

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Azalea Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, residents, and Nurse Practitioner (NP) interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of taking psychotropic medications prior to the administration of psychotropic medications for 5 of 5 residents reviewed. (Resident #23, #32, #72, #80 and #105). a). Resident #80 was admitted to the facility on [DATE]. Diagnoses included major depressive disorder. A physician order written on 12/19/25 until 06/26/26 revealed Sertraline 50 mg one tablet daily for depression. Review of Resident 80's electronic health record revealed there was no psychotropic consent signed for the medication prior to administration on 12/19/25. Review of Resident #80's medication administration record for December 2025 through June 2026 revealed Resident #80 received the psychotropic medication Sertraline 50 mg as physician ordered. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #80 was cognitively intact and demonstrated no mood or behaviors. He was coded as receiving antidepressant medication. An interview was conducted with Resident #80 on 07/29/26 at 11:17 AM. Resident #80 stated that no one had actually discussed the side effects or risks versus benefits of the medication with him and was not asked to sign any consent prior to the administration of the medication upon admission in December. b). Resident #72 was admitted to the facility on [DATE]. Diagnoses included depression and anxiety. A physician order written on 04/30/26 revealed Aripiprazole (antidepressant medication) 5 mg one tablet daily and Duloxetine (antidepressant medication) 60 mg one capsule twice daily. Review of Resident 72's electronic health record revealed there was no psychotropic consent signed for the psychotropic medications Aripiprazole or Duloxetine prior to administration on 04/30/26. The MDS admission assessment dated [DATE] revealed Resident #72 was cognitively intact and demonstrated no mood or behaviors. Resident was coded as receiving antidepressant medications. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #72's medication administration records for April, May, June and July 2026 revealed Resident #72 received the psychotropic medications Aripiprazole and Duloxetine as physician ordered. An interview was conducted with Resident #72 on 07/29/26 at 1:06 PM. Resident #72 reported that the physician nor the nursing staff had any discussion with her regarding her antidepressant medications and she did not sign a consent prior to the administration of the medications. c. Resident # 23 was admitted to the facility on [DATE] with diagnoses which included severe dementia with behavioral disturbance and anxiety. Review of Resident #23's electronic health record revealed physician orders for the following psychotropic medications: A physician order dated 4/21/26 for amitriptyline (a psychotropic medication classified as an antidepressant medication) 10 milligrams (mg) at bedtime for depression. A physician order dated 4/21/26 for fluoxetine (an antidepressant medication) 20 mg per 5 milliliters (ml) administer 10 ml daily for depression. A physician order dated 4/27/26 for lorazepam (a psychotropic medication classified as an antianxiety medication (a prescription benzodiazepine)) 0.5 mg one tablet twice per day as needed for anxiety. The order was discontinued on 5/5/26. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident # 23 was severely cognitively impaired, demonstrated no behaviors and received the following psychotropic medications: an antidepressant and an antianxiety medication during the lookback period. A review of the April 2026 electronic Medication Administration Record for Resident #23 revealed that the resident received the psychotropic medications amitriptyline, fluoxetine and lorazepam as ordered by the physician. A physician order dated 5/8/26 for lorazepam 0.5 mg one tablet twice per day as needed for anxiety. The order was discontinued on 5/11/26. A physician order dated 5/11/26 for lorazepam 0.5 mg one tablet twice per day as needed for anxiety. The order was discontinued on 5/21/26. A physician order dated 5/22/26 for lorazepam 0.5 mg one tablet twice per day as needed for anxiety. The order was discontinued on 5/26/26. A physician order dated 5/26/26 for lorazepam 0.5 mg one tablet twice per day as needed for anxiety. The order was discontinued on 6/5/26. A physician order dated 5/26/26 for lorazepam 2 mg/1 ml administer 0.25 ml twice per day as needed (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychotropic medications, the residents should be educated about the risks verses benefits of the medications prior to administration so that the resident has an understanding of the effects of the medications, and they could then decide if they wanted to take the medication or not.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, and Nurse Practitioner interviews, the facility failed to inform and provide written information to the residents/representatives pertaining to their right to accept or refuse medical/surgical treatment and to formulate an advanced directive (a form that indicates a resident's wish and what action to take for their health if the residents were no longer able to make their own decision). In addition, the facility failed to ensure code status was accurate throughout the medical record. This failure had the potential to affect 15 of 23 sampled residents (Resident #8, #9, #11, #12, #13, #16, #47, #71, #75, #80, #102, #103, #104, #105 and #107). Findings included: a. Resident #8 was admitted on [DATE]. Review of Resident #8's electronic health record revealed a physician order dated 4/29/24 for Do Not Resuscitate (DNR) status (a directive that designates that the resident does not wish to have Cardiopulmonary Resuscitation in the event of cardiac or respiratory arrest). Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. There was no indication in Resident # 8's electronic medical record that the facility provided written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. b. Resident #16 was admitted on [DATE]. Review of an annual MDS assessment dated [DATE] indicated the resident was cognitively intact. Review of a physician order dated 7/14/26 indicated an order for Resident #16 for Do Not Resuscitate (DNR) status. A Nurse Practitioner progress note dated 7/15/26 indicated that Resident #16 was listed as Full Code status, meaning staff were required to use all available life-saving measures, including cardiopulmonary resuscitation, if the resident's heart stopped or breathing ceased. The note did not include any documentation showing a change in code status from the DNR order written on 7/14/26 back to Full Code status. There was no new order written for Full Code status. There was no indication in Resident # 16's electronic medical record that the facility provided written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. An interview with Resident #16 on 7/29/26 at 1:20 PM indicated that advanced directives were not (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 7/22/26 revealed Resident #105 was a full code. The admission Minimum Data Set (MDS) assessment dated [DATE] was still in progress and contained no information regarding Resident #105's cognition. There was no indication in Resident #105's electronic medical record that the facility had provided written information concerning the right to accept or refuse medical or surgical treatment and/or to formulate an advanced directive. During an interview on 7/30/26 at 12:21 PM, Resident #105, who was alert and oriented to person, place, and time, stated she had not had any conversations with facility staff regarding advance directives. j. Resident #107 was admitted to the facility 7/10/26. A physician's order dated 7/10/26 revealed Resident #107 was a full code. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #107 was cognitively intact. There was no indication in Resident #107's electronic medical record that the facility had provided written information concerning the right to accept or refuse medical or surgical treatment and/or to formulate an advanced directive. k. Resident #9 was admitted to the facility on [DATE]. A physician order dated on 10/17/25 revealed Resident #9 was a DNR. The quarterly MDS assessment dated [DATE] revealed Resident #9 had moderately impaired cognition. There was no indication in Resident #9's electronic medical record that the facility provided written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. l. Resident #103 was admitted to the facility on [DATE]. A physician order dated on 07/18/26 revealed Resident #103 was a full code. The admission baseline assessment dated [DATE] revealed Resident #103 had intact cognition. The admission MDS assessment was not due at the time of the survey. There was no indication in Resident #103's electronic medical record that the facility provided written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to ensure expired food and food items with signs of spoilage were removed from 1 of 1 walk-in refrigerator. This failure had the potential to affect food served to residents. Findings included: During the initial tour of the kitchen with the Dietary Manager on 7/27/26 at 10:15 AM, the following expired or compromised food items were observed in the walk-in refrigerator: - Four (5 pound (lb.) bags of shredded lettuce, unopened, received 7/7/26, use-by date 7/14/26, -Two (5 lb.) bags of shredded mixed salad (lettuce/carrots), unopened, with brown discoloration, received 6/30/26, -Four (10 lb.) bags of shredded cabbage, unopened, observed to have a slimy, wet appearance, received 6/16/26, -Four heads of lettuce that appeared wilted with brown discoloration throughout, received 7/7/26, - Six heads of cabbage that appeared wilted with brown discoloration throughout, received 7/14/26, -One (5 lb.) bag of lettuce, unopened, with a use-by date of 7/20/26, -One (10 lb.) bag of shredded lettuce, unopened, with a use-by date of 7/22/26, -One gallon jug of salad dressing, opened with a use-by date of 10/20/25, -One (7 lb.) container of prepared coleslaw, with a use-by date of 7/23/26, -One (7 lb.) container of macaroni salad with a use-by date of 7/14/26, -Two (4 lb.) containers of prepared coleslaw with a use-by date of 7/15/26. During an interview on 7/27/26 at 11:20 AM, the interim Dietary Manager stated the food delivery truck arrived weekly on Tuesdays, and staff should remove any items that were past their use-by dates or compromised when putting away the delivery. He further stated all dietary staff were responsible for checking the refrigerators daily for expired foods and removing any items that were expired or compromised. During an interview on 7/27/26 at 11:45 AM, Dietary Aide #1 stated on Tuesdays one of the Dietary Aides typically pulled expired foods while putting away the delivery. She stated she was not aware that all staff were responsible for pulling expired foods. She indicated staff would work together to ensure expired foods were discarded as required. During an interview on 7/27/26 at 11:50 AM, Dietary Aide #2 stated all staff were responsible for checking the refrigerator for expired foods. She indicated they had not had time yet today to check for expired foods. During an interview on 7/27/26 at 11:55 AM, [NAME] #1 stated all dietary staff were responsible for checking and discarding expired foods daily. She stated she had not worked over the last several days and that the refrigerator had not been checked yet today for expired foods. During an interview on 7/30/26 at 1:00 PM, the Administrator stated all kitchen staff had received training instructing them to check the refrigerators daily for expired foods.		