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 02/22/2024

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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 from February 20, 2024 to February 22, 2024.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 8 of 8 exit doors accessible to residents, who were intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for a capacity of 81. Review of the facility's license renewal application dated 12/28/23 revealed as of 07/31/23, 29	D 067		

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residents had a diagnosis of mental illness, and 39 residents had a diagnosis of Alzheimer's Disease/related dementias.

Review of the facility's census on 02/20/24 revealed there were 64 residents.

Review of five resident records on 02/20/24 revealed:
-Review of a resident's FL-2 revealed a diagnosis of altered mental status and there was no information for orientation status.
-The resident's care plan revealed the resident was sometimes disoriented, was forgetful, and needed reminders.
-Review of a second resident's FL-2 revealed a diagnosis of schizophrenia and closed head injury and the resident was intermittently disoriented.
-The second resident's care plan revealed the resident was sometimes disoriented.
-Review of a third resident's FL-2 revealed a diagnosis of dementia and there was no information for orientation status.
-The third resident's care plan revealed there was no information for the resident's orientation status or memory.
Review of a fourth resident's FL-2 revealed a diagnosis of Alzheimer's disease and there was no information for orientation status.
-The fourth resident's care plan revealed the resident was sometimes disoriented.
-Review of a fifth resident's FL-2 revealed a diagnosis of vascular dementia and there was no information for orientation status.
-The fifth resident's care plan revealed the resident was intermittently confused.

Review of a resident's incident report date 10/21/23 revealed:
-At 7:30pm a resident made an attempt to leave

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the facility.
-A facility staff escorted the resident from the bus stop in from of the facility inside the facility without incident.
-The resident's family member was notified at 8:06pm.
-The supervisor and management was notified.

Observations of the facility's exit doors at various times on 02/20/24 from 8:00 am-5:00pm, on 02/21/24 from 7:30 am-6:00pm, and 02/22/24 from 7:30am-5:00pm revealed:
-On 02/20/24 at 8:00am, a resident opened the front door of the facility to allow the survey team to enter the facility.
-On 02/20/24 at 8:42am, a construction worker was observed coming in the side door, identified as door B, without using the keypad, and no alarm could be heard.
-On 02/20/24 at 8:44am, the side door closest to the nurses' station was opened without using the keypad, and no alarm could be heard.
-On 02/21/24 at 7:30am, a resident opened the front door of the facility to allow the survey team to enter the facility.
-On 02/21/24 at 7:52am, the front door to the facility was opened and an alarm could not be heard; there was no staff in the area.
-On 02/21/24 at 8:02am, the dining rooms outside exit door was opened and an alarm could not be heard; there was no staff in the area.
-On 02/21/24 at 8:19am, the door off of the resident television room was opened and no alarm could be heard.
-On 02/22/24 at 3:19pm, the side door, identified as the loading dock door, was opened without using the keypad, and no alarm could be heard.
-Residents were seen entering and exiting the facility to the smoking area throughout the day on 02/20/24-02/22/24, and no alarms sounded; the

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smoking area was not enclosed.

Interview with a personal care aide (PCA) on 02/22/24 at 1:46pm revealed:
-There was a named resident that the staff knew they needed to keep an eye on.
-Whoever was assigned to the smoking area would make sure the named resident had not walked off when the resident was outside smoking.
-The named resident had walked off a couple of times but "thank God, we caught him in time."

Interview with the facility's nurse on 02/22/24 at 3:23pm revealed the facility had arm bracelets on residents who they might be concerned the resident would go out and they wanted to keep up with the resident; there were no current residents of concern.

Interview with a medication aide (MA) on 02/22/24 at 2:19pm revealed:
-A named resident needed supervision.
-It was not documented anywhere the resident needed supervision; the staff just watched him to make sure he did not go anywhere.
-The named resident had not tried to go anywhere.
-The doors were labeled as to know what door had alarmed.
-If someone went out a door the staff were supposed to see who exited the door.

Interview with the Resident Care Coordinator on 02/22/24 at 3:15pm revealed:
-The exit doors were locked between 9:00pm and 10:00pm each night until 6:30am to 7:00am.
-The MAs were responsible for locking and unlocking the doors.
-Residents can go out the exit doors a night, but

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D 067	Continued From page 4 no one can get in. -When an exit door was opened, the alarm would beep three times. -There are no residents who wander from the facility. -The last time a resident wandered from the facility was in 2019 or 2020. Interview with the Administrator on 02/22/24 at 6:53pm revealed: -The facility doors did not need to be locked during the day. -Residents were in and out of the facility all day. -The residents could exit any of the doors at the facility. -Doors did not need to be checked during the day because they did not have any resident who were identified as wanderers.	D 067		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a	D 113		

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maximum of 116 degrees F for 10 of 10 fixtures (9 sinks and 1 shower) located in residents' rooms and a spa room used by the residents.

The findings are:

Review of the facility's county environmental health inspection report dated 02/16/24 revealed:
-The facility's score was 93.5.
-Comments included hot water ranged from 100 to 125 degrees F throughout the facility.
-The water temperature in room #13 was recorded as 125 degrees F.
-The water temperatures in room #17 and #25's was recorded as 123 degrees F.

Review of the facility's water temperature log dated 01/26/24 revealed:
-The water temperature in room #25 and #33 was 119 degrees F.
-The water temperatures in room #15 and #17 was 117 degrees F.
-There were 4 of 7 water temperatures greater than 116 degrees F as follows; room 25 and 33 water temperature was 119 and rooms 15 and 17 were 117.

Observation of the hot water temperature at the sink in resident room #12 on 02/20/24 at 10:15am revealed the hot water temperature was 126.7 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the sink in resident room #17 on 02/20/24 at 8:20am revealed the hot water temperature was 123.7 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the

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sink in resident room #19 on 02/20/24 at 10:05am revealed the hot water temperature was 127.0 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the sink in resident room #20 on 02/20/24 at 9:10am revealed the hot water temperature was 125.6 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the sink in resident room #22 on 02/20/24 at 8:19am revealed the hot water temperature was 126.0 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the sink in resident room #24 on 02/20/24 at 8:26am revealed the water temperature was 118.9 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the sink in resident room #25 on 02/20/24 at 8:32am revealed the water temperature was 125.2 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the sink in resident room #28 on 02/20/24 at 8:36am revealed the water temperature was 122.7 degrees F; there was no signage posted indicating the water was too hot.

Observation of the hot water temperature at the sink in resident room #23 on 02/20/24 at 9:45 am revealed the water temperature was 124.2 degrees F; there was no signage the water temperature was too hot.

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D 113	Continued From page 7 Observation of the hot water temperature in the spa room by the nurses' station on 02/20/24 at 10:17am revealed: -The hot water temperature at the sink was 126.7 degrees F. -The hot water temperature at the shower was 126.5 degrees F -There was no signage posted indicating the water was too hot. Observation of the hot water temperature in the same spa room by the nurses' station on 02/20/24 at 10:26am revealed: -The hot water temperature at the sink was 126.7 degrees F with the surveyor's thermometer. -The hot water temperature at the sink was 125.6 degrees F with the Administrator's thermometer. Calibration of thermometers on 02/20/24 at 10:38am revealed: -The surveyor's thermometer read 31.5 degrees F during calibration with an ice water slurry. -The facility's thermometer read 30.3 degrees F with an ice water slurry. Interview with a resident on 02/20/24 at 8:22am revealed: -The water had been "too hot" at her sink for over a month. -Her hands were getting "mighty raw" from the water being too hot at the sink in her room. -She asked the housekeeper to adjust the hot water, so she did not scald her hands. -No one had adjusted the hot water. -Her hands were not "as raw" since she started adding in more cold water. Interview with a second resident on 02/20/24 at 9:07am revealed the water was hot at the sink but	D 113		

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D 113	Continued From page 8 she just added cold water to adjust the temperature. Interview with a third resident on 02/20/24 at 9:47am revealed: -She knew the water was hot. -She would always turn the cold water and the hot water on together so it would not be so hot. Interview with a fourth resident on 02/20/24 at 10:15am revealed: -The water at her sink was "very hot" on her hands. -She had not told anyone the water was hot. Interviews with the Administrator on 02/20/24 at 10:08am and 10:29am revealed: -He was responsible for checking the water temperatures in the facility. -He checked the water temperatures once a month. -He had not checked the water temperatures for February 2024. -The water temperature should be between 100 degrees F to 116 degrees F. -The facility had new tanks installed less than a year ago. -He rechecked the water temperatures after the new tanks were installed; the water temperatures were within normal range, but he did not record the temperature readings. -The health inspector was in the facility on 02/16/24 and reported the water was too hot. -He called the facility's contracted plumber, and they were scheduled to come to the facility today, 02/20/24. -No one had complained about the water being too hot. -The hot water tank was set at 112 degrees F. -He had a new circulator put in, he thought in	D 113		

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December 2023, because the hot water temperature was fluctuating up and down.
-He had been checking the water temperatures more often than monthly but since the new circulator was installed the water temperatures had been fine.
-He had not posted signage by the fixtures with hot water greater than 116 degrees F until instructed to do so today, 02/20/24, by the surveyor.

Interview with the facility's contracted plumber on 02/20/24 at 2:46pm revealed:
-He received the ticket today, 02/20/24, to service the facility.
-He bled the water tank and water lines and set the temperature on the water tank at 105 degrees F.
-He checked multiple room water temperatures, and the temperature ranges were 103 degrees F to 107 degrees F.

Observation of the hot water temperature at the sink in resident room #23 on 02/20/24 at 2:51pm revealed the hot water temperature was 100.2 degrees F; there was signage alerting the resident to be careful due to hot water temperatures.

Observation of the hot water temperature at the sink in resident room #24 on 02/20/24 at 2:53pm revealed the hot water temperature was 99.1 degrees F; there was signage alerting the resident to be careful due to hot water temperatures.

Observation of the hot water temperature at the sink in resident room #25 on 02/20/24 at 2:57pm revealed the hot water temperature was 99.1 degrees F; there was signage alerting the

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resident to be careful due to hot water temperatures.

Observation of the hot water temperature at the sink in resident room #28 on 02/20/24 at 2:59pm revealed the hot water temperature was 98.6 degrees F; there was signage alerting the resident to be careful due to hot water temperatures.

Interview with the Administrator on 02/21/24 at 3:45pm revealed:
-The plumber bled the water tank and water lines, and turned the temperature down to 105 degrees F.
-It would take several hours for the water temperature to adjust since the water tank and water lines had been bled and the temperature had been turned down.

Observation of the hot water temperature at the sink in resident room #29 on 02/21/24 at 7:40am revealed the hot water temperature was 105.9 degrees F.

Observation of the hot water temperature at the sink in resident room #25 on 02/21/24 at 7:41am revealed the hot water temperature was 108.8 degrees F.

Observation of the hot water temperature at the sink in resident room #24 on 02/21/24 at 7:44am revealed the hot water temperature was 105.6 degrees F.

Observation of the hot water temperature at the sink in resident room #23 on 02/21/24 at 7:46am revealed the hot water temperature was 102.2 degrees F.

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D 113	Continued From page 11 Interview with the Administrator on 02/21/24 at 11:45am revealed: -The rooms with hot water temperature readings were within normal range of 100 degrees F to 116 degrees F. -The signage regarding hot water over the sinks could be removed. Review of the undated American Burn Association Scald Injury Prevention Educator's Guide revealed: -A water temperature of 127 degrees F would cause a third-degree burn in 1 minute. -A water temperature of 124 degrees F would cause a third-degree burn in 3 minutes. -A water temperature of 120 degrees F would cause a third-degree burn in 5 minutes. -Scald injuries could result in considerable pain, prolonged treatment, possible lifelong scarring, and even death. -Older adults have thinner skin so hot liquids could cause deeper burns with even brief exposure. Attempted interview with a housekeeper on 02/21/24 at 8:15am was unsuccessful. _____ The facility failed to ensure hot water temperatures were maintained between 100-116 degrees F as evidenced by hot water temperatures ranging from 118.9 to 127 degrees F at 10 fixtures used by the residents. A hot water temperature of 127 degrees F could result in a first degree burn in less than 45 seconds and a second degree burn in 1.5 minute. This failure 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	D 113		

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D 113	Continued From page 12 accordance with G.S. 131D-34 on 02/20/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 7, 2024.	D 113		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 3 of 5 sampled residents (#1, #4, #5) related to blood pressure checks. The findings are: 1. Review of Resident #1's current FL-2 dated 12/12/23 revealed diagnoses included end-stage renal disease, chronic kidney disease, stage 5, and type 2 diabetes. Review of Resident #1's signed physician's orders dated 01/09/24 revealed an order for weekly blood pressure (BP) checks. Review of Resident #1's January 2024 medication administration record (MAR) revealed: -There was an entry to check and record blood	D 276		

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pressure weekly.
-There were no blood pressure readings documented on the front or back of the MAR.

Interview with Resident #1 on 02/21/24 at 4:03pm revealed:
-Staff checked her BP once a month.
-She did not know how often her BP was supposed to be checked.

