

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Camellia Gardens Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 280 South Beckford Drive Henderson, NC 27536	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>43222</p> <p>Based on record review, Resident Council group interview and staff interviews, the facility failed to resolve and communicate the facility's efforts to address resident concerns voiced during 3 of 10 Resident Council meetings in October 2023, January 2024, and June 2024.</p> <p>Findings included:</p> <p>During a Resident Council group interview conducted on 8/27/24 at 1:08 PM, residents present shared an ongoing issue with the resolution of concerns voiced during Resident Council meetings.</p> <p>The Resident Council minutes for the period October 2023 through July 2024 were reviewed and revealed the following:</p> <p>Resident Council minutes dated November 2023 included no documentation of the facility's response to a concern voiced during the previous meeting of 10/26/23 which included one resident who requested money and did not receive it until 3 weeks later.</p> <p>Resident Council minutes dated 1/25/24 indicated residents voiced concerns related to having to beg for ice on 1st and 2nd shifts, clothing lost in laundry and yet to be found and waiting a long time to be put to bed after returning to the facility.</p> <p>Resident Council minutes dated 2/29/24 revealed no response from the facility for the previous month concerns.</p> <p>Resident Council minutes dated 06/27/24 indicated residents voiced concerns related to cold food, not enough variety at all meals, and laundry returned to other residents.</p> <p>Resident Council minutes dated 7/25/24 included no documentation of the facility's response to the concerns voiced during the previous meeting.</p> <p>An interview was conducted with the Activities Director on 8/27/24 at 1:47 PM. She revealed that when complaints were made in Resident Council meetings, she brought them to the Administrator who then delegated to department heads. The Activities Director stated she was not involved in the resolution process, unless the concern was related to activities.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Administrator on 8/28/24 at 11:50 AM, she revealed that all grievances, including Resident Council complaints, were forwarded to the Grievance Official, who was the Social Worker (SW). The grievances were discussed in the daily morning meeting and then the complaints were distributed to the designated department heads. She stated Resident Council complaints should be included on the grievance log, and the resolution should be included in the written grievance form. A letter would then be sent to the complainant. The Administrator indicated that the department heads probably still had not yet returned the resolutions from the months of October 2023, January 2024, and June 2024.</p> <p>The SW was interviewed on 8/28/24 at 12:08 PM. She revealed that the Activities Director wrote up the grievances from Resident Council meetings and presented them in the daily morning meeting. The SW then delegated the complaints to the assigned department heads. The department heads were then supposed to return the resolutions to her, she logged them and wrote the resolution letter. The Administrator then signed the grievance and resolution letter and returned them back to the SW. The SW stated that all complaints from Resident Council should be attached to the meeting minutes as the resolution to previous grievances. She indicated the problem was that grievance responses were often not returned from the department heads; therefore, she could not create a resolution letter. The Social Worker could not recall if the issues from the October 2023, January 2024, and June 2024 Resident Council meetings were discussed in morning meetings or if the resolutions from the department heads were handed back to her.</p> <p>During a follow-up interview with the SW on 8/28/24 at 12:16 PM, she revealed that if a Resident Council grievance was discussed in the daily morning meeting, then she took notes on the grievance details. If she recorded the grievance, then she followed up with the department heads. She did not always receive the grievances discussed from Resident Council meetings. The SW stated that grievances should be resolved within 48 hours of the initial complaint. She indicated that there was not a thorough process in place to log the grievances and check their status. The SW stated she was not notified that she was the Grievance Official, but rather the Administrator thus far.</p> <p>During a follow-up interview with the Administrator on 8/29/24 at 10:37 AM, she revealed that the department heads were not returning the grievance resolutions to the SW. They were supposed to resolve the issue and then bring it to the SW to log and communicate the resolution to Resident Council members. The Administrator indicated that the SW should follow-up with the department heads if the resolutions were not returned, and the complaints should have been resolved within 72 hours.</p>		

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<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>43222</p> <p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on resident and staff interviews, the facility failed to provide mail delivery to the residents on Saturdays. This had the potential to affect 65 of 65 residents residing in the facility.</p> <p>The findings included:</p> <p>An interview with members of the Resident Council on 8/27/24 at 1:33 PM revealed the facility did not deliver any mail on Saturdays. The members present for the meeting were Resident #2, Resident #6, Resident #11, Resident #12, Resident #39, Resident #40, Resident #51, Resident #55, and Resident #58. The Resident Council members stated the mail was only delivered Monday-Friday by the Activities Director, or if she was in the building on a Saturday.</p> <p>An interview was conducted with the Activities Director on 8/28/24 at 9:51 AM. She revealed that she passed the mail Monday-Friday, and the Manager on Duty was assigned to mail on Saturdays.</p> <p>During an interview with Medical Records/Central Supply on 8/28/24 at 12:35 PM, she revealed that she had never distributed mail when she worked on Saturdays as Manager on Duty. She stated the Activities Director normally passed out mail. Medical Records/Central Supply stated she did not know where the mailbox or the key were located.</p> <p>An interview was conducted with the Dietary Manager (DM) on 8/28/24 at 12:41 PM. He revealed that he had never distributed mail on Saturdays as Manager on Duty.</p> <p>During a follow-up interview with the DM on 8/28/24 at 12:45 PM, he stated that sometimes the Receptionist delivered mail to residents on Saturdays.