PRINTED: 11/10/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION IG	(X	(X3) DATE SURVEY COMPLETED		
		345557	B. WING _			10/28/2015	
NAME OF PROVIDER OR SUPPLIER AZALEA HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZI 3800 INDEPENDENCE BOULEVAL WILMINGTON, 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F 0	00			
F 278 SS=D	complaint investigation 2015. Event ID #CD4	SSMENT	F 2	78			
	The assessment mus resident's status.	t accurately reflect the					
	A registered nurse mu each assessment with participation of health						
	A registered nurse mu assessment is comple	ust sign and certify that the eted.					
		completes a portion of the n and certify the accuracy of sessment.					
	willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material an	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual and false statement in a is subject to a civil money nan \$5,000 for each					
	Clinical disagreement material and false sta	t does not constitute a tement.					
	This REQUIREMENT by:	is not met as evidenced					

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

(X6) DATE TITLE

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.

Facility ID: 100671

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345557	B. WING	B. WING		10/28/2015	
NAME OF PROVIDER OR SUPPLIER AZALEA HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP (3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 278	failed to code the Minassessment accurate symptoms for 1 of 1 # 41) Findings Included: Resident # 41 was a 3/27/2015 with multiple weakness, Dementia The quarterly MDS a indicated the resident symptoms. The resident's record September 2015 and resident exhibited be ranging from refusing Living (ADLs) to refus supplements from the On 10/27/2015 at 9:0 interviewed. He reversident was on different was on differ	d staff interview, the facility nimum Data Set (MDS) ely for the behavioral sampled resident. (Resident diagnoses including a Depression and anxiety. Seessment dated 10/2/2015 and to the diagnoses including a Depression and anxiety. Seessment dated 10/2/2015 and to the diagnoses including a Depression and anxiety. Seessment dated 10/2/2015 and to the diagnoses including a diagnoses including a persent dated 10/2/2015 and to the diagnoses and the diagnoses an	F	278			
		:00 AM, the Director of nterviewed. She reported ted daily behavioral					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345557	B. WING			10/:	28/2015
NAME OF PROVIDER OR SUPPLIER AZALEA HEALTH & REHAB CENTER			•	38	TREET ADDRESS, CITY, STATE, ZIP CODE 800 INDEPENDENCE BOULEVARD /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278 F 309 SS=D	should have been co resident behavioral s 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must r provide the necessar or maintain the highe mental, and psychos	Repectation was that the MDS ded accurately reflecting the symptoms. RE/SERVICES FOR NG Receive and the facility must y care and services to attain st practicable physical, ocial well-being, in		278 309			
	mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, physician and resident interviews and record review, the facility failed to provide evidence of communication with the dialysis clinic. The facility also failed to monitor the condition of a resident after dialysis treatment and implement safety precautions for a dialysis access site for 1 of 1 (Resident #193) reviewed for dialysis. Findings included: Resident #193 was admitted on 10/10/15 with a diagnosis of end stage renal disease (ERSD) requiring dialysis. The admission Minimum Data Set (MDS) dated 10/17/15 still in progress indicated Resident #193 was cognitively intact and extensive assistance with his activities of daily living except for eating which required supervision. Resident #193 was care planned for dialysis Tuesday, Thursday and Saturday with interventions to include monitoring the				Based on observations, staff, physicia and resident interviews and record revithe facility failed to provide evidence of communication with the dialysis clinic. The facility also failed to monitor the condition of a resident after dialysis treatment and implement safety precautions for a dialysis access site for 1 (Resident #193) reviewed for dialy Findings included: Resident #193 was admitted on 10/10/with a diagnosis of end stage renal disease (ERSD) requiring dialysis. The admission Minimum Data Set (MDS) dated 10/17/15 still in progress indicate Resident #193 was cognitively intact are extensive assistance with his activities daily living except for eating which required supervision. Resident #193 was care planned for dialysis Tuesday,	ew, or 1 sis. 15 ed and of	

