needed) pain				• :	100	
* ;		for the resident. The Nurse				1	;	
	stated she assessed	the ankle and leg by	.			•		
	palpating the area a	nd inspecting for redness,	ì					
	swelling and heat. T	he Nurse stated there was no				-		
	obvious swelling of t	he ankle or leg and when she	1			-		İ .
	moved the leg the re	esident did not complain of		٠.				
	pain. The Nurse sta	ted the RP grabbed the						
	resident 's leg and	he resident winced but she	1					
-		with the way the RP grabbed				-		
	an injury to the resid	stated she was not aware of dent's ankle or leg.						
								1.
_	NA#1 stated in a te	lephone interview on 5/14/14]		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	- : :		1 .
_	at 3:20 PM that duri	ng a transfer on 5/1/14 the	1.					
	resident 's leg was	stuck under the bed. The NA	-		/			
	stated the resident	denied pain and told her he						
	was OK. The NA sta	ated she was going to tell the						1.
	nurse about the inci	dent but something came up						
	with another resider	nt and sne torgot.	-					
	The Disserted of New	ning (DON) stated in an				_		
. '	The Director of Nur	sing (DON) stated in an		-			-	
	interview on 5/14/14	4 at 3:30 PM that as part of						
	their plan of correct	ion, the nursing staff had been				,	,	
	in-serviced that the	NAs (nursing assistants) were			1			

PRINTED: 05/23/2014 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING . С 05/15/2014 B. WING 345557 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3800 INDEPENDENCE BOULEVARD AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 309 Continued From page 4 F 309 to report immediately any injury or medical concerns to the nurse and the nurse was to report any injury of unknown origin to the DON or the administrator. The DON stated the staff monitored care on a daily basis but did not include specific monitoring in the plan of correction. The DON stated she had added monitoring the plan of correction and provided a copy of the plan of correction with handwriting at the top that read: "Revised 5/14/14 to include Res. # 1 had already been reassessed F323 for appropriate transfer method to mechanical lift monitoring. " 483.25(h) FREE OF ACCIDENT F 323 prior to the complaint survey HAZARDS/SUPERVISION/DEVICES SS=G 5/7/14 Resident care cards were reviewed at the time The facility must ensure that the resident of the notification of the incident on 5/2/14 and environment remains as free of accident hazards have been re-audited for appropriate transfer as is possible; and each resident receives adequate supervision and assistance devices to 5-30-14 Nursing staff has been re-educated on the prevent accidents. requirement to use a gait belt/mechanical lift to ensure proper and safe transfer. Re-education was provided on utilization of resident care cards on 5/2/14 and has been re-This REQUIREMENT is not met as evidenced educated as a result of the survey. by: Based on record review and staff interviews the 5-30-14 facility failed to ensure that staff transferred a The facility has implemented transfer education, resident per physical and occupational therapy care card utilization and return demonstration of instructions resulting in a fractured leg for 1 of 3 gait belt utilization, transfer and mechanical lift sampled residents (Resident #1) reviewed for as a part of the orientation process for new transfer and fall related injuries. DON/designee will monitor 9 random transfers/ The findings included:

Resident #1 was admitted to the facility on

The Care Plan dated 3/21/14 revealed the

3/21/14 with diagnoses of Paralysis and Diabetes.

week for 4 weeks.

