

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345522	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2025
NAME OF PROVIDER OR SUPPLIER FLETCHER REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 86 OLD AIRPORT ROAD FLETCHER, NC 28732		
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F 000	INITIAL COMMENTS	F 000			
F 583 SS=D	<p>A complaint investigation survey was conducted onsite on 03/25/25 through 03/26/25. Additional information was gathered offsite on 03/27/25, therefore the exit date was changed to 03/27/25. Event ID# XZF11. The following intake was investigated: NC00227937. One (1) of the 4 complaint allegations resulted in deficiency.</p> <p>Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)</p> <p>§483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable</p>	F 583		4/17/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/11/2025

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.

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F 583	<p>Continued From page 1</p> <p>federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interviews, the facility failed to protect a resident's right to privacy when the Assistant Director of Nursing (ADON) received a medical report from Emergency Medical Services (EMS) personnel about a resident returning to the facility while standing in the hallway by the resident's room for 1 of 1 sampled resident (Resident #1). A reasonable person would not have wanted their private medical information discussed out in the hallway where other staff, residents and visitors could overhear.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 10/18/19 with diagnoses that included Alzheimer's disease.</p> <p>The quarterly Minimum Data Set (MDS) dated 12/06/24 revealed Resident #1 had severe cognitive impairment.</p> <p>During an observation on 03/25/25 at 10:38 AM, EMS personnel were observed bringing Resident #1 back to her room. The Director of Nursing (DON) was in the room assisting Resident #1's roommate as staff assisted Resident #1 back to bed. The ADON and EMS personnel stepped out into the hallway just outside Resident #1's room door and EMS personnel proceeded to give the</p>	F 583	<p>F583</p> <p>1. Resident #1 was not affected by the alleged deficient practice.</p> <p>The Assistant Director of Nursing was immediately re-educated on not discussing resident private medical information in public areas, including when receiving report from Emergency Medical Services or any other agency. This education was completed on 3/25/2025.</p> <p>2. All residents being have the potential to be affected.</p> <p>3. The Nursing Home Administrator educated EMS of providing privacy while discussing resident private Medical information. This education was Complete on 4/10/2025.</p> <p>The Director of Nursing/Designee re-educated all staff, including agency staff, on not discussing resident private medical information in public areas, including when receiving</p>		

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F 583	<p>Continued From page 2</p> <p>ADON a detailed medical report, including Resident #1's name, regarding Resident #1's transport to the hospital for her follow-up Orthopedic appointment. The conversation could have been easily heard by other staff, residents and visitors in the vicinity, going up and down the hallway.</p> <p>During an interview on 03/26/25 at 3:40 PM, the ADON confirmed she had received a medical report from EMS regarding Resident #1 while standing out in the hallway. The ADON stated she thought they were just going to have her sign paperwork, but the EMS personnel kept talking. The ADON stated she should have interrupted the EMS personnel to take her back into Resident's room to finish the report in order to ensure Resident #1's privacy.</p> <p>During an interview on 03/25/25 at 5:10 PM, the DON explained EMS personnel typically gave report to nursing staff in a resident's room when bringing them back to the facility. The DON confirmed she was in the room assisting Resident #1's roommate at the time and she had not noticed that the ADON and EMS personnel had stepped outside into the hallway to discuss Resident #1's medical information. The DON stated she would want Resident #1's privacy maintained.</p> <p>During an interview on 03/26/25 at 4:15 PM, the Administrator revealed she would expect for staff to maintain Resident #1's privacy and not receive a medical report from EMS personnel while standing out in the hallway. The Administrator stated staff should have intervened to let EMS personnel know to step inside Resident #1's room and pulled the door closed to have the</p>	F 583	<p>report from EMS or any other agency, this education was completed with all staff via in-person or by phone for staff who were not on duty. This education was completed on 4/16/2025. This education will be added to the facility orientation program, including agency staff and all staff. Any staff who are on Leave of Absence will receive this education prior to returning to duty.</p> <p>4 The Director of Nursing/Designee will interview 3 employees weekly for 12 weeks on providing privacy and not discussing resident private medical information in public areas.</p> <p>The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits</p> <p>Date of Completion 4/17/2025</p>		