</p> <p>The Receptionist was interviewed on 8/28/24 at 12:57 PM. She revealed that she collected the mail from outside and placed it in the front office mailbox of the previous Business Office Manager (BOM). Currently, she was instructed by the Regional BOM to place all mail on Saturdays in the Activities Director's mailbox. The Receptionist stated she had never distributed mail to residents.</p> <p>An interview was conducted with the Regional BOM on 8/28/24 at 12:59 PM. She revealed that the Receptionist collected the mail and gave it to the Activities Director, who worked most Saturdays and delivered the mail to residents. When the Activities Director was not in the building on Saturday, the Receptionist distributed the mail.</p> <p>During an interview with the Administrator on 8/29/24 at 10:32 AM, she revealed that prior to 7/20/24, the mail was not delivered to residents on Saturdays unless the Activities Director was present. After 7/20/24, all Managers on Duty and the Receptionist were instructed to pass out the mail to residents on Saturdays. However, the Managers on Duty and Receptionists were not carrying out what was put in place.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222</p> <p>Based on record review, resident and staff interviews the facility failed to provide written advance directive information and/or an opportunity to formulate an advance directive for 5 of 65 residents reviewed for advance directives. (Residents #1, #5, #28, #29, and #47).</p> <p>The findings include:</p> <p>a. Review of Resident #1's medical record revealed the resident was readmitted to the facility on [DATE], with diagnoses that include heart failure, chronic obstructive pulmonary disorder, and anemia. He held a physician order for full code status. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.</p> <p>b. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses that include diabetes, chronic kidney disorder, and seizures. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.</p> <p>The Medical Orders for Scope of Treatment form was signed by the Nurse Practitioner on 7/9/24. There were not any signatures by Resident #5 or their responsible party (RP). Only a note was documented on the form that the RP was called via telephone on 7/8/24. The MOST form was blank and not filled out.</p> <p>Resident #5's RP was interviewed on 8/28/24 at 10:32 AM. She revealed that she had assisted with Resident #5's admission paperwork and could not recall if Advance Directive Care Planning was discussed by a facility staff member.</p> <p>c. Review of Resident #28's medical record revealed the resident was readmitted to the facility on [DATE], with diagnoses that include diabetes, seizures, and anemia. She held a physician order for full code status. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.</p> <p>d. Review of Resident #29's medical record revealed the resident was readmitted to the facility on [DATE], with diagnoses that include stroke, hypertension, and diabetes. He held a do not resuscitate physician order for code status. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.</p> <p>e. Review of Resident #47's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that include spastic quadriplegia, emphysema, and seizures. She held a physician order for full code status. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 8/26/24 at 2:33 PM with the Regional Nurse Consultant. She stated all that was available from the facility for Advance Directives was the Medical Orders for Scope of Treatment (MOST) form stored in binders at the nurses' stations.</p> <p>The Administrator was interviewed on 8/29/24 at 10:44 AM. She revealed that education/discussion of Advance Directives should have been documented for each resident in the facility. The Administrator stated that residents should be reassessed for advance directives every 3 months or when there was a significant change in condition.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>Based on record review, staff interviews, Nurse Practitioner interview, and Medical Director interview, the facility failed to notify the physician that prescribed medications were not administered as ordered for 2 of 5 residents reviewed for unnecessary medications (Resident #24 and Resident #269).</p> <p>The findings included:</p> <p>1. Resident #24 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of female breast and vascular dementia.</p> <p>Resident #24 had an active physician order dated 6/05/24 for letrozole oral tablet (a medication used to treat some types of breast cancer by decreasing the amount of estrogen hormone the body makes) 2.5 milligram (mg) give 1 tablet by mouth one time a day for breast cancer.</p> <p>Review of Resident #24's Medication Administration Record (MAR) for the month of August 2024 revealed the letrozole medication was not administered on the following dates: 8/03/24, 8/04/24, 8/06/24, 08/08/24, 08/09/24, 8/10/24, 8/12/24, 8/13/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 8/18/24, 8/19/24, and 8/21/24 through 8/27/24. The MAR documentation noted the medication was on order as the reason it was not administered.</p> <p>Record review of Resident #24's nursing notes for 8/01/24 through 8/27/24 revealed no documentation that the Nurse Practitioner (NP) and/or the Medical Director were notified of the missed doses of the letrozole medication.</p> <p>During an interview on 8/27/24 at 12:34 pm with Medication Aide #2, who was assigned to administer Resident #24's medication on 8/16/24, 8/22/24, 8/24/24, 8/25/24, and 8/27/24, revealed the letrozole medication was not available to be administered. Medication Aide #2 reported that she had previously reordered the medication from pharmacy on one of the previous dates that she worked, but she did not recall the date. Medication Aide #2 stated she notified Nurse #2, who was her assigned nurse, today that Resident #24's medication was not available so she could call the pharmacy about the medication.</p> <p>An interview was conducted on 8/27/24 at 12:47 pm with Nurse #2 who confirmed Medication Aide #2 notified her today (8/27/24) that Resident #24's letrozole medication was not available on the medication cart. Nurse #2 stated she planned to notify the provider and the Director of Nursing (DON) about the medication not being available, but she had not had the chance at this time.</p> <p>An interview was conducted on 8/27/24 at 1:09 pm with the Medical Director who revealed she was not notified by the facility that Resident #24's letrozole medication had not been administered as ordered. She stated she or the Nurse Practitioner (NP) should have been notified by the facility regarding Resident #24's medication not being administered as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 8/28/24 at 1:29 pm with the NP who revealed she was made aware today (8/28/24) by the DON of Resident #24's missed doses of letrozole.