Interview with a medication aide (MA)/Resident Care Coordinator (RCC) on 02/22/24 at 4:13pm revealed:
-Resident #1's BP was documented on the MAR.
-She recalled in January 2024 that Resident #1 would not let staff check her BP.
-She should have documented Resident #1's refusal on the MAR.

Telephone interview with Resident #1's primary care provider (PCP) on 02/22/24 at 4:55pm revealed he expected staff to check Resident #1's BP as ordered.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

2. Review of Resident #4's current FL-2 dated 12/12/22 revealed:
-Diagnoses included hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and morbid obesity.
-There was an order to check the resident's BP twice weekly.

Review of Resident #4's January 2024 medication administration record (MAR) revealed:
-There was an entry to check and record blood pressure twice weekly.
-There were no blood pressure readings

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documented on the front or back of the MAR for January 2024; there were no exceptions documented.

Interview with Resident #4 on 02/22/24 at 4:49pm revealed:
-Staff took his BP once a month.
-His BP had not been checked this month, February 2024.

Interview with a medication aide (MA) on 02/22/24 at 3:03pm revealed:
-She had not taken Resident #4's BP because the BP checks had not fallen on her working days.
-The RCC always took the residents' BPs.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 4:13pm revealed:
-She thought Resident #4's BP was taken, and the BP readings did not get documented on the MAR.
-When staff took the residents' BP's the reading was written on "scrap paper" and then documented on the MAR.

Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 02/22/24 at 4:56pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

3. Review of Resident #5's current FL-2 dated 02/17/23 revealed diagnoses included hypertension, glaucoma disease, heart disease, and cerebrovascular disease.

Review of Resident #5's signed physician's order dated 12/04/23 revealed:
-There was an order to check the resident's BP

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every Monday, Wednesday, and Friday.
-There was a second order to contact the Primary Care Provider (PCP) if Resident #5's BP was greater than 160/90 or less than 100/60 and if the resident's heart rate was greater than 100 or less than 60.

Review of Resident #5's December 2023 medication administration record (MAR) from 12/04/23-12/31/23 revealed:
-There was a handwritten entry to check Resident #5's BP every Monday, Wednesday, and Friday; there was no parameter documented.
-There were no blood pressure readings documented on the front or back of the MAR for Friday, 12/15/23, or 12/29/23; there were no exceptions documented.
-On 12/06/23, Resident #5's diastolic BP was documented as 90; there was no documentation that the PCP had been notified.
-There were no heart rates documented as checked for Resident #5 from 12/06/23-12/22/23.

Review of Resident #5's January 2024 MAR revealed:
-There was an entry to check and record blood pressure every Monday, Wednesday, and Friday; there was no parameter documented.
-There were no blood pressure readings documented on the front or back of the MAR for Friday, 01/12/24, or 01/19/24; there were no exceptions documented.
-On 01/08/24, Resident #5's diastolic BP was documented as 90; there was no documentation the PCP had been notified.

Review of Resident #5's February 2024 MAR between 02/01/24-02/20/24 revealed:
-There was an entry to check and record blood pressure every Monday, Wednesday, and Friday;

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there was no parameter documented.
-There were no blood pressure readings documented on the front or back of the MAR for Friday, 02/16/24.
-There were no exceptions documented.
-On 02/19/24, Resident #5's diastolic BP was documented as 90; there was no documentation the PCP had been notified.

Interview with Resident #5 on 02/22/24 at 9:11am revealed:
-She had to remind staff to check her BP every Monday, Wednesday, and Friday.
-There were times when staff did not take her BP, even after reminding them, but it was not often.

Interview with a medication aide (MA) on 02/22/24 at 3:03pm revealed:
-She did not know Resident #5 had a parameter to call the PCP for BP readings.
-She would not know there was a parameter for Resident #5's BP if it was not on the MAR.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 4:26pm revealed:
-She checked Resident #5's BP every Monday, Wednesday, and Friday.
-She did not know Resident #5 had an order for parameters for her BP.

Attempted telephone interview with Resident #5's PCP on 02/22/24 at 4:59pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

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Interview with the Administrator on 02/22/24 at 5:36pm revealed if a resident had an order for BP checks, he expected the resident's BP to be checked and the results documented on the

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D 276	Continued From page 17 MAR; if it was not documented, it did not happen.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 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 observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 3 sampled residents with a diet order for a renal diet (#1). The findings are: Review of the facility's diet order dated 02/20/24 revealed Resident #1 was on a no-concentrated sweet (NCS) diet. Review of Resident #1's current FL-2 dated 09/25/23 revealed: -Diagnoses included dialysis, congestive heart failure, osteoarthritis. -There was no information documented for the diet. Review of Resident #1's signed hospital discharge papers dated 12/14/23 revealed: -Resident #1's diagnoses included type 2 diabetes and end-stage renal disease. -There was an order for a renal diet (A renal diet is a diet aimed at keeping levels of fluids, electrolytes, and minerals balanced in the body in individuals with chronic kidney disease or who are on dialysis.).	D 310		

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Review of the facility's therapeutic menu spreadsheets for 02/20/24-02/22/24 revealed:
-The facility's spreadsheet included a liberal renal diet.
-A liberal renal diet was not to be served citrus juice.
-On 02/20/24, a liberal renal diet was to be served a tossed salad instead of baked potato soup which was listed for the NCS diet.

Observation of the lunch meal service on 02/20/24 between 12:10pm-12:28pm revealed Resident #6 was served a meatball sandwich with cheese, fried okra, a bowl of soup, and Jello with fruit, and milk; she ate 100% of her meal.

Observation of the breakfast meal service on 02/21/24 between 8:10am-8:28am revealed:
-Resident #1 was served eggs, bacon, a biscuit, orange juice, and coffee.
-Resident #1 drank 75% of her orange juice.

Interview with Resident #1 on 02/20/24 at 4:08pm revealed:
-She thought she was on a diabetic diet.
-She ate whatever they gave her.
-The kitchen staff should know what she was supposed to have.
-She did not know what foods she should have or not have on a renal diet.

Interview with the cook on 02/22/24 at 8:55am revealed the only diets she served currently to the residents were either regular or NCS, she did not have any residents on anything different.

Interview with the medication aide (MA) on 02/22/24 at 3:10pm revealed:
-When a resident returned from a hospitalization

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the staff were responsible for reading the discharge papers from beginning to end.
-She thought Resident #1 was on an NCS diet.
-She did not know a renal diet had been ordered for Resident #1.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 4:19pm revealed:
-The staff that was working when Resident #1 returned from the hospital would have reviewed the hospital discharge papers.
-She was not aware of a diet change for Resident #1.
-Resident #1 was supposed to be on an NCS diet but she refused the NCS diet and was provided a regular diet.
-The facility did not offer a renal diet.
-When there was a diet order change, they would notify the facility's nurse and the resident's primary care provider (PCP).

Telephone interview with Resident #1's Primary Care Provider (PCP) on 02/22/24 at 4:55pm revealed:
-He did not know Resident #1's hospital discharge summary had ordered a renal diet for the resident.
-Resident #1 probably should have been on a renal diet all along.
-A renal diet was to prevent excessive electrolytes.

Interview with the Administrator on 02/22/24 at 5:36pm revealed:
-The MA who was working when Resident #1 returned from the hospital should have reviewed the discharge papers for any new orders.
-If any orders needed to be clarified he expected the medication aide to contact the PCP for clarification.

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D 310	Continued From page 20 -He was concerned Resident #1 had not received the diet she was supposed to receive, and the diet order had not been clarified.	D 310		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Review of the facility's census on 02/20/24 revealed there were 64 residents. Observation of the bulletin board at the back of the facility near the nurse's station on 02/20/24 revealed: -There was an activity calendar posted for February 2024. -The activities listed for 02/20/24 included scrapbooking from 2:00pm-3:00pm and movies from 6:00pm-8:00pm. -The activities listed for 02/21/24 included coffee hour/current events 10:00am-11:00am and a	D 315		

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Minister from 11:00am-3:00pm.
-The activities listed for 02/22/24 included bingo from 1:00pm-2:30pm.

Observation of the large bulletin board outside the dining room on 02/20/24 revealed:
-The board was labeled as activity fun.
-There were 6 small pictures of residents sitting at a table posted on the bulletin board.
-There were no activities calendars posted on the bulletin board.
-The center of the large bulletin board was blank.

Observations of the facility on 02/20/24 between 8:00am-5:00pm revealed no activities were observed.

Observations of the facility on 02/21/24 between 8:00am-5:00pm revealed:
-A staff member was seen taking coffee to the residents' rooms between the breakfast meal service and lunch.
-There was no Minister identified as providing spiritual programs.

Observation of the facility on 02/22/24 between 8:00am-5:00pm revealed no activities observed.

Interview with a resident on 02/21/24 at 8:55am revealed:
-The facility had activities "every blue moon."
-An outside group did an activity, he thought it was a month ago.
-There was an activity room, but the room had been locked "for a while."
-He spent his time smoking, watching television, and visiting with other residents.
-he would like to have more activities.

Interview with a second resident on 02/21/24 at

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9:34am revealed:
-"What activities?"
-An outside group did bingo for Valentine's.
-They used to play games, but the Administrator told the residents he did not have enough staff to take the residents' places and do things with the residents.

Interview with a third resident on 02/21/24 at 9:41am revealed:
-When she first moved to the facility people from a church would come and do things with them, but not anymore.
-Watching television was mindless.
-She enjoyed singing and playing games.

Interview with a fourth resident on 02/21/24 at 9:49am revealed:
-She had only been at the facility a couple of months, and there had not been any activities since she moved in.
-She would love to go for a ride so she could see what the world was like.

Interview with a fifth resident on 02/21/24 at 11:31am revealed:
-Would like to have activities.
-She spent a lot of time in her room and the bed.
-She would like to do things that used her brain.

Interview with a sixth resident on 02/21/24 at 11:38am revealed:
-The facility did not offer any activities or programs.
-She would like to have at least one activity every day.
-Even if an activity was posted on the calendar, it would get rescheduled and then never happen.
-The residents never got to go anywhere.
-She had lived at the facility for over two years

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and had never been anywhere but to medical appointments.
-She would love to go shopping.

Interview with a personal care aide (PCA) on 02/22/24 at 1:46pm revealed:
-Different organizations came to the facility and did things with the residents, usually on a Saturday.
-She had not been assigned to do any activities with the residents.

Interview with a medication aide (MA) on 02/22/24 at 2:35pm revealed:
-A named organization recently had bingo for the residents.
-The weekend of 01/27/24-01/28/24 she had done karaoke with the residents.
-People from church came to the facility every Saturday at 2:00pm.
-A named Minister was at the facility every Sunday.
-The staff played movies for the residents whenever they were told; the last movie played was last year.

Interview with the Administrator on 02/22/24 at 6:53pm revealed:
-The facility's nurse was the Activity Director and was responsible for making sure the activities were carried out.
-Staff were supposed to help with activities.
-The transport staff would sometimes take 2-3 residents with her when she had to run errands.

The Activity Director was not available for an interview on 02/22/24 before the exit of the survey.

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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to treat residents with dignity and respect related to requiring masks to be worn when out of their rooms when there was no communicable disease present in the facility and requiring residents to leave their rooms to go to the nurses' station to be administered medications while other residents were waiting on their medications.

a. Observation of the facility on 02/20/24 at 8:00am revealed:
-Staff were observed wearing masks.
-Residents were observed in the hallway outside the dining room and all the residents were observed wearing masks.

Interview with a resident on 02/22/24 at 8:55am revealed:
-The facility did not have COVID in the facility, so he wanted to know why the residents had to wear masks.
-He would prefer not to wear masks because the mask was irritating.
-If residents did not wear their masks when outside their room, the staff would "fuss" at the residents until they pulled their masks up.

Interview with a second resident on 02/22/24 at 9:33am revealed:
-Staff made the residents wear masks anytime

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the resident was outside of their room.
-The staff was "nasty" to the residents if they did not have their masks on; the staff spoke to them like children.

Interview with a third resident on 02/22/24 at 9:47am revealed:
-If she left her room, she had to wear a mask.
-If she came out of her room without a mask, the staff would tell her she had to put the mask on.
-She had been to appointments and even a hospital-based clinic and was not required to wear a mask.
-It had been a while since there had been any COVID in the facility.

Interview with a fourth resident on 02/22/24 at 11:24am revealed:
-Residents had to wear masks every day, "all the time."
-She wanted to know why the residents had to wear masks.
-The staff told the residents they had to wear the masks and the staff "did not say it with grace."
-She preferred not to have to wear a mask, but she went along with it because she had to.

Interview with a fifth resident on 02/22/24 at 11:38am revealed:
-Wearing masks was "getting old."
-If a resident did not have their mask on, the staff would call the resident out in front of everyone, and it was embarrassing.
-She did not forget to wear her mask on purpose.
-She stayed in her room more "just to avoid wearing a mask."