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F 583	Continued From page 3 discussion.	F 583			
F 692 SS=D	<p>Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)</p> <p>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure fluids were available within reach for staff to offer and assist a resident with fluid intake in-between meals for 1 of 3 residents reviewed for hydration (Resident #2).</p> <p>Findings included:</p> <p>Resident #2 was admitted to the facility on 05/20/19. Her cumulative diagnoses included</p>	F 692	<p>F 692</p> <p>1. The Director of Nursing discarded the alleged out dated thickened liquids at the bedside for Resident #2 and thickened liquids were replaced with fresh thickened liquids placed in the cooler at the bedside of Resident #2. The Director of Nursing offered resident #2 thickened liquids. Resident #2 was not affected by alleged</p>	4/17/25	

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F 692	<p>Continued From page 4</p> <p>dysphagia (difficulty swallowing), contracture of the right and left elbows, contracture of the right and left hands, and vascular dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 01/10/25 revealed Resident #2 had moderate impairment in cognition, impairment on both sides of the upper and lower extremities and was dependent of staff for assistance with eating.</p> <p>A physician order dated 03/09/25 for Resident #2 revealed she was to receive a pureed diet with honey consistency thickened liquids.</p> <p>A care plan, last revised on 03/12/25, revealed Resident #2 was dependent on staff for feeding assistance, received a mechanically altered and thickened liquids diet and was at risk for dehydration. Interventions included to provide and serve diet as ordered and assist with all meals.</p> <p>An observation and interview was conducted with Resident #2 on 03/25/25 at 10:23 AM. Resident #2 was in her room sitting up in her reclining wheelchair, alert and well-groomed. On the top of the nightstand located in back of Resident #2's recliner was a red, soft fabric cooler that had a warm ice pack and no fluids. Beside the cooler was a 4-ounce cup that contained a milky colored fluid substance and covered in saran wrap that was not dated or labeled to indicate the contents. On the back of the nightstand by the wall was an opened 46-ounce carton of honey thick lemon flavored water with a date of 02/04 written in red ink on top of the carton. When asked if she was thirsty, Resident #2 replied yes. When asked if staff assisted or offered her something to drink</p>	F 692	<p>deficient practice.</p> <p>2. All residents that require staff assistance with hydration have the potential to be affected. On 3/27/2025 nursing administration completed a 100% audit of residents that requires assistance with hydration to ensure fluids were available, offered and within reach. No concerns were identified.</p> <p>On 3/26/2025 dietary obtained individual 4-oz thickened liquids. These were placed in residents individual coolers at the resident's bedside who have orders for thickened liquids.</p> <p>3. All nursing staff, including agency staff were re-educated by the Director of Nursing/Nursing Administration on Hydration, including offering fluids routinely with rounds, with meals and as requested and ensuring fluids are within reach. This re-education was completed on 4/16/2025 with all nursing staff who were on duty via in-person and with all nursing staff who were off via phone. This education will be added to the facility orientation program, including new agency staff. Any staff who were on Leave of absence will receive education upon return to duty prior to their first shift.</p> <p>4. The Director of Nursing/Designee will observe 10 residents weekly for 12 weeks that require assistance with hydration to ensure fluids are offered, available and</p>		