</p> <p>An interview was conducted on 8/27/24 at 1:05 pm with the DON who revealed she was not notified or aware that Resident #24's letrozole medication had not been administered as ordered. The DON stated the nurse on the medication cart was responsible to notify the doctor that the medication was not available.</p> <p>2. Resident #269 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis and complications of stump infection.</p> <p>Resident #269 had an active physician order dated 8/23/24, entered by the Unit Manager, for piperacillin sodium-tazobactam solution (antibiotic medication) infuse 3.375 grams intravenously (a soft, flexible tube placed inside a vein for to give medications or fluids) every 8 hours for wound infection.</p> <p>Review of the Medication Administration Record (MAR) revealed Resident #269's piperacillin sodium-tazobactam solution was not documented as administered on 8/23/24 at 10:00 pm, 8/24/24 at 6:00 am, and 8/24/24 at 10:00 pm.</p> <p>Record review of Resident #269's nursing notes from 8/23/24 through 8/27/24 revealed no documentation that the physician was notified of Resident #269's missed doses of the antibiotic.</p> <p>A telephone interview was conducted with Nurse #5 on 8/29/24 at 9:41 am who revealed she was not able to administer Resident #269's antibiotic on 8/23/24 at 10:00 pm because the medication had not been delivered to the facility at that time. Nurse #5 did not notify anyone that the antibiotic was not administered, but she stated she documented the reason she was unable to administer the medication on the MAR.</p> <p>During an interview on 8/29/24 at 1:23 pm with the Nurse Practitioner (NP) she revealed she was not notified of the missed doses of piperacillin sodium-tazobactam solution for Resident #269. The NP stated the facility should have notified the provider to make them aware of Resident #269's missed doses of the antibiotic.</p> <p>An interview was conducted on 8/29/24 at 10:56 pm with the Director of Nursing (DON) who revealed she was not made aware of Resident #269's antibiotic not being administered. The DON stated the nurse on the medication cart was responsible to notify the doctor that Resident #269's antibiotic medication was not administered.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222</p> <p>Based on record review and staff interview the facility failed to maintain documented evidence that an allegation of staff to resident abuse was thoroughly investigated for 1 of 3 residents (Resident #29) reviewed for abuse.</p> <p>The findings included:</p> <p>Resident #29 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included stroke and mild cognitive impairment.</p> <p>A review of the 5-day Investigation Report dated 8/31/23 completed by the previous Administrator revealed that on 8/29/23 Resident #29 accused a nurse aide of getting on top of him, trying to break his leg, and pull his arm off. The nurse aide was suspended immediately. The investigation report indicated all residents on the accused nurse aide's assignment were to be questioned and assessed on 8/30/23 and all residents would be assessed by 9/1/23. The investigation did not include any evidence that the resident interviews and assessments were completed. The allegation was not substantiated.</p> <p>An interview with the [NAME] President of Operations on 8/28/24 at 8:52 AM revealed that the abuse investigation files for Resident #29's allegation on 8/29/23 could not be found.</p> <p>The previous Administrator was interviewed on 8/28/24 at 2:10 PM. He stated that he maintained a folder of abuse investigation reports with evidence of the investigation when he was at the facility. He indicated there was a folder for the 8/29/23 staff to resident abuse allegation for Resident #29, but it could not be located per conversations with current facility staff.</p> <p>During an interview with the Administrator on 8/29/24 at 10:40 AM, she indicated she expected documented evidence of abuse investigations to be maintained to demonstrate a thorough investigation was completed.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45044</p> <p>Based on record review, staff interviews, and Ombudsman interview the facility failed to notify the resident's responsible party in writing of the reason for transfer to the hospital for 1 of 2 residents (Resident #221) reviewed for hospitalization . The facility also failed to notify the Ombudsman in writing of the reason for the residents' transfer from the facility for 2 of 2 residents reviewed for hospitalization (Resident #119, Resident #221).</p> <p>The findings included:</p> <p>1.Resident #221 was admitted to the facility on [DATE].</p> <p>The quarterly MDS dated [DATE] revealed Resident #221 was severely cognitively impaired.</p> <p>Review of Resident #221's progress notes revealed Resident #221 was transferred to the hospital on 1/21/24 and did not return to the facility.</p> <p>Review of Resident #221's medical records on 8/28/24 revealed no documentation in the medical record that the Ombudsman, Resident or Responsible Party were notified of the reason for transfer to the hospital.</p> <p>Interviews attempted with the nurse that was assigned to Resident #221 when she was transferred to the hospital on 1/21/24 were unsuccessful.</p> <p>Interviews attempted with the Resident's Responsible Party were unsuccessful.</p> <p>An interview was completed on 8/29/24 at 10:20 AM with the Director of Nursing (DON). The DON stated she was unaware the facility was required to send written notification of the reason for transfer from the facility to a resident and their responsible party. Additionally, the DON revealed she did not know if the facility notified the Ombudsman of Resident #221's discharge from the facility to the hospital.</p> <p>A telephone interview was completed on 8/29/24 at 10:35 AM with the Ombudsman. The Ombudsman stated the facility had not notified her of resident discharges from the facility. The Ombudsman revealed she had spoken with the facility Administrator and requested notification of resident discharges.</p> <p>An interview was completed on 8/29/24 at 10:27 AM with the facility Administrator. The Administrator stated she was unsure if Resident #221 or her Responsible Party received written notification of the reason for the Resident's' transfer to the hospital. The Administrator revealed the facility had not sent the Ombudsman notifications of discharge from the facility for Resident #221. The Administrator revealed it was the Social Worker's responsibility to notify the Ombudsman of a resident's transfer from the facility each month. The Administrator stated she was unsure of who was responsible for providing written notification of the reason for transfer to a resident and their responsible party.