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 04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

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F 000	INITIAL COMMENTS An onsite revisit and complaint investigation survey was conducted on 4/20/21 through 4/28/21.Tags F641 and F880 were corrected as of 4/28/21. However, new tags were cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. Event ID# CE9511.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		5/1/21

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

Electronically Signed | 05/06/2021

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Responsible Party (RP) of a fall with injuries for 1 of 1 resident reviewed for notification of changes (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/16/21 and discharged to the hospital on 4/3/21. She had diagnoses which included anemia and gastrointestinal hemorrhage. Resident #1's most recent Minimum Data Set dated 4/03/21 indicated she had moderately impaired cognition and she was coded as requiring supervision for eating, limited	F 580	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. 1. Resident #1 is no longer a resident at this building. 2. To identify other residents that have the potential to be affected, current residents with new fall with a new skin injury from a fall will be identified by completing an audit of orders and incident reports looking back 30 days. Any identified issues will be addressed.	

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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. 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 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 done so. He also stated he did not remember if he informed the oncoming day shift he had been unable 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 hand and the bridge of her nose. She stated the RP should be notified of a resident's fall as soon as practical after a fall.	F 580	3. To prevent this from reoccurring, current licensed nurses will be reeducated concerning the requirement to notify the resident representative when there is a new fall and skin tear. This education will be completed by the Director of Nursing or designee. Any licensed staff that cannot be reached within the initial reeducation time frame of 24 hours, will not take an assignment until they have received this reeducation. Newly hired nurses and agency licensed nurses will have this education during their orientation. 4.To monitor and maintain ongoing compliance, the Director of Nursing or designee will review the 24 hour report and validate that resident representative notification had been completed for any change of condition or new orders. Any identified issues will be addressed and the resident representative will be notified as soon as possible. This will be documented daily for 7 days, 5 days a week for 3 weeks, and a weekly audit for these issues for 8 weeks. The Director of nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 580	Continued From page 3 An interview on 4/28/21 at 10:59 AM with the Administrator revealed she was unaware of the facility's failure to notify the RP of Resident #1's fall with injuries to her right hand and the bridge of her nose. She stated the family should be notified as soon as possible of a resident's fall.	F 580		
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 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 Nurse Practitioner (NP) interviews, the facility failed to assess and obtain orders for treatment of a right hand skin tear and abrasion on the bridge of the and failed to follow the NP's order to obtain a urinalysis for 1 of 1 resident (Resident #1) reviewed for supervision to prevent accidents. Findings included: 1. Resident #1 was admitted to the facility on 3/16/21. She had diagnoses which included anemia and gastrointestinal hemorrhage. Resident #1's most recent Minimum Data Set dated 4/03/21 indicated she had moderately impaired cognition and she was coded as	F 684	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. F 684 1. Resident #1 is no longer a resident in the building 2. Current residents are at risk for these issues. a. An audit of incidents looking back 30 days will be completed to identify any skin injury and validate that it was assessed	5/1/21

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F 684	Continued From page 4 requiring supervision for eating, limited assistance for locomotion off unit, total dependence for bathing, and extensive assistance for all other activities of daily living. a. Review of the Incident Report completed by Nurse #1 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. Review of physician's orders for March 2021 and April 2021 revealed no orders for wound care treatment for Resident #1's right hand or the bridge of her nose. Review of Resident #1's Treatment Administration Record (TAR) for March 2021 and April 2021 revealed no treatments completed for her right hand or the bridge of her nose. Review of nurses' progress notes revealed no documentation of wound care for Resident #1's right hand skin tear or abrasion on the bridge of her nose. 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 it 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 did not complete wound measurements for the two injuries. Nurse #1 revealed he believed that completion of the fall injuries section on the risk management report triggered a notification to the wound care nurse. He stated he completed that section of the risk	F 684	and treatment orders were written, b. An audit of orders looking back 30 days will be complete to identify any labs ordered to validate that the order was carried out. Any issues identified will be addressed. 3. To prevent from recurring a. The current licensed nurses have been reeducated concerning the policy "Resident Change of Condition." This reeducation includes the expectation that any new skin injury will be assessed and treatment orders will be written at the time of injury. The documentation of the presence of the skin injury is for the nurse who is assigned to the resident at the time of the incident. b. The current licensed nurses have been reeducated to follow physician orders as they are written. If unable to follow physician orders, the physician must be notified This education will be completed by the Director of Nursing or designee. Any licensed staff that cannot be reached within the initial reeducation time frame of 24 hours, will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation	