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F 692	<p>Continued From page 5</p> <p>throughout the day, she stated she only received something to drink with meals and nothing in-between. During the conversation, staff were informed at 10:25 AM that Resident #1 voiced she was thirsty and requested something to drink. At 10:35 AM when no one had returned to assist Resident #2, a second request was made to the Director of Nursing (DON) for assistance with getting Resident #2 something to drink. The DON brought Resident #2 a 4-ounce cup of thickened water that she had gotten from the kitchen, assisted Resident #2 with taking a drink and Resident #2 consumed the 4-ounces of fluid provided.</p> <p>During an interview on 03/26/25 at 1:27 PM, Nurse Aide (NA) #1 revealed Resident #2 received thickened liquids and usually there were individual containers of thickened liquids kept in the cooler in her room but the kitchen had been out of those for a while. NA #1 stated she did not notice the container of thickened liquid or cup of thickened liquid on top of Resident #2's nightstand. She explained if Resident #2 wanted something to drink in-between meals, she went to the kitchen to get her something to drink. NA #1 stated she asked Resident #2 if she wanted something to drink during rounds and if she did, NA #1 assisted her. NA #1 stated Resident #2 usually drank about 8-ounces of fluid with meals but she could not recall if she had offered and assisted Resident #2 with a drink of fluids in-between meals on 03/25/25 or 03/26/25.</p> <p>During an interview on 03/26/25 at 1:45 PM, NA #2 revealed Resident #2 was not able to use her hands and required staff assistance with eating and drinking. NA #2 explained she normally offered fluids when doing rounds, at meals or</p>	F 692	<p>are within reach.</p> <p>The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits</p> <p>Completion date 4/17/2025</p>		

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F 692	Continued From page 6 when passing ice. NA #2 stated she didn't pay attention to the cooler nor did she notice the carton of thickened liquid that were both placed on top of Resident #2's nightstand. She explained when a resident wanted something to drink and was on thickened liquids, she typically got something from the kitchen. NA #2 could not recall if she had offered and assisted Resident #2 with a drink of fluids in-between meals on 03/25/25 or 03/26/25. During an interview on 03/26/25 at 4:15 PM, the Administrator stated nursing staff should be offering and assisting residents as needed with a drink of fluids in-between meals, during rounds. During a joint interview on 03/26/25 with the Administrator present, the District Dietary Manager explained when containers of thickened liquids arrived, they were dated with the received date and once opened, should be marked with a use-by date of 3 days if not refrigerated. The District Dietary Manager stated they had been out of the individual 4-ounce containers of thickened liquids to keep in the coolers at bedside, so dietary staff had been pre-pouring thickened liquids into 4-ounce cups that were covered with saran wrap and stored in the kitchen refrigerator for staff to request when needed. He stated that dietary staff should be putting a date on the pre-poured cups of thickened liquids that were used when staff requested something for a resident but they did not put dates on the cups that went out with the resident's meal because they assumed the resident would be drinking it with the meal.	F 692			
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		4/17/25	

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F 695	<p>Continued From page 7</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and resident and staff interviews, the facility failed to post cautionary and safety signs that indicated the use of oxygen, ensure oxygen concentrators were clean of debris, and ensure nebulizer masks were covered when not in use for 4 of 10 sampled residents (Residents #2, #4, #5, and #6).</p> <p>Findings included:</p> <p>a. Resident #2 was admitted to the facility on 05/20/19. Her cumulative diagnoses included respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions).</p> <p>A physician's order dated 12/18/24 for Resident #2 read, oxygen at 2 liters per minute (LPM) via nasal cannula every shift.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 01/10/25 revealed Resident #2 had moderate impairment in cognition and received oxygen therapy during the MDS assessment period.</p>	F 695	<p>F 695</p> <p>1. On 3/25/2025 oxygen tubing and/or nebulizer tubing for resident(s) #2, #4, #5 and #6 were immediately discarded, replaced and storage bags were placed in room. Oxygen concentrators for resident #2 and nebulizer machine for resident #4 were cleaned. Oxygen signs were immediately placed on resident #2, #5 and #6 door frames.</p> <p>2. All residents receiving oxygen and nebulizer treatments have the potential to be affected. The Director of Nursing and Nursing Administration completed a 100% audit of all residents receiving oxygen and nebulizer treatments to ensure all oxygen and nebulizer tubing were changed and placed in bags when not in use and concentrators/nebulizer machines were clean. Any areas of concern were immediately corrected. This audit was</p>		

