reveived via email 11/25/19

HP

PRINTED: 10/01/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032071	A. BUILDING: _____ B. WING _____	R 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 a Follow-up survey on September 11-12, 2019.	{D 000}	PLAN RN Consultant and OR pharmacy Team will re-educate staff on proper storage of medication and the storage shall include safe techniques for storage. Facility will schedule A MEDICATION REVIEW ~~MEDSERVICE~~. (10-17-19).	
{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 were stored safely, securely, and under the supervision of medication staff for 2 of 5 sampled residents (#1, and #4) related to an over the counter eye drop, prescribed eye drop, and topical skin creams (#4), and a topical dry skin cream (#1). The findings are: 1. Review of Resident #4's current FL-2 dated 02/06/19 revealed diagnoses included schizoaffective disorder, bipolar and seasonal allergies. Review of Resident #4's current medications list from a physician's encounter form dated 08/02/19 revealed: -There was an order for hydrocortisone 1% ointment (used for minor skin irritations, apply to	{D 378}	MONITORING RN Consultant / MED TECHS will perform routine monitoring of MED CARTS, MED ROOMS and resident ROOMS at least Monthly randomly. Documentation will be maintained in Facility. CORRECTION DATE 10/21/19	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/22/19

STATE FORM 6899 K9V812 If continuation sheet 1 of 8

Reviewed and accepted 11-25-19
HP

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{D 378}	Continued From page 1	{D 378}		

skin 2 times daily as needed.
-There was an order for Lotrimin Ultra 1% (used to treat fungal irritations) apply to skin twice a day as needed.
-There was an order for Refresh eye drops (used to treat dry eyes) one drop 3 times a day.
-There was an order for Travatan Z 0.004% eye drops (use to treat high pressure in the eye) one drop at bedtime.

Review of Resident #4's contract pharmacy's "Request Refill Authorization" form revealed there was an order dated 10/12/18 for Artifical Tears (used to moisten dry eyes) 1.4% eye solution apply to both eyes 4 times daily.

Review of Resident #4's record revealed documentation the contracted pharmacy notified the prescriber on 12/12/18 that Artifical Tears were no longer covered on insurance and Refresh Tears was ordered on 12/14/18.

Observation on 09/11/19 at 11:41am of Resident #4's room revealed 4 containers of medications on the nightstand bedside the bed as follows:
-There was a partial tube of hydrocortisone 1% ointment with a medication label indicating the cream was dispensed on 05/23/16 with an expiration date of 05/23/17.
-There was a partial tube of Mentax cream (generic for Lotrimin Ultra 1%) with no information regarding the date dispensed or directions for administration and an expiration date of 02/2016.
-There was a partial bottle of Artifical Tears in the original over the counter container with no additional instructions for use.
-There was a partial bottle of Travatan Z 0.004% eye drops in the manufacturer's container labeled with the resident's name dispensed on 12/30/18.

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{D 378}	Continued From page 2 Interview on 09/11/19 at 4:00pm with a Medication Aide (MA) revealed: -Resident #4 did not have hydrocortisone 1% ointment on the medication cart for administration. -Resident #4 did not have Refresh eye drops on the cart for administration, the last time the eye drops used was last evening and reordered to arrive today. -Resident #4 had a partial bottle of Travatan Z eye drops dispensed on 08/27/19 on the medication cart for administration. -The medications were to be stored in the medication cart in the bottom drawer with the other creams and powders. -The medications for Resident #4 should not be stored in the resident's room, they should be secured in the medication cart. -She did not know when or how Resident #4's medications appeared in her room. Interview on 09/111/19 at 4:10pm with Resident #4 revealed: -She usually kept the medications in a drawer beside her bed. -She had the medications in her room a long time. -She had not used the creams in a long time. -She used the Artifical Tears once in a while when her eyes got dry and today, because she did not get drops this morning. -She was not sure when the other drops (Travatan Z) appeared in her room. -She usually received her medications at the Nurse's desk and the MA rarely came into her room. Interview on 09/11/19 at 4:25pm with a second MA revealed: -She had never seen medications on the	{D 378}		