Observation audits will be taken to QA/QI for

review and with any variances the plan of correction will be revised. 5/30/14

ATEMENT O	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	:	345557	B. WING		1 . '	15/2014
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		٠.	
4	EALTH & REHAB CENT	reo		800 INDEPENDENCE BOULEVARD		:
ZĄLEA N	·			NILMINGTON, NC 28412		
(X4) ID PREFIX TAG	" (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE -	(X5) COMPLETIO DATE
F 323	Continued From pag	e 5	F 323			
	resident was to be tr	ansferred with the assist of				
	one to two persons.					
	The Admission Minin	num Data Set (MDS)				
	assessment dated 4	/1/14 revealed the resident				
	nad short and long to	erm memory loss and was ely impaired. The MDS				
	revealed the residen	t required extensive	1	The property of the second of	1.	S 11
-	assistance of one pe	erson for transfers. The MDS			-	
-	revealed that with su	urface to surface transfers the			:	
	resident was not ste	ady and only able to stabilize	1			٠.
	with staff assistance	. The MDS revealed the				
	resident used a whe	elchair for mobility and had	1			
	experienced no rece	ent falls.				į
		COAA) to Follo dated				}
•	The Care Area Asse	essment (CAA) for Falls dated resident did not attempt to get				
	4/2/14 revealed the	ng history of Polio with				1
	Dorolidio Syndrome	and had been bed bound for				
	many years.	and ned been bod boding to	-			1 .
	many years.					
	A Record of In-Serv	rice form revealed transfer		-	,	
	training for Residen	t #1 was initiated on 4/17/14				
	with the staff based	on physical and occupational				
	therapy evaluations	. The record listed the				,
	following: Gait belt	must be used. Must be two	ļ.:			
	person assist. (Nam	ne of mechanical lift) if				
	necessary. The sigi	nature sheet revealed NA				1
		#1 attended the in-service on	1	1	•	ŀ
	4/21/14.					1 .
	An Occupational Th	nerapy Discharge Summary for			-	1
	Resident #1 dated	4/23/14 under Discharge				
	Status and Recomm	mendations revealed caregiver	1			1
	education was com	plete and staff training	1 .			
-	focused on mobility	and transfers. The summary				
	revealed the reside	ent required maximum assist of	1		,	1
	2 noreone for trans	fers and used a wheelchair for				1

mobility.

PRINTED: 05/23/2014 --FORM APPROVED

PRINTED: 05/23/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 05/15/2014 B, WNG 345557 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3800 INDEPENDENCE BOULEVARD AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 323 Continued From page 6 F 323 A Physical Therapy Discharge Summary for Resident #1 dated 4/30/14 under Discharge Status and Recommendations revealed the resident was totally dependent on staff for transfers and that in-service training was performed with the NAs with instruction on positioning, use of gait belt, transfer with assist of 2 persons at all times and use of (name of mechanical lift) if necessary to decrease the risk of caregiver and patient injury. The summary revealed the NAs had signed an in-service form in the medical record to acknowledge agreement. A Witness Statement of Incident/Accident or Injury of Unknown Origin by the Administrator dated 5/2/14 revealed the RP came to the administrator's office on the morning of 5/2/14 saying the staff had broken the resident 's foot.

conducted.

The statement revealed the RP stated the resident told her his foot got caught in the wheelchair and the NAs did not stop to dislodge it but kept pulling until his foot was free. The statement revealed the RP stated she told the nurse last night on the 3PM-11PM shift. The statement revealed the RP was accompanied to the nurse 's station by the administrator and the resident 's nurse was questioned about an. incident with the resident's foot but the nurse was not aware of such an incident. The note revealed the PA was in the facility at the time and saw the resident and a portable x-ray was done which showed an acute fracture. The note revealed the resident was sent to the ED and the RP was informed that an investigation would be

A nursing progress note dated 5/2/14 at 10:23AM revealed at 8:30 that morning the resident's