</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was completed on 8/29/24 at 11:00 AM with the facility's Social Worker. The Social Worker stated she was unaware it was her responsibility to notify the Ombudsman of a resident's transfer from the facility.</p> <p>2. Resident #119 was admitted to the facility on [DATE].</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #119 was severely cognitively impaired.</p> <p>Review of Resident #119's progress notes revealed Resident #119 was transferred to the hospital on 5/23/24 and did not return to the facility.</p> <p>Review of Resident #119's medical records on 8/28/24 revealed no documentation in the medical record that the Ombudsman was notified of the reason for transfer to the hospital.</p> <p>An interview was completed on 8/29/24 at 10:20 AM with the Director of Nursing (DON). The DON revealed she was not aware if the facility notified the Ombudsman of Resident #119's discharge from the facility to the hospital.</p> <p>A telephone interview was completed on 8/29/24 at 10:35 AM with the Ombudsman. The Ombudsman stated the facility had not notified her of resident discharges from the facility. The Ombudsman revealed she had spoken with the facility Administrator and requested notification of resident discharges.</p> <p>An interview was completed on 8/29/24 at 10:27 AM with the facility Administrator. The Administrator revealed the facility had not sent the Ombudsman notification of discharge from the facility for Resident #119. The Administrator revealed it was the Social Worker's responsibility to notify the Ombudsman of a resident's transfer from the facility each month.</p> <p>An interview was completed on 8/29/24 at 11:00 AM with the facility's Social Worker. The Social Worker stated she was unaware it was her responsibility to notify the Ombudsman of a resident's transfer from the facility.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>Based on observation, record review, and staff interviews, and resident interview, the facility failed to obtain a physician order for the management of a peripherally inserted central catheter (PICC) for 1 of 2 residents reviewed for intravenous antibiotic use (Resident #269).</p> <p>The findings included:</p> <p>Resident #269 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis and complications of stump infection.</p> <p>Review of the nursing admission progress note dated 8/23/24 at 5:39 pm by Nurse #4 revealed Resident #269 had a PICC line to the right upper arm for intravenous antibiotic therapy.</p> <p>Resident #269 had a care plan initiated on 8/23/24 for enhanced barrier precautions related to the PICC line and wound with an intervention to monitor for redness or drainage around PICC and wound site.</p> <p>An observation and interview on 8/26/24 at 11:10 am with Resident #269 revealed a double lumen (2 ports) PICC line (form of intravenous access that can be used for a prolonged period of time for the administration of medications) was located in the right upper arm with antibiotic medication infusing. Resident #269 stated she just arrived at the facility a few days prior and was taking the intravenous antibiotic medication for a bad wound infection.</p> <p>Review of Resident #269's active physician orders on 8/26/24 revealed no physician orders for the right upper extremity PICC use and management.</p> <p>A telephone interview was conducted on 8/29/24 at 9:46 am with Nurse # 4 who was assigned to Resident #269 at the time of admission. Nurse #4 stated he completed Resident #269's admission assessment, but he did not enter the physician orders. Nurse #4 stated that typically the Unit Manager entered the physician orders into the system when the resident arrived at the facility. Nurse #4 stated he did not administer any antibiotics for Resident #269 during his shift.</p> <p>An interview was conducted on 8/27/24 at 10:16 am with the Unit Manager who revealed she entered Resident #269's physicians orders when Resident #269's arrived at the facility, and confirmed she was aware of the PICC line for antibiotic therapy. The Unit Manager stated the PICC line orders were set up as batch order set that would populate all required physician orders related to the use and management of the line when it was chosen. She stated she just forgot to click for the PICC line order set to generate all the required orders. The Unit Manager stated the physician orders were checked on new admissions and reviewed in the morning clinical meeting, but she was unable to state how she missed Resident #269's PICC line orders.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 8/27/24 at 10:47 am with Nurse #2 who was assigned to administer Resident #269's antibiotic medications. Nurse #2 stated she did not notice that PICC line orders were not entered, but she stated she flushed the PICC line before and after the antibiotic medication was administered. She stated she knew from previous experience that the PICC line required to be flushed prior to the antibiotic to make sure it was not clogged and after the medication was completed to make sure all the medication was administered. Nurse #2 stated she did not know if other orders were required for Resident #269's PICC line use and management.</p> <p>During an interview on 8/27/24 at 1:22 pm with the Director of Nursing (DON) she revealed physician orders for the use and management of Resident #269's PICC line should have been entered when she was admitted to the facility. The DON stated the Unit Manager was responsible to enter the orders when she completed the admission orders. The DON stated the new admission review was completed by the Unit Manager and reviewed in the clinical meeting, but she was unable to state how the orders were missed for Resident #269's PICC line.</p> <p>An interview was conducted on 8/28/24 at 9:53 am with the Regional Nurse Consultant who revealed the nurse did not need to have an order to flush the PICC line before and after the antibiotic medication because it was part of the facility policy. The Regional Nurse Consultant stated she was not aware that Resident #269 did not have any physician orders for management and care of the PICC line and she stated those orders should have been entered upon admission.</p> <p>During an interview on 8/29/24 at 9:10 am the Administrator stated the DON and Unit Manager were responsible to ensure all physician orders were in place for Resident #269.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789</p> <p>Based on observation, record review and staff interview the facility failed to provide supervision and provide a smoking apron for a resident that required supervision smoking for 1 of 2 residents sampled for smoking. (Resident #9)</p> <p>Findings include:</p> <p>Resident #9 was admitted to the facility on [DATE].</p> <p>The most recent Minimum Data Set (MDS) dated [DATE], revealed Resident #9 had severe cognitive impairment and indicated Resident #9 was a tobacco user.