STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilkesboro Health and Rehabilitation	204 Old Brickyard Road North Wilkesboro, NC 28659

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to assess a resident's ability to keep over the counter lubricating eye drops for self-administration in the residents' room for 1 of 1 resident reviewed for self administration (Resident #28).The findings included:Resident #28 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease and diabetes.Resident #28's admission Minimum Data Set (MDS) assessment dated [DATE] showed she was cognitively intact.A review of Resident #28's medical record revealed she had not been assessed for self administration of medication. On 12/08/25 at 1:52 PM, observation and interview with Resident #28 revealed a 10 milliliter bottle of over the counter lubricating eye drops containing .5% povidone (lubricant) on her overbed table, within reach as she sat in her wheelchair. She stated she had brought the eye drops from home when she moved into the facility and used them once a day or so when her eyes felt dry. On 12/09/25 at 8:38 AM, Resident #28 was observed lying in bed with the bottle of lubricating eye drops on the overbed table positioned next to her bed. During a telephone interview with Nurse #3 on 12/11/25 at 11:52 AM, she stated she had not seen the bottle of eye drops in Resident #28's room when she was assigned to her on 12/08/25 and 12/09/25 and would have removed it if she had. Nurse #3 reported she did not believe Resident #28 had been assessed for the ability to self administer medication and explained that residents should be evaluated for safety before being permitted to self administer their medications. On 12/11/25 at 12:03 PM, an interview with the Director of Nursing (DON) revealed the bottle of lubricating eye drops should not have been in Resident #28's room. The DON stated Resident #28 had not been assessed to self administer medication and explained that if she wanted to self administer the eye drops, she would need to be assessed as safe to do so, a physician order would have to be obtained, and the medication would be kept in a locked box in her room.On 12/11/25 at 1:37 PM, an interview with the Administrator revealed the bottle of eye drops should not have been left in Resident #28's room unless she had been assessed as safe to self administer medication and the medication was stored in a locked box.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and resident interviews, the facility failed to remove petroleum based jelly from a resident's room who received oxygen for 1 of 2 residents reviewed for respiratory care (Resident #96).The findings included:Resident #96 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and chronic bronchitis.Resident #96 had a physician's order dated 11/17/25 for oxygen via nasal cannula at 1 to 5 liters per minute continuously.Resident #96's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and coded for continuous oxygen therapy.A review of Resident #96's care plan dated 11/17/25 revealed a risk for potential breathing problems with interventions including assessing for signs and symptoms of respiratory distress and administering medications as ordered.An observation on 12/08/25 at 2:38 PM revealed Resident #96 sitting in his wheelchair in his room with oxygen being administered via nasal cannula by an oxygen concentrator set at 4 liters. There was a container of petroleum based jelly on the overbed table in front of Resident #96. An observation on 12/09/25 at 8:42 AM revealed Resident #96 sitting in his wheelchair in his room with oxygen being administered via nasal cannula by an oxygen concentrator set at 4 liters. There was a container of petroleum based jelly on the overbed table in front of Resident #96.An interview with Resident #96 on 12/10/25 at 8:53 AM revealed he used the petroleum based jelly on his lips when they felt dry and indicated he applied it maybe once a day. Resident #28 stated he wasn't sure who brought him the petroleum-based jelly but thought it was probably a family member.A telephone interview with Nurse #3 on 12/11/25 at 11:52 AM revealed she did not see the container of petroleum based jelly in Resident #96's room while taking care of him on 12/08/25 or 12/09/25. She indicated she knew petroleum based jelly was a potential hazard while oxygen was in use and it should not have been in his room.On 12/11/25 at 12:03 PM, an interview with the Director of Nursing (DON) revealed the container of petroleum based jelly should not have been in Resident #96's room as he was on oxygen and it was a potential hazard. The DON indicated she was going to remove the container immediately and educate nursing staff on removal of petroleum based products from the rooms of residents receiving oxygen therapy.An interview with the Administrator on 12/11/25 at 1:37 PM revealed she and the nursing staff knew that petroleum based products should not be in the rooms of residents on oxygen therapy, but families often did not remember even after education. She indicated nurses were educated to look for and remove petroleum based products during room rounds, and family members and residents were educated on admission. The Administrator confirmed the petroleum based jelly should not have been in Resident #96's room and she would immediately confirm it had been removed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to store medicated powder in a secure locked storage area for 1 of 1 resident observed with medication at bedside (Resident #15). Findings included:Resident # 15 was admitted to the facility 09/01/21. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was moderately cognitively impaired. Review of Resident #15's medical record revealed no order for miconazole nitrate 2% powder (an anti-fungal medication). An observation of Resident #15's room on 12/09/25 at 9:57 AM revealed a 3-ounce bottle of miconazole nitrate 2% powder sitting beside her bed on top of a dresser.An interview with Resident #15 was attempted on 12/09/25 at 9:57 AM but the resident did not answer when asked about the anti-fungal powder. Additional observations of Resident #15's room on 12/09/25 at 1:23 PM, 12/10/25 at 9:38 AM, 12/10/25 at 1:05 PM, and 12/11/25 at 10:10 AM revealed a 3-ounce bottle of miconazole nitrate 2% powder sitting beside her bed on top of a dresser.An observation of Resident #15's room with Nurse #1 on 12/11/25 at 10:19 AM revealed the 3-ounce anti-fungal powder on a dresser beside her bed. Nurse #1 removed the anti-fungal powder from Resident #15's room. An interview with Nurse #1 on 12/11/25 at 10:21 AM revealed she had been in Resident #15's room once that morning and did not notice the anti-fungal powder on top of her dresser. She stated if she had seen the anti-fungal powder in Resident #15's room she would have removed it at that time. Nurse #1 stated the anti-fungal powder should be stored on the treatment cart and not in the resident's room unless there was a physician order to leave in the room. A telephone interview with Nurse #2 on 12/11/25 at 1:21 PM revealed she cared for Resident #15 on 12/09/25 during the 7:00 AM to 7:00 PM shift. She stated she did not notice anti-fungal powder in Resident #15's room, and if she had seen it, she would have removed it from the room. Nurse #2 stated unless Resident #15 had a physician order to leave the medication in her room it should be stored on the treatment cart. An interview with the Director of Nursing (DON) on 12/11/25 at 10:36 AM revealed the anti-fungal powder should not have been left in Resident #15's room. She stated the medicated powder should be stored in the treatment cart unless Resident #15 had a physician order to leave the medication in the room. An interview with the Administrator on 12/11/25 at 12:54 PM revealed the medication should not be left in Resident #15's room unless there was a physician order to do so.