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	05/30/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews the facility failed to hold a blood pressure medication according to the physician ordered parameters and administered the blood pressure medication unnecessarily to 1 of 5 residents reviewed for unnecessary medication administration (Resident # 55). Findings included: Resident #55 was admitted to the facility on [DATE] with diagnoses including high blood pressure. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #55 was cognitively intact. A physician order written on 12/28/24 revealed an order for Metoprolol Succinate Extended Release (a medication used to treat high blood pressure), 25 milligrams (mg) one tablet once a day. Hold for Systolic Blood Pressure (SBP) less than 110 millimeters of mercury (mm/Hg). Review of the April 2025 Medication Administration Record revealed to administer Metoprolol Succinate 25 mg and hold for SBP of less than 110 mm/Hg with a section to include the recorded blood pressure. On 04/12/25, Resident #55's blood pressure was recorded as 101/73 mm/Hg and the medication was signed off as given by Nurse #1, and on 04/19/25 the blood pressure was recorded at 105/60 mm/Hg and the medication was signed off as given by Nurse #3. The blood pressure recording was within normal limits on 04/13/25 despite the administration of the blood pressure medication given on 04/12/25, however, the blood pressure recording on 04/20/25 was lower and recorded as 100/69 mm/Hg after receiving the medication on 04/19/25. Review of the May Medication Administration Record revealed to administer Metoprolol Succinate 25 mg and hold for SBP of less than 110 mm/Hg with a section to include the recorded blood pressures. On 05/03/25 Resident #55's blood pressure was recorded as 93/60 mm/Hg and the medication was signed off as given by Nurse #3, on 05/10/25 the blood pressure was recorded as 103/67 mm/Hg and signed off as given by Nurse #2. On 05/25/25 the blood pressure was recorded as 97/69 mm/Hg and signed off as given by Nurse #3, on 05/16/25 the blood pressure was recorded as 109/80 mm/Hg and signed off as given by Nurse #1. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #1 on 05/29/25 at 1:02 PM. Nurse #1 reported that Resident #55's blood pressure can run low at times and she believed there was an order to hold the medication if the systolic blood pressure was less than 100 mm/Hg. Nurse #1 reviewed the order that was written on 12/28/24 and confirmed that the Metoprolol Succinate should have been held if the SBP was less than 110 mg/Hg. Nurse #1 stated on 04/16/25 and 05/12/25 she was thinking only to hold it if the SBP was less than100 mm/Hg, but she could not say for certain if that was why she did not hold it. Nurse #1 stated she should not have given the medication since his SBP was less than 110 mm/Hg per the physician order. An interview was conducted with Nurse #2 on 05/30/25 at 10:30 AM. Nurse #2 reviewed the May Medication Administration Record and stated she did not know why she administered Resident #55 his blood pressure medication on 05/10/25. Nurse #2 stated the order read to hold the medication if the SBP was less than 110 mm/Hg and she should have held it. An interview was attempted with Nurse #3 via phone 05/30/25 at 12:19 PM by voice message and text. Nurse #3 did not return the call or the text to be interviewed. An interview was conducted with Nurse Practitioner #1 via phone on 05/30/25 at 12:30 PM. The Nurse Practitioner stated she would expect the nursing staff to be following the physician order as written. She stated the parameters were in place for a reason and although Resident #55 was receiving a low dose of the medication, receiving the medicine outside the parameters could put him at risk for hypotension and he should not have received the medication unnecessarily. An interview was conducted with the Director of Nursing on 05/30/25 at 3:35 PM. The Director of Nursing stated she would expect the physician's order to be followed and for the nursing staff to ensure they were holding the blood pressure medication per parameters. The Director of Nursing added, Resident #55's blood pressure has a history of getting low and the parameters were in place for that reason. She stated it did not matter if the blood pressure reading was just one point lower than 110 mm/hg, the order should be followed as written so that the resident would not receive the medication unnecessarily.