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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 and follow-up survey on June 8-10, 2022 with a telephone exit on June 13, 2022.	D 000		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director (2) The activity director hired on or after July 1, 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity Professionals meets this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to have a qualified activity director with documentation of completion of the basic activity course for assisted living offered by community colleges or a comparable course. The findings are: Review of the facility census dated June 2022	D 129		

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revealed the current census was 70 residents.

Observation of two facility bulletin boards on 06/08/22 at 10:53am revealed:
-An activity calendar for June 2022 was posted on a large bulletin board near the medication aide station.
-The week of 06/05/22 to 06/10/22 had less than 14 hours of activities scheduled.

Observation of the large bulletin board on 06/08/22 at 9:19 am revealed:
-There were 3-4 pictures of residents having a drink snack attached on both sides of the bulletin board.
-There were no activities calendars posted on the bulletin board.
-The center of the large bulletin board was blank.

Observation of the facility common areas on 06/08/21 at 12:00pm revealed there was no activity calendar posted in the resident areas of the facility which included the living room, dining room and activity room/chapel.

Observations of activities from 06/08/22 to 06/10/22 at 10:00am to 5:00pm revealed:
-On 06/08/22 from 10:00am to 5:00pm, there were no activities held for the residents.
-On 06/09/22 from 10:15am to 11:07am, a bingo game was held in the dining room.
-On 06/10/22 at 10:13am, a checkers game was held in the dining room.
-One 06/10/22 at 10:00am, a personal care aide (PCA) was observed going from room to room to announce the checkers game.

Interview with a resident on 06/08/22 at 8:55am revealed:
-There were no activities here.

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-He was not aware of a posted activities calendar and no staff had asked him if he wanted to participate in any activities.
-He liked to play Bingo, dominoes and going on outings.
-He had been at the facility for over a year and had never been taken on an outing.
- He was not aware of any resident going to activities.

Interview with a second resident on 06/08/22 at 9:04am revealed:
-There had been no activities offered at the facility in a year or two; she did get to play Bingo two months ago.
-An activities calendar was not posted on the bulletin board at the nurses' station.
-The residents needed planned activities so they could get to know other residents.

Interview with a third resident on 06/08/22 at 9:20am revealed:
-There were no activities any more since some residents in the facility were sick with a virus.
-Her family member came to see her every three weeks and bring her a few things.
-There were no activity calendars posted on the bulletin board, if there was one, it would be inaccurate.

Interview with a fourth resident on 06/08/22 at 10:00am revealed:
-He had been a resident at the facility for a year and had not been able to visit his home or his family.
-The facility did not offer activities for residents to occupy and enjoy themselves.
-In the time he had been at the facility he did not have the opportunity to meet many other residents.

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- Residents went to eat in the dining room but did not socialize; they just ate fast and left.
-Sometimes he would go outside and walk around a little.

Interview with a fifth resident on 06/08/22 at 10:23am revealed:
-He was told that the Administrator in Charge (AIC) was the activity director.
-There were no daily activities at the facility.
-There was a chapel in the facility, but he had not seen it used recently for a chapel service.
-The Administrator in Charge used the chapel to store items.
-A minister came in the past to speak with the residents, but no one had come in a long time.
-He was concerned about activities because he was bored daily.

Interview with a sixth resident on 06/08/22 at 11:05am revealed there were no activities offered except in the winter when it was too chilly to walk outside.

Interview with a seventh resident on 06/08/22 at 11:30am revealed:
-He was told by personal care staff (PCA) the facility had not offered activities to the residents in almost 2 years because of a contagious virus.
-The residents sat together in the dining room to eat but they were not offered activity time to socialize.
-There were no outings except for going to appointments.
-He liked to play card games and Bingo.
-The facility had an activity room to use that was large enough for several residents to use at one time.
-He did not know why the facility did not provide activities to the residents.

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Interview with a eighth resident on 06/08/22 at 11:50 am revealed:
-There had been no outings or activities at the facility for a very long time.
-Residents walked the halls or just stayed in their rooms.
-Some residents went outside to smoke and socialize.
-He was luckier than most of the residents because he worked outside the facility a few days a week and could be away some during the day.
-Residents needed activities to occupy themselves and socialize with other residents.

Interview with a medication aide (MA) on 06/10/22 at 1:27pm revealed:
-She thought the AIC was an activity director at the facility.
-Activities were conducted for residents by the MAs or PCAs when time allowed.
-Local organizations came to the facility before the pandemic in 2020 to conduct activities with the residents.
-No local organizations came to the facility now, but some called to inquire about returning to the facility to conduct activities for residents.

Interview with the Resident Care Coordinator (RCC) on 06/10/22 at 5:32pm revealed:
-The AIC was the activity director.
-She was told the AIC was the activity director when she began working at the facility in 2004.
-Activities were held for residents but the residents did not participate unless there was an incentive offered for participation.

Telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am revealed:
-She was responsible for completing the monthly

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D 129	Continued From page 5 activity calendar at the facility. -Activities were offered to residents but the residents did not attend unless there was an incentive offered. -She was the activity director for the facility. -She had completed an activity director course over 15 years ago held at a local nursing home. -She could not remember which college sponsored the course or who taught the course. -She thought her activity director certificate was mixed in with other paperwork that was copied for a survey 10 years ago. -She did not have a copy of her activity director certificate. -She thought a copy might be in a file kept in another storage area, but she had to wait for the Administrator to access the storage area. -She tried to obtain a copy of the certificate years ago, but she was told a copy could not be located.	D 129		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the	D 234		

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facility failed to ensure 2 of 5 residents sampled (#2, #3) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services.