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F 695	<p>Continued From page 8</p> <p>An observation conducted on 03/25/25 at 10:23 AM revealed Resident #2 lying in her reclining wheelchair receiving supplemental oxygen via nasal cannula at 2 LPM. There was dried debris on the top of the concentrator and on the dial used to adjust the amount of oxygen. There was no sign posted on the door, doorframe or in Resident #2's room to indicate oxygen was in use.</p> <p>During an observation and interview on 03/25/25 at 5:10 PM, the Director of Nursing (DON) confirmed there was no signage posted to indicate Resident #2 used oxygen. The DON acknowledged the oxygen concentrator had dried debris and explained staff should clean the oxygen concentrator weekly when the tubing was changed and as needed when visibly soiled.</p> <p>b. Resident #4 was admitted to the facility on 02/06/25 with diagnoses that included chronic obstructive pulmonary disease (COPD; lung disease that blocks airflow making it difficult to breathe).</p> <p>A physician's order dated 02/06/25 for Resident #4 read, formoterol fumarate inhalation nebulization solution (used to treat COPD by opening the airways of the lungs making it easier to breathe) 20 micrograms (mcg)/2 milliliters (ml) - inhale 2 ml via nebulizer two times a day for COPD.</p> <p>The admission Minimum Data Set (MDS) assessment dated 02/14/25 revealed Resident #4 had intact cognition.</p> <p>During an observation and interview on 03/25/25 at 9:29 AM, Resident #4's nebulizer machine was</p>	F 695	<p>completed on 3/26/2025</p> <p>The Director of Nursing and Nursing Administration completed a 100% audit of all residents receiving oxygen to ensure each room had oxygen signs posted outside the doors. Any areas of concerns were immediately corrected. This audit was completed on 3/26/2025.</p> <p>3. All nursing staff, including agency staff, were re-educated on proper storage of oxygen and nebulizers when not in use, changing tubing routinely and as needed when soiled or noted on the floor, including equipment is clean and ensuring rooms where oxygen is in use has the proper oxygen signage. This education was completed on 4/16/2025 with all nursing staff via in-person that were on duty and via phone with all nursing staff who were off. This education will be added to the facility orientation program, including new agency staff. Any staff who were on Leave of Absence will be educated upon return to duty prior to their first shift.</p> <p>4. The Director of Nursing and/or Designee will audit 5 residents receiving oxygen and 5 residents receiving nebulizer treatments</p>		

