DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FOR	MAPPROVED			
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION		E SURVEY PLETED			
		345557	B. WING			C 04/28/2021				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
				3800	INDEPENDENCE BOULEVARD					
AZALEA HEALTH & REHAB CENTER				WIL	MINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 000	INITIAL COMMENTS		F 0	00						
	survey was conducted 4/28/21.Tags F641 ar of 4/28/21. However, result of the complain was conducted at the	complaint investigation d on 4/20/21 through nd F880 were corrected as new tags were cited as a t investigation survey that same time as the revisit. of compliance. Event ID#								
F 580 SS=D	Notify of Changes (In	jury/Decline/Room, etc.))(i)-(iv)(15)	F 5	80			5/1/21			
	consult with the residu consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new for (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provin physician.	ediately inform the resident; ent's physician; and notify, her authority, the resident on there is- ving the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the								
		SUPPLIER REPRESENTATIVE'S SIGNATURI	=		TITLE		(X6) DATE			

Electronically Signed

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

05/06/2021

	MENT OF HEALTH AN S FOR MEDICARE & I		FORM	D: 06/02/2021 MAPPROVED D. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345557		B. WING _				C 28/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	800 INDEPENDENCE BOULEVARD		
AZALEA HEALTH & REHAB CENTER			WILMINGTON, NC 28412				
(X4) ID PREFIX TAG			ID PREFI TAG	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 580	resident and the resid when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section. (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite dis §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi facility failed to notify of a fall with injuries for for notification of char Findings included: Resident #1 was adm 3/16/21 and discharge She had diagnoses w gastrointestinal hemo Resident #1's most re	lent representative, if any, or roommate assignment (0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement ion, including the various be the composite distinct y the policies that apply to en its different locations is not met as evidenced ew and staff interviews, the the Responsible Party (RP) or 1 of 1 resident reviewed nges (Resident #1).	F	580	Preparation and submission of this PC is required by state and federal law. TI POC does not constitute an admission purpose of general liability, professional malpractice or any other court proceed 1. Resident #1 is no longer a resident at this building. 2. To identify other residents that have potential to be affected, current resider with new fall with a new skin injury from fall will be identified by completing an audit of orders and incident reports looking back 30 days. Any identified issues will be addressed.	his for al ling. at the nts	