The findings are:

1..Review of Resident #2's current FL-2 dated 05/17/22 revealed diagnoses included chronic kidney disease, stroke, hypertension, hyponatremia, altered mental status and schizophrenia.

Review of Resident #2's Resident Register revealed there was an admission date of 02/23/21.

Review of Resident #2's record for a tuberculosis (TB) skin test revealed:
-There was documentation of a TB skin test given on 03/07/21 and read as negative on 03/09/21.
-There was documentation of Resident #2 refusing a TB skin test on 08/24/21.
-There was documentation that Resident #2's case manager and family member were made aware of the refusal.
-There was no documentation of other TB skin tests for Resident #2.

Interview with Resident #2 on 06/10/22 at 1:25pm revealed:
-He had a TB skin test completed when he was at a rehabilitation center.
-His test results were negative.
-He had not taken a TB skin test during his time at the facility.

Telephone interview with Resident #2's family member on 06/10/22 at 12:51pm revealed:

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-He was not notified of Resident #2's refusal to receive a TB skin test.
-He was not aware of any notifications concerning attempts to administer a TB skin test to Resident #2.

Telephone interview with Resident #2's primary care provider (PCP) on 06/10/22 at 12:35pm revealed:
-He had recently initialized care of Resident #2.
-He was not aware that Resident #2 had refused a TB skin test.
-He expected staff at the facility to make him aware of a resident's refusal to accept a TB skin test.

Interview with the Administrator in Charge (AIC) on 06/09/22 at 9:30am revealed:
-Resident #2 was admitted with a TB skin test.
-A contracted Registered Nurse (RN) came to the facility to administer a second TB skin test to Resident #2.
-Resident #2 refused the second TB skin test.
-She thought Resident #2 had refused twice but she did not have documentation of the second attempt to administer a second TB skin test.
-She notified Resident #2's former psychiatric provider, his case manager, and family member.
-She did not have documentation of notifying Resident #2's former psychiatric provider, case manager, and family member.
-She had not taken any other measures to get a second TB skin test or other accepted measures for TB testing.
2. Review of Resident #3's current FL-2 dated 11/30/21 revealed diagnoses of acute hepatitis C, type B hepatitis, schizophrenia, anxiety disorder and depression.

Review of Resident #3's Resident Register

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revealed the resident was admitted to the facility on 04/20/2015.

Review of Resident #3's record revealed:
-Resident #3 had a TB skin test placed on 08/13/18 and read on 08/05/18.
-The result of the skin test was negative.
-The form was signed by a registered nurse.
-There was no documentation of a second skin test for Resident #3.

Interview with Resident #3 on 06/10/22 at 5:50pm revealed:
-He had a TB skin test at the facility several years ago and it was negative.
-He was never given a second TB skin test or asked if he had been given a second TB test.

Interview with the Resident Care Coordinator (RCC) on 06/13/13 at 10:28:am revealed:
-Residents should be admitted to the facility already having their first TB skin test and receive the second one shortly afterwards.
-The facility had two contracted nurses who audit residents' records for TB testing and review for completion of the testing.

Attempted interviews with the contracted nurses at 10:43am was unsuccessful.

Interview on 06/13/22 with the Administrator in charge (AIC) revealed:
-She was not aware Resident #3's TB skin testing was incomplete.
-There should be documentation of a second TB skin test in Resident 3's records.
-Sometimes she would go through residents' charts randomly to check to ensure the records were complete.
-Sometimes residents' documents would be

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removed from their records for appointments.
-Screening for tuberculosis documents may have been thinned from the charts by mistake.
-Resident #3 would need to do the TB testing over and have the completed testing documented in his records.
-She was responsible for all residents records to be complete.

D 310 — 10A NCAC 13F .0904(e)(4) Nutrition and Food Service — D 310

10A NCAC 13F .0904 Nutrition and Food Service
(e) Therapeutic Diets in Adult Care Homes:
(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 1 of 4 residents having a chopped/mechanically altered diet with honey thickened liquids..

The findings are:

Review of documentation from a regional medical center dated 11/24/21 revealed:
-The diet of record for Resident #2 upon admission was Regular.
-Current diagnoses for Resident #2 included

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stroke and articulation deficiency.

Review of Resident #2's current FL 2 dated 05/17/22 revealed:
-Diagnoses included stroke, chronic kidney disease, stage 3, schizophrenia, altered mental status, hypertension and hypernatremia.
-There was a diet order for chopped/mechanically altered meats and honey thickened liquids.

Review of the residents' Modified Diets list dated 06/07/22 and posted in the kitchen revealed Resident #2 was to be served chopped meats and thickened liquids.

Review of the dietitian's therapeutic diet spreadsheet for 6/09/22 for a mechanical soft (MS) diet for lunch revealed a menu of ground baked turkey, buttered rice, chopped, soft cooked vegetable blend, peaches with whipped topping, white or wheat roll and beverage of choice.

Observation of Resident #2's lunch meal on 06/09/22 served at 11:50am revealed:
-Resident #6's meal was served in his room.
-Resident #6 was seated on the side of his bed looking at the tray of food in front of him.
-Resident #6's meal consisted of a chicken thigh covered with skin, buttered rice, chopped greens and a fruit cup.
-There was a small pitcher of water containing one quarter cup of plain water and a cup containing 5 small cubes of ice.
-There were no honey thickener liquids to drink with his meal.

