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	HAL032071	A. BUILDING: _____ B. WING _____	05/03/2019

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CAMELLIA GARDENS	5010 S ALSTON AVENUE DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 1-3, 2019.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidence by the storage of oxygen in an unsafe manner in resident room #1. The findings are: Observation of resident room #1 on 05/01/19 at 10:30am revealed: -There were six 11-inch oxygen tanks sitting in an upright position and unracked beside a crate next to the entrance door. -Two of the six oxygen tanks were empty, and four of the six oxygen tanks were full. Interview with a resident who resided in room #1 on 05/01/19 at 10:30am revealed the oxygen tanks had been stored in the residents' room for about two to three months.	D 079		

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D 079	Continued From page 1 Interview with a second resident who resided in room #1 on 05/02/19 at 5:00pm revealed: -The oxygen tanks had been stored in his room since his admission date of 01/22/19. -He did not know oxygen tanks should be racked and not stored in his room. -The oxygen tanks were delivered to his room on 04/30/19, and he signed for the oxygen tanks. -There was not enough room to put the six oxygen tanks inside the crate in his room. Interview with the Maintenance/Administrator on 05/01/19 at 12:34pm revealed: -He knew oxygen tanks were stored in a crate in resident room #1. -He knew oxygen tanks should be racked to prevent falling over and causing an explosion. -He did not know six oxygen tanks were stored around the crate, and he did not know the oxygen tanks should be stored in a storage room. Interview with a medication aide (MA) on 05/03/19 at 12:45pm revealed unracked oxygen tanks could turn over and cause an explosion. Interview with a second MA on 05/03/19 at 1:00pm revealed the unracked oxygen tanks could be knocked over and cause damage or harm. Interview with the Administrator on 05/01/19 at 5:00pm revealed the staff would have an in-service on 05/01/19 on the importance of storing oxygen tank in a separate storage room and away from the residents' room.	D 079		
D 108	10A NCAC 13F .0311(b)(2) Other Requirements 10A NCAC 13F .0311Other Requirements	D 108		

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D 108	Continued From page 2 (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. This rule apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure a heating unit in room #7 was working efficiently and failed to prevent the use of a prohibited portable electric heater in a resident's room. The findings are: Observation of resident room #7 on 05/01/19 at 10:30am revealed a portable electric heater was plugged in and turned on in the resident's room sitting near the chest of drawer. Interview with the resident who resided in room #7 on 05/01/19 at 10:30am revealed: -The staff gave him the portable electric heater to use in his room because the heating unit in his room was blowing cold air. -The heating unit had not been working for two to three weeks. -He had notified the Supervisor of the heating system not working properly. -He had been using the portable electric heater for about a week. -He only used the portable electric heater to knock the chill off, and then he turned the heater off.	D 108		

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D 108	Continued From page 3 Interview with the Supervisor on 05/01/19 at 12:40pm revealed: -She knew about a portable electric heater in resident room #7. -The resident's heating unit was blowing out cold air instead of warm air. -The portable electric heater was put in the resident's room on 04/26/19 by staff. -She did not know a portable electric heater could not be used in the facility. -She did not tell the Administrator about the portable electric heater being put in the resident's room. -She did not tell the Administrator about the heating unit not working in the resident's room. "It was an oversight. Interview with a medication aide (MA) on 05/03/19 at 12:45pm revealed: -"We are not allowed to use portable electric heaters in the facility." -They could cause a fire at the facility. Interview with a second MA on 05/03/19 at 1:00pm revealed: -He knew an electric heater could not be used in the facility. -The heater was a trip and fire hazard. Interview with the Maintenance/Administrator on 05/01/19 at various times between 12:34pm and 12:43pm revealed: -He did not know the staff gave the resident in room #7 a portable electric heater to use in his room. -He knew portable electric heaters could not be used in the facility. -He did not know the heating unit in resident room #7 was not working properly.	D 108		