Facility ID: 100671

If continuation sheet Page 2 of 8

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OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDIN	6		с		
	345557	B. WING _		_	04/28/2021		
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	04/20/2021		
			3800 INDEPENDENCE BOU	JLEVARD			
IEALTH & REHAB CENT	ER		WILMINGTON, NC 2841	2			
(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	(X5) COMPLETION DATE			
Continued From page	2 2		20				
		ΓJ					
			3. To prevent this f	rom reoccurring			
Review of the Inciden	t Report dated 3/31/21			-			
			new fall and skin te	ear.			
			Director of Nursing	or designee.			
the daughter was not	ined on 3/31/21 at 9.37 PM.		Any licensed staff t	bat cannot be reached			
An interview on 4/27/	21 at 9:03 PM with Nurse #1		-				
	-			-			
unwitnessed fall. He	stated he assessed the						
resident and provided	I first aid by cleaning the		Newly hired nurses	and agency licensed			
	-			is education during			
			their orientation.				
the RP one time but h	nad not talked with the		4.To monitor and m	naintain ongoing			
				•			
-							
				•			
	e had been unable to notity						
An interview on 4/27/2	21 at 1:08 PM with the RP						
			soon as possible.				
#1's fall on 3/31/21 ar	nd had not been notified of						
the injuries to her righ	nt hand or the bridge of her						
nose.							
An interview on 4/28/2	21 at 10:37 AM with the						
			The Director of nur	sing will report the			
÷ ,							
	a resident's fall as soon as			od or as it is amended			
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page assistance for locomod dependence for bathi assistance for all other Review of the Incider revealed Resident #1 3/31/21 at 9:50 PM w to her right hand and her nose. The Incider the daughter was not An interview on 4/27// revealed he had beer Resident #1 on 3/31// unwitnessed fall. He s resident and provided area and applied a ba her right hand and cle bridge of her nose. N the RP one time but f daughter or left a mest to call the RP again b stated he did not rem oncoming day shift he the RP. An interview on 4/27// revealed she had not #1's fall on 3/31/21 ar the injuries to her right nose. An interview on 4/28// Director of Nursing (E unaware of the facility Resident #1's fall witht and the bridge of her	Additional and a second state of the second state of the rose. Nurse #1 stated he had called the RP one time but had not talked with the daughter or left a message. He stated he meant to call the RP again but had not been notified of Resident #1's fall on 3/31/21 at 10:37 AM with the Director of Nursing (DON) revealed she was unaware of the facility's failure to notify the RP.	A BUILDIN 345557 BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 assistance for locomotion off unit, total dependence for bathing, and extensive assistance for all other activities of daily living. Review of the Incident Report dated 3/31/21 revealed Resident #1 had an unwitnessed fall on 3/31/21 at 9:50 PM which resulted in a skin tear to her right hand and an abrasion to the bridge of her nose. The Incident Report read in part that the daughter was notified on 3/31/21 at 9:37 PM. An interview on 4/27/21 at 9:03 PM with Nurse #1 revealed he had been assigned as the nurse for Resident #1 on 3/31/21 when she had an unwitnessed fall. He stated he assessed the resident and provided first aid by cleaning the area and applied a bandage for the skin tear on her right hand and cleaned the abrasion on the bridge of her nose. Nurse #1 stated he meant to call the RP again but had not toke with the daughter or left a message. He stated he meant to call the RP again but had not done so. He also stated he did not remember if he informed the oncoming day shift he had been numble to notify the RP. An interview on 4/27/21 at 1:08 PM with the RP revealed she had not been notified of Resident #1's fall on 3/31/21 and had not been notified of the injuries to her right hand or the bridge of her nose. An interview on 4/28/21 at 10:37 AM with the Director of Nursing (DON) revealed she was unaware of the facility's failure to notify the RP of Resident #1's fall with injuries to her right	345557 B. WING EALTH & REHAB CENTER STREET ADDRESS, CITY, ST 3800 INDEPENDENCE BOD WILLINGTON, NC. 22441 EALTH & REHAB CENTER DP EALTH & REHAB CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID Continued From page 2 F 580 assistance for locomotion off unit, total dependence for bathing, and extensive assistance for all other activities of daily living. S. To prevent this f current licensed in u- concerning the req resident represent new fall and an unwitnessed fall on 3/31/21 at 9:50 PM which resulted in a skin tear to her right hand and an abrasion to the bridge of her nose. The Incident Report matin part that the revealed Resident #1 hand an abrasion to the bridge of her nose. The Incident Report matin part that they have snotified on 3/31/21 at 9:37 PM. Any licensed staff within the initial ree 24 hours, will not to they have received An interview on 4/27/21 at 9:03 PM with Nurse #1 revealed he had been assigned as the nurse for Resident #1 on 3/31/21 when she had an unwitnessed fall. He stated he assessed the resident math to talked with the daughter or left a message. He stated he meant to call the RP again but had not talked with the daughter or left a message. He stated he meant to call the RP again but had not done so. He also stated he did not memout if he informed the oncoming day shift he had been unable to notify the RP. This will be docum soon as possible. An interview on 4/27/21 at 10:37 AM with the Director of Nursing (DON) revealed she was unaware of the facilit	NUMBER OR SUPPLIER A BUILING EALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTION ACTION RECORDERY PLUL REDULATORY OR LGC DENTIFYING INFORMATION) ID PREVIDENCY MUST PLAN OF CORRECTION (EACH ORRECTIVE ACTION REDULE DE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY ALSO DENTIFYING INFORMATION) Continued From page 2 assistance for locomotion off unit, total dependence for bathing, and extensive assistance for all other activities of daily living. F 580 Continued From page 2 assistance for locomotion off unit, total dependence for bathing, and extensive assistance for all other activities of daily living. F 580 Continued From page 2 assistance for all other activities of daily living. F 580 Review of the Incident Report tead in part that the daughter was notified on 3/31/21 at 9:37 PM. F 580 An interview on 4/27/21 at 9:03 PM with Nurse #1 revealed head been assigned as the nurse for revealed head been assigned the bridge of her nose. Nurse #1 stated he abases of the resident and not anot take an assignment until they have received this reeducation. Newly hired nurses and applied a bandage for the skin tear on her right hand on target the had called the RP one time but had not done so. He also stated he din or treembert f he informed the oncoming day shift he had been unable to notify the RP. Newly hired nurses and agency licensed nurses will have this education during their orientation. An interview on 4/27/21 at 1:08 PM with the Prevaled be had not teen notified of he injuries to her		