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{D 378}	Continued From page 3 nightstand beside Resident #4's bed. -She routinely administered Resident #4's medications at the Nurse's desk or at her door. -Resident #4 does not routinely want MA staff in her room. -She would have removed the medications if she had seen them. Telephone interview on 09/12/19 at 12:05pm with the contracted Pharmacist revealed: -Medications should be stored on the medication cart and secured. -Resident #4's medications should have been stored and locked on the medication cart when not in use. Interview on 09/11/19 at 5:15pm with a personal care aide (PCA) revealed: -She was responsible for assisting Resident #4 with bathing, and dressing. -She had never seen medication on the nightstand in Resident #4's room. -If she saw medication in a resident's room, she would take the medication or notify a MA. Interview on 09/11/19 at 5:18pm with a second PCA revealed: -She assisted Resident #4 with bathing, and dressing. -She had never seen medication on the nightstand in Resident #4's room. -If she saw medication in a resident's room, she would notify a MA. Interview on 09/12/19 at 11:30am with a housekeeping staff revealed: -She was responsible for cleaning residents' room and changing bed linen. -She had never seen medication on the nightstand in Resident #4's room.	{D 378}		

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{D 378}	Continued From page 4 -If she saw medication in a resident's room, she would notify a MA. Interview on 09/12/19 at 11:33am with a second housekeeping staff revealed: -She was responsible for cleaning residents' room and changing bed linen. -She cleaned Resident #4's room occasionally but had never seen medication on the nightstand in Resident #4's room. -If she saw medication in a resident's room, she would notify a MA. Interview on 09/12/19 at 3:20pm with the facility Nurse Consultant revealed: -"The MAs were to get the medication from the cart, apply as ordered, and return the medications to the medication cart for storage." -The staff had checked residents' room for any medications visible after the last survey in May 2019, and randomly since then. -Staff had been trained to watch for medications in the residents' rooms in May 2019. Interview on 09/12/19 at 3:40pm with the Administrator revealed: -He did not know any resident had medications stored in their room. -The medication aides and other staff had been retrained on medication storage. -No medications should be left in residents' rooms. -"Medications need to be secured and locked." 2. Review of Resident #1's current FL-2 dated 12/14/18 revealed: -Diagnoses included vascular dementia, hypertension, chronic kidney disease, and gastroesophageal reflux disorder. -There was an order for minerin topical apply to	{D 378}		

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{D 378}	Continued From page 5 the skin twice daily (used to treat dry skin). Review of Resident #1's signed physician orders dated 04/30/19 revealed there was an order for minerin topical apply to the skin twice daily. Observation on 09/11/19 at 10:40 am of the night stand, beside Resident #1's bed revealed 2 partial containers of minerin cream with a medication label indicating the cream was dispensed 03/03/18. Interview with a personal care aide (PCA) on 09/11/19 at 4:35 pm revealed: -She did not know Resident #1 had minerin cream in his room. -The minerin cream was supposed to be on the medication cart. Interview on 09/11/19 at 4:00pm with a Medication Aide (MA) revealed: -She did not know Resident #1's minerin cream was in his room. -She believed the minerin cream came from the hospital as she did not recognize the label. -Resident #1 had just moved to a new room and it was possible he just found it in his belongings in his closet. -Resident #1 did not have minerin cream on the medication cart for administration, it was last applied yesterday evening at 8:00 pm from a container on the medication cart. -The medications were to be stored in the medication cart in the bottom drawer with other creams. -The medications for Resident #1 should not be stored in the resident's room, they should be secured in the medication cart. Interview on 09/11/19 at 4:20 pm with Resident	{D 378}		

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{D 378}	Continued From page 6 #1 revealed: -He did not know he could not store minerin cream beside his bed. -The MA usually kept the minerin cream on her cart. -He believed the cream may have been given to him the last time he was in the hospital. -He had applied the cream for dry skin. (He did not say how often he applied the cream). Telephone interview on 09/12/19 at 12:04 pm with the contracted Pharmacist revealed: -Resident #1 had been prescribed minerin cream since 12/22/16. -Minerin cream can be purchased over the counter. -The container in Resident #1's room came from the hospital. -The pharmacy had last dispensed minerin cream on 09/11/19. Observation of Resident #1's medication on hand for administration on 09/12/19 at 11:00am revealed there was a container of minerin cream on the medication cart dispensed on 09/11/19. Interview on 09/12/19 at 3:20pm with the facility Nurse Consultant revealed: -She did not know Resident #1 had minerin cream in his room. -The MA's routinely checked rooms for medications. -Resident #1 had just moved into a new room and may have found it in his belongings. Interview on 09/12/19 at 3:40pm with the Administrator revealed: -He did not know any resident had medications stored in their rooms. -The MAs and other staff had been retrained on	{D 378}		

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{D 378}	Continued From page 7 medication storage. -No medications should be left in residents' rooms. -The MAs and staff were responsible to ensure medications were not left in resident rooms and stored appropriately.	{D 378}		