Interview with Resident #2 on 06/09/22 at 12:08pm revealed:
-Resident #6 pointed to the piece of chicken on the plate with his fork and said he could not eat

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the chicken, it was tough, and he could not cut it with a fork.
-He ate all his fruit because they were in pieces and they were soft.
-He had a stroke that affected the left side of his face and how he could chew.
- He also did not have many teeth to chew with.
-He was supposed to have his meats chopped so he could chew and swallow more easily.
-He was not brought anything to drink with his meal.
-He was supposed to have honey thickened liquids to drink.

Interview with Resident #2's power of attorney (POA) on 06/13/22 at 8:57am revealed:
-Resident #2 had a swallowing difficulty for several years before his stroke and needed to eat soft foods.
-He did not know what the facility's diet was for Resident #2.
-He did not know what type of diet the primary care provider (PCP) ordered for Resident #2.
-He often brought Resident #2 a hamburger, as the meat was easy for Resident #2 to eat.

Interview with the kitchen's Head Cook on 06/10/22 at 9:40am revealed:
-She plated the foodat the steam table, 2 dietary aides prepared the beverages and helped pass the plates to residents in the dining room and resident's rooms.
-The therapeutic diet list was posted abovet the steam table where staff could read the PCP's diet orders.
-She was aware Resident #2 had an order pf chopped meats and honey thickened liquids.
-She was responsible for plating Rsident #2's correct diet order.
-She was in a hurry to get the lunch meals

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distributed and forgot to chop the chicken on the plate for Resident #2.
-The honey thickened liquids for Resident #2 were made at the nurses' station using powdered thickener packets.
-The medication aides were to pour the thickener into the glass of measured water and take it to Resident #2's room at mealtimes.
-She did not see if Resident #2 was served honey thickened liquids with his noon meal.
-She needed to make the honey thickened liquid drinks for Resident #2 herself to ensure the diet order was followed.

Interview with Resident #2's current primary care provider (PCP) on 06/10/22 at 9:09am revealed:
-Resident #2 had a history of having swallowing difficulty and stroke.
-Resident #2 needed to drink honey thickened liquids and eat chopped soft foods to prevent choking and aspiration from his drink and food.
-He knew nothing of Resident #2 having an order for a Regular diet.
-He read Resident #2's history notes and ordered the resident chopped meats/mechanically altered with honey thickened liquids on 05/17/22.
The staff of the facility needed to follow the order to prevent Resident #2 from choking and aspirating into his lungs.

Interview with the Administrator in charge (AIC) on 06/10/22 at 1:40pm revealed:
-She was not aware Resident #2 did not receive his lunch meal as ordered.
-She was not aware Resident #2's chicken was not correctly prepared before the plate left the kitchen.
-She did not know if Resident #2 had a swallowing study before he was admitted to the facility.

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D 310	Continued From page 13 -He had a therapeutic diet order for chopped/mechanical soft diet with honey thickened liquids. -Resident #2 ate his meals in his room; the medication aide (MA), personal care aide (PCA) or dietary aide would deliver his meals to his room. -The listing of residents having therapeutic diets was posted at the steam table for reference. -Staff plating the meals were to see that the therapeutic diets were plated correctly, according to the order, before leaving the kitchen. She was not aware Resident #2 did not receive beverages at his meal. -He should have given honey thickened liquids as ordered. -The honey thickened liquids for Resident #2 should be made in the kitchen and overseen by the Head Cook.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) for a medication to treat nerve pain, a short-acting insulin, and a medication	D 358		

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used to control high blood sugar.

The findings are:

1. Review of Resident #1's current FL-2 dated 01/26/22 revealed diagnoses included type 2 diabetes mellitus, foot ulcer, muscle weakness, diabetic peripheral angioplasty, and peripheral vascular disease.

a. Review of Resident #1's current FL-2 dated 01/26/22 revealed there was an order for gabapentin 100mg (used to treat neuropathic pain or prevent seizures) capsule one capsule three times daily.

Review of Resident #1's physician orders revealed:
-There was an order dated 01/27/22 for gabapentin 100mg two capsules twice daily.
-There was an order dated 05/23/22 for gabapentin 300mg one capsule twice daily.

Review of Resident #1's six-month physician orders dated 03/29/22 revealed there was an order for gabapentin 100mg two capsules twice daily.

Review of Resident #1's May 2022 printed medication administration record (MAR) revealed:
-There was an entry for gabapentin 100mg capsule take two capsules twice daily, scheduled for 9:00am and 8:00pm.
-There was documentation of administration of gabapentin 100mg from 05/01/22 to 05/18/22 at 9:00am and 8:00pm.
-There was documentation of refusals from 05/18/22 to 05/23/22 at 9:00am and 8:00pm and on 05/24/22 at 9:00am.
-There was another entry that was handwritten for

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gabapentin 300mg capsule take one capsule twice daily, scheduled for 8:00am and 8:00pm.
-There was no documentation of administration of gabapentin 300mg capsule from 05/25/22 to 05/31/22 at 8:00am.
-There was documentation of administration of gabapentin 300mg from 05/24/22 to 05/31/22 at 8:00pm.