</p> <p>A review of the smoking assessment dated [DATE] revealed Resident #9 was a supervised smoker.</p> <p>A review of the smoking policy revealed a signed copy of the policy dated 4/11/2024 signed by the Responsible Party for Resident #9.</p> <p>Resident #9's care plan dated 5/20/2024 revealed he was a supervised smoker and required to wear a smoking apron when smoking.</p> <p>On 8/27/2024 at 11:55 a.m. Resident #9 who was a supervised smoker was observed at the front entrance of the facility wheeling himself to the smoking area, which was near the front entrance of the facility. There were no observed staff members at the smoking area. Resident #9 was observed to approach Resident #55, a non-supervised smoker, at the smoking area. Resident #55 proceeded to give Resident #9 a cigarette and lit the cigarette for him. Resident #9 was observed to smoke the cigarette unsupervised and was not wearing a smoking apron. Resident #9 was observed to control and manage the lit cigarette and ash it safely.</p> <p>On 8/27/2024 at 11:59 a.m. Nurse Aide (NA) #1 was observed joining the residents to smoke and later assist Resident #9 back inside of the building. Resident #9 did not have any cigarette burns visible on his skin or clothing.</p> <p>In an interview with NA #1 on 8/27/2024 at 12:05 p.m. he revealed that he was assigned to supervise Resident #9 during his smoking times at 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., and 5:00 p.m. He revealed he had left Resident #9 outside of the main entrance to the building to go back to the building to retrieve Resident #9's cigarettes and lighter. NA #1 stated he returned and found Resident #9 at the smoking area smoking a cigarette. NA #1 stated Resident #9 was a supervised smoker and must wear a smoking apron when smoking. NA #1 stated it was an error on his part to leave Resident #9 unsupervised and without his smoking apron on.</p> <p>During an interview with the Administrator on 8/27/2024 at 12:10 p.m. she reported that staff knew the smoking protocol and must get cigarettes and smoking aprons for supervised smokers before exiting the building to the smoking area. The Administrator further revealed that there was a list of supervised smokers and non-supervised smokers placed in the nursing station for reference.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>45789</p> <p>Based on staff interviews and record review, the facility failed to have a Registered Nurse (RN) for at least eight consecutive hours a day, 7 days a week for 48 of 180 days reviewed.</p> <p>Findings include:</p> <p>The Nursing Staff Schedule and the Daily Staffing Form were reviewed from 8/1/23 through 8/29/24. The Nursing Staff Schedule and the Daily Staffing Form indicated an RN was not scheduled for at least eight consecutive hours a day on the following dates: 8/5/23, 8/26/23, 8/27/23, 9/9/23, 9/10/23, 9/23/23, 11/5/23, 11/17/23, 11/19/23, 12/3/23, 12/10/23, 12/24/23, 12/25/23, 12/28/23, 1/1/24, 1/6/24, 1/7/24, 1/20/24, 1/21/24, 1/26/24, 2/4/24, 2/8/24, 2/9/24, 2/10/24, 2/11/24, 2/12/24, 2/13/24, 2/14/24, 2/15/24, 2/16/24, 2/17/24, 2/18/24, 2/19/24, 2/21/24, 2/23/24, 2/24/24, 2/25/24, 2/26/24, 2/28/24, 2/29/24, 3/2/24, 3/5/24, 3/7/24, 3/8/24, 3/9/24, 3/10/24, 3/12/24, and 3/14/24.</p> <p>Telephone interviews with the prior Director of Nursing (DON) and Scheduler were attempted but calls and messages were not returned.</p> <p>During an interview with the Administrator on 8/29/24 at 10:22 A.M. she revealed it was the responsibility of DON and the Scheduler to ensure 8 hours of consecutive RN coverage daily was met. The Administrator explained there had been staffing changes and things have improved.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>Based on record review, staff interviews, and Consultant Pharmacist interview, the facility failed to ensure intravenous (a soft, flexible tube placed inside a vein used to give medicine or fluids) antibiotic medication was available as ordered for a newly admitted resident for 1 of 2 residents reviewed for intravenous (IV) antibiotic therapy (Resident #269).</p> <p>The findings included:</p> <p>Resident #269 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis and complications of stump infection.</p> <p>Resident #269 had an active physician order dated 8/23/24 for piperacillin sodium-tazobactam solution (antibiotic medication) infuse 3.375 grams intravenously every 8 hours for wound infection. The medication was scheduled to be administered at 6:00 am, 2:00 pm, and 10:00 pm.</p> <p>The care plan initiated on 8/23/24 revealed Resident #269 was on antibiotic therapy related to wound infection with an intervention to administer antibiotic medication as ordered by the physician.</p> <p>The Medication Administration Record (MAR) for 8/23/24 revealed Resident #269's piperacillin sodium-tazobactam solution was not administered at 10:00 pm. Resident #269's MAR for the 10:00 pm dose was noted by Nurse #5 as new admission, pharmacy to deliver.</p> <p>A telephone interview was conducted on 8/29/24 at 9:46 am with Nurse # 4 who was assigned to Resident #269 at the time of admission. Nurse #4 stated he worked during the 7:00 am-3:00 pm shift and Resident #269 was admitted to the facility at approximately 2:00 pm. Nurse #4 reported he completed Resident #269's admission and the Unit Manager put the medication orders into the system. Nurse #4 stated that the pharmacy made deliveries twice a day, with the first delivery around noon and the second delivery in the early morning hours.</p> <p>A telephone interview was conducted on 8/29/24 at 9:41 am with Nurse #5 who was assigned to Resident #269 on 8/23/24 during the 3:00 pm-11:00 pm shift. Nurse #5 revealed she was unable to administer Resident #269's antibiotic for the 10:00 pm dose because it was not delivered to the facility at that time. Nurse #5 stated the pharmacy did not normally deliver the medications for new admissions until around 2:00 am, so she documented the antibiotic as not administered.</p> <p>An interview was conducted on 8/27/24 at 10:06 am with the Admissions Director who revealed once a new admission was confirmed to arrive on that day she would give the discharge summary to the Unit Manager. She stated the discharge summary was given prior to the resident arriving at the facility and included all the medications that the resident would be taking once admitted to the facility.</p> <p>An interview was conducted on 8/27/24 at 10:16 am with the Unit Manager who revealed she received the discharge summary from the Admissions Director that did have Resident #269's medications listed. The Unit Manager stated that when Resident #269 arrived at the facility the orders were entered for the medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview was conducted on 8/29/24 8:15 am with the Consultant Pharmacist who revealed medication orders would be active once the resident was admitted to the facility. He stated the medication orders would be reviewed and verified for any contraindications before being sent to the facility.