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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalea Health & Rehab Center	3800 Independence Boulevard Wilmington, NC 28412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on staff, Nurse Practitioner, and resident interviews, the facility failed to treat a resident with dignity and respect when Nursing Assistant (NA) #2 spoke to Resident #1 in a manner that made her cry, feel nervous, anxious, and as if she was going to have a panic attack. Resident #1 was observed by staff crying inconsolably (unable to be comforted) following an interaction with NA #2. This deficient practice affected 1 of 3 residents reviewed for dignity and respect. Findings included: Resident #1 was admitted on [DATE] with anxiety, worsening generalized weakness, peripheral numbness, and recurrent falls. Review of Resident #1's 3/19/24 quarterly Minimum Data Set assessment indicated resident was cognitively intact with no hallucinations or delusions, no behaviors and was coded as frequently incontinent of bowel and bladder. Resident #1 required extensive assistance with bed mobility, transfers and toileting. Resident #1 received an antianxiety medication. Review of Resident #1's care plan which was most recently updated on 3/26/24 revealed problem areas related to continence and Activities of Daily Living (ADL's). The care plan indicated Resident #1 had a self-care deficit related to decline in functional abilities, physical deconditioning, and pain. Interventions included getting out of bed to wheelchair as tolerated and toilet transfers with assistance of 1. The care plan indicated Resident #1 had episodes of bladder and bowel incontinence and interventions included to provide incontinence care as needed. (continued on next page)

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.

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Observation of Resident #1 on 5/29/24 at 10:00 AM was conducted in conjunction with an interview. The resident was well groomed and was sitting in a wheelchair in her room. Resident #1 was alert with no confusion noted. Resident #1 stated she had an incident with NA #2 in April 2024. Resident #1 stated NA #2 was very aggressive, loud, heavy handed, rude and was getting worse prior to the incident on 4/6/24. Resident #1 stated NA #2 made her anxious when she came on duty but she (Resident #1) stated she had not reported this. Resident #1 stated in the afternoon when she knew NA #2 was coming on duty for 3-11 shift, she would get nervous and anxious like she was having a panic attack. Resident #1 stated her anxiety was made worse by NA #2 and how she treated her. Resident #1 stated at the time of the incident, she was weak and required increased assistance due to a recent hospital stay. Resident #1 stated on the evening of the incident on 4/6/24 she used her call bell to request assistance. NA #2 responded to her call light, screamed, What do you want? in an aggressive tone and threw the incontinent wipes at her with them landing on her stomach. NA #2 left the room and was very loud in the hallway talking about her (Resident #1) to the other staff saying, I guess she [Resident #1] can't help herself today. Resident #1 stated NA #2 returned to provide care for her with another NA. Resident #1 stated she believed NA #2 was frustrated with her for requiring assistance and she (NA #2) made her feel bad. Resident #1 stated Nurse #6 provided care for her for the rest of the shift. Resident #1 stated it had been difficult adjusting to the facility when she was admitted last year being a younger person than most residents in the facility and then she had a setback with her hospitalization that caused increased weakness. This incident with NA #2 was hard on her but she was trying to move on and stay positive. An interview was conducted with NA #2 on 5/30/24 at 12:15 PM. NA #2 stated she was assigned to Resident #1 on 4/6/24 on the 3:00 PM to 11:00 PM shift. NA #2 stated she was familiar with Resident #1 and was assigned to her frequently. NA #2 stated she thought Resident #1 was jealous when she helped her roommate and did not like her (NA#2). NA #2 indicated prior to this incident, she should not have been assigned to Resident #1 as they did not have a good rapport. NA #2 stated on 4/6/24, Resident #1 was in bed which was not her usual routine and Resident #1 stated she did not feel good that day. Around 6:30 or 7:30 PM Resident #1 activated her call bell and said she needed to be changed. NA #2 stated she gave Resident #1 the cleansing wipes to clean herself. NA #2 stated she noticed the bed was wet, so she went to get linens to change the bed. NA #2 stated she came back in the room, changed the bed and then Resident #1 needed to be pulled up. NA #2 stated she got another nursing assistant (NA #4) to assist her because she (NA #2) had a heart attack and could not pull on the residents. NA #2 said around 8:30 or 9:00 PM Nurse #6 told her not to go back in Resident #1's room but did not tell her why. NA #2 stated she continued to work the rest of the shift that evening. NA #2 stated on 4/7/24 around 1:30 PM she received a call stating she was not to come in to work for 3:00 PM to 11:00 PM shift but was not told why. NA #2 stated about a week later she was called to come for a meeting with the Administrator and Nurse #3 where she was informed, she was terminated. NA #2 stated she was terminated for incontinence abuse. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with NA #4 on 5/30/24 at 11:50 AM. NA #4 was working 3-11 shift on 4/6/24 on the other end of the hall from Resident #1's room. NA #4 stated that evening she was at the nurse's station when NA #2 called out requesting help with pulling Resident #1 up in the bed. NA #4 stated Resident #1 was crying when she entered the room. NA #4 stated NA #2 instructed Resident #1 to use her legs to assist with pushing up in the bed. NA #4 stated Resident #1 tried to assist but could not and she observed that NA #2 was visibly frustrated with Resident #1. NA #4 stated NA #2 told Resident #1 that she had a heart attack and could not pull on her. NA# 4 stated she helped pull Resident #1 up in the bed and left the room. NA#4 stated she had been working at the facility through an agency since December 2023. NA #4 stated she frequently worked 3-11 shift on the 100 hall. NA #4 stated Resident #1 would frequently ask who was assigned to her and when it was NA #2, she voiced that she did not want NA #2 taking care of her and would get upset. NA #4 stated she was working as a NA through an agency, so she did not get involved with asking why she did not want NA #2 to take care of her. NA #4 stated Resident #1 and NA #2 did not have a good relationship. NA #4 indicated she was familiar with Resident #1 and was assigned to her occasionally. NA #4 stated Resident #1 was cognitively intact and pleasant when she was assigned to her. An interview was conducted with Nurse #6 on 5/29/24 at 12:30 PM. Nurse #6 revealed she worked the 3:00 PM to 11:00 PM shift on 4/6/24 and was assigned to Resident #1. Nurse #6 stated she entered Resident #1's room on the evening of 4/6/24 after NA #2 provided care and found the resident crying and visibly upset. Resident #1 stated she did not want NA #2 to provide care for her again. Nurse #6 stated NA #2 continued to work the rest of the shift but did not provide care for Resident #1. Nurse #6 indicated she had not heard nor witnessed the interaction between NA #2 and Resident #1 that evening and was unaware of any prior incidents. An interview was conducted with Nurse #3 on 5/29/24 at 1:30 PM. Nurse #3 stated she was the interim DON at the time of this incident on 4/6/24. Nurse #3 stated she received a call on 4/7/24 around 12:00 PM from Nurse #6. Nurse #6 informed Nurse #3 that on 4/6/24 Resident #1 was crying inconsolably and visibly upset and stated she did not want NA #2 to provide care for her any longer. Nurse #3 stated she interviewed Resident #1 and was concerned about NA #2 refusing to provide care, her demeanor and how she spoke to the resident. Nurse #3 stated Resident #1 was cognitively intact, and she was not aware of any issues with NA #2 and Resident #1 prior to this incident. Nurse #3 stated she called NA #2 and informed her she was suspended pending investigation of the incident. Nurse #3 stated NA #2 was later terminated due to poor customer service and refusing to provide care. Nurse #3 indicated she expected all residents would be treated with dignity and respect. An interview was conducted on 5/30/24 at 2:30 PM with the Nurse Practitioner (NP). The NP stated Resident #1 was cognitively intact, pleasant and self-aware. The NP stated at the time of the incident between Resident #1 and NA #2 the resident had weakness and deconditioning due to a hospital stay for sepsis. The NP stated she was made aware of the incident that occurred on 4/6/24 between Resident #1 and NA #2. The NP indicated she was monitoring Resident #1 closely for depression and anxiety. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 5/30/24 at 3:40 PM with Nurse #11. Nurse #11 was assigned to Resident #1 on 4/7/24 on the 7:00 AM to 3:00 PM shift. Nurse #11 stated she was an agency nurse. Nurse #11 stated Resident #1 approached her on 4/7/24 and asked to talk to her privately. Resident #1 indicated on 4/6/24 on the 3:00 to 11:00 PM NA #2 went in to assist her and was rough and rude to her, slamming things around. Resident #1 stated NA #2 told her she did not clean up people that were continent. Resident #1 stated NA #2 told her to pull herself up in the bed. Resident #1 stated she told NA #2 she could not pull herself up as she was not feeling well that day and was weak. NA #2 told Resident #1 she couldn't pull her up since she (NA #2) had a medical issue, so she (NA #2) yelled into the hallway for someone to help her. Resident #1 was crying visibly upset what did that look like? when describing the incident. Resident #1 stated she reported another incident to Nurse #3 in which NA #2 had talked to her in a mean way and made her feel bad. Resident #1 stated nothing was done about it. Nurse #11 stated she wrote a note about what Resident #1 said and put it under the Administrator's door to follow up. An interview was conducted with the Administrator on 5/31/24 at 10:20 AM. The Administrator stated there was an incident which occurred on the evening of 4/6/24 in which Resident #1 required assistance with incontinence care. In the interview, the Administrator initially stated she became aware of the incident in the morning on 4/8/24 but later stated she was informed by Nurse #3 in the evening on 4/7/24. The Administrator stated Resident #1 reported she was observed visibly upset and expressed that she did not want NA #2 to enter her room or provide care for her again due to the NAs demeanor. The Administrator stated she expected residents to be treated with dignity and respect and for residents to receive care as needed or requested. The facility provided the following Corrective Action Plan with a completion date of 4/10/24: 1.On 4/6/24, Resident #1 was crying and visibly upset and expressed to Nurse #6 that she did not want NA#2 to provide care for her again. Nurse #6 provided care to Resident #1 for the remainder of the shift. Resident #1 was assessed for redness or skin breakdown with no negative findings noted. On 4/7/24, the Nurse Aide in question (NA#2) was suspended pending investigation of the incident that occurred on 4/6/24. NA #2 was terminated for poor customer service and declining to preform duties per job description. On 4/7/24, Resident #1 was interviewed regarding the incident and an investigation was initiated. 2. To identify residents with the potential to be affected: The Director of Nursing (DON)/designee completed interviews by 4/8/24 with cognitively intact residents regarding mistreatment. No other issues were identified. The Unit Managers/designee completed skin checks by 4/8/24 on all cognitively impaired residents to ensure there were no signs or symptoms of mistreatment. No negative findings were noted. 3. On 4/8/24, to prevent this from happening again, the Administrator/designee educated staff on resident rights. All newly hired staff are educated on abuse and resident rights. All agency staff are educated on resident rights. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	4.To monitor and maintain ongoing compliance, the Social Worker/designee will interview 5 cognitively intact residents weekly for 8 weeks to ensure they feel they are treated with dignity and respect. In addition, the DON/designee will assess 5 cognitively impaired residents weekly for 8 weeks to ensure there are no signs of mistreatment. Results of the audits will be brought to the Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations as needed. A QAPI meeting was held on 4/8/24 with the Medical Director and members of QAPI committee. The incident that occurred on 4/6/24 and the plan of corrective action was reviewed by the committee. 5. The allegation of compliance date was 4/10/24. The corrective action plan was validated on 5/31/24 and concluded the facility implemented an acceptable corrective action plan. Interviews conducted with staff revealed the facility provided education and training on the treatment of residents with dignity and respect. The initial interviews with residents and skin checks were validated as completed on 4/8/24. The ongoing monitoring audits were validated as completed weekly starting the week of 4/8/24. The facility's corrective action plan's completion date was verified as 4/10/24.