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F 695	<p>Continued From page 9</p> <p>sitting on top of his nightstand with the mask lying directly behind the machine dirty and uncovered. Resident #4 stated the nebulizer treatments helped his breathing and he last used the machine approximately 30 minutes ago.</p> <p>During an observation and interview on 03/25/25 at 4:45 PM, the Director of Nursing (DON) acknowledged the mask for the nebulizer machine appeared dirty and was uncovered on top of Resident #4's nightstand. The DON explained when not in use, the nebulizer mask should be covered and stored in a plastic bag.</p> <p>c. Resident #5 was admitted to the facility on 03/07/25 with diagnoses that included respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), obstructive sleep apnea (intermittent airflow blockage during sleep) and dependence on supplemental oxygen.</p> <p>A Nurse Admission Data Collection assessment dated 03/07/25 noted Resident #5 was alert and oriented to person, place and time and needed assistance with decisions at times.</p> <p>Review of the physician orders for Resident #5 revealed the following: -03/07/25: oxygen at 4 liters per minute (LPM) via nasal cannula, continuous every shift. -03/07/25: Levalbuterol HCL nebulization solution (used to treat COPD by opening the airways of the lungs making it easier to breathe) 0.63 milligrams (mg)/3 milliliters (ml) - inhale 3 ml orally via nebulizer every 6 hours as needed for COPD, shortness of breath.</p> <p>During an observation of Resident #5's room on</p>	F 695	<p>weekly for 12 weeks to ensure tubing and mask have been changed per schedule, are in storage bags when not in use and concentrators/nebulizer machines are clean.</p> <p>The Director of Nursing/Designee will audit 5 rooms of resident receiving oxygen weekly for 12 weeks to ensure oxygen signs are in place.</p> <p>The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of these audits</p> <p>Completion date 4/17/2025</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 695	<p>Continued From page 10</p> <p>03/25/25 at 10:02 AM, an oxygen concentrator was observed on with oxygen administration set at 4 LPM. There was no sign posted on the door, doorframe or in Resident #5's room to indicate oxygen was in use. On the nightstand was a nebulizer machine with the uncovered mask placed on top of the machine.</p> <p>During an observation and interview on 03/25/25 at 5:03 PM, the Director of Nursing (DON) confirmed there was no signage posted to indicate Resident #5 used oxygen. The DON also confirmed the mask for the nebulizer machine was uncovered and stored on top of Resident #5's nightstand. The DON explained when not in use, the nebulizer mask should be covered and stored in a plastic bag.</p> <p>d. Resident #6 was admitted to the facility on 12/13/24 with diagnoses that included chronic obstructive pulmonary disease (COPD; lung disease that blocks airflow making it difficult to breathe).</p> <p>The admission Minimum Data Set (MDS) assessment dated 12/20/24 revealed Resident #6 had intact cognition and she did not receive oxygen therapy during the MDS assessment period.</p> <p>A physician order dated 03/17/25 for Resident #6 read, ipratropium-albuterol (used to treat COPD by opening the airways of the lungs making it easier to breathe) 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) solution - administer one ampule (small, sealed container used to store and administer sterile solutions) every 6 hours as needed for shortness of breath/whooping.</p>	F 695			

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F 695	<p>Continued From page 11</p> <p>A physician order dated 03/17/25 for Resident #6 read, oxygen at 2 liters per minute (LPM) via nasal cannula as needed for oxygen saturation under 90%.</p> <p>During observations on 03/25/25 at 10:19 AM and 3:20 PM, an oxygen concentrator was observed on with oxygen administration set at 2 LPM and a nebulizer machine was placed on top of the nightstand. There was no sign posted on the door, doorframe or in Resident #6's room to indicate oxygen was in use. The nebulizer tubing and uncovered mask were hanging down the side of the nightstand with the mask almost touching the floor. Resident #6 was not present in the room during the observations.</p> <p>During an observation and interview on 03/25/25 at 5:06 PM, the Director of Nursing (DON) confirmed there was no sign posted on the door, doorframe or in Resident #6's room to indicate oxygen was in use. The DON acknowledged the nebulizer tubing and uncovered mask were hanging down the side of the nightstand with the mask almost touching the floor. The DON explained when not in use, the nebulizer mask should be covered and stored in a plastic bag.</p> <p>During an interview on 03/26/25 at 4:15 PM, the Administrator stated they had received conflicting information regarding the posting of oxygen signage for residents receiving supplemental oxygen. She explained the facility would be cited during federal surveys for oxygen signage not being in place but then Life Safety would tell them the oxygen signage did not need to be placed outside of or in individual resident rooms. The Administrator stated staff should be checking nebulizer masks during rounds to ensure they</p>	F 695			

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F 695	Continued From page 12	F 695			
F 761	Label/Store Drugs and Biologicals	F 761		4/17/25	
SS=D	CFR(s): 483.45(g)(h)(1)(2)				
	<p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to secure nasal sprays and medicated creams stored in resident rooms in clear view at the bedside for 3 of 10 sampled residents (Residents #3, #4 and #5).</p>		<p>F 761</p> <p>1. Skin protectant paste was removed from the rooms of residents #3 and #4. Nasal spray was removed from the rooms of residents #4 and #5. Residents #3, #4 and #5 did</p>		