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F 684	Continued From page 5 management report which was to notify the wound care nurse to further assess, measure, and continue treatment as needed for Resident #1's right hand skin tear and nose abrasion. An interview on 4/26/21 at 11:54 AM with the Wound Care Nurse revealed she was not aware of Resident #1's fall injuries to her right hand and nose. She stated she had not provided any wound care to Resident #1's skin tear on her right hand or the abrasion on her nose. She further stated when staff completed a resident skin assessment and checked the box for a new area, it triggered for her to be notified and she would assess and initiate treatment. A follow-up interview on 4/28/21 at 9:37 AM with the Wound Care Nurse revealed the risk management report did not trigger any notification to the Wound Care Nurse when there was an injury. An interview on 4/27/21 at 12:41 PM with the NP revealed she was aware Resident #1 had a skin tear on her right hand. She stated the facility had wound care protocols in place and she had not provided any additional orders for treatment. She stated she remembered seeing a 'scratch' on the resident's hand but could provide no other details. An interview on 4/28/21 at 10:37 AM with the Director of Nursing (DON) revealed she was aware of the facility's failure to provide Resident #1 with wound care for her right-hand skin tear and abrasion on the bridge of her nose. She stated this deficiency had been identified during a mock survey performed on April 13 through April 15, 2021. She stated that staff had received education on April 22, 2021 and audit tools had	F 684	4. To monitor and maintain on going compliance, the Director of Nursing or designee will: a. Review the incidents to identify any injury has been assessed and orders are in place for treatment. b. Review the 24 hour report and validate that the orders for labs have been carried out. Any issues identified will be addressed immediately. This will be documented daily for 7 days, 5 days a week for 3 weeks, and a weekly audit for these issues for 8 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 684	Continued From page 6	F 684		

been put into place to monitor compliance. She stated it was a system breakdown in communication that resulted in the wound care nurse not being notified of the new skin injuries for Resident #1.

An interview on 4/28/21 at 10:59 AM with the Administrator revealed she was aware that the risk management report did not trigger a notification for the wound care nurse. She stated this issue had already been identified and addressed during the mock survey and related training.

b. Review of Physician Progress Note dated 3/31/21 at 2:20 PM revealed the Nurse Practitioner (NP) had assessed Resident #1 for increased confusion and ordered a STAT (now) urinalysis and laboratory tests.

Review of the nurses' progress notes revealed no documentation related to attempts for collection or resident refusal of the urinalysis ordered for Resident #1.

An interview on 4/27/21 at 9:03 PM with Nurse #1 revealed he assigned to provide care for Resident #1 on the night of 3/31/21 and he was unaware a urinalysis had been ordered for Resident #1. He stated he did not remember if he was informed of the urinalysis order from the prior shift.

An interview on 4/27/21 at 2:41 PM with the NP revealed she had not been notified that the facility was unable to obtain the urinalysis. She stated the facility should have notified her if they were unable to obtain the urinalysis and she had not been notified. She also stated the facility had a protocol to perform an in and out urinary

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F 684	Continued From page 7	F 684		

catheterization to obtain a urine specimen if the resident was incontinent.

An interview on 4/26/21 at 1:38 PM with the Director of Nursing (DON) revealed she was aware the urinalysis had not been obtained for Resident #1. She stated she believed the resident had refused to have an in and out catheterization performed but confirmed there was no documentation related to the collection attempt, refusal, or that the NP had been notified the urinalysis specimen had not been obtained. The DON stated this deficiency had been identified during a mock survey performed at the facility on April 13 through April 15, 2021. She also stated that the staff had received education on April 22, 2021 and audit tools had been put into place to monitor compliance.

An interview on 4/27/21 at 1:38 PM with the Administrator revealed she was aware of the facility's failure to obtain the urinalysis specimen. She stated this deficiency was identified during the mock survey performed at the facility on April 13 through April 15, 2021.