Review of Resident #1's June 2022 MAR revealed:
-There was entry for gabapentin 300mg capsule take one capsule twice daily, scheduled for 9:00am and 8:00pm.
-There was documentation of administration of gabapentin 300mg from 06/01/22 to 06/07/22 at 8:00pm.
-There was documentation of administration of gabapentin 300mg on 06/01/22, 06/04/22, and 06/05/22 at 9:00am
-There was no documentation of administration of gabapentin 300mg from 06/02/22 to 06/03/22 and from 06/06/22 to 06/07/22 at 9:00am.

Observation of Resident #1's medications on hand on 06/10/22 at 10:25am revealed:
-There was two bubble packages of gabapentin 300mg capsules.
-Thirty capsules per package were dispensed on 05/04/22.
-There were 4 capsules remaining in one bubble package and there were 30 capsules in the other bubble package.

Telephone interview with a pharmacist technician at the facility's contracted pharmacy on 06/10/22 at 12:20pm revealed:
-Resident #1 had an order for gabapentin 300mg received on hospital discharge paperwork dated 05/23/22.

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-There were 60 capsules of gabapentin 300mg dispensed on 05/24/22.
-Gabapentin was used to treat nerve pain and/or seizures.
-There was no documentation in Resident #1's profile indicating the reason gabapentin was ordered for her.

Based on MAR documentation, medications dispensed, and medications on hand, there would have been 26 capsules remaining from the 05/24/22 dispensing.

Interview with a medication aide (MA) on 06/10/22 at 3:30pm revealed:
-The new MARs were checked by two senior MAs and one of those MAs was the Resident Care Coordinator (RCC).
-She did not know of a process in place to review the MARs at the end of the month.
-The MAs were supposed to review the MARs daily for holes or places where documentation was missing.
-Her process for administering medications was as follows: review the resident's MAR, remove the medication from the medication cart, place medications into a cup, administer medications, and document administration of the medication on the MAR.
-She thought the lack of documentation on Resident #1's May 2022 and June 2022 MARs indicated the medication was not administered.
-She thought if the MAs had reviewed the MARs at the end of the shift the holes would have been observed.

Interview with the MA/Resident Care Coordinator (RCC) on 06/10/22 at 5:32pm revealed:
-She expected MAs to document administration of medications after medications were

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administered.
-She was not aware of the missed doses of gabapentin 300mg for Resident #1.
-She expected the MAs to review the MARs at the end of the shift to ensure accurate documentation of administration of medications.

Telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am revealed:
-She thought the lack of documentation for the gabapentin did not indicate that the medication was not administered.
-She thought the medication was administered and the MAs forgot to document the administration.

Attempted interviews with Resident #1 on 06/10/22 at 12:00pm and 3:00pm was unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/10/22 at 12:07pm was unsuccessful.

Refer to telephone interview with the AIC on 06/13/22 at 9:21am.

b. Review of Resident #1's current FL-2 dated 01/26/22 revealed there was an order for Novolog 70/30 (used to improve glycemic control related to diabetes mellitus) insulin 15 units subcutaneous daily at lunch.

Review of Resident #1's physician orders revealed:
-There was an order dated 05/04/22 for Novolog 100 unit/ml 15 units daily at lunch.
-There was an order dated 05/11/22 for Novolog 100u/ml 12 units daily at lunch.
-There was an order dated 05/23/22 for Novolog

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100u/ml 7 units daily at lunch.
-There was an order dated 05/31/22 for Novolog 100u/ml 15 units daily at lunch.

Review of Resident #1's six-month physician orders dated 03/29/22 revealed there was an order for Novolog 100u/ml 15 units daily at lunch.

Review of Resident #1's June 2022 printed medication administration record (MAR) revealed:
-There was a handwritten entry for Novolog 100u/ml flex-pen inject 15 units for lunch, scheduled for 11:30am.
-There was documentation of administration of Novolog from 06/06/22 to 06/07/22 at 11:30am.
-There was documentation of refusal of Novolog from 06/01/22 to 06/02/22 at 11:30am.
-There was no documentation of administration of Novolog from 06/03/22 to 06/05/22 at 11:30am.

Observation of Resident #1's medications on hand on 06/10/22 at 10:26am revealed:
-There was a box with one unopened flex-pen of Novolog 100u/ml dispensed on 02/15/22.
-There was an unopened box with 5 flex- pens of Novolog 100u/ml dispensed on 04/11/22.
-There was an opened flex-pen with approximately 120 units remaining without a documented open date.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/10/22 at 12:20pm revealed:
-Resident #1 had an order for Novolog 7 units three times a day dated 05/23/22.
-There was no order dated 05/31/22 under Resident #1's profile.
-Resident #1 had an order for a local physician's office dated 06/07/22 for Novolog 15 units at lunch.

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-When orders were received electronically, a copy of the order was sent to the facility via fax or with the next medication delivery.
-A sixty-day supply of Novolog, 1500ml or 5 flex pens, was sent on 04/25/22.
-Novolog was used to treat diabetes mellitus.

Interview with a medication aide (MA) on 06/10/22 at 3:30pm revealed:
-She thought the holes on the MAR indicated Novolog was not administered to Resident #1.
-She did not know Resident #1 had missed three doses of Novolog insulin at lunch time.

Interview with the MA/Resident Care Coordinator (RCC) on 06/10/22 at 5:32pm revealed she did not know Resident #1 had three lunch time doses of Novolog insulin not documented as administered in June 2022.