Facility ID: 100671

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DA	NO. 0938-039 TE SURVEY MPLETED		
			B. WING			С		
		345557	B. WING			4/28/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
AZALEA HEALTH & REHAB CENTER				3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO DATE		
F 580	Continued From page	e 3	F 58	30				
	An interview on 4/28/	21 at 10:59 AM with the						
	Administrator reveale	ed she was unaware of the						
		ify the RP of Resident #1's						
		r right hand and the bridge						
		ed the family should be						
F 684	notified as soon as possible of a resident's fall. Quality of Care		F 68	34		5/1/21		
SS=D	CFR(s): 483.25					0, 1/21		
	§ 483.25 Quality of ca							
		indamental principle that						
		nt and care provided to						
		ed on the comprehensive dent, the facility must ensure						
		e treatment and care in						
		essional standards of						
		nensive person-centered						
	care plan, and the res							
		is not met as evidenced						
	by: Based on record rev	iew_staff_and_Nurse		Preparation and submission	of this POC			
		rviews, the facility failed to		is required by state and federa				
		ders for treatment of a right		POC does not constitute an a				
		prasion on the bridge of the		purpose of general liability, pr				
		e NP's order to obtain a		malpractice or any other court	t proceeding.			
	urinalysis for 1 of 1 re reviewed for supervis	sion to prevent accidents.		F 684				
	Findings included:			1. Resident #1 is no longer a	resident in			
				the building				
		dmitted to the facility on gnoses which included		2. Current residents are at ris	c for these			
	anemia and gastroint	-		issues.				
	Resident #1's most re	ecent Minimum Data Set		a. An audit of incidents lookin	g back 30			
		ed she had moderately		days will be completed to ider	ntify any skin			
	impaired cognition ar	nd she was coded as		injury and validate that it was	assessed			

Event ID: CE9511

Facility ID: 100671

If continuation sheet Page 4 of 8

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/02/202 RM APPROVEI IO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		345557				0	C 4/28/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	AZALEA HEALTH & REHAB CENTER			3800 INDEPENDENCE BOULEVARD			
AZALEA F				W	ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	e 1	F 68	0 1			
1 004	requiring supervision	for eating, limited	FOC	04	and treatment orders were written,		
	assistance for locom						
	dependence for bath	ing, and extensive er activities of daily living.			b. An audit of orders looking back 30 will be complete to identify any labs	uays	
		er activities of daily living.			ordered to validate that the order was		
		cident Report completed by /21 revealed Resident #1			carried out.		
	had an unwitnessed	fall on 3/31/21 at 9:50 PM kin tear to her right hand and			Any issues identified will be addresse	ed.	
	an abrasion to the br	-			3. To prevent from recurring		
	Review of physician's	s orders for March 2021 and			a. The current licensed nurses have b	been	
	April 2021 revealed r	no orders for wound care			reeducated concerning the policy		
		nt #1's right hand or the			"Resident Change of Condition." This		
	bridge of her nose.				reeducation includes the expectation		
	Poviow of Posidont t	#1's Treatment Administration			any new skin injury will be assessed a treatment orders will be written at the		
		rch 2021 and April 2021			of injury. The documentation of the	ume	
		nts completed for her right			presence of the skin injury is for the r	urse	
	hand or the bridge of				who is assigned to the resident at the		
	Ŭ				of the incident.		
		ogress notes revealed no					
		und care for Resident #1's			b. The current licensed nurses have b		
		or abrasion on the bridge of			reeducated to follow physician orders	as	
	her nose.				they are written. If unable to follow physician orders, the physician must	ha	
	An interview on 4/27	/21 at 9:03 PM with Nurse #1			notified	be	
		n assigned as the nurse for			liotiliot		
	Resident #1 on 3/31/				This education will be completed by t	he	
	unwitnessed fall. He	stated he assessed the			Director of Nursing or designee.		
	-	d first aid by cleaning it and					
		or the skin tear on her right			Any licensed staff that cannot be read		
		e abrasion on the bridge of			within the initial reeducation time fran		
		stated he did not complete ts for the two injuries. Nurse			24 hours, will not take an assignment they have received this reeducation.	untii	
		ved that completion of the fall					
		e risk management report			Agency licensed nurses and newly hi	red	
		on to the wound care nurse.			licensed nurses will have this educati		
		ted that section of the risk			during their orientation		