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		345557	B. WING _	B. WING		1	0/28/2015	
NAME OF P	ROVIDER OR SUPPLIER		 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	0/20/2015	
	10115211 011 001 1 2.2.1				800 INDEPENDENCE BOULEVARD			
AZALEA H	IEALTH & REHAB CENT	ER			VILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From page	e 3	F;	309				
		thrill or bruit as ordered,			Thursday and Saturday with intervention	one		
		ds for edema, vital signs as			to include monitoring the	5115		
		nication with the dialysis staff			shunt/vascular/catheter access for sign	า		
	and physician as per	_			and symptoms of bleeding or infection			
	, , ,				assessment of the access site for a thi			
	A review of the hospi	tal stay for Resident #193			or bruit as ordered, monitoring lung			
	indicated he had an a	arterial/vascular fistula			sounds for edema, vital signs as order	ed		
	procedure done June	2015 in preparation for			and communication with the dialysis st	aff		
		itted to the hospital on			and physician as per routine.			
	9/24/15 in acute rena							
	(intravenous access used for dialysis) placed.				A review of the hospital stay for Reside			
		is treatment, Resident #193			#193 indicated he had an arterial/vasc	ular		
		est with cardio-pulmonary			fistula procedure done June 2015 in			
		given. He was admitted to			preparation for dialysis. He was admitt			
	times weekly.	5 with orders for dialysis 3			to the hospital on 9/24/15 in acute renafailure and had a Permcath (intravenous			
	uilles weekly.				access used for dialysis) placed. Durin			
	In an interview on 10	/26/15 at 11:00 AM, Resident			his first dialysis treatment, Resident #1	-		
		i fistula in his right lower arm			went into cardiac arrest with	00		
		d the Permcath to his right			cardio-pulmonary resuscitation (CPR)			
	_	. He stated the facility had			given. He was admitted to the facility	on		
		ince his admission and he			10/10/15 with orders for dialysis 3 time			
	told the staff not to ta	ke is blood pressure in his			weekly.			
	right arm. He stated h	ne thought the staff would						
	have known that he o	couldn ' t have anything			In an interview on 10/26/15 at 11:00 A	M,		
	constricting his right a	arm.			Resident #193 stated he had a fistula			
					his right lower arm that was maturing a	and		
		/27/15 at 9:00 AM, Nurse			the Permcath to his right chest was			
		issess his vital signs and			temporary. He stated the facility had n			
		o make sure it was intact			drawn any labs since his admission ar	iu		
		ed with him. She stated she #193 had a fistula to his right			he told the staff not to take is blood pressure in his right arm. He stated he			
		t have any blood draws from			thought the staff would have known that			
	that arm.	Thave any blood draws from			he couldn't have anything constricting right arm.			
	On 10/27/15 at 9:30 /	AM, Resident #193 left the						
		treatment. In his closet was			In an interview on 10/27/15 at 9:00 AM	l,		
		tions for caring for a resident			Nurse #1stated she would assess his			
	no longer residing in Resident #193 's room.				signs and look at the catheter to make			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345557	B. WING		10/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3800 INDEPENDENCE BOULEVARD		
AZALEA H	IEALTH & REHAB CEN	TER	,	WILMINGTON, NC 28412		
(X4) ID	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PRÉFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 309	Continued From pag	ge 4	F 309			
				sure it was intact every time she worke	ed	
	In an interview on 10	0/27/15 at 2:00 PM, unit		with him. She stated she was aware		
		here was a communication		Resident #193 had a fistula to his right	ı l	
	_	at should be completed after		arm and he could not have any blood		
	each dialysis treatme	ent but she was only able to		draws from that arm.		
	produce a form date	d 10/27/15 created at 1:10				
	PM with vital signs d	locumented as taken earlier		On 10/27/15 at 9:30 AM, Resident #19	3	
	in the shift. Unit mar	nager #1 also stated she had		left the facility for his dialysis treatment		
		communication between the		his closet was a kardex with instruction		
		e facility regarding any of his		for caring for a resident no longer resident	ling	
		Unit manager #1 stated the		in Resident #193 's room.		
		uld know anything about his				
	-	ould be if she asked Resident		In an interview on 10/27/15 at 2:00 PM	l,	
	#193 or called the di	alysis clinic.		unit manager #1 stated there was a		
		NO7/45 1 0 40 DM		communication assessment form that		
		0/27/15 at 2; 10 PM nursing		should be completed after each dialysi	S	
	1 1	ated she had worked at the half years and she was		treatment but she was only able to produce a form dated 10/27/15 created	d at	
		nt #193. NA #1 stated she		1:10 PM with vital signs documented a		
		y need to obtain vital signs		taken earlier in the shift. Unit manage		
		or was she aware that		also stated she had no documentation		
		a fistula in his right arm. She		communication between the dialysis cl		
		had instructions about their		and the facility regarding any of his		
	care in their closets			dialysis treatments. Unit manager #1		
				stated the only way anyone would kno	w	
	In another interview	on 10/27/15 at 2:30 PM,		anything about his dialysis treatment		
	Nurse #1 stated she	worked at the facility for two		would be if she asked Resident #193 of	or	
	and one half years a	ind the nurses were		called the dialysis clinic.		
	responsible for puttir	ng the kardex forms with				
	l ·	resident closet. She verified		In an interview on 10/27/15 at 2; 10 PM		
		no information inside his		nursing assistant (NA) #1 stated she h		
	closet directing the s	staff in care precautions.		worked at the facility for 2 and one half		
				years and she was familiar with Reside		
		0/27/15 at 2:40 PM, the		#193. NA #1 stated she was not aware	tot	
		ed the facility should be in		any need to obtain vital signs after his		
		the dialysis clinic if there was		treatments or was she aware that		
	, ,	esident #193 during his		Resident #193 had a fistula in his right		
		ould be thoroughly assessed		arm. She stated the residents had		
	i including his vital sig	Ins and his vascular access		instructions about their care in their		