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D 108	Continued From page 4 The facility failed to assure the heating unit in resident room #7 was working efficiently. The facility's failure resulted in the use of a portable electric heater in resident room #7 which could create a fire hazard which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/01/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2019.	D 108		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served twice daily to residents. The findings are:	D 299		

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D 299	Continued From page 5 Observation on 05/02/19 at 8:27am of the kitchen refrigerator revealed: -There were 8 unopened gallons of milk on the shelf and 4 unopened gallons of milk in a cardboard case for a total of 12 gallons of milk available to be served to residents.. -The facility census was 75; 9.4 gallons would be required to serve all residents two, 8 ounce glasses of milk per day. Review of the facility's menu spreadsheet for 05/02/19 revealed 8 ounces of milk was to be served to the residents twice a day at breakfast and at the dinner meal. Observation of the breakfast meal on 05/02/09 from 8:05am to 8:35am revealed: -There were 46 residents seated in the dining room for breakfast. -A beverage cart containing pitchers of orange juice, coffee and water was brought into the dining room and glasses of juice and water were placed on the tables for each resident. -The residents were served juice, water, and coffee if requested. -There were no milk containers or glasses for milk on the cart. -No resident requested milk to drink. Interview on 05/02/19 at 8:15am with 3 residents in the dining room revealed: -None of the residents were offered or served milk to drink with their breakfast. -Residents were not served or offered milk at the breakfast, lunch or dinner meals. -There was no milk placed on the beverage cart at meals. -"I thought milk was not available and did not ask for it".	D 299		

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-"I do want a glass of milk to drink with my breakfast, I would like to have milk every day at breakfast!"

Interview on 05/02/19 at 8:22am with a fourth resident in the dining room revealed:
-He was not served or offered milk at breakfast or any other meal at the facility.
-He would like to have milk in the morning; "it made his stomach feel good!"

Interview on 05/02/19 at 8:25am with a fifth resident revealed:
- Mlk was not served or offered at breakfast or other meals.
-She had eggs, a biscuit, and a sausage patty for breakfast; having milk to drink would have been good with the meal.
-She did not know she needed to ask for milk to drink.

Interview on 05/02/19 at 8:36am with a sixth resident revealed:
-Milk was not served to residents at any meal.
-If a resident wanted milk to drink, they would have to ask staff.
-Residents were not asked if they would like milk to drink at any time.

Interview on 05/02/19 at 8:27am with the Dietary Manager/Cook (DM) revealed:
-Milk was not placed on the beverage cart to serve with meals.
-She read the dietary menus, but thought milk was an option for breakfast and dinner meals:; residents needed to ask for milk if they wanted it to drink at meals.
-A lot of residents did not want to drink milk.

Observation of the dinner meal on 05/02/19 from

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5:05pm to 5:35pm revealed:
-There were 59 residents seated in the dining room for the dinner meal.
-A beverage cart containing pitchers of tea and water was brought into the dining room.
-Glasses of tea and water were placed in front of eash resident.
-There were no containers of milk or glasses for milk on the beverage cart.
-Residents were not asked or offered milk to drink for the dinner meal.
-No residents asked for milk to drink with their meal

Interview on 05/02/19 at 5:20pm with the DM revealed:
-She read the menu spreadsheet when preparing and serving the residents' meals, milk was listed with the dinner meal.
-She would serve milk to residents who asked for milk.

Interview on 05/02/19 at 5:27pm with a dietary aide revealed:
-She prepared beverages according to what the residents liked to drink.
-She was not told to serve milk to the residents at meals.
-Residents liked tea and water to drink with meals.

Interview on 05/02/19 at 5:32pm with the facility Nurse Consultant revealed:
-No milk was served at the dinner meal.
-She did not know milk was on the menu to be served at dinner.
-She did not know two 8 ounce servings of milk a day was to be served to residents at meals.