Interview with a sixth resident on 02/20/24 at 8:57am revealed:
-The residents must wear masks to protect

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themselves from germs.
-The residents would be reprimanded if the masks were not worn.
-"Why did she have to wear a mask and the survey team did not."

Interview with a seventh resident on 07/22/24 at 7:30am revealed:
-The residents had to wear masks because of COVID and the flu.
-He did not know if anyone had COVID or the flu that lived at the facility.
-Staff would tell the residents to wear masks, and the staff would remind the residents to put masks on if they see residents in the hallway without masks.

Interview with a medication aide (MA) on 02/22/24 at 3:15pm revealed:
-Residents and staff wore masks if they wanted to.
-The residents had a choice to wear masks or not.
-If there was a respiratory outbreak in the facility, the residents and staff would have to wear masks.
-Residents had not complained to her about wearing masks in the facility.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 9:47am revealed:
-Residents could choose whether to wear masks or not.
-Masks were required if anyone had COVID or RSV; no one had it since last year (2023).
-She had not heard any residents complain of wearing masks.
-If she saw someone without a mask, she would probably not say anything to the resident.

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Interview with the Administrator on 02/22/24 at 6:53pm revealed:
-Residents were not required to wear masks.
-He preferred the residents to wear masks.
-Staff should not be telling residents they needed to wear masks in the facility.
-No residents had complained to him about wearing masks; it was the residents choice whether to wear them or not.

b. Observation of a hallway and the area around the nurse's station on 02/20/24 at 8:40am revealed:
-There were 11 residents waiting to have their medications administered.
-The MA was seated at the nurses station with the medication cart; she would call the residents to the nurses station to have their medications administered.

Interview with a resident on 02/20/24 at 9:05am revealed:
-He had to go to the nurse's station to get his medications.
-The MAs did not bring the medications to the room.
-He would go to the nurse's station before breakfast to have his FSBS checked, and his insulin administered.
-Sometimes he would take his pills before breakfast and sometimes after breakfast.
-If he waited until after breakfast, he would have to wait in a line, because most residents took their medications after breakfast.
-After breakfast, the residents lined up in the hallway and waited for their medications to be administered.

Observation of the nurse's station on 02/21/22 at 8:00am revealed the MA was heard over the

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intercom calling residents by name to the nurse's station to take their morning medications.

Observation of the area around the nurses station on 02/21/24 at 8:42am revealed there were 8 residents sitting and/or standing around the wall across from the nurses station; there was no staff present.

Interview with a second residents standing at the nurses station on 02/21/24 at 8:42am revealed "we are waiting on our medicine."

Interview with a third resident on 02/21/24 at 11:38am revealed:
-She did not like being called to the nurses station to get her medication.
-Even after the MA called her name to go to the nurses station, she would still have to stand there waiting for a long time before her medication was administered.

Observation of the nurse's station and the hallway to the left of the nurse's station on 02/22/24 at 8:45am revealed:
-There were 6 residents in wheelchairs seated along the hallway waiting for their medications to be administered.
-There were 3 residents in wheelchairs and one resident seated around the nurse's station waiting for their medications to be administered.
-The MA was seated in a desk chair at the edge of the nurse's station, beside the medication cart, and called residents to the nurse's station to administer their morning medications.

Interview with a fourth Resident on 02/22/24 at 7:36am revealed:
-He had to go to the nurse's station to get his medication.

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D 338	Continued From page 29 -The MAs did not bring the medication to the resident's room. -The MAs will call residents over the intercom to come to the nurse's station to get their medications if the residents were not at the nurse's station when the MA was ready to administer the medications. Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 9:47am revealed: -The residents come to the nurses station to get their medications. -She would call residents to the nurses station if needed, to administer their medications. -The residents had not complained to her about coming to the nurses station to get their medications. Interview with the Administrator on 02/22/24 at 6:53pm revealed: -The resident's medications should be administered in the resident's room. -The MAs should push the medication cart up and down the hallways to each resident's room -He expected the MAs to go to the resident to administer the medications and not have the residents come to the MAs.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or	D 344		

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(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify orders for 1 of 5 sampled residents (#1) for an order for honey thick liquids.

The findings are:

Review of Resident #6's FL-2 dated 05/17/22 revealed:
-The FL-2 was the most current FL-2 in the resident's record.
-Diagnoses included stroke, hypertension, and stage 3 chronic kidney disease.
-There was an order for chopped/mechanically altered and honey-thick liquids.

Review of Resident #6's physician's order dated 06/15/22 revealed the order as a clarification, Resident #6 should be on a regular diet with honey thick liquids.

Review of Resident #6's FL-2 provided on 02/22/24 at 7:40am revealed:
-The FL-2 was signed by the primary care provider (PCP) on 02/20/24.
-Diet was listed as regular.
-There was no order for the consistency of Resident #6's liquids.

Interview with the cook on 02/20/24 at 8:42am revealed:
-She did not have a diet list, it was taken down

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yesterday, 02/19/24, and was being reprinted.
-The only modified diet she had was Resident #6 who had chopped meats and thickened liquids.

Review of the facility's diet list provided on 02/20/24 revealed:
-The diet list was a typed document updated on 02/20/24 with the subheadings of no concentrated sweets, mechanical soft, and additional notes.
-Resident #6 was not listed on the diet list.

Observation of the lunch meal service on 02/20/24 between 12:33pm-12:35pm revealed:
-Resident #6 was served a carbonated beverage with ice; it was not thickened.
-A personal care aide (PCA) took a container of pre-thickened iced tea to Resident #6 at 12:35pm.
-Resident #6 was observed multiple times coughing, after drinking both his carbonated beverage and his thickened tea.

Observation of the breakfast meal service on 02/21/24 at 8:40am revealed Resident #6 was served orange juice that was not thickened.

Observation of the lunch meal service on 02/21/24 at 12:29pm revealed Resident #6 was served a carbonated beverage with ice; it was not thickened.
Observation of the breakfast meal service on 02/21/24 at 8:18am revealed Resident #6 was served orange juice that was not thickened.

Interview with Resident #6 on 02/22/24 at 8:45am revealed:
-He was told he was supposed to be on thickened liquids.
-He drank whatever the staff gave him to drink.

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-The staff did not always give him thickened liquids.
-He had "regular" water when he took his medications.
-He coughed when he drank liquids because "it went down where he breathed."
-He coughed with whatever he was drinking.

Second interview with the cook on 02/22/24 at 8:55am revealed:
-There were a lot of thickened liquids available for Resident #6.
-She was responsible for sending thickened liquids with meals for Resident #6.
-There was a thickener at the nurses' station to be used with any other beverages for Resident #6.
-The nurse told her on 02/20/24 that Resident #6's diet order had been changed.
-She sent thickened liquids with Resident #6's breakfast on 02/20/24, but after she was told the diet order changed, she did not send thickened liquids.

Interview with a medication aide (MA) on 02/22/24 at 9:50am revealed:
-She completed Resident #6's FL-2 based on the previous FL-2.
-She did not write in Resident #6's order for honey thick liquids because she had been told it had been discontinued.
-The facility nurse told her Resident #6's honey thick liquids had been discontinued after his last hospitalization.
-The last hospitalization was about a month ago.
-She would provide a copy of the last hospitalization.

Review of Resident #6's hospital discharge summary provided by the Resident Care

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Coordinator (RCC) on 02/22/24 revealed:
-The diet had been highlighted and was documented as regular.
-The hospital discharge summary was dated 11/24/21.

Interview with a personal care aide (PCA) on 02/22/24 at 1:46pm revealed:
-Resident #6 was served thickened liquids with his meals.
-Resident #6 loved a named carbonated beverage so the staff treated the resident with the named beverage.
-She served Resident #6 lemonade off the snack cart.
-If Resident #6 drank too fast the resident would start coughing.
-She served Resident #6 thickened tea on 02/20/24 at lunch because the medication aide (MA) reminded her to make sure the resident had thickened liquids.

Interview with the RCC on 02/22/24 at 3:22pm revealed she "really did not know anything about Resident #6's diet orders."

Telephone interview with Resident #6's PCP on 02/22/24 at 8:25am and 4:55pm revealed:
-Resident #6 had a stroke several years ago.
-He did not recall making any changes to Resident #6's diet.
-He thought honey thick liquids were appropriate for Resident #6.
-He would not have made a change in Resident #6's liquids without consulting a speech therapist.
-He did not notice Resident #6's FL-2 did not have honey-thick liquids when he signed it.
-Honey-thick liquids should have been written in on the FL-2.
-Resident #6 had been on honey-thick liquids for

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D 344	Continued From page 34 as long as he had known the resident. -If Resident #6 was coughing with beverages, it could lead to pneumonia. Interview with the Administrator on 02/22/24 at 5:36pm revealed: -He was not aware Resident #6 had not been served thickened liquids. -The facility purchased thickened liquids to be served to Resident #6. -Concerned if Resident #6 was not served thickened liquids the resident could aspirate. -He expected the order for Resident #6 to be clarified.	D 344		
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 observed during the morning medication pass including errors with a blood pressure medication, a fluid pill, and a supplement (#5); and for 4 of 5 sampled residents for record review (#1, #3, #4, #5) including a dialysis medication used to lower phosphorus levels (#1); a pain medication (#3); a	D 358		

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medication used to prevent blood clots and two supplements (#4); and eye drops used to treat glaucoma and two stool softeners (#5).

The findings are:

Review of the facility's undated policy on medication administration revealed medications that require a blood pressure reading should be checked before the medication was prepared for administration.

1. The medication error rate was 9% as evidenced by 3 errors out of 32 opportunities during the 8:00am/9:00am medication passes on 02/21/24.

a. Review of Resident #5's current FL-2 dated 02/17/23 revealed diagnoses included Alzheimer's disease, hypertension, cerebrovascular disease, seizure disorder, glaucoma, falls risk, heart failure, and anxiety.

1. Review of Resident #5's current FL-2 dated 02/17/23 revealed there was an order for hydralazine 25mg (used to treat high blood pressure) three times daily.

Review of Resident #5's signed physician order dated 12/17/23 revealed:
-There was an order for hydralazine 25mg three times daily, hold for systolic blood pressure (BP) less than 100.
-There was an order to check Resident #5's BP three times a week, Monday, Wednesday and Friday.

Observation of the 8:00am/9:00am medication pass on 02/21/24 revealed:
-The medication aide (MA)/Resident Care

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Coordinator (RCC) prepared 7 pills for administration to Resident #5, one of them being hydralazine 25mg.
-The MA/RCC placed a dot on the medication administration record (MAR) where the MA would sign her initials after administration.
-The MA/RCC administered the 7 pills, including hydralazine 25mg, to Resident #5.
-The MA/RCC checked Resident #5's blood pressure after the 7 pills had been administered.
-Resident #5's blood pressure was 144/93.

Review of Resident #5's February 2024 medication administration record (MAR) from 02/01/24 to 02/21/24 revealed:
-There was an entry for hydralazine 25mg three times daily, hold if systolic BP less than 100.
-There was a dot placed on the MAR where the MA would initial after medication administration.
-There was an entry to check BP on Monday, Wednesday, and Friday.
-There was documentation Resident #5's BP was 144/93.

Observation of medication on hand for Resident #5 on 02/21/24 revealed:
-There was a blister pack of hydralazine 25mg dispensed on 02/18/24.
-The prescription label read take one tablet three times daily, hold for systolic BP less than 100.

Telephone interview with a representative at the facility's contracted pharmacy on 02/21/24 at 10:45am revealed the pharmacy had an order for hydralazine 25mg three times daily, hold if systolic BP less than 100, dated 12/17/23.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/22/24 at 12:59pm revealed:

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-Resident #5's blood pressure should be taken before hydralazine was administered.
-Hydralazine lowers blood pressure, and if Resident #5's blood pressure was low prior to the administration of hydralazine, then Resident #5's BP could drop even lower, increasing the risk for falls.

Interview with the MA/RCC on 02/21/24 at 11:35am revealed:
-She knew there was an order to hold Resident #5's hydralazine if the systolic BP was less than 100.
-Resident #5 had an order to check her BP three times a week, so her BP was not taken each time before hydralazine was administered.
-She should have taken Resident #5's BP before administering hydralazine in order to know whether to administer the hydralazine or hold it.

Interview with the Administrator on 02/22/24 at 5:37pm revealed:
-Resident #5 should have her BP checked to see if hydralazine was to be held.
-If hydralazine was administered before Resident #5's BP was checked, Resident #5's BP could drop.
-The BP had to be taken before medication administration to determine if hydralazine was to be administered or not.
-He expected the MAs to check Resident #5's BP before administering medications as ordered.

