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 06/28/2017

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 000	INITIAL COMMENTS No deficiences were cited as a result of the complaint investigation. Event ID# P9L311.	F 000		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		7/17/17

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

Electronically Signed | 07/16/2017

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F 441	Continued From page 1 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain infection control for 1 of 3 residents observed during a medication administration pass (Resident #4). Findings included:	F 441	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purpose of general liability, professional malpractice or any other court proceeding. F441	

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F 441	Continued From page 2 Record review showed that Resident #4 was originally admitted to the facility on 04/01/13, was discharged on 01/12/16, and then readmitted on 01/20/16. Current diagnoses include: Hypertension, Atherosclerotic Heart Disease, Angina, Dysphagia, Osteoarthritis, Spinal Stenosis, Muscle Weakness, Anxiety, Abnormal Gait, History of Falling, Adult Failure to Thrive, Cardiac Arrhythmia and Cardiac Pacemaker. An observation of medication administration on 06/27/17 at 9:09 AM by Nurse #1 revealed that when preparing medications for Resident #4 the nurse cut a pill in half intending to drop half into the dispensing cup but accidentally dropped both halves into the cup. She then reached into the cup to extract 1/2 of the pill touching all the pills in the cup with her bare hand after she had touched many items including the computer keyboard several times, multiple medication bubble packs, the keys for the medication cart, the narcotic book, and her pen. After surveyor intervention, the nurse discarded the contaminated medications. In an interview with Nurse #1 on 06/27/17 at 9:15 AM she stated that she had intended to administer the medications to Resident #4 because she had used hand sanitizer before she started to prepare the medications. When she realized all the items she had touched after she had sanitized her hands, she stated that the pills were contaminated by reaching into the cup and touching all the pills with her bare hand. In an interview with the Director of Nursing on 06/27/17 at 9:36 AM she revealed that it is her	F 441	Steps taken for the resident affected: Resident #4's contaminated medications were discarded on 6/27/17 by the licensed nurse. Steps taken for other residents with the potential to be affected: Education was provided by the DON/or designee completed on 7/15/17 to licensed nurses regarding the appropriate manner to discard medication from cup containing other medications to prevent contamination Measures put in place to ensure the deficient practice does not recur: The DON/or designee will audit four nurses per week times 4 weeks and then four nurses per month times 2 months to ensure medications are not contaminated during discard of medication from cup containing other medications Monitoring effectiveness of correction action plan: These audits will be brought by the DON/or designee to the Quality Assurance Committee for 3 months for review. Any areas of concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 441	Continued From page 3 expectation that if a pill needed to be taken out of a medication cup containing other pills that the nurse would use a spoon or wear a glove so that the remaining pills would not be contaminated. She stated that she would expect the nurse to discard any medications that were contaminated.	F 441		