Interview on 05/03/19 at 10:45am with the

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D 299	Continued From page 8 Administrator revealed: -He was not aware milk was not being served to residents; there was plenty of milk (in the refrigerator) to serve 8 ounces to residents twice a day. -The dietary staff were trained to read the menu and spreadsheet and to follow it when preparing and serving meals for residents.	D 299		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure medications that were used for skin rash and for skin breakdown were stored safely, securely, and under the supervision of medication staff for 1 of 5 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 02/06/19 revealed: -Diagnoses included vascular dementia, hypertension and gastroesophageal reflux disease. -The resident was intermittently disoriented and	D 378		

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needed personal care assistance with bathing, dressing and toileting.
-The resident was ambulatory using a wheelchair.

Review of Resident #1's Physician's orders dated 04/17/19 revealed:
-There was an order for Zinc Oxide 10% ointment (used for skin rash), apply 3 times daily with incontinent brief changes.
-There was an order for Nystatin powder (used for skin breakdown) used twice daily for 2 weeks to groin folds to prevent skin breakdown and yeast infection.

Observation on 05/01/10 at 11:25am revealed:
-Resident #1 was seated on the edge of his bed with his feet on the floor.
-On the windowsill, beside the residents' bed, were 2 containers of medications, Zinc Oxide ointment and Nystatin topical powder.

Interview on 05/01/10 at 11:26am with Resident #1 revealed:
-The Zinc Oxide ointment and the Nystatin powder were used by staff to "place on my backside" when changing his incontinent brief during toileting.
-The medications had been stored on his windowsill for 2 to 3 days or more, he could not remember how long.
-Staff left them in his room to use when toileting him.

Intrview on 05/02/19 at 9:20am with a Medication Aide (MA) revealed:
-Resident #1 had medication for his skin.
-The medications were to be stored in the medication cart, in the bottom drawer, with the other creams and powders.
-The medications for Resident #1 should not be

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stored in the resident's room, they should be secured in the medication cart.
-She was not aware Resident #1's Zinc Oxide and Nystatin powder had been stored in his room.

Interview on 05/02/19 at 3:08pm with a second MA revealed:
-Zinc Oxide and Nystatin powder were ordered on 04/17/19 to be used at each incontinent brief change for Resident #1.
-The Personal Care Aides (PCA) checked Resident #1 to determine if an incontinent brief change was needed and the MAs applied the Zinc Oxide and Nystatin powder to his skin.
-The medications were to be stored on the medication cart; the medication cart was locked when not in use.
-Sometimes the Zinc Oxide and Nystatin powder were left at Resident #1's bedside for staff convenience.
-Staff had been told not to leave medications in residents' rooms.
-The medications were observed in Resident #1's room, beside the television, 2-3 days ago; the staff leaving the medications beside the television was unknown.
-The medications were picked up and placed in the medication cart when he made rounds at the beginning of first shift 2-3 days ago.

Telephone interview on 05/02/19 at 4:41pm with the contracted Pharmacist revealed:
-Medications should be stored on the medication cart and secured.
-Residents should not have access to medications period.
-Resident #1's medications should have been stored and locked on the medication cart when not in use.

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D 378	Continued From page 11 Interview on 05/03/19 at 10:13am with the facility Nurse Consultant revealed: -She was not aware the medications for Resident #1 (Zinc Oxide, Nystatin powder) had been stored in his room on the windowsill. -"The MAs were to get the medication from the cart, apply as ordered, and return the medications to the medication cart for storage." Interview on 05/03/19 at 10:30am with the Administrator revealed: -"Resident #1's medications (Zinc Oxide, Nystatin powder) should have been stored on the medication cart, not in his room. -The MAs should take the medications from the cart, do the treatment, and return the medications to the medication cart. -Staff should not leave the medications in Resident #1's room. -"Medications need to be secured and locked."	D 378		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure every resident had the right to receive care and services which	D912		

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D912	Continued From page 12 were adequate, appropriate, and in compliance with relevant state laws and rules related to other requirements. The findings are: Based on observations and interviews, the facility failed to assure a heating unit in room #7 was working efficiently and failed to prevent the use of a prohibited portable electric heater in a resident's room. [Refer to Tag D 108 10A NCAC 13F .0311(b)(2) Other Requirements (Type B Violation)].	D912		