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F 761	<p>Continued From page 13</p> <p>Findings included:</p> <p>a. A Nurse Admission Data Collection assessment dated 03/20/25 noted Resident #3 was alert and oriented to person, place and time with intact short-term and long-term memory recall. It was further noted Resident #3 did not wish to self-administer medications.</p> <p>During an observation and interview on 03/25/25 at 9:47 AM, in clear view on Resident #3's overbed table was a 2-ounce tube of skin protectant paste with an active ingredient of 17% zinc oxide. Resident #3 stated the skin protectant was applied by staff and they must have left it in the room.</p> <p>During an observation and interview on 03/25/25 at 4:48 PM, the Director of Nursing (DON) observed the skin protectant paste on Resident #3's overbed table and stated it should not have been left in the room. The DON explained the skin protectant paste was applied by the nurse and should be stored on the treatment cart when not being used.</p> <p>b. A Nurse Admission Data Collection assessment dated 02/06/25 noted Resident #4 did not wish to self-administer medications.</p> <p>During an observation on 03/25/25 at 09:29 AM in clear view on top of Resident #4's nightstand was a 1.5 ounce bottle of saline nasal spray with an active ingredient of sodium chloride and a 1.5 ounce tube of skin cream with an active ingredient of 1.5% dimethicone.</p> <p>During an interview on 03/26/25 at 9:49 AM Resident #4 explained staff applied the cream to</p>	F 761	<p>not wish to self-administer medications. Residents #3, #4, and #5 were not harmed by alleged deficient practice and received medications/treatments as ordered by MD.</p> <p>2. All residents have the potential to be affected. The Director of Nursing/Nursing Management completed a 100% room audit to ensure medications were not left at bedside, unless otherwise ordered. This audit was completed on 3/27/2025.</p> <p>3. All Licensed Nursing staff, including agency staff were re-educated on the process for medications/treatments at the bedside. All Certified Nursing Assistants, including agency staff were re-educated on notifying the Licensed Nurse of any medications/treatments observed at the bedside. This education was completed with all nursing staff on duty via in-person and by phone to all nursing staff who were off by the Director of Nursing/Nursing Administration on 4/16/2025. This education will be added to the facility orientation program, including new agency staff. Any staff who were on Leave of absence will be educated upon return to duty prior to working their first shift.</p> <p>4. The Director of Nursing/Designee will randomly audit 10 rooms weekly for 12 weeks to ensure medications/treatments are not</p>		

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F 761	<p>Continued From page 14</p> <p>his abdomen and he hadn't noticed it was left on his nightstand. Resident #4 could not recall when he last used the nasal spray or who had provided it for him.</p> <p>During an observation and interview on 03/25/25 at 4:45 PM, the Director of Nursing (DON) observed the nasal spray and skin cream on Resident #4's nightstand. The DON explained the saline nasal spray should have been stored in the nurse medication cart, not left in the resident's room and the skin cream was usually left in a resident's room for staff and/or residents to use when needed.</p> <p>c. A Nurse Admission Data Collection assessment dated 03/07/25 noted Resident #5 was alert and oriented to person, place and time and needed assistance with decisions at times. It was further noted Resident #5 did not wish to self-administer medications.</p> <p>During an observation on 03/25/25 at 10:02 AM, in clear view on Resident #5's desk table was a 3 ounce bottle of nasal spray with active ingredients of 65% sodium chloride, disodium phosphate, phenylcarbinol, monosodium phosphate, and benzalkonium chloride.</p> <p>During an observation and interview on 03/25/25 at 5:03 PM, the Director of Nursing (DON) observed the nasal spray on Resident #5's table and stated it should have been stored in the nurse medication cart, not left in the resident's room.</p>	F 761	<p>at the bedside, unless otherwise ordered.</p> <p>The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of these audits.</p> <p>Completion date 4/17/2025</p>		