Attempted telephone interview with Resident #5's Primary Care Provider (PCP) on 02/22/24 at 4:56pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

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D 358	Continued From page 38 2. Review of the facility's undated policy on medication administration revealed the MA was to recheck the MAR to ensure all medications were administered and documented appropriately at the completion of the medication pass. Review of Resident #5's current FL-2 dated 02/17/23 revealed there was an order for Lasix 20mg (used to treat fluid retention) every 48 hours. Observation of the 8:00am/9:00am medication pass on 02/21/24 revealed: -The medication aide (MA)/Resident Care Coordinator (RCC) prepared 7 pills for administration to Resident #5. -Lasix was not one of the 7 pills prepared for administration. -The MA initialed the MAR and circled her initials on 02/20/24, instead of 02/21/24. Review of Resident #5's February 2024 medication administration record (MAR) from 02/01/24 to 02/21/24 revealed: -There was an entry for Lasix 20mg every other day with a scheduled administration time of 9:00am. -There was no documentation Lasix 20mg was administered during the 9:00am administration time on 02/21/24.. -There was documentation Lasix 20mg was last administered on 02/19/24 at 9:00am. Observation of medication on hand for Resident #5 on 02/21/24 at 11:37am revealed: -There was a blister pack of Lasix 20mg dispensed on 02/18/24. -The prescription label read take one tablet every other day.	D 358		

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Telephone interview with a representative at the facility's contracted pharmacy on 02/21/24 at 10:45am revealed the pharmacy had an order for Lasix 20mg every other day dated 12/04/23.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/22/24 at 12:59pm revealed:
-Lasix was a diuretic used to get rid of excess fluid of the body.
-Lasix assisted in lowering the blood pressure by getting rid of the excess fluid of the body.
-Resident #5 could have an increase in swelling of the lower extremities if Lasix was not administered as ordered.

Interview with Resident #5 on 02/21/24 at 11:38am revealed:
-She took her fluid pill after eating breakfast.
-She did not want to interrupt her breakfast to go to the bathroom.
-She took her fluid pill every other day.
-She took her medications this morning after breakfast; she did not know if she took her fluid pill or not.

Interview with the MA/RCC on 02/21/24 at 11:35am revealed:
-She did not give Resident #5 Lasix this morning, 02/21/24, because Resident #5 was ordered Lasix every other day.
-She initialed the MAR and circled her initials, indicating she did not administer Lasix 20mg to Resident #5.
-She did not realize she initialed and circled her initials on 02/20/24, instead of 02/21/24.
-She should have administered Resident #5 her Lasix 20mg this morning, 02/21/24.
-Resident #5's MAR was not initialed yesterday, 02/20/24, and that confused her.

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Interview with the Administrator on 02/22/24 at 5:37pm revealed the MA should have administered Resident #5's Lasix as scheduled every other day.

Attempted telephone interview with Resident #5's Primary Care Provider (PCP) on 02/22/24 at 4:56pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

3. Review of Resident #5's current FL-2 dated 02/17/24 revealed there was no order for vitamin D3 5000 units (used as a supplement) daily.

Observation of the 8:00am/9:00am medication pass on 02/21/24 revealed:
-The medication aide (MA)/Resident Care Coordinator (RCC) prepared 7 pills for administration, including vitamin D3 5000 units.
-The MA administered 7 pills to Resident #5, including vitamin D3 5000 units.
-The MA failed to return to the MAR and document administration of the 7 pills.

Review of Resident #5's February 2024 medication administration record (MAR) revealed:
-There was an entry for vitamin D3 5000 units daily with a scheduled administration time of 9:00am.
-There was no documentation vitamin D3 5000 units was administered on 02/21/24.
-There was a dot placed on the MAR for 02/21/24 where the MA/RCC would document her initials after the administration of the medication.

Telephone interview with a representative at the facility's contracted pharmacy on 02/21/24 at

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10:45am revealed:
-The pharmacy had an order for vitamin D3 5000 units dated 01/01/23.
-The pharmacy did not received Resident #5's FL-2 dated 02/17//23.
-If the pharmacy had received the FL-2 dated 02/17/23, they would have notified the PCP for clarification whether the vitamin D3 5000 units was to be discontinued.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/22/24 at 12:59pm revealed vitamin D was used as a supplement.

Interview with Resident #5 on 02/21/24 at 11:38am revealed:
-She took her medications this morning after breakfast,
-She thought she took her vitamin D but she was not sure if she did.

Interview with the MA/RCC on 02/21/24 at 11:35am revealed:
-She administered Resident #5's vitamin D2 5000 units as it was entered on the MAR.
-She did not know there was no current order for vitamin D3 5000 units.
-The FL-2 dated 02/17/23 was completed by the Primary Care Provider's (PCP) office staff or the facility staff.
-She did not know who completed Resident #5's FL-2.
-Vitamin D3 5000 units was left off the most recent FL-2 dated 02/17/23.
-When a new FL-2 was signed, the MA/RCC would compare the medications on the FL-2 with the medications on the current MAR.
-If there was a medication listed on the MAR and not the new FL-2, the MA would discontinue the

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medication on the current MAR and fax the new FL-2 to the pharmacy so the medication could be discontinued from the system.
-She did not know if the new FL-2 was faxed to the pharmacy.
-The MA who received the FL-2 should have faxed the FL-2 to the pharmacy.

Interview with the Administrator on 02/22/24 at 5:37pm revealed:
-The MAs and RCC were expected to compare medications on the FL-2 with the medications on the MAR.
-If the vitamin D3 5000 units was not on the FL-2, the MA or RCC should notify the PCP to verify if the medication was to be discontinued.
-The FL-2 would be faxed to the pharmacy to update the MARS with any changes on the FL-2.

Attempted telephone interview with Resident #5's Primary Care Provider (PCP) on 02/22/24 at 4:56pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

2. Review of Resident #3's current FL-2 dated 02/15/24 revealed:
-Diagnoses included chronic pain, chronic continuous use of opioids, and depressive disorder.
-There was an order for oxycodone 15mg (used to relieve pain) three times a day as needed for chronic pain.

Review of Resident #3's February 2024 medication administration record (MAR) from 02/16/24 to 02/20/24 revealed:
-There was an entry for oxycodone 15mg one tablet three times daily with a scheduled

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administration time of 9:00am, 2:00pm, and 6:00pm.
-There was documentation oxycodone 15mg was administered three times daily from 02/15/24 to 02/20/24.
-There was no entry for oxycodone 15mg one three times daily as needed (PRN) on the February 2024 MAR.

Observation of medication of hand for Resident #3 on 02/22/24 at 8:47am revealed:
-There was a bubble pack of oxycodone 15mg available for administration.
-The pharmacy dispensed 15 oxycodone 15mg on 02/16/24 with directions to take one tablet three times daily PRN pain.

Telephone interview with the representative at the facility's contracted pharmacy on 02/22/24 at 9:36am revealed:
-The pharmacy received Resident #3's current FL-2 dated 02/15/24.
-There was an order for oxycodone 15mg three times daily PRN dated 02/15/24.
-The pharmacy dispensed 15 oxycodone 15mg on 02/16/24.
-The facility was on paper MARs and it was the responsibility of the facility staff to make medication changes on the MAR.
-The pharmacy would enter the medication change in the system and the medication changes would print on the next months MAR.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/22/24 at 12:59pm revealed:
-Resident #3's oxycodone was scheduled three times daily prior to 02/15/24.
-Oxycodone was addictive and residents could become dependent on the medication.

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D 358	Continued From page 44 Interview with Resident #3 on 02/02/24 at 8:49am revealed: -He was in chronic pain and received his oxycodone three times a day. -The Primary Care Provider (PCP) tried to change the oxycodone to PRN, but he needed it three times a day to help control his pain. Interview with a medication aide (MA) on 02/22/24 at 2:54pm revealed: -She reviewed Resident #3's FL-2 dated 02/15/24. -She knew there was an order for Oxycodone 15mg three times daily PRN. -She did not change the order from scheduled to PRN because Resident #3 always asked for oxycodone three times daily. -She should have written the new order for oxycodone PRN on the MAR and discontinued the scheduled oxycodone. Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 3:23pm revealed: -She did not review Resident #3's FL-2 dated 02/15/24. -The MA who received the FL-2 would review for medication changes and document changes on the MAR. -The MA should have changed oxycodone from a scheduled medication to a PRN medications as ordered. Interview with the Administrator on 02/22/24 at 5:37pm revealed the MA should compare new FL-2s with the MAR and make changes to the MAR as ordered. Attempted telephone interview with Resident #3's PCP on 02/22/24 at 1:20pm was unsuccessful.	D 358		

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D 358	Continued From page 45 Refer to the interview with the Administrator on 02/22/24 at 5:36pm. 2. Review of Resident #1's current FL-2 dated 12/12/23 revealed: -Diagnoses included end-stage renal disease, chronic kidney disease, stage 5, and type 2 diabetes. -There was an order for Calcium Acetate 667mg take 2 tablets once daily with lunch (Calcium Acetate is used to lower phosphorus levels in dialysis patients.) Review of Resident #1's signed physician orders dated 01/09/24 revealed there was an order for Calcium Acetate 667mg take 2 tablets once daily with lunch. Review of Resident #1's January 2024 medication administration record (MAR) from 01/18/24-01/31/24 revealed: -There was an entry for Calcium Acetate 667mg take 2 tablets once daily with lunch scheduled for 12:00pm. -Calcium Acetate was documented as administered at 12:00pm nine times; there were five times the medication was documented as not administered. Review of Resident #1's February 2024 MAR from 02/01/24-02/20/24 revealed: -There was an entry for Calcium Acetate 667mg take 2 tablets once daily with lunch scheduled for 12:00pm. -Calcium Acetate was documented as administered at 12:00pm eight times; there were eleven times the medication was documented as not administered.	D 358		

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D 358	Continued From page 46 Observation of Resident #1's medications on hand on 02/20/24 at 12:48pm revealed: -There was a punch card dispensed on 01/18/24 for Calcium Acetate 667mg take two capsules by mouth every day with lunch. -There were 30 bubbles on the punch card and each bubble contained two gel capsules for a total of 60 capsules; two bubbles had been punched. -There were 28 unpunched bubbles leaving 56 Calcium Acetate capsules. Telephone interview with a representative with the facility's contracted pharmacy on 02/22/24 at 10:10am revealed Resident #1's Calcium Acetate 667mg take two tablets at lunch was filled on 12/18/23, 01/18/23, and 02/18/23; each dispensing was a 30-day supply. Based on interviews, record reviews, and observations, Resident #1 should have received 18 doses of Calcium Acetate between 01/18/24-01/18/24 on the 18 days she was not at dialysis (Tuesdays, Thursdays, Saturdays, and Sundays) and only 2 doses had been administered from the medication dispensed on 01/18/24. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 02/24/24 at 1:09pm revealed: -Calcium Acetate was prescribed to remove excess phosphate from the blood because Resident #1's kidneys were not excreting the phosphate properly. -If phosphate built up in the body, it could eventually cause cardiovascular disease and/or a stroke.	D 358		

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Interview with Resident #1 on 02/20/24 at 4:08pm revealed:
-She was diabetic.
-She went to dialysis on Monday, Wednesday, and Friday.
-She took her morning medications before she left for dialysis.
-She did not take any medications with her to dialysis.
-She took medications twice a day, in the mornings and the evenings.

Interview with a medication aide (MA) on 02/22/24 at 3:10pm revealed:
-Resident #1's medications were administered before she went to dialysis.
-She did not send any medications with Resident #1 on her dialysis days.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 4:13pm revealed:
-She did not send Resident #1's Calcium Acetate with the resident to her dialysis appointment.
-The staff at the dialysis center told her they would provide and administer Resident #1's Calcium Acetate on her dialysis days.
-She administered Resident #1's Calcium Acetate on the days the resident was not at the dialysis center.
-She may have forgotten to document exceptions when Resident #1 was not administered her Calcium Acetate because of appointments and the resident being out of the facility.

Telephone interview with Resident #1's primary care provider (PCP) on 02/22/24 at 4:55pm revealed:
-Calcium acetate was a binder for phosphate.
-He would be concerned Resident #1 could experience hyperphosphatemia (extra

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phosphorus in your blood) if the medication was not administered as ordered.
-He expected Resident #1's Calcium acetate to be administered every day as ordered.
-He would not want Resident #1 to experience cramps and tingling which could happen if the medication was not administered as ordered.

According to the National Institute of Health, hyperphosphatemia is associated with cardiovascular disease. Management of hyperphosphatemia depends on phosphate binder medication, a low-phosphorous diet, and dialysis.

Interview with the Administrator on 02/22/24 at 5:36pm revealed:
-He was not aware Resident #1's Calcium Acetate had not been administered.
-He expected Resident #1's Calcium Acetate to be administered as ordered.

Attempted telephone interview with staff at Resident #1's dialysis center on 01/22/24 at 8:37am was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

3. Review of Resident #5's current FL-2 dated 02/17/23 revealed diagnoses included hypertension, glaucoma disease, heart disease, and cerebrovascular disease.

a. Review of Resident #5's current FL-2 dated 02/17/23 revealed an order for Lumigan (used to treat glaucoma) 0.01% eye drops one drop in both eyes at bedtime.

Review of Resident #5's January 2024

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medication administration record (MAR) from 01/04/24-01/31/24 revealed:
-There was an entry for Lumigan eye drops 0.01% one drop in each eye with a scheduled administration time of 8:00pm.
-Lumigan eye drops were documented as administered at 8:00pm from 01/04/24-01/31/24.