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Physician and staff interviews, the facility failed to thoroughly review the hospital discharge summary and clarify physician orders for a newly admitted resident (Resident #231) resulting in the failure to transcribe and administer an intravenous (a catheter inserted into a vein for medication administration) antibiotic medication listed on the discharge summary. Penicillin G (antibiotic) was not administered from 03/29/25 through 03/30/25 resulting in 6 missed doses of the antibiotic treatment. This deficient practice occurred for 1 of 1 resident reviewed for significant medication errors. Findings included: Resident #231 was admitted to the facility on [DATE]. Diagnoses included osteomyelitis (an infection in the bone), and discitis (an infection in the intervertebral disc space). Review of the Discharge summary dated [DATE] from the hospital on page 1 revealed Resident #231's discharge diagnoses was discitis / osteomyelitis of the thoracic region and to continue intravenous (IV) antibiotics with a tentative stop date of 05/02/25. The discharge new medications list included Heparin (a blood thinning agent) flush 10 units per milliliter (ml) solution injection; flush IV catheter daily, and Heparin flush 10 units per ml injection; flush IV catheter with 5 ml as needed after each use, Sodium Chloride 0.9% injection 10 ml; flush IV catheter daily and Sodium Chloride 0.9% 10 ml; flush IV catheter as needed before and after each use (prior to Heparin). Under the new medications list on the discharge summary there were no antibiotics noted, however, the discharge summary included 14 pages total and on page 9 under discitis and osteomyelitis of the thoracic region it stated resident transitioned from vancomycin/cefepime (types of antibiotics) to penicillin with plans of 6 to 8 weeks of IV antibiotics. Final antibiotic recommendations per infectious disease as follows: Penicillin G 4 million units IV every 4 hours, tentative stop date of antibiotics 05/02/25 (6 weeks) and in capital letters ATTENTION SKILLED NURSING FACILITY (SNF's) IF QUESTIONS REGARDING ANTIBIOTICS/DRUG LEVELS/LABS AFTER HOURS, PLEASE CALL. The discharge summary included additional orders below this statement for a peripherally inserted central catheter (PICC - used for long term or frequent IV treatments due to providing a longer lasting method of accessing the bloodstream) was placed on 03/28/25 however, had to be replaced as it was too deep on 03/29/25, PICC line care, and PICC line to be removed after last dose of antibiotics administered. A nursing note written on 03/29/25 at 6:00 PM by Nurse #6 revealed Resident #231 was admitted to the facility via transport. Resident's vital signs were stable with a PICC line to right arm. Medication orders were verified with the on call Physician Assistant and sent to pharmacy. A review of the physician orders dated 03/29/25 revealed the Heparin Flush and the Sodium Chloride Flush (medications to keep an IV line clear and unobstructed) orders were transcribed on 03/29/25 with a start date of 03/30/25. There were no orders transcribed for the Penicillin G 4 million units IV every 4 hours with a stop date of 05/02/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Medication Administration Record for March 2025 revealed the Heparin Flush and the Sodium Chloride Flush orders were transcribed to the record. On 03/30/25 at 1:00 AM the IV line for Resident #231 was flushed with the Heparin and the Sodium Chloride as evidenced by Nurse #5's initials. There were no orders transcribed for the antibiotic on the Medication Administration Record. The Minimum Data Set admission assessment dated [DATE] revealed Resident #231 was severely cognitively impaired and was coded as being on antibiotics and having IV medications with a PICC line while in the hospital. A nursing note written on 03/30/25 at 1:52 AM by Nurse #5 revealed the PICC line was removed per discharge orders. Intravenous antibiotics course was completed in hospital. A nursing note written on 03/30/25 at 3:53 PM by Nurse #2 revealed she spoke with the physician hospitalist in the emergency room (ER) on the phone and he wanted the resident sent to the ER for PICC line insertion. A nursing note written on 03/30/25 at 7:17 PM by Nurse #7 revealed per family report from hospital, resident will be admitted . Resident will have a peripheral IV placed for IV antibiotics until the surgeon was able to place the PICC line. An interview was conducted with Nurse #6 on 05/28/25 at 3:45 PM. Nurse #6 stated she recalled doing the admission orders for Resident #231 on 03/29/25. She stated she was given a packet which contained all of the discharge summary orders. She stated she reviewed the orders and called the on call Physician Assistant to verify the orders on 03/29/25. Nurse #6 stated she entered the orders into the electronic medical record which automatically synced