</p> <p>An interview was conducted on 8/29/24 at 10:56 am with the Director of Nursing (DON) who revealed medication orders were received prior to the admission but were not entered until the resident arrived at the facility. The DON stated the medication orders were entered and confirmed when Resident #269 arrived and would be expected to be delivered to the facility on the night delivery. The DON confirmed Resident #269's piperacillin sodium-tazobactam solution was delivered to the facility on [DATE] at 1:10 am.</p> <p>During an interview on 8/29/24 at 9:10 am the Administrator stated the DON and Unit Manager were responsible to ensure Resident #269's medications were available and administered as ordered.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>Based on record review, staff interviews, and Consultant Pharmacist interview, the facility failed to address recommendations made by the Consultant Pharmacist based on the monthly Medication Regimen Review (MRR) for 1 of 5 residents reviewed for unnecessary medications (Resident #24).</p> <p>The findings included:</p> <p>Resident #24 was admitted to the facility on [DATE] with diagnoses which included vascular dementia and schizophrenia.</p> <p>The care plan initiated on 5/01/24 revealed Resident #24 used psychotropic medication related to diagnosis of schizophrenia.</p> <p>Resident #24 had an active physician order dated 6/03/24 for haloperidol (an antipsychotic medication used to treat schizophrenia) oral tablet 5 milligrams (mg) give one tablet by mouth two times a day for dementia.</p> <p>Review of the Consultant Pharmacist Recommendation to Physician report dated 6/18/24 revealed Resident #24 received the antipsychotic medication haloperidol but lacked an allowable diagnosis to support the use. The report provided allowable diagnoses for the medication which included schizophrenia. The diagnosis of schizophrenia was chosen, and the report was signed by the provider.</p> <p>Review of the Consultant Pharmacist Recommendation to Physician report dated 7/18/24 revealed Resident #24 received the antipsychotic medication haloperidol but lacked an allowable diagnosis to support the use. The report provided allowable diagnoses for the medication which included schizophrenia. The diagnosis of schizophrenia was chosen, and the report was signed by the provider.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #24 had severe cognitive impairment and was coded for use of an antipsychotic medication.</p> <p>A telephone interview was conducted on 8/29/24 at 8:15 am with the Consultant Pharmacist revealed he completed the MRR monthly, and the reports were sent to the Director of Nursing (DON) to be completed. He stated the normal process was to notify the facility of the diagnosis requirement and the facility would make the appropriate changes to the medication order. The Consultant Pharmacist stated if the recommendation was not completed at the time of the next MRR another recommendation would be sent to the DON. The Consultant Pharmacist stated the facility was responsible to update the physician order with the appropriate diagnosis when the report was completed by the provider.</p> <p>An interview was conducted with the Director of Nursing (DON) on 8/29/24 at 9:25 am who revealed she received the Consultant Pharmacist Recommendation reports and she gave the reports to the providers to complete. The DON stated she received the reports back from the providers when they were completed and signed. The DON stated she received the completed recommendation report for Resident #24's haloperidol, but she did not verify the order was corrected. The DON stated she was responsible to make sure the Consultant Pharmacist Recommendation to Physician reports were completed.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/29/24 at 9:13 am with the Administrator she revealed the DON received the Consultant Pharmacist Recommendation to Physician reports from the Consultant Pharmacist and the DON was responsible to ensure Resident #24's diagnosis was updated for the haloperidol medication.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>Based on observation, record review, staff interviews, resident interview, Pharmacy Manager interview, Nurse Practitioner interview, and Medical Director interview, the facility failed to administer significant medications as ordered for 2 of 5 residents reviewed for unnecessary medications (Resident #24 and Resident #269).</p> <p>The findings included:</p> <p>1. Resident #24 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of female breast and vascular dementia.</p> <p>The care plan initiated on 5/02/24 revealed Resident #24 received oral chemotherapy related to cancer of the breast with an intervention to give medications as ordered.</p> <p>Resident #24 had an active physician order dated 6/05/24 for letrozole oral tablet (a medication used to treat some types of breast cancer by decreasing the amount of estrogen hormone the body makes) 2.5 milligram (mg) give 1 tablet by mouth one time a day for breast cancer.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #24 had severe cognitive impairment and was coded for chemotherapy medication.</p> <p>A telephone interview was conducted with the Pharmacy Manager on 8/27/24 at 1:53 pm who confirmed Resident #24's 30-day supply of the letrozole was delivered to the facility on [DATE] and was signed as received by Medication Aide #3.</p> <p>An interview conducted on 8/28/24 at 1:19 pm with Medication Aide #3 revealed when she received medications from the pharmacy she would confirm the medication was there with the order sheet and sign the slip as received. She stated she put the received medications for the residents in the appropriate medication carts after signing for them. Medication Aide #3 stated she did not specifically recall signing for the Resident #24's letrozole medication on 7/31/24, but she stated she would not have signed off on the slip if the medication was not delivered.</p> <p>Review of Resident #24's Medication Administration Record (MAR) for the month of August 2024 revealed the letrozole medication administration on the following dates:</p> <p>8/01/24 noted as administered by Medication Aide (MA) #4.</p> <p>8/02/24 noted as administered by Nurse #14.</p> <p>8/03/24 noted as on order by Nurse #12.</p> <p>8/04/24 noted as on order by Nurse #3.</p> <p>8/05/24 noted as administered by Nurse #1.</p> <p>(continued on next page)</p>		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/06/24 noted as on order by MA #3. 8/07/24 noted as administered by MA #1 8/08/24 noted as on order by MA #3. 8/09/24 noted as on order by MA #3. 8/10/24 noted as on order by Nurse #13. 8/11/24 noted as administered by Nurse #11. 8/12/24 noted as on order by MA #3. 8/13/24 noted as not administered, no further documentation. 8/14/24 noted as not administered, no further documentation. 8/15/24 noted as on order by MA #3. 8/16/24 noted as on order by MA #2. 8/17/24 noted as on order by MA #3. 8/18/24 noted as on order by MA #3. 8/19/24 noted as on order by MA #3. 8/20/24 noted as administered by Nurse #8. 8/21/24 noted as on order by MA #3. 8/22/24 noted as not administered by MA #2. 8/23/24 noted as on order by MA #3. 8/24/24 noted as not administered by MA #2. 8/25/24 notes as not administered by MA #2. 8/26/24 noted as on order, calling pharmacy by MA #3. 8/27/24 noted as not administered by MA #2. (continued on next page)