Attempted interviews with Resident #1 on 06/10/22 at 12:00pm and 3:00pm was unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/10/22 at 12:07pm was unsuccessful.

Refer to telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am.

c. Review of Resident #1's current FL-2 dated 01/26/22 revealed there was an order for Trulicity (used to control high blood sugars related to diabetes mellitus) 1.5mg/0.5ml 1.5mg on Tuesdays.

Review of Resident #1's physician orders revealed there was an order dated 05/11/22 to

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discontinue Trulicity.

Review of Resident #1's six-month physician orders dated 03/29/22 revealed there was an order for Trulicity 1.5mg/0.5ml inject 0.5ml subcutaneous weekly.

Review of Resident #1's April 2022 printed medication administration record (MAR) revealed:
-There was an entry for Trulicity 1.5mg/0.5ml inject 0.5ml weekly, scheduled for 8:00am.
-There was documentation of administration of Trulicity on 04/03/22, 04/10/22, and 04/17/22 at 8:00am.
-There was no documentation of administration on 04/24/22 at 8:00am which was highlighted on the MAR.

Review of Resident #1's May 2022 MAR revealed:
-There was an entry for Trulicity 1.5mg/0.5ml inject 0.5ml weekly, scheduled for 8:00am.
-There was documentation of administration of Trulicity on 05/01/22 at 8:00am.
-There was no documentation of administration on 05/08/22 at 8:00am which was highlighted on the MAR.
-There was documentation that Trulicity was discontinued on 05/11/22.

Observation of Resident #1's medications on hand on 06/10/22 at 10:26am revealed there was no Trulicity in the medication refrigerator.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/10/22 at 12:21pm revealed:
-Trulicity was ordered for Resident #1 on 01/26/22 and the order was 1.5mg inject 0.5ml weekly.

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-Trulicity was discontinued for Resident #1 on 05/11/22.
-A thirty-day supply of Trulicity was dispensed on 02/18/22 for Resident #1.
-This was the last dispense date for Resident #1's Trulicity.
-He thought Resident #1 started utilizing a new medication to treat high blood sugar.
-He thought with the initiation of the new medication the pharmacy stopped dispensing Trulicity for Resident #1 after 02/18/22.

Based on MAR documentation, medications dispensed, and medications on hand, there would have been no Trulicity remaining 30 days after the 02/18/22 dispensing.

Interview with a medication aide (MA) on 06/10/22 at 3:30pm revealed:
-The facility was on a cycle fill for refills of medications.
-The blank spaces on Resident #1's MARs for 04/24/22 and 05/08/22 indicated Trulicity was not administered.

Interview with the MA/Resident Care Coordinator (RCC) on 06/10/22 at 5:32pm revealed she did not know that Resident #1 had not received Trulicity on 04/24/22 and 05/08/22.

Telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am revealed:
-The facility was on a cycle fill and she knew that Resident #1 had many order changes related to her insulin.
-She thought Resident #1 received her medication and that staff forgot to document the administration.

Attempted interviews with Resident #1 on

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06/10/22 at 12:00pm and 3:00pm was unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/10/22 at 12:07pm was unsuccessful.

Refer to telephone interview with the AIC on 06/13/22 at 9:21am.

____

Telephone interview with the AIC on 06/13/22 at 9:21am revealed she held the MA administering the medications responsible for administering medications as ordered.

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10A NCAC 13F .1004(f) Medication Administration

10A NCAC 13F .1004 Medication Administration
(f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage:
(1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container;
(2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of

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each medication prepared and the resident's name;
(3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and
(4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were identified by name and strength up to the point of administration and protected from contamination and spillage for 2 of 2 residents (#6 and #7).

The findings are:

1. Observation of a first shift medication aide (MA) on 06/09/22 at 6:25pm revealed:
-The MA opened the top drawer of her medication cart.
-There was a plastic cup containing 8 pills beside a paper medication cup containing one white pill.
-The cups were uncovered, unsealed and unlabeled.
-There were no other medication cups with pills in the top drawer of the medication cart.

Review of Resident #6's current FL2 dated 04/12/22 revealed:

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D 363	Continued From page 24 -Diagnoses included non-traumatic intracerebral hemorrhage, hyperlipidemia, major depression, anxiety disorder, pseudobulbar affect, encephalopathy, and atherosclerotic heart disease. -There was an order for aspirin 81mg (used to treat blood clots) twice daily. -There was an order for amlodipine 10mg (used to treat hypertension) twice daily. -There was an order for Depakote 250 mg (used to treat certain mental disorders) twice daily. -There was an order for Depakote 500 mg (used to treat certain mental disorders) twice daily. -There was an order for docusate (used to treat constipation) 100mg twice daily. -There was an order for Keppra (used to treat seizures) 500mg twice daily. -There was an order for magnesium (used to maintain heart health) 400mg twice daily. -There was an order for dextromethorphan (used to for temporary relief of cough) 20-10mg twice daily. -There was an order for sertraline (used to treat depression) 100mg daily. Review of the facility's census list revealed Resident #6 was in the hospital and her first day in the hospital was 06/05/22. Interview with the same first shift MA on 06/10/22 at 1:27pm revealed: -The medications in the top drawer of the medication cart were for Resident #6 and she placed them there. -Resident #6 became ill and was sent out to the hospital 4 days ago. -She planned to discard the medications in the cups in the top drawer of the medication cart. -However, she kept forgetting to discard the medications.	D 363		

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-She intended to administer them to Resident #6 but Resident #6 was transferred to the hospital.