Facility ID: 100671

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED		
		345557	B. WING		C 04/28/2021		
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO		
F 684	management report v wound care nurse to and continue treatme #1's right hand skin te An interview on 4/26/ Wound Care Nurse re of Resident #1's fall in nose. She stated she wound care to Reside hand or the abrasion stated when staff com assessment and chee it triggered for her to assess and initiate tre A follow-up interview the Wound Care Nurse management report of to the Wound Care Nurse provided any addition stated she remember resident's hand but of An interview on 4/28/ Director of Nursing (E aware of the facility's #1 with wound care fo and abrasion on the b stated this deficiency mock survey perform 15, 2021. She stated	which was to notify the further assess, measure, ant as needed for Resident ear and nose abrasion. 21 at 11:54 AM with the evealed she was not aware njuries to her right hand and had not provided any ent #1's skin tear on her right on her nose. She further npleted a resident skin cked the box for a new area, be notified and she would eatment. on 4/28/21 at 9:37 AM with	F 68-	 4 4. To monitor and maintain on going compliance, the Director of Nursing designee will: a. Review the incidents to identify a injury has been assessed and order in place for treatment. b. Review the 24 hour report and vathat the orders for labs have been cout. Any issues identified will be address immediately. This will be documented daily for 7 to 5 days a week for 3 weeks, and a waudit for these issues for 8 weeks. The Director of Nursing will report the results of the monitoring to the QAP committee for review and recommendations for the time frame the monitoring period or as it is ame by the committee. 	or ny rs are alidate arried sed days, veekly ne Pl e of		

If continuation sheet Page 6 of 8

DEPARTMENT OF HEALTH AND					FORM	APPROVED
CENTERS FOR MEDICARE & M	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED	
						С
	345557	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	04/	28/2021
NAME OF PROVIDER OR SUPPLIER				800 INDEPENDENCE BOULEVARD		
AZALEA HEALTH & REHAB CENTER				VILMINGTON, NC 28412		
PREFIX (EACH DEFICIENCY			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
 stated it was a system communication that renurse not being notifie for Resident #1. An interview on 4/28/2 Administrator revealed risk management report notification for the wout this issue had already addressed during the net training. b. Review of Physici 3/31/21 at 2:20 PM reverses Practitioner (NP) had a increased confusion and urinalysis and laborated or resident refusal of the Resident #1. An interview on 4/27/2 revealed he assigned #1 on the night of 3/31 urinalysis order from stated he did not remet the urinalysis order from An interview on 4/27/2 revealed she had not the was unable to obtain the urinality should have unable to obtain the urinality should have	monitor compliance. She breakdown in sulted in the wound care d of the new skin injuries 21 at 10:59 AM with the d she was aware that the ort did not trigger a und care nurse. She stated been identified and mock survey and related ian Progress Note dated vealed the Nurse assessed Resident #1 for nd ordered a STAT (now) ory tests. progress notes revealed no to attempts for collection he urinalysis ordered for 21 at 9:03 PM with Nurse #1 to provide care for Resident 1/21 and he was unaware a dered for Resident #1. He ember if he was informed of om the prior shift. 21 at 2:41 PM with the NP been notified that the facility he urinalysis. She stated e notified her if they were rinalysis and she had not o stated the facility had a	F	684			

Facility ID: 100671

If continuation sheet Page 7 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/02/2021 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COM	E SURVEY PLETED	
		345557	B. WING				C / 28/2021
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AZALEA H	IEALTH & REHAB CENT	ER			3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page catheterization to obta resident was incontine An interview on 4/26/. Director of Nursing (D aware the urinalysis h Resident #1. She stat had refused to have a performed but confirm documentation related refusal, or that the NF urinalysis specimen h DON stated this defice during a mock survey April 13 through April that the staff had rece 2021 and audit tools I monitor compliance. An interview on 4/27/2 Administrator reveale facility's failure to obta She stated this deficed	e 7 ain a urine specimen if the ent. 21 at 1:38 PM with the DON) revealed she was had not been obtained for ted she believed the resident an in and out catheterization hed there was no d to the collection attempt, P had been notified the had not been obtained. The iency had been identified performed at the facility on 15, 2021. She also stated eived education on April 22, had been put into place to 21 at 1:38 PM with the d she was aware of the ain the urinalysis specimen. ency was identified during ormed at the facility on April		684	DEFICIENCY)		

If continuation sheet Page 8 of 8