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
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		345557	B. WING		05/	15/2014	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	·	<u></u>		3800 INDEPENDENCE BOULEVARD			
AZALEA H	EALTH & REHAB CENT	EK		WILMINGTON, NC 28412	· · ·	. :	
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F 323	Continued From pag	e 7	F 32	23		-	
	Responsible Party (F	RP) reported that Resident #1					
	had swelling and pai	n in the left foot that				-	
•	increased with move	ment. The Nurse			• • •		
	documented the resi	dent had pain of the left	1.				
	lower extremity at a	level of 4 on a pain scale of	· 1 321.				
	0-10, 0 being no pair	n and 10 being unbearable					
	pain. The progress r	ote revealed the					
		e physician ' s assistant (PA)	ļ.,			1'	
	was notified.		ŀ .				
	A nursing progress r	note dated 5/2/14 at 12:19 PM assessed the resident and				į .	
	revealed the PA had	y of the left lower extremity.			·		
	The note revealed the	ne resident stated he thought	1				
	hie louier extremity of	ot caught when he was being	1 -				
-	transferred back to	ped the night before. The note					
	revealed a positive	k-ray and an order had been	1.				
	given to send the re	sident to the Emergency	-				
	Department (ED) for	evaluation and treatment.					
	,						
	A physician 's progr	ress note dated 5/2/14	1				
	revealed Resident #	1 stated he got his left lower					
	leg stuck under the	bed during an assisted				ļ	
· .		eelchair to the bed. The note	- }-				
. '		nt was unsure as to when it					
	happened or the na	me of the staff member			1	1.	
	assisting him at the	time. The note revealed a					
		wer leg and ankle was done					
	that revealed a non-	-displaced mid shaft tibla				1.	
	fracture (There are	2 bones in the leg between	1 .				
		kle, the larger of the two				1.	
	being the tibia).						
	Doutous of the resid	ent's record revealed					
		follow-up visit with an			-		
	orthopodiet on 5/0/	14. The orthopedist note					
l	revealed the reside	nt had a spiral non-displaced				1	
l	fracture of the left ti					1.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/23/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

C

B. WING 05/15/2014 345557 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3800 INDEPENDENCE BOULEVARD AZALEA HEALTH & REHAB CENTER WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 8 An interview was conducted with the Administrator and the Director of Nursing (DON) on 5/14/14 at 1:50 PM. The DON stated the NAs

had been in-serviced to transfer Resident #1 with a gait belt and 2 persons. The DON stated Resident #1 gave several variations of the incident. The DON stated Resident #1 described the NA that transferred him when his leg was injured and described NA #1 who was assigned to the resident on the 3PM to 11PM shift on 5/1/14. The DON stated that she interviewed NA #1 on three separate occasions and the NA 's story changed each time she interviewed her. The DON stated on the initial interview with NA #1 on 5/2/14, the NA stated she was not aware of the problem with the resident 's foot until the RP told her the resident 's foot was broken. The DON stated the NA did not mention she transferred the resident or that anything happened during a transfer. The DON stated the NA was off on the weekend and she called her back in on Monday 5/5/14. The DON stated NA #1 told her that she and another NA pulled the resident up in the bed and noted his foot was caught between the wheels of the bed. The DON stated the NA stated she could not remember who assisted her to pull the resident up in bed. The DON stated the NA told her the resident was OK and was not injured. The DON stated she asked NA #1 to demonstrate how she transferred the resident and the NA put her arm under the DON's arm and held onto the waist band of her pants for the transfer. The DON stated the NA did not refer to the positioning of another staff member assisting with the transfer. The DON stated the NA told her she forgot to tell the nurse that the resident's leg got caught during the transfer. The DON provided written statements from the NAs working on 5/1/14 and according to

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION .	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
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		345557	B. WING		05/15/2014
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THE OF T	to the city of the city		1 :	3800 INDEPENDENCE BOULEVARD	
AZALEA H	EALTH & REHAB CENT	TER .		WILMINGTON, NC 28412	,
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F 323	Continued From pag	e 9	F 323	3	
	, -	NAs wrote they did not			- 1
		fer Resident #1 on 5/1/14.			
		NA #1 was suspended on	1.7		
		ts of the investigation. The		and the state of t	
		rviewed NA #1 again on			
-	5/6/14 and the NA de		1.		
		#1 on 5/1/14. The DON			
		ceived training in April 2014			
		#1 with a gait belt and 2			
		A #1 signed the in-service			
•		DON stated the x-ray			
		had a spiral fracture of the		-1 -1 -1	
		t's physician told her the	1		
		e than 24 hours old. The			
		ed on the investigation, she			
	believed NA#1 trans				
		aused the fracture of the			
	resident 's leg.		1		
	0- 54444 - 0.05 5	PM an interview was			
		e #1 who worked the 3PM to			
-		Nurse #1 stated on the			
		ne RP told her she thought the			
	resident 's ankle wa	s swollen and could he have			
		The Nurse stated she did an	1		
		inkle and leg by inspecting		ľ	
		ness, swelling and heat and			
	palpated the area. T	he Nurse stated she moved	. [
,	the resident 's leg a	nd he did not complain of			
		ted there was no obvious			
	problem with the ext	tremity. The Nurse stated the			
7		and the resident winced but			1.
		with the way the RP grabbed			
		tated the RP did not say			
		njury to the resident 's foot or	1-		
		ed she observed no obvious			
1		r ankle and was not aware of	.].		
1	an injury to the resid	dent's foot or leg.			