Refer to the telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am.

2. Observation of a first shift medication aide/Resident Care Coordinator (MA/RCC) during the morning medication pass on 06/09/22 at 8:01am revealed:
-The MA/RCC prepared the morning medications for administration to Resident #7.
-The MA/RCC prepared 10 oral medications for Resident #7 in a paper medication cup.
-Resident #7 was sitting on her rollator beside the MA/RCC waiting for her medications.
-The MA/RCC told Resident #7 to go and see another MA to get her insulin injection.
- The MA/RCC placed the medication cup inside the top drawer of the medication cart.
-The cup was not labeled with the resident's name, the names of the medications, the cup was uncovered and not sealed.
-The MA/RCC remained at the medication cart and continued with the medication pass.
-Resident #7 entered the medication room with another MA to have her insulin administered.
-There were no other medication cups with pills in the top drawer of the medication cart.

Review of Resident #7's current FL-2 dated 03/22/22 revealed:
-Diagnoses included dementia, type 2 diabetes mellitus, chronic pain, schizophrenia, post traumatic stress disorder, and gastro-esophageal reflux disease (GERD).
-There was an order for aspirin enteric coated (EC) (used to prevent blood clots) 81mg daily.
-There was an order for omeprazole (used to

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(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
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treat GERD) 20mg daily.
-There was an order for diltiazem (used to treat prevent chest pain) ER 120mg one capsule daily.
-There was an order for lasix (used to treat hypertension) 20mg one tablet daily.
-There was an order for losartan (used to treat hypertension) 50mg daily.
-There was an order for Imodium AD (used to treat sudden diarrhea) 2mg twice daily.
-There was an order for gabapentin (used to treat prevent and control seizures) 100mg one capsule twice daily.
-There was an order for metformin (used to control high blood sugar) 1000mg twice daily.
-There was an order for hydrocodone/acetaminophen (used to treat pain) 5-325mg one tablet twice daily.
-There was an order for clozapine (used to treat certain mood/mental disorders) 50mg one tablet daily.

Interview with Resident #7 on 06/08/22 at 8:26am revealed the MAs gave her medications to her in the morning and in the evening.

Interview with the MA/RCC who conducted the 06/09/22 morning medication pass on 06/10/22 at 5:32pm revealed:
-There was no process for preparing medications in advance because pre-pouring medications was not allowed.
-She prepared Resident #7's medications but she wanted to check to see if she had any vitamin B12 in the back up medication cart.
-She placed Resident #7's medication cup with medications in it unlabeled, uncovered, and unsealed in the top drawer of the medication cart.
-She looked for Resident #7's vitamin B12 in the back-up medication cart but did not find any for Resident #7.

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-She told Resident #7 to go to the medication room to obtain injections of insulin administered by another MA.
-When Resident #7 finished obtaining her insulin, she removed the pre-poured medications from the top drawer of the medication cart and administered the medications to Resident #7.
-She knew the medications she administered to Resident #7 because she had prepared them moments before administering the medications.
-She had not labeled Resident #7's medication cup with the names or strength of the medications.
-She had not labeled Resident #7's medication cup with the resident's name.
-She did not consider preparing Resident #7's medications and placing them in the top drawer of the medication cart a pre-pour because she administered the medications minutes later.
-She had not administered Resident #7's medications immediately after the preparation.
-She wanted to ensure she had all of Resident #7's oral medications.
-Resident #7 would not take medications at different times because she would accuse the MAs of trying to "poison her" due to her mental health history.

Telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am revealed:
-She thought the MA/RCC had to step away to perform personal care when she placed Resident #7's medication cup filled with medications in the top drawer of the medication cart.
-She did not know that the MA/RCC looked for a missing medication for Resident #7.
-She thought it was appropriate for the MA/RCC to place Resident #7's medication cup with medications in it in the drawer of the medication cart if she was trying to find a missing medication.

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-She thought Resident #7 would not take medications later in the morning if approached with additional medications due to her mental health history.

Refer to the telephone interview with the AIC on 06/13/22 at 9:21am.

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Telephone interview with the AIC on 06/13/22 at 9:21am revealed:
-Medications should not be prepared in advance.
-She held the MAs responsible for ensuring medications were not prepared in advance.

D 366 — 10A NCAC 13F .1004 (i) Medication Administration — D 366

10A NCAC 13F .1004 Medication Administration

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure the Medication Administration Records (MARs) were accurate to include the initials of the Medication Aide (MA) who administered the medication for 2 of 2 sampled residents (#7 and #8) related to insulin administration.

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The findings are:

1. Observation of the 06/09/22 8:00am medication pass revealed:
-Resident #7 went into the medication room with a male medication aide (MA).
-The male MA stepped back out of the medication room to obtain Resident #7's medication administration record (MAR).
-The MA prepared and administered 10 units of Levemir to Resident #7.
-He injected the Levemir into the left side of Resident #7's abdomen.
-The MA then prepared and administered 20 units of Novolog to Resident #7.
-He injected the Novolog into the right side of Resident #7's abdomen.
-He did not document the administration of Resident #7's Levemir and Novolog insulins.

Review of Resident #7's current FL-2 dated 03/22/22 revealed:
-Diagnoses included dementia, type 2 diabetes mellitus, chronic pain, schizophrenia, post-traumatic stress disorder, and gastro-esophageal reflux disease (GERD).
-There was an order for Levemir (used to control high blood sugar in people with diabetes) 10 units twice daily.
-There was an order for Novolog (a short acting insulin used to control high blood sugar) 20 units three times a day.

