

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  Azalea Health Center by Harborview		STREET ADDRESS, CITY, STATE, ZIP CODE  1600 Anthony Road Augusta, GA 30904	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, staff interviews, and review of the facility policy titled, Medication Storage the facility, failed to ensure that one of three medication carts which had a medication bottle and a medication cup with medication inside was secure when left unattended and out of the site of the nursing staff. The deficient practice had the potential to allow residents and/or visitors unauthorized access to medications. Findings include: A review of the facility policy titled, Medication Storage with a reviewed/revised of 03/1/2025 documented, Policy Explanation and Compliance Guidelines: 1. General Guidelines c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Observation on 04/20/2026 at 2:27 PM revealed a medication cart that was unattended and unlocked. On top of the medication cart there was a bottle of medication as well as a medication cup which had two loose pills in the cup. There was no nursing staff in proximity of the cart nor in the hallway. Interview on 4/20/2026 at 2:27 pm Licensed Practical Nurse (LPN) KK revealed medication should not be left out on the medication cart. LPN KK further revealed the resident he was going to give the medication to needed to get insulin checked first. He took the resident back in the room leaving the medications on the cart. Interview on 04/20/2026 at 3:08 PM with the Director of Nursing (DON) revealed medications should not be left unattended on the med cart. The expectation is for when the medications are taken out they should be given to the resident. Interview on 04/20/2026 at 3:46 PM with the Administrator revealed that is not the standard of practice.</p>		

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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