Review of Resident #5's February 2024 MAR from 02/01/24-02/20/24 revealed:
-There was an entry for Lumigan eye drops 0.01% one drop in each eye with a scheduled administration time of 8:00pm.
-Lumigan eye drops were documented as administered at 8:00pm from 02/01/24-02/20/24.

Observation of Resident #5's medications on hand on 02/20/24 at 12:48pm revealed:
-There was a bottle of Lumigan 0.01% eye drops with a dispensed date of 01/04/24; the date opened was not documented.
-The bottle contained a small amount of liquid when the bottle was shaken.

Telephone interview with a representative with the facility's contracted pharmacy on 02/22/24 at 9:29am revealed Resident #5's Lumigan 0.01% eye drops were filled on 10/26/23, 12/18/23, and 01/04/24; each dispensing was an 18-20 day supply.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 02/24/24 at 1:09pm revealed:
-Resident #5's Lumigan was prescribed to treat glaucoma.
-It was important for Resident #5's Lumigan to be administered every day or her glaucoma could worsen.
-Untreated glaucoma could eventually lead to loss

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D 358	Continued From page 50 of vision. Interview with Resident #5 on 02/22/24 at 9:11am revealed: -She did not get eye drops administered every night. -There was only one named MA that administered her eye drops. -If a named MA was not working, she did not get her eye drops. Interview with a medication aide (MA) on 02/22/24 at 3:10pm and 5:25pm revealed: -She administered Resident #5's Lumigan eye drops every night she worked. -She thought Resident #5's Lumigan eye drops were sent with cycled medication but when the eye drops were not delivered with the cycled medication on 02/20/24, she called the pharmacy on 02/21/24 to reorder the Lumigan eye drops because the bottle was almost empty. Interview with the Administrator on 02/22/24 at 5:36pm revealed he was concerned Resident #5 may not be getting her Lumigan eye drops as prescribed. Attempted telephone interview with Resident #5's primary care provider (PCP) on 02/22/24 at 4:59pm was unsuccessful. Refer to the interview with the Administrator on 02/22/24 at 5:36pm. b. Review of Resident #5's physicians after visit summary dated 07/10/23 revealed: -Resident #5 was seen by her PCP for hematochezia (the passing of fresh blood with stools). -Resident #5 was ordered Senna Plus 8.6 one	D 358		

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tablet twice weekly to be taken along with Miralax powder.

Review of Resident #5's physician's order dated 12/04/23 revealed an order to increase Resident #5's Senna to every Tuesday, Thursday, Saturday, and Sunday.

Review of Resident #5's December 2023 medication administration record (MAR) from 12/04/23-12/31/23 revealed:
-There was an entry for Senna Plus 8.6 with a scheduled administration time of 9:00am.
-Senna was documented as administered at 9:00am beginning Tuesday, 12/05/23, and every Tuesday, Thursday, Saturday, and Sunday with exceptions documented on 12/23/23, 12/25/23, and 12/26/23.
-The reason for the exceptions was not documented.

Review of Resident #5's January 2024 MAR revealed:
-There was an entry for Senna Plus 8.6 with a scheduled administration time of 9:00am.
-Senna was documented as administered at 9:00am every Tuesday, Thursday, Saturday, and Sunday with exceptions documented on 01/06/24, 01/13/24, 01/14/24, 01/27/24, 01/28/24, and 01/30/24.
-The reason for the exceptions was not documented.

Review of Resident #5's February 2024 MAR between 02/01/24-02/20/24 revealed:
-There was an entry for Senna Plus 8.6 with a scheduled administration time of 9:00am.
-Senna was documented as administered at 9:00am every Tuesday, Thursday, Saturday, and Sunday with exceptions documented on 02/10/24,

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D 358	Continued From page 52 02/11/24, 02/15/24, 02/18/24, and 02/20/24. -The reason for the exceptions was not documented. Observation of Resident #5's medications on hand on 02/20/24 at 12:48pm revealed there was no Senna Plus available to be administered. Telephone interview with a representative with the facility's contracted pharmacy on 02/22/24 at 9:29am revealed Resident #5's Senna was last filled on 12/04/23 for a 90-day supply. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 02/24/24 at 1:09pm revealed Resident #5's Senna Plus was prescribed to prevent constipation and if the medication was not administered as ordered the issue would not be resolved. Interview with Resident #5 on 02/22/24 at 9:11am revealed: -She thought she was supposed to get Senna Plus every day, but she had not had the medication since last week (she did not recall the date). -She had not had a bowel movement since Monday, 02/19/24, and she would like to have one every day. Interview with a MA on 02/22/24 at 3:10pm revealed: -Resident #5 asked for her Senna Plus, today, 02/22/24, but she had to apologize that she did not have any Senna available to be administered. -She did call the pharmacy and it was delivered immediately. -She administered Resident #5's Senna today, 02/22/24 "right before lunch."	D 358		

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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
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Attempted telephone interview with Resident #5's PCP on 02/22/24 at 4:59pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

c. Review of Resident #5's current FL-2 dated 02/17/23 revealed an order for Miralax (used to treat constipation) 17gm daily.

Review of Resident #5's December 2023 medication administration record (MAR) revealed:
-There was an entry for Miralax 17gm with a scheduled administration time of 9:00am.
-Miralax was documented as administered at 9:00am from 12/01/23-12/14/23 and 12/16/23-12/31/23; there was an exception documented for 12/15/23.

Review of Resident #5's January 2024 MAR revealed:
-There was an entry for Miralax 17gm with a scheduled administration time of 9:00am.
-Miralax was documented as administered at 9:00am from 01/01/24-01/11/24 and 01/13/24-01/31/24; there was an exception documented for 01/12/24.

Review of Resident #5's February 2024 MAR from 02/01/24-02/20/24 revealed:
-There was an entry for Miralax 17gm with a scheduled administration time of 9:00am.
-Miralax was documented as administered at 9:00am from 02/01/24-02/20/24.

Observation of Resident #5's medications on hand on 02/20/24 at 12:48pm revealed there was no Miralax available to be administered.

Telephone interview with a representative with the

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facility's contracted pharmacy on 02/22/24 at 9:29am revealed Resident #5's Miralax was last filled on 09/15/22, 10/18/22, and 12/17/22; each dispensing was a 30-day supply.
-There had been no refills for Resident #5's Miralax in 2023 or 2024.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 02/24/24 at 1:09pm revealed Resident #5's Miralax was prescribed to prevent constipation and if the medication was not administered as ordered the issue would not be resolved.

Interview with Resident #5 on 02/22/24 at 9:11am revealed:
-She did not get Miralax every day.
-She would know if she received Miralax because she could taste it in whatever it was put in.
-It had been so long since she was administered Miralax that she could not recall a date.

Interview with a medication aide (MA) on 02/21/24 at 4:47pm revealed:
-Resident #5 had run out of Miralax (she did not know when the Miralax had run out).
-She had last administered Miralax to Resident #5 the weekend of 02/10/24 and 1-2 doses were remaining in the bottle.
-The pharmacy had delivered Miralax today, 02/22/24.

Attempted telephone interview with Resident #5's PCP on 02/22/24 at 4:59pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

4. Review of Resident #4's current FL-2 dated 12/12/22 revealed diagnoses included

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hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and morbid obesity.

a. Review of Resident #4's current FL-2 dated 12/12/22 revealed there was an order for Aspirin (used to prevent a heart attack or stroke) 81mg daily.

Review of Resident #4's December 2023 medication administration record (MAR) revealed:
-There was an entry for Aspirin 81mg with a scheduled administration time of 9:00am.
-Aspirin 81mg was documented as administered at 9:00am from 12/01/23-12/31/23.

Review of Resident #4's January 2024 MAR revealed:
-There was an entry for Aspirin 81mg with a scheduled administration time of 9:00am.
-Aspirin 81mg was documented as administered at 9:00am from 01/01/24-01/31/24.

Review of Resident #4's February 2024 MAR from 02/01/24-02/20/24 revealed:
-There was an entry for Aspirin 81mg with a scheduled administration time of 9:00am.
-Aspirin 81mg was documented as administered at 9:00am from 02/01/24-02/20/24.

Observation of Resident #4's medications on hand on 02/21/24 at 10:55am revealed there was no Aspirin 81mg available to be administered.

Telephone interview with a representative with the facility's contracted pharmacy on 02/22/24 at 10:25am revealed:
-Resident #4's Aspirin 81mg was last filled by the pharmacy on 10/07/21 for a 60-day supply.
-They were told to not dispense Resident #4's Aspirin 81mg because the medication could be

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purchased over the counter (OTC), and the family would be providing all OTC medications.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 02/24/24 at 1:09pm revealed:
-Aspirin 81mg was prescribed to help prevent blood clots to prevent problems with cardiovascular disease.
-If Resident #4's Aspirin was not administered as ordered the resident would be more at risk for cardiovascular disease.

Interview with a medication aide (MA) on 02/22/24 at 3:03pm revealed:
-Resident #4's Aspirin was sent to the facility from the pharmacy on a punch card.
-She did not know there was no Aspirin 81mg on the medication cart for Resident #4.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 4:36pm revealed:
-She administered Resident #4's Aspirin from a punch card sent from the pharmacy.
-She did not know the pharmacy had not dispensed Resident #4's Aspirin.

Interview with the Administrator on 02/22/24 at 5:36pm revealed:
-If Resident #4's Aspirin was not available on the medication cart he would have expected the MAs to contact the pharmacy and Resident #4's family member about the medication.
-If Resident #4's family member was not going to provide the medication he would expect the MA to have the pharmacy provide the medication to bridge the gap.

Attempted telephone interview with Resident #4's family member on 02/21/24 at 2:36pm was

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D 358	Continued From page 57 unsuccessful. Attempted telephone interview with Resident #4's primary care provider (PCP) on 02/21/24 at 4:58pm was unsuccessful. Refer to the interview with the Administrator on 02/22/24 at 5:36pm. b. Review of Resident #4's current FL-2 dated 12/12/22 revealed there was an order for Vitamin D3 (a supplement) to take 1000iu once daily. Review of Resident #4's December 2023 medication administration record (MAR) revealed: -There was an entry for Vitamin D3 1000iu with a scheduled administration time of 9:00am. -Vitamin D3 was documented as administered at 9:00am from 12/01/23-12/31/23. Review of Resident #4's January 2024 MAR revealed: -There was an entry for Vitamin D3 1000iu with a scheduled administration time of 9:00am. -Vitamin D3 was documented as administered at 9:00am from 01/01/24-01/31/24. Review of Resident #4's February 2024 MAR from 02/01/24-02/20/24 revealed: -There was an entry for Vitamin D3 1000iu with a scheduled administration time of 9:00am. -Vitamin D3 was documented as administered at 9:00am from 02/01/24-02/20/24. Observation of Resident #4's medications on hand on 02/21/24 at 10:55am revealed: -There was an OTC bottle of Vitamin D3 5000iu. -Resident #4's name was not on the bottle or a pharmacy label.	D 358		

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Telephone interview with a representative with the facility's contracted pharmacy on 02/22/24 at 10:25am revealed Resident #4's Vitamin D3 was not filled by the facility's contracted pharmacy because it was an OTC medication and would be provided by Resident #4's family.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 02/24/24 at 1:09pm revealed:
-Vitamin D3 5000iu daily for Resident #4 was too high.
-Resident #4 had an order for Vitamin D3 1000iu daily.
-If Resident #4 did not need a higher dose of Vitamin D3 based on current labs, the higher amount could cause nausea, increased fatigue, and dizziness.

Interview with Resident #4 on 02/20/24 at 11:20am revealed:
-He only took OTC supplements; he did not take any medications.
-He stopped taking medications because he felt the medications had made him toxic.
-He could not answer the question as to when he stopped taking medications.

Interview with Resident #4 on 02/22/24 at 4:49pm revealed:
-He felt bad a lot of the time, "it was like my body is toxic from too much medication."
-He could not explain how he felt, he just felt bad.

Interview with a MA on 02/22/24 at 3:03pm revealed:
-She administered Resident #4's Vitamin D3 from the OTC on the medication cart.
-Resident #4's supplements were provided by the residents family member and placed on the

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medication cart.
-She had not compared the OTC bottle of Vitamin D3 on the medication cart to the order on the MAR.
-She was concerned she was administering too much Vitamin D3 to Resident #4.

Interview with the RCC on 02/22/24 at 4:36pm revealed:
-She administered Resident #4's Vitamin D3 from the OTC bottle on the medication cart.
-She was not the one who checked the medication in, so she did not compare the MAR to the Vitamin D3 bottle.
-She did not know she was administering the wrong dose of Vitamin D3.

Interview with the Administrator on 02/22/24 at 5:36pm revealed:
-He expected the MAs to compare the OTC bottle to the order on the MAR before administering the medication.
-If the OTC bottle and the MAR did not match, the MA should let the family know they needed to provide the correct dosage, and if they did not, the MA should contact the pharmacy to order the medication.
-He was concerned Resident #4 was being overmedicated with his supplements.