Review of Resident #7's six-month physician orders dated 03/29/22 revealed:
-There was an order for Levemir flex-touch inject 10 units in the morning and 40 units in the evening.
-There was an order for Novolog inject 20 units three times daily.

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Review of Resident #7's June 2022 MAR revealed:
-There was an entry for Levemir flex-touch inject 10 units in the morning and 40 units in the evening, scheduled for 9:00am and 8:00pm.
-There was an entry for Novolog 20 units three times daily with meals, scheduled for 9:00am, 11:30am, and 5:00pm.
-The only staff initials documented on 06/09/22 at 9:00am when medications were administered were the Resident Care Coordinator (RCC).

Interview with Resident #7 on 06/08/22 at 8:26am revealed the medication aides (MA) gave her medications to her in the morning and in the evening.

Interview with the male MA on 06/10/22 at 8:25am revealed:
-He had administered Levemir and Novolog insulin to Resident #7 during the morning medication pass on 06/09/22.
-He saw Resident #7's June 2022 MAR and his initials were not documented for Resident #7's Levemir and Novolog scheduled on 06/09/22 at 9:00am.
-He forgot to sign Resident #7's June 2022 MAR for the administration of Resident #7's insulin on 06/09/22.

Interview with the RCC on 06/10/22 at 5:32pm revealed:
-She had signed Resident #7's June 2022 MAR for the 06/09/22 9:00am medications.
-She thought the MA who administered insulin to Resident #7 on 06/09/22 had signed Resident #7's MARs because he took the MAR into the medication room.

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Refer to the interview with the RCC on 06/10/22 at 5:32pm.

Refer to the telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am.

2. Observation of the 06/09/22 8:00am medication pass revealed:
-Resident #8 went into the medication room with a male medication aide (MA).
-The male MA stepped back out of the medication room to obtain Resident #8's medication administration record (MAR).
-The MA prepared and administered 8 units of Lantus to Resident #8.
-He injected the Lantus into Resident #7's abdomen.

Review of Resident #8's current FL-2 dated 06/14/21 revealed:
-Diagnoses included schizophrenia, type 2 diabetes, hypertension, chronic obstructive pulmonary disease, obesity, hypertensive heart disease with heart failure and right heart failure.
-There was a medication order for Lantus (a long acting insulin used for blood sugar control) 17 units at bedtime.

Review of Resident #8's physician orders revealed:
-There was an order dated 02/26/22 to discontinue Lantus at bedtime and start Lantus 8 units daily.
-There was an order dated 05/03/22 to hold Lantus if blood sugar less than 100.

Review of Resident #8's June 2022 MAR revealed:
-There was an entry for Lantus 8 units before

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breakfast, scheduled for 8:00am.
-The only staff initials documented when medications were administered on 06/09/22 at 8:00am were the day shift MA.

Interview with the male MA on 06/10/22 at 8:25am revealed:
-He had administered Lantus to Resident #8, but he did not sign Resident #8's June 2022 MAR for administration of the Lantus.
-He forgot to sign Resident #8's June 2022 MAR.
-His initials were not documented on 06/09/22 for Resident #8's Lantus.

Interview with a day shift MA on 06/10/22 at 1:27pm revealed:
-She often signed the MARs for the MA administering the insulin and this practice was not new.
-The MA administering the insulin might ask her to read the MAR and then repeated the dose aloud prior to administering insulin.
-The MAs had signed the MAR for the MA administering insulin for a while.
-She had signed for Resident #8's insulin but the night shift male MA administered the insulin to Resident #8.

Attempted interview with Resident #8 on 06/08/022 at 9:49am was unsuccessful.

Refer to interview with the MA/Resident Care Coordinator (MA/RCC) on 06/10/22 at 5:32pm.

Refer to telephone interview with the Administrator in Charge (AIC) on 06/13/22 at 9:21am.

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Interview with the MA/RCC on 06/10/22 at

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5:32pm revealed:
-She expected the MAs to remind each other if one MA forgot to sign for a medication that they administered.
-The MAs were expected to sign the MARs after a medication was administered.

Telephone interview with the AIC on 06/13/22 at 9:21am revealed she held the MA who administered the medications responsible for documenting administration of the medications.

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 and interviews, the facility failed to ensure medications were under locked security related to a back-up medication cart being left unlocked and unattended by medication aides (MA).

The findings are:

Observation of the MA workstation on 06/08/22 at 12:00pm revealed:
-There was a medication cart located on the outer rim of a semi-circular workstation.
-The medication cart had medications in all three drawers and there was no lock in the space for a

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lock.
-The drawers on the medication cart opened when pulled and closed freely without locking.
-There was a sealed box of lidocaine patches sitting on top of the medication cart.
-There was a bottle of polyethylene glycol sitting on the counter of the workstation behind the medication cart.
-The medication cart sat in an area where residents walked back and forth, and sat and waited for medication administration.

Another observation of the MA workstation on 06/09/22 at 11:27am revealed:
-The medication cart remained on the outer rim of the workstation not secured in an area where residents were not able to access it.
-The drawers on the medication cart opened when pulled and closed freely without locking.
-A sealed box of lidocaine patches sat on top of the medication cart.
-A bottle of polyethylene glycol at on the counter of the workstation behind the medication cart.