to the pharmacy and then the pharmacy would send the medications on their next delivery. Nurse #6 stated she reviewed the new medications list and changed medications list with the on call Physician Assistant. She stated there were no antibiotics on either of these lists. Nurse #6 stated she believed she discussed the orders for the Heparin flushes and the Sodium Chloride flushes for the IV line, but she could not remember. Nurse #6 stated she did not clarify with the on call Physician Assistant that Resident #231 had an IV line with flushes ordered but no antibiotics were ordered. Nurse #6 stated the Physician Assistant did not question it either. Nurse #6 stated she learned later that Resident #231 was sent out to the emergency room on [DATE] to get another PICC line placed because Nurse #5 removed Resident #231's PICC line during the night shift because there were no orders for antibiotics. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview was conducted with Nurse #5 on 05/29/25 at 3:30 PM. Nurse #5 stated she was working the night shift on 03/29/25 into 03/30/25. She stated she was reviewing the physician discharge summary orders and doing a second check to be sure all of the medications were transcribed correctly by Nurse #6. Nurse #5 stated she had questions regarding Resident #231's orders because she saw orders for the PICC line care, but did not see orders for an antibiotic. She stated she was reading through the discharge summary and questioned if he received his last dose of antibiotics in the hospital. Nurse #5 stated there was an order to remove the PICC line after last dose of antibiotics administered and since she could not find orders for the antibiotic, she removed the PICC line because she felt Resident #231 was at risk for infection. Nurse #5 stated the next day on 03/30/25, Nurse #2 told her she reviewed the discharge summary orders and she found that there were orders in place for the antibiotic. Nurse #5 stated the order for the antibiotic was not written under the new medications list so it was not easy to find and was missed. Nurse #5 stated she should have read through the orders more clearly and if she had questions, she should have clarified them with the on call Physician Assistant before removing the PICC line. An interview was conducted with Nurse #2 on 05/30/25 at 10:30 AM. Nurse #2 stated on 03/30/25 she had asked Nurse #5 if the antibiotics were delivered from the pharmacy for Resident #231. Nurse #2 stated Nurse #5 told her she removed the PICC line because the discharge summary indicated the antibiotics had finished. Nurse #2 stated she explained to Nurse #5 there were current orders for Penicillin to be given every 4 hours and that the order was written on discharge summary above the order PICC line to be removed after last dose of antibiotics administered which Nurse #2 had circled. Nurse #2 stated there was also an order to call if there were any questions regarding the antibiotics. Nurse #2 stated no where in the discharge summary did it indicate the last dose of the antibiotic (Penicillin G) was given in the hospital. Nurse #2 stated that Nurse #5 should have called the on call physician and had the orders clarified. Nurse #2 stated as a result of her removing the PICC line, Resident #231 missed 6 doses of the antibiotic and had to be sent back to the hospital for another PICC line to be placed. A phone interview was conducted with the family member on 05/30/25 at 2:42 PM. The family member stated Resident #231 had no further difficulties when he was sent back to the ER to the get the PICC line replaced, but she had decided not to send him back to this facility. An interview was conducted with the Director of Nursing on 05/30/25 at 10:15 AM. The Director of Nursing stated there was some confusion with the discharge summary and the orders were in the packet, but it was worded as antibiotic recommendation and not listed on the new medications list along with the Heparin and Sodium Chloride flush orders. The Director of Nursing stated she would have expected Nurse #6 and Nurse #5 to read the entire discharge summary to include all the orders, and if they had questions, she would have expected them to clarify the orders with the on call physician. The Director of Nursing stated there was nothing in the discharge summary to indicate Resident #231 had completed the course of the Penicillin G antibiotic in the hospital, but that Resident #231 had completed a course of antibiotic treatments with other antibiotics. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview was conducted with the Physician on 05/30/25 at 2:15 PM. The Physician stated there have been some recent problems with the discharge summary orders from the hospital due to the hospital's new system and nurses at the facility need to be reading the discharge summaries closer. The Physician stated there were red flags such as the Heparin and Sodium Chloride flush orders. She stated the nurses verifying and reviewing the orders should have used their nursing judgement and questioned the antibiotic order if they were unsure. The Physician stated an error was made which resulted in 6 missed doses of the antibiotic. She stated she did not feel there was any harm to Resident #231 since has was not acutely ill or septic at the time, but he did have to get another PICC line replaced unnecessarily. The Physician stated Resident #231 was going to be on this antibiotic for 6 weeks to treat the osteomyelitis and get rid of the bacteria and the antibiotic treatment of 6 weeks was a slow process in healing the osteomyelitis and discitis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and Nurse Practitioner, the facility failed to have a complete and accurate medication administration record related to a blood pressure medication. This was for 1 of 5 residents (Resident #55) reviewed for unnecessary medications. Findings included: Resident #55 was admitted to the facility on [DATE]. Diagnoses included high blood pressure. A physician order written on 12/28/24 revealed an order for Metoprolol Succinate Extended Release (a medication used to treat high blood pressure), 25 milligrams (mg) one tablet once a day. Hold for Systolic Blood Pressure (SBP) less than 110 millimeters of mercury (mm/Hg). Review of the April 2025 Medication Administration Record revealed to administer Metoprolol Succinate 25 mg and hold for SBP of less than 110 mm/Hg with a section to include the recorded blood pressure. On 04/19/25, Resident #55's blood pressure was recorded as 105/60 mm/Hg and the medication was signed off as given by Nurse #3. Review of the May Medication Administration Record revealed to administer Metoprolol Succinate 25 mg and hold for SBP of less than 110 mm/Hg with a section to include the recorded blood pressures. On 05/01/25 Resident #55's blood pressure was recorded as 105/58 mm/Hg and the medication was signed off as given by Nurse #4, on 05/07/25 the blood pressure was recorded as 108/64 mm/Hg and the medication was signed off as given by Medication Aide #1, and on 05/28/25 the blood pressure was recorded as 109/80 mm/Hg and the medication was signed off as given by Nurse #1. An interview was conducted with Nurse #4 via phone on 05/30/25 at 12:50 PM. Nurse #4 revealed if there were parameters included in the order she was sure she would have held the medication. Nurse #4 stated it was an error in documenting and she should have written that the blood pressure medication was held for Resident #55 instead of signing it off to look as though it was given. An interview was conducted with Nurse #1 on 05/29/25 at 1:02 PM. Nurse #1 reported she recalled checking the blood pressure on 05/28/25 for Resident #55 and she took the blood pressure twice. Nurse #1 stated the first time the reading was 109/80 mm/Hg and then she took it again before she administered the medication and it was 116/80 mm/Hg. She stated she inaccurately documented the wrong blood pressure on the Medication Administration Record and added she should have documented 116/80 mm/Hg so the record would be clear that he was within the parameters to receive the medication. An interview was conducted with Medication Aide #1 on 05/30/25 at 1:15 PM. Medication Aide #1 reported she did not administer the blood pressure medication to Resident #55 on 05/07/25 when the reading was 108/64, and that she inaccurately documented that she did. Medication Aide #1 stated it was a documentation error and she should have recorded that it was not given and let her nurse know it was held due to the parameters to hold if SBP was less than 110 mm/Hg. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse Practitioner #1 via phone on 05/30/25 at 12:30 PM. The Nurse Practitioner stated she would expect the nursing staff to document accurately when a blood pressure medication was given or held. Nurse Practitioner #1 stated she relied on accurate documentation when she completed a chart review to get a clear clinical picture of how the resident was responding to the medication. An interview was conducted with the Director of Nursing on 05/30/25 at 3:35 PM. The Director of Nursing stated she would expect her nursing staff to utilize the electronic medical record system to accurately document when a blood pressure medication was given or held. The Director of Nursing stated she would provide education regarding the importance of accurate documentation.