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NAME OF PI	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	·
				3800 INDEPENDENCE BOULEVARD	
AZALEA H	HEALTH & REHAB CI	ENTER		WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE
F 309	Continued From p	page 5	F	309	
	1	ent to ensure he was stable	, ,		
				closets	
		story of a recent cardiac arrest		In another interview on 10/	27/15 at 2:20
		s dialysis treatment. The urther stated his expectation		PM, Nurse #1 stated she w	
		ow the proper precautions		facility for two and one half	
		ring for a dialysis resident.		nurses were responsible fo	-
	required writer car	ing for a diarysis resident.		kardex forms with precaution	
	In an interview on	10/27/15 at 2:50 PM, NA #2		resident closet. She verifie	
		orked at the facility for two and		#193 had no information in	
	one half years and she was assigned Resident			directing the staff in care p	
	· ·	stated she took his vital signs			
		his dialysis treatment this		In an interview on 10/27/15	5 at 2:40 PM.
	morning. She stated Resident #193 arrived back			the medical director stated	•
		nd 2:45 PM. NA #2 stated she		should be in communicatio	
	· ·	vital signs on his return and he		dialysis clinic if there was a	
		erapy. NA #2 also stated he		with Resident #193 during	
		get back on her shift but rather		and he should be thorough	
	_	IA #2 stated she was unaware		including his vital signs and	-
	that Resident #19	3 had a fistula in his right arm		access after each treatmer	
		blood pressure should not be		was stable since his had a	history of a
	obtained in his rig	ht arm.		recent cardiac arrest assoc	ciated with his
				dialysis treatment. The me	dical director
	In an interview on	10/27/15 at 3:40 PM, Resident		further stated his expectation	on that the
	#193 stated nobo	dy had obtained his vital signs		facility know the proper pre	ecautions
		r assessed him since he got		required when caring for a	dialysis
		today. He stated she went		resident.	
	straight to therapy	then to bed because he felt			
	really tired.			In an interview on 10/27/15	,
				NA #2 stated she had work	
		10/27/15 at 4:00 PM,		facility for two and one half	_
		ector of nursing and nurse		was assigned Resident #1	-
		the facility had no policy or		stated she took his vital sig	
	•	ng for dialysis residents. The		went to his dialysis treatme	
		also stated there was no		morning. She stated Resid	
		etween the facility and the		arrived back from dialysis a	
	dialysis clinic.			PM. NA #2 stated she did r	
		107/4F at 4.40 DM Nove - #0		vital signs on his return and	
		/27/15 at 4:10 PM Nurse #2 t assessed Resident#193 yet		straight to therapy. NA #2 a normally does not get back	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345557		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			10	/28/2015		
NAME OF PROVIDER OR SUPPLIER AZALEA HEALTH & REHAB CENTER				38	REET ADDRESS, CITY, STATE, ZIP CODE 00 INDEPENDENCE BOULEVARD ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 309	Continued From page	e 6	F3	309				
	but she check on him from therapy. She sta medication pass and as of yet.			but rather on second shift. NA #2 state she was unaware that Resident #193 ha fistula in his right arm and not aware blood pressure should not be obtained his right arm.	nad his in			
	yesterday and they p informing staff not to pressure in his right a his permission before felt a lot better knowi	If they got his vital signs out up a sign in his room do lab draws or blood arm. He stated they asked a putting up the sign and he ng it was up there. The ved with the caps secured			In an interview on 10/27/15 at 3:40 PM Resident #193 stated nobody had obtained his vital signs since yesterday assessed him since he got back from dialysis today. He stated she went stra to therapy then to bed because he felt really tired.	or ight		
	In an interview on 10/28/15 at 10:40 AM, the rehabilitation director stated Resident #193 came straight to therapy yesterday and stood for 6 minutes before tiring. She stated therapy did not assess his vital signs or access prior to therapy. In an interview 10/28/15 at 11:40 AM the nurse consultant and the administrator stated their expectation would be for the facility staff know how to adequately care for a dialysis resident to include access safety and precautions, clinical assessment and have communication with the dialysis clinic.				In an interview on 10/27/15 at 4:00 PM administrator, director of nursing and nurse consultant stated the facility had policy or procedure for caring for dialys residents. The nurse consultant also stated there was no communication between the facility and the dialysis clir. In an interview 10/27/15 at 4:10 PM Nurse #2 stated she had not assessed Resident#193 yet but she check on him when she after he got back from therap. She stated she started her medication pass and did not obtain his vital signs a of yet.	no sis nic. n		