A third observation of the MA workstation on 06/10/22 at 10:50am revealed:
-The medication cart remained in an area where residents were able to access it.
-The drawers on the medication cart opened when pulled and closed freely without locking.
-There was a sealed box of lidocaine patches sitting on top of the medication cart.
-There was a bottle of polyethylene glycol sitting on the counter of the workstation behind the medication cart.

Interview with a night shift MA on 06/10/22 at 1:27pm revealed:
-Medications were not allowed to be stored on top of the medication cart or on the counter.

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-He was taught that controlled-substances were to be double locked.
-All medications were supposed to be secured.
-He did not notice there was a box of lidocaine patches for a resident on top of the medication cart.
-He had not seen the bottle of polyethylene glycol on the counter.
-The unsecured medication cart was used to store extra medications for residents.
-The lock had been broken for a long time.
-He had not told the Administrator in Charge (AIC) that the lock was broken.

Interview with the MA/Resident Care Coordinator (MA/RCC) on 06/10/22 at 5:32pm revealed:
-The medication cart was used to store medications that did not fit into the other two medication carts.
-The medication cart did not lock because the lock was broken.
-She told the Administrator and he planned to get it fixed.
-She did not remember if she told the AIC.
-She did not know there was a box of lidocaine patches on top of the medication cart and a bottle of polyethylene glycol on the counter.
-Whoever accepted the medication delivery from the pharmacy should have secured the medications.

Telephone interview with Administrator in Charge (AIC) on 06/13/22 at 9:21am revealed:
-Medication carts were to remain locked when unattended.
-She did not know the medication cart's lock was broken.
-The medication cart was previously stored behind the MA workstation and it was not accessible to residents.

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D 378	Continued From page 36 -She did not know when it was moved to the outer portion of the workstation. -The MA/RCC and the MAs were responsible for ensuring the medication carts were locked and secured when unattended.	D 378		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to 70 residents during the global coronavirus (COVID-19) pandemic as related to the screening of residents.	D 612		

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The findings are:

Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever.

Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19.

Review of the facility's COVID-19 binder revealed:
-The binder contained guidance concerning COVID-19 from NC DHHS dated 10/16/20, 12/20/20, 02/10/21 and 03/16/21.
-There was guidance concerning COVID-19 from the local health department (LHD) dated 07/30/20.
-There was guidance on enrolling in the state's COVID-19 vaccination plan.

Review of five residents' April 2022, May 2022, and June 2022 medication administration records (MARs) revealed there was no documentation of daily temperatures.

Review of the residents' temperature logs revealed there were no temperature logs dated for 2022, but there was one log dated October 2021.

Observation of thermometers in the facility on 06/08/22 at 11:57am revealed there was a

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thermal scan thermometer on a stand near the medication aide (MA) workstation.

Interview with a resident on 06/08/22 at 8:35am revealed the staff did not check her temperature daily.

Interview with another resident on 06/08/22 at 9:42am revealed:
-He had his vital signs checked monthly.
-His temperature was not checked daily.
-He had not had his temperature checked that day.

Interview with a third resident on 06/08/22 at 11:04am revealed:
-The staff had not taken her temperature recently.
-At some point staff were checking her temperature, but not regularly, and not every day.

Interview with a night shift MA on 06/10/22 at 8:25am revealed:
-He did not check residents' temperatures daily.
-He checked residents' temperatures if they did not feel well.
-He did not know if the temperatures were checked on a regular basis.
-He thought second shift might check temperatures for the residents.

Interview with another MA on 06/10/22 at 1:27pm revealed:
-Resident's vital signs were obtained monthly.
-When the facility had residents who tested positive for COVID-19, staff checked the residents' temperatures daily.
-Now the resident's temperatures were not checked daily.
-Staff stopped daily temperature checks for the residents.

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D 612	Continued From page 39 -She could not remember the date that staff stopped obtaining daily temperatures for the residents. -If the residents had symptoms, staff would check residents' temperatures. -There was a log that the residents' temperatures were documented on given to them by Administrator in Charge (AIC). -She did not know where the resident temperature logs were located. Interview with the MA/Resident Care Coordinator (MA/RCC) on 06/10/22 at 5:32pm revealed: -Resident temperatures were being taken daily. -If a resident had any signs or symptoms of COVID-19, a rapid test was performed for that resident. -If residents did not feel well, a temperature was obtained for that resident. -She was not aware that residents' temperatures were not taken daily by the other MAs. -She told them to continue taking the residents' temperatures daily. -She could not locate the residents' temperature logs. -She thought the Administrator in Charge (AIC) had the residents' temperature logs. -She did not know the CDC guidelines related to daily temperature monitoring for residents. Telephone interview with the AIC on 06/13/22 at 9:21am revealed: -The facility had a COVID-19 policy. -Daily temperatures were being checked on the residents. -One month ago, there were residents on quarantine, and temperatures were checked daily. -Now residents' temperatures were checked daily or weekly.	D 612		

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 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELLIA GARDENS	**5010 S ALSTON AVENUE DURHAM, NC 27713**

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D 612	Continued From page 40 -She told the MAs to check residents' temperatures daily and provided a log with each residents' name on it. -She did not know the MAs were not checking residents' temperatures daily. -She did not ensure that the MAs were obtaining the residents' temperatures. -She held the MAs responsible for ensuring the residents' temperatures were obtained daily.	D 612		