Attempted telephone interview with Resident #4's family member on 02/21/24 at 2:36pm was unsuccessful.

Attempted telephone interview with Resident #4's PCP on 02/21/24 at 4:58pm was unsuccessful.

Refer to the interview with the Administrator on 02/22/24 at 5:36pm.

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c. Review of Resident #4's physician's order dated 02/22/23 revealed an order for Vitamin B12 (a supplement) 3000iu take one tablet daily.

Review of Resident #4's December 2023 medication administration record (MAR) revealed:
-There was an entry for Vitamin B12 1000iu, take three tablets once daily to equal 3000iu with a scheduled administration time of 9:00am.
- Vitamin B12 1000iu (3 tablets) was documented as administered at 9:00am from 12/01/23-12/31/23.

Review of Resident #4's January 2024 MAR revealed:
-There was an entry for Vitamin B12 1000iu, take three tablets once daily to equal 3000iu with a scheduled administration time of 9:00am.
- Vitamin B12 1000iu (3 tablets) was documented as administered at 9:00am from 01/01/24-01/31/24.

Review of Resident #4's February 2024 MAR between 02/01/24-02/20/24 revealed:
-There was an entry for Vitamin B12 1000iu, take three tablets once daily to equal 3000iu with a scheduled administration time of 9:00am.
- Vitamin B12 1000iu (3 tablets) was documented as administered at 9:00am from 02/01/24-02/20/24.

Observation of Resident #4's medications on hand on 02/21/24 at 10:55am revealed:
-There was an OTC bottle of Vitamin B12 2500iu.
-Resident #4's name was not on the bottle or a pharmacy label.

Telephone interview with a representative with the facility's contracted pharmacy on 02/22/24 at 10:25am revealed Resident #4's Vitamin B12 was

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not filled by the facility's contracted pharmacy because it was an OTC medication and would be provided by Resident #4's family.

Interview with Resident #4 on 02/20/24 at 11:20am revealed:
-He only took OTC supplements; he did not take any medications.
-He was not sure what OTC supplements he was administered.

Interview with Resident #4 on 02/22/24 at 4:49pm revealed:
-He felt bad a lot of the time, "it was like my body is toxic from too much medication."
-He could not explain how he felt, he just felt bad.

Interview with a MA on 02/22/24 at 3:03pm revealed:
-She administered three tablets of Resident #4's Vitamin B12 from the OTC on the medication cart.
-Resident #4's OTC medication was provided by his family member.
-She had not compared the OTC bottle of Vitamin B12 to the order on the MAR.
-She was concerned she was administering too much Vitamin B12 to Resident #4.

Interview with the RCC on 02/22/24 at 4:36pm revealed:
-She administered Resident #4's Vitamin B12 from the OTC bottle on the medication cart.
-Resident #4's OTC medication was provided by his family member; she administered three tablets from the bottle.
-She was not the one who checked the medication in, so she did not compare the MAR to the Vitamin B12 bottle.
-She did not know she was administering the

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D 358	Continued From page 62 wrong dose of Vitamin B12. Interview with the Administrator on 02/22/24 at 5:36pm revealed: -He expected the MAs to compare the OTC bottle to the order on the MAR before administering the medication. -If the OTC bottle and the MAR did not match, the MA should let the family know they needed to provide the correct dosage, and if they did not, the MA should contact the pharmacy to order the medication. -He was concerned Resident #4 was being overmedicated with his supplements. Attempted telephone interview with Resident #4's family member on 02/21/24 at 2:36pm was unsuccessful. Attempted telephone interview with Resident #4's PCP on 02/21/24 at 4:58pm was unsuccessful. Refer to the interview with the Administrator on 02/22/24 at 5:36pm. _____ Interview with the Administrator on 02/22/24 at 5:36pm revealed: -The facility staff worked with the PCP to complete FL-2s. -He expected the FL-2 to be compared to the MAR to ensure they both matched. -He expected medication to be administered as ordered. -He expected the MAs to compare the MAR to the medication on hand and if there was a discrepancy to contact the pharmacy for clarification. -If a medication was not administered, he expected the MA to circle their initials on the front and then document on the back why the	D 358		

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D 358	Continued From page 63 medication was not administered.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 2 of 5 sampled residents observed during the 8:00am/9:00am morning medication pass (#5, #8) and 1 of 5 sampled residents (#3) for chart review. The findings were: 1. Review of Resident #3's current FL-2 dated 02/15/24 revealed diagnoses included chronic pain, chronic continuous use of opioids, and depressive disorder. a. Review of Resident #3's current FL-2 dated 02/15/24 revealed there was an order for oxycodone 15mg three times a day as needed for chronic pain. Review of Resident #3's February 2024 medication administration record (MAR) from 02/16/24 to 02/20/24 revealed: -There was an entry for oxycodone 15mg three times daily with a scheduled administration time of 9:00am, 2:00pm, and 6:00pm. -There was documentation oxycodone 15mg was	D 364		

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administered three times daily at 9:00am, 2:00pm, and 6:00pm from 02/16/24 to 02/20/24.

Review of Resident #3's February 2024 controlled substance count sheets (CSCS) revealed oxycodone 15mg was signed out at 6:00am for administration from 02/16/24 to 02/20/24, three hours before the scheduled time of 9:00am.

Interview with Resident #3 on 02/22/24 at 8:49am revealed:
-He would go to the nurse's station each morning between 6:00am and 7:00am and the third shift medication aide (MA) would administer his controlled medications.
-He would go to the nurse's station around after dinner, around 6:00pm, and the MA would administer his evening controlled medication.
-He did not know what time his controlled medications were scheduled.
-The MAs would administer the medications to him when he went to the nurses station.
-He was never told it was too early to take his medications.

Interview with the MA on 02/22/24 at 3:15pm revealed:
-She had administered Resident #3 his controlled medications
-Resident #3 would ask for his controlled medications before breakfast and after dinner.
-She wound administer Resident #3's medication when he came to the nurse's station and requested the medications.
-She would sign the MAR and the CSCS sheet.
-She did not realize the controlled medications were being administered 2 and 3 hours earlier than scheduled.

Refer to the interview with the Administrator on

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D 364	Continued From page 65 02/22/24 at 5:30pm. b. Review of Resident #3's current FL-2 dated 02/15/24 revealed there was an order for carisoprodol 350mg two tablets twice daily. Review of Resident #3's February 2024 medication administration record (MAR) from 02/16/24 to 02/20/24 revealed: -There was an entry for carisoprodol 350mg two tablets twice daily with a scheduled administration time of 9:00am and 8:00pm. -There was documentation carisoprodol 350mg was administered twice daily at 9:00am and 8:00pm from 02/16/24 to 02/20/24. Review of Resident #3's February 2024 controlled substance count sheets (CSCS) revealed: -Carisoprodol 350mg was signed out at 6:00am for administration from 02/16/24 to 02/20/24, three hours before the scheduled time of 9:00am. -Carisoprodol 350mg was signed out at 6:00pm for administration from 02/16/24 to 02/20/24, two hours before the scheduled time of 8:00pm. Interview with Resident #3 on 02/22/24 at 8:49am revealed: -He would go to the nurse's station each morning between 6:00am and 7:00am and the third shift medication aide (MA) would administer his controlled medications. -He would go to the nurse's station around after dinner, around 6:00pm, and the MA would administer his evening controlled medication. -He did not know what time his controlled medications were scheduled. -The MAs would administer the medications to him when he went to the nurses station. -He was never told it was too early to take his medications.	D 364		

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D 364	Continued From page 66 Interview with the MA on 02/22/24 at 3:15pm revealed: -She had administered Resident #3 his controlled medications -Resident #3 would ask for his controlled medications before breakfast and after dinner. -She wound administer Resident #3's medication when he came to the nurse's station and requested the medications. -She would sign the MAR and the CSCS sheet. -She did not realize the controlled medications were being administered 2 and 3 hours earlier than scheduled. Refer to the interview with the Administrator on 02/22/24 at 5:30pm. 2. Review of Resident #5's current FL-2 dated 02/17/23 revealed: -Diagnoses included Alzheimer's disease, hypertension, cerebrovascular disease, seizure disorder, glaucoma, falls risk, heart failure, and anxiety. -There was an order for Lasix 20mg (used to treat fluid retention) every other day. Observation of the 8:00am/9:00am medication pass on 02/21/24 at 8:46am revealed: -There was a blister pack of Lasix 20mg on the medication cart. -The medication aide (MA) did not prepare Lasix 20mg for administration. Review of Resident #5's February 2024 medication administration record (MAR) on 02/21/24 revealed there was an entry for Lasix 20mg every other day with a scheduled administration time of 8:00am.	D 364		

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Observation of Resident #5's room on 02/21/24 at 11:38am revealed the MA administered Resident #5 Lasix 20mg.

Interview with Resident #5 on 02/21/24 at 11:38am revealed:
-She took her fluid pill every other day after breakfast.
-She did not take her fluid pill this morning after breakfast.
-She was administered her fluid pill at 11:38am.

Interview with the MA/Resident Care Coordinator (RCC) on 02/21/24 at 11:35am revealed:
-She did not give Resident #5 Lasix this morning, 02/21/24, because Resident #5 was ordered Lasix every other day.
-She initialed the MAR and circled her initials, indicating she did not administer Lasix 20mg to Resident #5.
-She did not realize she initialed and circled her initial on 02/20/24.
-She should have administered Resident #5 her Lasix 20mg this morning, 02/21/24.
-Resident #5's MAR was not initialed yesterday, 02/20/24, and that confused her.

Refer to the interview with the Administrator on 02/22/24 at 5:30pm.

3. Review of Resident #8 current FL-2 dated 10/16/23 revealed:
-Diagnoses included epilepsy, major depressive disorder, hypertension, and alcoholic cirrhosis of liver.
-There was an order for polyethylene glycol 17 grams twice daily.

Observation of the 8:00am/9:00am medication pass on 02/21/24 at 8:30am revealed:

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-The medication aide (MA) did not prepare polyethylene glycol 17gm for administration.
-Polyethylene glycol was not on the medication cart for administration.

Interview with the MA on 02/21/24 at 8:32am revealed:
-Polyethylene glycol was not on the medication cart.
-She had to get the medication from the overstock at the nurse's station.
-The MA would let the surveyor know when she administered the medication.

Review of Resident #8's February 2024 medication administration record (MAR) revealed there was an entry for polyethylene glycol 17gms in 4 to 8 ounces of fluid twice daily with a scheduled administration time of 8:00am.

Observation of the nurse's station on 02/21/24 at 11:05am revealed:
-The MA prepared polyethylene glycol 17gms for administration to Resident #8.
-The MA administered polyethylene glycol to Resident #8 at 11:05am.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

Refer to the interview with the Administrator on 02/22/24 at 5:30pm.

_____
Interview with the Administrator on 02/22/24 at 5:30pm revealed.
-The MAs have 1 hour before and 1 hour after the scheduled administration time to administer a medication.
-Any other times were unacceptable unless the

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D 364	Continued From page 69 MA documented a reason for the administration of the medication at a different time.	D 364		
D 366	10A NCAC 13F .1004 (i) Medication Administration 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, interviews, and reviews of medication administration records (MAR), the facility failed to ensure staff documented on the MARs immediately following administration of and pre-charting medication for 2 of 5 residents during the morning medication pass;and medications left at the bedside for 1 of 5 sampled residents. The findings were: Review of the facility's undated medication administration policy revealed: -Documentation of medication administration should be done after medications were administered. -The MAR was to be signed immediately after the medications were administered and prior to the administration of the next resident's medications. 1. Observation of the morning medication pass	D 366		

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on 02/21/24 at 8:48am for Resident #5 revealed the medication aide (MA) did not initial the medication administration record (MAR) immediately following the administration of each of the following medications: aspirin 81mg (used to thin blood), losartan potassium 50mg (used to lower blood pressure), atorvastatin 20mg (used to lower cholesterol), vitamin D3 5000 units (used as a supplement) , carvedilol 6.25mg, levetiracetam 750mg, and hydralazine 25mg.

Interview with the A hall MA/Resident Care Coordinator (RCC) on 02/21/24 at 2:06pm revealed:
-The MA should document on the MAR after the medications have been administered to the resident.
-She placed a dot on the MAR to indicate she had prepared the medication for administration.
-She thought she documented administration of the medication on the MAR after she administered the medications.
-She should have signed the MAR immediately after administering Resident #5 her medications.

Interview with the Administrator on 02/22/24 at 5:37pm revealed:
-The MA should document on the MAR immediately after medications were administered.
-If the MA did not document on the MAR the medications were administered, then it appeared that the medications were not administered. .

2. Observation of the morning medication pass on 02/21/24 at 8:30am for Resident #8 revealed the medication aide (MA) did not initial the medication administration record (MAR) immediately following the administration of levetiracetam 500mg.