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted on 8/28/24 at 10:34 am with Nurse #3 who was assigned to Resident #24 on 8/03/24 and documented the letrozole medication as not administered, on order. Nurse #3 stated if she marked the MAR as not administered due to being on order from the pharmacy then she was unable to find the medication to administer to Resident #24. Nurse #3 stated she was unable to recall if she reordered Resident #24's medication or was told by another nurse that it was on order.</p> <p>A telephone interview was conducted on 8/28/24 at 9:00 am with Nurse #1 who was assigned to Resident #24 on 8/05/24 and documented the letrozole as administered. Nurse #1 stated she was able to administer Resident #24's letrozole as ordered on 8/05/24 because it was in the medication cart. Nurse #1 reported she would not have signed out the medication as administered if it was not available.</p> <p>A telephone interview attempt on 8/28/24 at 9:05 am with Medication Aide #1, who was assigned to Resident #24 on 8/07/24 and documented the letrozole as administered was unsuccessful.</p> <p>An interview was conducted on 8/28/24 at 1:19 pm with Medication Aide #3, who was assigned to Resident #24 on 8/06/24, 8/08/24, 8/09/24, 8/12/24, 8/15/24, 8/17/24, 8/18/24, 8/19/24, 8/21/24, 8/23/24, and 8/26/24 revealed she was unable to remember for sure but if she documented Resident #24's medication was not available then she was unable to find it on that day. Medication Aide #3 stated she was unable to say where Resident #24's medication could have been put.</p> <p>During an interview on 8/27/24 at 12:34 pm with Medication Aide #2, who was assigned to administer Resident #24's medication on 8/16/24, 8/22/24, 8/24/24, 8/25/24, and 8/27/24, revealed the letrozole medication was not available to be administered. Medication Aide #2 reported that she had previously reordered the medication from pharmacy one of the previous dates that she worked, but she was unable to recall the exact date. She stated the medication was able to be reordered in Resident #24's electronic medical record by clicking the reorder button which sent the order notification directly to the pharmacy. Medication Aide #2 stated she was going to notify Nurse # 2, who was assigned to supervise her, to check with pharmacy on the delivery status because she stated it seemed like it was a long time since she ordered the medication.</p> <p>An observation was conducted on 8/27/24 at 12:34 pm with Medication Aide #2 of the medication cart drawers. Medication Aide #2 checked the medication cart with this surveyor and confirmed the letrozole was not available in the medication cart assigned to Resident #24.</p> <p>An interview was conducted on 8/27/24 at 12:47 pm with Nurse #2 who was assigned to supervise Medication Aide #2. Nurse #2 confirmed that she was notified by Medication Aide #2 that Resident #24 did not have the letrozole medication available to administer today. She stated she would notify the Unit Manager to follow-up with the pharmacy once Medication Aide #2 completed the medication pass.</p> <p>During an interview on 8/27/24 at 10:16 am with the Unit Manager she revealed she was not aware Resident #24's letrozole was not available and noted as not administered on the MAR. The Unit Manager stated she reviewed the MAR documentation before the daily clinical meeting but was only looking for blank spaces when she reviewed them to make sure the medications were being administered. The Unit Manager stated she did not look at what was being documented on the MAR regarding the medication for Resident #24. The Unit Manager reported she checked all of the facility medication carts and the medication storage room Resident #24's letrozole medication but she was unable to locate the medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted with the Pharmacy Manager on 8/27/24 at 1:53 pm who confirmed Resident #24's letrozole medication was not returned to pharmacy as unused.</p> <p>An interview was conducted on 8/27/24 at 1:09 pm with the Medical Director who revealed she was not notified by the facility that Resident #24's letrozole medication had not been administered. She stated she or the Nurse Practitioner (NP) should have been notified by the facility regarding Resident #24's medication not being available. The Medical Director stated she was not an oncologist (doctor specialized in diagnosing and treating cancer) but she understood that Resident #24's letrozole medication was needed and it should have been administered as ordered.</p> <p>An interview was conducted on 8/28/24 at 1:29 pm with the NP who revealed she was made aware today (8/28/24) by the Director of Nursing (DON) of Resident #24's missed doses of letrozole. The NP stated that Resident #24's medications were expected to be administered as ordered.</p> <p>An interview was conducted on 8/27/24 at 1:05 pm with the Director of Nursing who revealed she was not notified or aware that Resident #24's letrozole medication had not been administered as ordered. She stated the nurse on the cart was responsible to notify the doctor that the medication was not available and notify nursing management (DON or Unit Manger) so a follow-up call to the pharmacy could be made. The DON stated the Nurses or Medication Aides should have notified the Unit Manager or herself when the medication was not found on the medication cart. The DON stated she was not able to say what happened to Resident #24's medication, but stated the medication was delivered to the facility and should have been in the medication cart.</p> <p>An interview was conducted with the Administrator on 8/29/24 at 9:10 am who revealed the DON and Unit Manager were responsible to make sure medications were administered as ordered.</p> <p>2. Resident #269 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis and complications of stump infection.</p> <p>Resident #269 had an active physician order dated 8/23/24, entered by the Unit Manager, for piperacillin sodium-tazobactam solution (antibiotic medication) infuse 3.375 grams intravenously (IV, a soft, flexible tube placed inside a vein for to give medications or fluids) every 8 hours for wound infection. The medication was scheduled to be administered at 6:00 am, 2:00 pm, and 10:00 pm.