AZALEA HEALTH & REHAB CENTER AZALEA HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3000 INDEPREDINCE BOULLEVAND WILMINGTON, NC 254112 DOB 10 FREDIX GENOMERY STATEMENT OF DEFICIENCIES TAG SULMINGTON, NC 254112 DEFICIENCY MUST SEP PRECIDED BY FULL TAG FREDIX FROUNDERS FLAM OF CORRECTION CANNERS TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG FREDIX TAG RANGE THE ABOUNDERS FLAM OF CORRECTION CONTAINED TAG FREDIX TAG RANGE THE ABOUNDERS FLAM OF CORRECTION CANNER TAG FREDIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG FREDIX TAG FREDIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG FREDIX TAG FREDIX TAG FREDIX TAG FREDIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG FREDIX TAG FREDIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG FREDIX FRE		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			
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at 3:20 PM that she did not transfer Resident #1 by herself on 5/1/14 but could not remember who assisted her with the transfer. The NA stated during the transfer the resident "s leg was stuck under the bed and when the resident was back in bed the resident denied pain and said he was OK. The NA stated she was going to tell the nurse about the incident but something came up with another resident and she forgot. Review of the facility "s investigation of the incident revealed the facility filed a 24 hour and 5 day report to the state. The DON stated in an interview on 5/14/14 at 3:30 PM that in-services had been provided for the nursing staff regarding proper transfer procedures for residents and information provided regarding the NA 's responsibility to report immediately any injury or medical concerns to the nurse and the responsibility of the nurse to report any injury of unknown origin to the DON or Administrator. The DON stated the NAs were required to use a gait belt when manually transferring residents and according to NA #1" s demonstration, the NA did not use a gait belt for the transfer. The DON stated all resident care guides were reviewed to ensure they had proper instructions for transferring the residents. The DON stated that orientation of all nursing staff would include a return demonstration that the staff could successfully use the gait belt to transfer residents. The DON stated that orientation of all nursing staff would include a return demonstration that the staff could successfully use the gait belt to transfer residents. The DON stated the staff were always monitoring resident care but did not institute a specific monitoring plan in the plan of correction. The DON stated she had spoken with the medical director and the physician 's assistant about the incident but did not include the incident in their	. F 323			F 3	23			
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED			
			B. WING			::
		345657	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	05/	5/2014
NAME OF P	ROVIDER OR SUPPLIER			3800 INDEPENDENCE BOULEVARD		
AZALEA H	EALTH & REHAB CENT	(ER	1	WILMINGTON, NC 28412		
		THE PERSON OF TH		PROVIDER'S PLAN OF CORRECTION	<u>u.</u> 1	- 00
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG		BE .	(X5) COMPLETION DATE
F 323			F3	23		
	the information in the the monthly statistics					
-	in an interview on 5/	oist Assistant (OTA) #1 stated 15/14 at 8:36AM that he				
1		vice for the NAs in April 2014				
		or Resident #1. The OTA instructed to use 2 persons				
		anual transfer and if the	1			
		sisting with the transfer to use				100
-	the (name of mecha	nical lift). The OTA stated that			2.5	
		ays use 2 persons when	1.			
	using a (name of me resident.	echanical lift) to transfer a				
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