					In an another interview on 10/28/15 at 8:30 AM, Resident #193 stated they go his vital signs yesterday and they put u sign in his room informing staff not to d lab draws or blood pressure in his right arm. He stated they asked his permissibefore putting up the sign and he felt a better knowing it was up there. The Permcath was observed with the caps	p a o i ion		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345557	B. WING _	B. WING		10/:	28/2015
	ROVIDER OR SUPPLIER	ER		38	TREET ADDRESS, CITY, STATE, ZIP CODE 800 INDEPENDENCE BOULEVARD /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356 SS=C	INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number ar by the following categunlicensed nursing stresident care per shift - Registered nurse - Licensed practic vocational nurses (as - Certified nurse a o Resident census. The facility must post specified above on a	NURSE STAFFING The following information on the actual hours worked gories of licensed and aff directly responsible for trues. The seal nurses or licensed adefined under State law). The actual hours worked gories of licensed and aff directly responsible for trues. The nurse staffing data daily basis at the beginning ust be posted as follows:		3356	In an interview on 10/28/15 at 10:40 AM the rehabilitation director stated Reside #193 came straight to therapy yesterda and stood for 6 minutes before tiring. S stated therapy did not assess his vital signs or access prior to therapy. In an interview 10/28/15 at 11:40 AM the nurse consultant and the administrator stated their expectation would be for the facility staff know how to adequately cafor a dialysis resident to include access safety and precautions, clinical assessment and have communication with the dialysis clinic.	ent ny he ne e e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	` ′	(X3) DATE SURVEY COMPLETED			
		345557	B. WING		,	10/28/2015		
NAME OF PROVIDER OR SUPPLIER AZALEA HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412		10/20/2013		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 356	residents and visitor. The facility must, up make nurse staffing for review at a cost standard. The facility must may staffing data for a magnification required by State later. This REQUIREMENT by: Based on observation interviews, the facility with the resident convoked of registeres the actual hours worked of registeres the actual hours worked interviews. The findings included the convoked of the convoked of the actual hours worked on 10/25/15 at 4:30 posting of daily staff hours worked by all by shift. The posting	ace readily accessible to rs. con oral or written request, g data available to the public not to exceed the community aintain the posted daily nurse ninimum of 18 months, or as law, whichever is greater. NT is not met as evidenced clions, record review and staff lity failed to post daily staffing lensus and the actual hours d nurse (RN) separate from lorked by licensed practical of 4 days of the survey. ed: D PM, during the initial tour, the fing included the total actual licensed nurse (RN and LPN) and did not list separately the	F 3	,				
	on 10/26/15 at 8:00 staffing included the all licensed nurse (I posting did not list sworked by RN and include the resident	d by RN and LPN. The daily ude the resident census. O AM, the posting of daily e total actual hours worked by RN and LPN) by shift. The separately the actual hours LPN. The daily staffing did not totensus. O AM, the posting of daily						

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F 356	staffing included the tall licensed nurse (RN posting did not list seworked by RN and LF include the resident con 10/28/15 at 8:00 A staffing included the tall licensed nurse (RN posting did not list seworked by RN and LF include the resident conclude the resident concluded the tall licensed nurse (RN posting did not list seworked by RN and LF include the resident concluded the resident control to the form that 9:45 AM revealed to format on the form that form did not list the acregistered nurse separactical nurse hours further stated that goi sure the form is revise resident census and the state of the state	otal actual hours worked by and LPN) by shift. The parately the actual hours PN. The daily staffing did not ensus. AM, the posting of daily otal actual hours worked by and LPN) by shift. The parately the actual hours PN. The daily staffing did not ensus. ector of Nursing on 10/28/15 hat she followed the same at was completed in the ministrator on 10/28/15 at the she was not aware that the ctual hours worked by the entate from the licensed worked. The Administrator ing forth she would make and it captures the daily he actual hours worked by the actual hours worked	F 3	56		