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Interview with the B hall MA on 02/21/24 at 2:41pm revealed:
-She should document on the medication administration record (MAR) immediately after she administered the medication.
-She thought she documented all the medications she administered at 9:00am to Resident #8.
-She did not realize she did not document on the MAR that all the medications were administered.
-She needed to be careful to ensure the documentation was correct.

Interview with the Administrator on 02/22/24 at 5:37pm revealed:
-The MA should document on the MAR immediately after medications were administered.
-If the MA did not document on the MAR the medications were administered, then it appeared that the medications were not administered.

3. Review of the facility's undated medication administration policy revealed pre-charting was not allowed, including signing the MAR anytime prior to the medications being administered.

Observation of the morning medication pass on 02/21/24 at 8:30am for Resident #8 revealed the medication aide (MA) pre-charted the administration of polyethylene glycol before administering the medication.

Interview with the B hall MA on 02/21/24 at 2:41pm revealed:
-She should not document on the MAR the medication was administered before it was administered.
-She did not have Resident #8's polyethylene on the medication cart during the medication pass.
-She did not realize she documented the administration of polyethylene glycol when she

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administered Resident #8 his other medications.
-She should have waited until she administered the medication before she documented on the MAR the medication was administered.
-She needed to be careful to ensure the documentation was correct.

Interview with the Administrator on 02/22/24 at 5:37pm revealed:
-Pre-charting was not allowed; the resident may refuse to take the medication and the documentation would not be correct.
-The MA should document on the MAR immediately after administering the medication.

4. Review of the facility's undated medication administration policy revealed:
-Medications were not to be left at the resident's bedside.
-The MA must observe the residents taking the medication.

Review of Resident #4's current FL-2 dated 02/20/24 revealed:
-Diagnoses included schizophrenia, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and morbid obesity.
-There was an order for Hydrochlorothiazide (used to treat high blood pressure and fluid retention) 12.5mg take one tablet daily.
-There was an order for Aspirin (used in preventing heart attack or stroke) 81mg once daily.
-There was an order for Vitamin B-12 (a supplement) 1000mcg take three tablets once daily.
-There was an order for Vitamin D3 (a supplement) 1000IU take one tablet once daily.
-There was an order for Citalopram (used to treat depression) 20mg once daily.

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-There was an order for Lisinopril (used to treat high blood pressure) 20mg take one tablet daily.
-There was an order for Risperidone (used to treat schizophrenia) 2mg take one tablet daily.
-There was an order for Vitamin C (a supplement) 500mg take one tablet twice daily.
-There was an order for Inderal (used to treat high blood pressure) 20mg take one tablet twice daily.
-There was an order for Vitamin E (a supplement) 400IU take one tablet twice daily.
-There was an order for Benztropine (used to treat tremors) 1mg take one tablet twice daily.
-There was an order for Simvastatin (used to treat high blood pressure) 10mg take one tablet at bedtime.
-There was an order for Risperidone 4mg take one tablet at bedtime.

Review of Resident #4's February 2024 medication administration record (MAR) for 02/20/24 revealed:
-There was an entry for Hydrochlorothiazide 12.5mg take one tablet daily with a scheduled administration time of 9:00am.
-Hydrochlorothiazide was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Aspirin 81mg once daily with a scheduled administration time of 9:00am.
-Aspirin was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Vitamin B-12) 1000mcg take three tablets once daily with a scheduled administration time of 9:00am.
-Vitamin B-12 was documented administered on 02/20/24 at 9:00am.
-There was an entry for Vitamin D3 (a supplement) 1000IU take one tablet once daily with a scheduled administration time of 9:00am.
-Vitamin D3 was documented as administered on

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02/20/24 at 9:00am.
-There was an entry for Citalopram (used to treat depression) 20mg once daily with a scheduled administration time of 9:00am.
-Citalopram was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Lisinopril (used to treat high blood pressure) 20mg take one tablet daily with a scheduled administration time of 9:00am.
-Lisinopril was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Risperidone (used to treat schizophrenia) 2mg take one tablet daily with a scheduled administration time of 9:00am.
-Risperidone was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Vitamin C (a supplement) 500mg take one tablet twice daily with a scheduled administration time of 9:00am and 8:00pm.
-Vitamin C was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Inderal (used to treat high blood pressure) 20mg take one tablet twice daily with a scheduled administration time of 9:00am and 8:00pm.
-Inderal was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Vitamin E (a supplement) 400IU take one tablet twice daily with a scheduled administration time of 9:00am and 8:00pm.
-Vitamin E was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Benztropine (used to treat tremors) 1mg take one tablet twice daily with a scheduled administration time of 9:00am and 8:00pm.
-Benztropine was documented as administered on 02/20/24 at 9:00am.
-There was an entry for Simvastatin (used to treat

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high blood pressure) 10mg take one tablet at bedtime.
-There was an entry for Risperidone 4mg take one tablet at bedtime.

Observation of Resident #4's room on 02/20/24 at 8:19am revealed a medication cup, containing 4 tablets was sitting on the resident's bedside table; the resident was not in the room.

Observation of Resident #4's room on 02/20/24 at 8:19am revealed the medication cup, containing 4 tablets was sitting on the resident's bedside table; the resident was not in the room.

Observation of Resident #4's room on 02/21/24 at 7:38am revealed the medication cup, containing 4 tablets was sitting on the resident's bedside table; the resident was not in the room.

Interview with Resident #4 on 02/20/24 at 11:20am revealed:
-Medication was left by the MA on his bedside table every morning around 5:30am.
-He would take the medication as soon as he got up.
-He did not take his medication today, 02/20/24, because he thought his medications were making him "toxic."
-He did not know what medications were in the cup left at his bedside today, 02/20/24.

Interview with the Resident Care Coordinator on 02/22/24 at 4:36pm revealed:
-She thought the medications left in Resident #4's room were the evening medications from 02/19/24.
-The evening medication aide (MA) should have watched Resident #4 take his medications.

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D 366	Continued From page 76 Interview with the evening MA on 02/22/24 at 5:29pm revealed: -She administered Resident #4's evening medications on 02/19/24 and the resident took his medications. -She thought the medications shown to her in a picture taken on 02/20/24 were the resident's morning medications. -She was not sure what all the medications were in the cup, but she knew they were not Resident #4's evening medications. Interview with the Administrator on 02/22/24 at 5:36pm revealed: -He expected the MAs to make sure Resident #4 was out of bed and ready to take his medication before attempting to administer the medication. -It was concerning that medication was left in a resident's room because another resident could have taken the medication. . -The MA should not leave medications at the bedside. -The MA should observe the resident taking their medications,	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	D 367		

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medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the medication administration record was accurate for 3 of 5 sampled residents (#1, #2, and #3) including the administration of an iron supplement (#1), insulin administration (#2), and a nicotine patch (#3).

The findings are:

1. Review of Resident #1's current FL-2 dated 12/12/23 revealed diagnoses included end-stage renal disease, chronic kidney disease, stage 5, and type 2 diabetes.

Review of Resident #1's signed physician orders dated 01/09/24 revealed There was an order for Iron (a supplement) 65mg take 1 tablet on Monday, Wednesday, and Friday.

Review of Resident #1's January 2024 medication administration record (MAR) revealed:
-There was an entry for Iron 65mg take one tablet on Monday, Wednesday, and Friday with a scheduled administration time of 9:00am.
-Resident #1's iron was documented as administered daily from 01/01/24-01/31/24.

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D 367	Continued From page 78 Review of Resident #1's February 2024 MAR from 02/01/24-02/20/24 revealed: -There was an entry for Iron 65mg take one tablet on Monday, Wednesday, and Friday with a scheduled administration time of 9:00am. -Resident #1's iron was documented as administered daily from 02/01/24-02/20/24. Observation of Resident #1's medications on hand on 02/20/24 at 12:48pm revealed: -There was a punch card dispensed on 02/13/24 for Iron 65mg take one tablet on Monday, Wednesday, and Friday. -There were 13 tablets dispensed and 4 had been punched. -There were 9 Iron tablets remaining on the punch card. Interview with a medication aide (MA) on 02/22/24 at 3:10pm revealed: -She administered Resident #1's Iron on Mondays, Wednesdays, and Fridays. -If she documented Resident #1's Iron every day it was because she was not paying attention. Interview with the Resident Care Coordinator (RCC) on 02/22/24 a 4:21pm revealed: -She administered Resident #1's Iron on Mondays, Wednesdays, and Fridays. -She did not realize the documentation on the MAR was incorrect. Refer to the interview with the Administrator on 02/22/24 at 5:30pm: 2. Review of Resident #2's current FL-2 dated 03/14/23 revealed: -Diagnosis included diabetes mellitus 2. -There was an order for Novolog 12 (a rapid acting insulin used to lower blood sugar) units	D 367		

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daily with meals.

Review of Resident #2's signed physician orders dated 01/09/24 revealed:
-There was an order for Novolog 12 units daily with meals.
-There was an order to hold insulin if blood sugar reading was less than 140.

Review of Resident #1's January 2024 medication administration record (MAR) from 01/09/24 to 01/31/24 revealed:
-There was an entry for finger stick blood sugar (FSBS) checks three times daily before meals with a scheduled time of 7:30am, 11:30am, and 4:30pm.
-There was an entry for Novolog 12 units with meals.
-There was an entry to hold insulin for a blood sugar reading less than 140.
-There was documentation the blood sugar reading at 7:30am on 01/09/24 of 98; on 01/10/24 of 95; on 01/11/24 of 124; on 01/14/24 of 80; on 01/15/24 of 134; on 01/16/24 of 105; on 01/17/24 of 117; on 01/18/24 of 125; on 01/19/24 of 116; on 01/20/24 of 126; on 01/21/24 of 113; on 01/22/24 of 85; on 01/23/24 of 133; on 01/25/24 of 108; on 01/26/24 of 95; on 01/27/24 of 101; on 01/28/24 of 119; on 01/29/24 of 113; on 01/30/24 of 100; and on 01/31/24 of 82.
-There was documentation Novolog 12 units was administered at 7:30am on 01/09/24, on 01/10/24, on 01/11/24, on 01/14/24, on 01/15/24, on 01/16/24, on 01/17/24, on 01/18/24, on 01/19/24, on 01/20/24, on 01/21/24, on 01/22/24, on 01/23/24, on 01/25/24, on 01/26/24, on 01/27/24, on 01/28/24, on 01/29/24, on 01/30/24, and on 01/31/24.
-There was no documentation Novolog insulin was held at 7:30am for blood sugar readings less

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than 140.
-There was documentation the blood sugar reading at 11:30am on 01/11/24 of 122; on 01/12/24 of 129; 01/20/24 of 108; on 01/31/24 of 136.
-There was documentation Novolog 12 units was administered at 11:30am on 01/11/24, on 01/12/24, on 01/20/24, and on 01/31/24. 12
-There was no documentation Novolog insulins was held at 11:30am for blood sugar readings less than 140.
-There was documentation the blood sugar reading at 4:30am on 01/14/24 of 129; on 01/20/24 of 108; on 01/23/24 of 101; 01/30/24 of 136.
-There was documentation Novolog 12 units was administered at 4:30pm on 01/14/24, on 01/20/24, on 01/23/24, and on 01/30/24.

Review of Resident #2's February 2024 MAR from 02/01/24 to 02/21/24 revealed:
-There was an entry for FSBS checks three times daily before meals with a scheduled time of 7:30am, 11:30am, and 4:30pm.
-There was an entry for Novolog 12 units with meals.
-There was an entry to hold insulin for a blood sugar reading less than 140.
-There was documentation the blood sugar reading at 7:30am on 02/01/24 of 73; on 02/02/24 of 107; on 02/03/24 of 73; on 02/04/24 of 103; on 02/05/24 of 123; on 02/07/24 of 132; on 02/08/24 of 91; on 02/09/24 of 114; on 02/14/24 of 127; on 02/17/24 of 134; and on 02/18/24 of 85.
-There was documentation Novolog 12 units was administered at 7:30am on 02/01/24; on 02/02/24; on 02/03/24; on 02/04/24; on 02/05/24; on 02/07/24; on 02/08/24; on 02/09/24; on 02/14/24; on 02/17/24; and on 02/18/24.
-There was no documentation Novolog insulin

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was held at 7:30am for blood sugar readings less than 140.
-There was documentation the blood sugar reading at 11:30am on 01/05/24 of 119.
-There was documentation Novolog 12 units was administered at 11:30am on 01/05/24.
-There was no documentation Novolog insulin was held at 11:30am for blood sugar readings less than 140.
There was documentation the blood sugar reading at 4:30pm on 02/16/24 of 137 and on 02/17/24 of 122.
-There was documentation Novolog 12 units was administered at 4:30pm on 02/16/24 and 02/17/24.
-There was no documentation Novolog insulin was held at 4:30pm for blood sugar readings of 140 or less.

Observation of medication on hand on 02/20/24 at 12:50pm revealed:
-There were 4 unopened Novolog pens and one opened Novolog pen that contained 250 units of insulin.
-The pharmacy label on the box of Novolog pens indicated 5 Novolog pens were dispensed on 01/26/24

Telephone interview with the representative at the facility's contracted pharmacy on 02/20/24 at 1:03pm revealed:
-The pharmacy had an order to check FSBSs before meals and administer 12 units of Novolog insulin, hold insulin if blood sugar reading was less than 140.
-The pharmacy dispensed one box of 5 Novolog pens on 01/30/24.

Interview with Resident #2 on 02/21/24 at 7:35am revealed:

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-The MAs checked his blood sugar before each meal.
-He did not receive insulin if his blood sugar reading was below a certain number, which was 150.
-The MAs did not give him insulin if his blood sugar was too low.

Interview with a MA on 02/21/24 at 2:06pm revealed:
-She did not administer Novolog insulin to Resident #2 when his blood sugar reading was below 140.
-She signed the MAR as if she administered the insulin, but she should have circled her initials, indicating the medication was not administered.
-The documentation was incorrect.
-She signed the MAR and did not realize what she was signing.

Interview with the MA/RCC on 02/21/24 at 2:35pm revealed:
-She checked Resident #2's blood sugar before meals.
-Resident #2 received Novolog insulin for blood sugar reading greater than 140.
-If Resident #2's blood sugar reading was less than 140, the Novolog insulin would be held.
-She did not administer Novolog insulin to Resident #2 when his blood sugar reading was below 140.
-The documentation on the MAR was incorrect; the MA initials should be circled.

Interview with the Administrator on 02/22/24 at 5:30pm revealed:
-If Resident #2 did not require Novolog insulin because his blood sugar was below 140, the MAs should have documented and circled their initials, and documented on the back of the MAR why

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Novolog insulin was not given.

Refer to the interview with the Administrator on 02/22/24 at 5:30pm.

3. Review of Resident #3's current FL-2 dated 02/15/24 revealed:
-Diagnoses included chronic kidney disease, coronary artery disease, hyperlipidemia, chronic pain, and anxiety.
-There was an order for nicotine 14mg/24hr patch apply one patch on skin daily.

Review of Resident 3's February medication administration record from 02/16/24 to 02/20/24 revealed:
-There was an entry for Nicotine 14mg/24hr patch, apply one patch on skin daily with an administration time of 9:00am.
-There was documentation the Nicotine patch had been applied to skin daily from 02/16/24 to 02/20/24.

Observation of Resident #3's medication on hand on 02/20/24 at 3:50pm revealed:
-There were 2 boxes of Nicotine 14mg/24hr patches on the medication cart available for administration.
-Each box of Nicotine patches contained 14 patches, for a total of 28.
-Both boxes of Nicotine patches were not opened and were sealed closed.

Interview with a medication aide (MA) on 02/22/24 at 2:20pm revealed:
-Resident #3 did not wear the nicotine patches because he wanted to smoke.
-She documented on the MAR incorrectly.
-She should have documented her initials, circled her initials, and documented on the back of the

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D 367	Continued From page 84 MAR that Resident #3 refused his nicotine patch. Interview with the Resident Care Coordinator (RCC) on 02/22/24 a 4:42pm revealed: -Resident #3 refused to wear the nicotine patches. -She did not realize the documentation on the MAR was incorrect. -The documentation on the MAR looks as if Resident #3 was wearing the nicotine patches as ordered. -The MA should document and circle her initials and document on the back of the MAR Resident #3 refused the medication. Interview with the Administrator on 02/22/24 at 5:30pm revealed if Resident #3 was refusing his medication the MAs should have initialed the MAR, circled their initials and documented on the back of the MAR Resident #3's refusal of the medication. Refer to the interview with the Administrator on 02/22/24 at 5:30pm. _____ Interview with the Administrator on 02/22/24 at 5:30pm revealed: -The MAs should document correctly on the MAR. -He expected the MAs to document correctly on the resident's MAR.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development	D 371		

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and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.

This Rule is not met as evidenced by:
Based on observation and interviews, the facility failed to ensure infection control measures were implements as evidenced by a medication aide (MA), who used her finger to remove a pill from the blister pack and who picked up a pill that fell onto the top of the medication cart.

The findings were:

Review of the facility's undated medication administration policy revealed medications should not be touched or handled by employee's hands.

Observation of a medication aide (MA)/Resident Care Coordinator (RCC) administering medications during the 8:00am/9:00am medication pass on 02/21/24 at 8:48am revealed:
-The MA initiated preparing medications for administration to a resident.
-The MA popped 7 pills from 7 different blister packs.
-One pill did not pop into the souffle cup but was caught in the blister pack.
-The MA used her fingers to maneuver the pill into the souffle cup.

Interview with the MA/RCC on 02/21/24 at 2:06pm revealed:
-She was careful to administer residents medications without touching or dropping the medication.
-When she popped one a resident pill, it did not come out of the foil.
-She thought she maneuvered the pill into the souffle cup without touching the medication.

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D 371	Continued From page 86 -She did not realize she used her fingernail to remove the pill from the foil. -She should have donned gloves to remove the pill from the foil. Observation of a second MA administering medications during the 8:00am/9:00am medication pass on 02/21/24 at 9:15am revealed: -The MA initiated preparing medications for administration to a resident. -The MA popped 6 pills from 6 different blister packs. -One pill did not pop into the souffle cup but fell onto the top of the medication cart. -The MA used her fingers to pick-up the pill and place it into the souffle cup. Interview with the MA on 02/21/24 at 2:30 revealed: -When she was administering medications to a resident today, a pill fell on top of the medication cart. -She picked the pill up with her fingers and placed it in the souffle cup with the other pills. -She should have discarded the pill and prepared another pill for administration. Interview with the Administrator on 02/22/24 at 5:30pm revealed: -MAs should not touch pills with their hands. -If the MA needed to touch a pill, they should don gloves. -If the pill was contaminated by touching the medication cart, the pill should have been wasted. -He expected the MAs to follow infection control procedures when administering medications.	D 371		

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D 375	Continued From page 87	D 375		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 2 sampled residents (#3) had a signed physician's order to self-administer an inhaler. The findings are: Observation of Resident #3's room on 02/20/24 at 9:01am revealed there was a Spiriva inhaler (used to improve air flow to the lungs) on the bedside table. Observation of Resident #3's room on 02/21/24 at 7:58am revealed there was a Spiriva inhaler on the bedside table. Review of Resident #3's current FL-2 dated 02/15/24 revealed: -There was an order for Spiriva 2.5mg 2 puffs	D 375		

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daily.
-There was no order for Resident #3 to self-administer Spiriva.

Review of Resident #3's February 2024 medication administration record (MAR) from 02/16/20 to 02/20/24 revealed:
-There was an entry for Spiriva Respimat 2.5mcg inhale 2 puffs daily with a scheduled administration time of 8:00am.
-There was documentation Spiriva Respimat 2.5mcg was administered each morning at 8:00am.
-There was no entry for Resident #3 to self-administer Spiriva inhaler.

Interview with Resident #3 on 02/22/24 at 8:49am revealed:
-He kept his Spiriva inhaler at the bedside.
-The MAs knew he had the Spiriva inhaler in his room.
-He used his Spiriva inhaler daily and sometimes twice daily if he felt short of breath.
-He was capable of keeping his Spiriva in his room and administering the medication himself.
-The MA reviewed how to administer the Spiriva inhaler.

Interview with a representative from the facility's contracted pharmacy on 02/22/24 at 9:56am revealed Resident #3 did not have a self-administration order for Spiriva.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/22/24 at 12:59pm revealed:
-Resident #3 should not take Spiriva as needed.
-Resident #3's heart rate could increase if he administered Spiriva too often.

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Interview with a personal care aide (PCA) on 02/22/24 at 1:45pm revealed:
-She had not seen any medications in the resident's room.
-If she did see medications in a resident's room, she would report it to the MA.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/22/24 at 5:15pm revealed:
-Resident #3 did not have an order to self-administer medications.
-He did not know Resident #3 had a Spiriva inhaler at his bedside.
-Resident #3 should not have medications at his bedside for self-administration.
-Resident #3 could have tremors or cardiac problems from excessive Spiriva inhalation.

Interview with a medication aide (MA) on 02/22/24 at 2:20pm revealed:
-Resident #3 did not have a self-administration order.
-He should not have medications in his room, and he should not be administering medications to himself.
-She had not seen any medications in Resident #3's room.
-If she did, she would remove the medications and report it to the RCC.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 3:15pm revealed:
-Resident #3 did not have an order to self-administer his medications.
-The MAs administered all of his medications, including his Spiriva inhaler.
-She did not know Resident #3 had a Spiriva inhaler in his room and was self-administering his inhaler.

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D 375	Continued From page 90 Interview with the Administrator on 02/22/24 at 5:30pm revealed: -A resident who self-administers medications had to be evaluated by the PCP and had to have an order to self-administer medications. -He was not aware Resident #3 had a Spiriva inhaler in his bedroom. -Resident #3 did not have an order to self-administer medications and medication should be removed from his room.	D 375		
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 under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication room door was closed and locked, the medication carts were locked, and keys were secure, and medications left on top of a medication cart and at nursing station were locked when not under the direct physical supervision, of a medication aide observed during the 8:00am to 5:00pm on 02/20/24 to 02/22/24. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a	D 378		

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	HAL032071	A. BUILDING: _____ B. WING _____	R 02/22/2024

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 378	Continued From page 91 capacity of 81 residents. Review of the facility's resident census report dated 02/20/24 revealed there was a census for 64 residents. Review of the facility's undated medication storage policy revealed: -Medications were to be stored in a locked area, unless under the direct supervision of facility staff. (Direct supervision means the cart was in-site and the facility staff could get to the cart quickly, if necessary). -The controlled substances were to be double locked. -The medication cart should be locked and stored in the locked medication room. -When the medication cart was not being used, it should be stored in a locked area or stored in an area where it was under the supervision of staff. Observation on the nurse's station on 02/20/24 revealed: -At 7:48am, there was a cart with insulin pens, lancets, glucometers, and vials of insulin at the nurse's station and a bottle of medication sitting on the desk, unattended by facility staff. -At 7:49am, the medication room door was open, with medications noted in plastic bins, unattended by the facility staff. -At 8:25am, the cart with insulin pens, lancets, glucometers, and vials of insulin remained at the nurse's station, unattended by facility staff. -At 12:45pm, there was a plastic container sitting on top of the A hall medication cart containing two sealed boxes of transdermal patches and 8 bottles of eye drops, unattended by the facility staff. Observation of the nurse's station on 02/21/24	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 378	Continued From page 92	D 378		

revealed:
-At 7:49am, there were three bottles of eyes drops sitting on top of the B hall medication cart, unattended by facility staff.
-At 8:02am, the unlocked overstock medication cart was sitting outside of the nurse's station, unattended by the facility staff.
-At 8:03am, there were two unidentified white round tablets in a souffle cup sitting on top of the A hall medication cart, unattended by the facility staff.
-At 8:09am, the unlocked A hall medication cart was unattended by the facility staff, with the keys to the medication cart in the controlled drawer lock, while she and a resident entered the medication room to check a blood sugar.
-From 8:02am to 8:13am, the overstock medication cart remained unlocked while resident ambulated by the unlocked medication cart.
At 8:12am, the overstocked medication cart remained unlocked, the drawers were able to be opened to expose overstock medications.

Observation of the nurse's station on 02/22/24 revealed:
-At 7:29am, 3 of 3 medication carts at the nursing station were unlocked and unattended by the staff with one resident seated next to the nursing station.
-At 8:09am, the medication room door was unlocked exposing medications in plastic bin, there were medications at the nurse's station on the desk and in a box on the floor, and the A hall medication cart was unlocked and unattended.

Interview with a medication aide (MA) on 02/22/24 at 2:40pm revealed:
-The medication cart should be locked all the time when not in use.
-There were some eye drops and nicotine

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patches kept on top of a medication cart.
-The medication room should be locked at all times.
-She did not realize the medication carts were left unlocked and the medication room was left unlocked when there was no MA at the nurse's station.
-The eye drops, and nicotine patches were not secure.
-A resident could walk by and take the eye drops and the nicotine patches.
-The purpose of having medication locked was so no one could take them.
-The insulin cart should be in the medication room when not in use by a MA.
-Residents could take another residents medication.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 4:42pm revealed:
-Medications should be kept under two locks for security reasons.
-She did not realize the medication carts and medication rooms were left unattended and unlocked.
-Residents could take medications bottles and cards that did not belong to them.
-Medications should not be left at the desk or on top of the medication carts.
-All medications should be secured when a medication aide was not present.

Interview with the Administrator on 02/22/24 at 5:30pm revealed:
-Medication rooms should be locked when a MA was not present in the medication room.
-All medication carts should be locked when not under the direct supervision of a MA.
-No medications should be on top of the medication cart or at the nurse's station unless

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D 378	Continued From page 94 there was a MA present. -He was concerned that residents may get medications that were not there, take them and become sick. -He expected the MAs to always secure all medications.	D 378		