</p> <p>The care plan initiated on 8/23/24 revealed Resident #269 was on antibiotic therapy related to wound infection with an intervention to administer antibiotic medication as ordered by the physician.</p> <p>The Medication Administration Record (MAR) for August 2024 revealed the following:</p> <p>8/23/24 at 10:00 pm the piperacillin sodium-tazobactam solution was not administered. The MAR noted as new admit, pharmacy to delivery by Nurse #5.</p> <p>8/24/24 at 6:00 am the piperacillin sodium-tazobactam solution was not documented as administered with no further information noted. The nurse assigned to Resident #269 at this time was Nurse #6.</p> <p>8/24/24 at 10:00 pm the piperacillin sodium-tazobactam solution was not documented as administered with no further information noted. The nurse assigned to Resident #269 at this time was Nurse #10.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The MAR from 8/25/24 through 8/28/24 revealed Resident #269's the piperacillin sodium-tazobactam solution was administered as ordered.</p> <p>A telephone interview was conducted on 8/29/24 at 9:46 am with Nurse # 4 who was assigned to Resident #269 at the time of admission. Nurse #4 stated he completed Resident #269's admission, but the Unit Manager put the medication orders into the system. He stated he did not have any antibiotics due for Resident #269 during his shift.</p> <p>A telephone interview was conducted on 8/29/24 at 9:41 am with Nurse #5 who was assigned to Resident #269 on 8/23/24 during the 3:00 pm - 11:00 pm shift. Nurse #5 stated she did not administer the antibiotic to Resident #269 during her shift because the new admission antibiotics normally arrived after her shift ended. Nurse #5 stated she documented on Resident #269's MAR that she did not administer the medication.</p> <p>A telephone interview was conducted on 8/29/24 at 9:50 am with Nurse #6 who was assigned to Resident #269 on 8/24/24 at the time of the 6:00 am dose of the antibiotic. Nurse #6 stated the pharmacy delivery normally occurred between 1:00 am and 2:00 am. Nurse #6 stated she was unable to remember if Resident #269's medication was delivered or administered, but she stated if the medication was delivered she should have given it.</p> <p>An attempt to interview Nurse #10 on 8/29/24 at 10:05 am, who was assigned to Resident #269 on 8/29/24 for the 10:00 pm dose of the antibiotic, was unsuccessful.</p> <p>During an interview on 8/29/24 at 1:23 pm with the Nurse Practitioner (NP) she revealed she was not notified of the missing doses of piperacillin sodium-tazobactam solution for Resident #269. The NP stated Resident #269 was on two antibiotics for the wound infection and the other antibiotic was administered as ordered which covered the bacteria noted in the wound, but she stated the facility should have notified the provider to make them aware of the missed doses. The NP stated all of Resident #24's antibiotics should have been administered as ordered.</p> <p>An interview was conducted on 8/29/24 at 10:56 pm with the Director of Nursing (DON) revealed she was not aware of the missing doses of Resident #269's piperacillin sodium-tazobactam solution. The DON stated she was unable to determine why the medication was not administered because the medication was at the facility for the scheduled 8/24/24 administrations.</p> <p>An interview was conducted with the Administrator on 8/29/24 at 9:10 am who revealed the DON and Unit Manager were responsible to make sure medications were administered as ordered.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>Based on record review and staff interviews, the facility failed to maintain vaccination consents or declination forms and failed to maintain a record of education provided for the influenza and pneumococcal immunizations for 4 of 5 residents reviewed for immunizations (Resident #28, Resident #16, Resident #29, and Resident #10).</p> <p>The findings included:</p> <p>a. Resident #28 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed Resident #28 declined to have the pneumococcal vaccine. Resident #28's medical record did not include the date of declination. Resident #28's medical record further noted that the influenza vaccine was administered at the facility on 10/01/23.</p> <p>The facility was unable to provide documentation that a signed immunization consent and/or declination form was obtained, and that the vaccination education was provided to Resident #28 or their Responsible Party (RP) regarding the influenza and pneumococcal vaccines.</p> <p>b. Resident #16 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed Resident #16 was administered the influenza immunization at the facility on 10/17/23.</p> <p>The facility was unable to provide documentation that a signed immunization consent form was obtained, and that the vaccination education was provided to Resident #16 or their RP regarding the influenza immunization.</p> <p>c. Resident #29 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed Resident #29 declined the pneumococcal immunization, unknown date, and he was administered the influenza immunization at the facility on 10/16/23.</p> <p>The facility was unable to provide documentation that a signed immunization consent form for the influenza vaccine was obtained prior to administration, a signed and date declination form for the pneumococcal vaccine was obtained, or that the vaccination education was provided to Resident #29 or their RP regarding the influenza and pneumococcal vaccines.</p> <p>d. Resident #10 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed Resident #10 was noted to have obtained the influenza vaccine at the facility on 10/17/23.</p> <p>The facility was unable to provide documentation that a signed consent form for the influenza vaccine was obtained prior to administration or that the vaccination education was provided to Resident #10 or their RP regarding the influenza vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 8/28/24 at 11:37 am with the Regional Nurse Consultant who revealed she was unable to locate the documentation of consents or declinations for the immunizations for the residents reviewed. She further reported the facility was unable to locate the documentation that the vaccine education was provided to the residents or their RP's regarding the influenza or pneumococcal immunizations risks and possible side effects. The Regional Nurse Consultant stated she was unable to state what the previous administrative team did with the required immunization information.</p> <p>During an interview on 8/29/24 at 8:38 am with the Infection Preventionist, she revealed she was new to the position and was unable to state why the immunization information was not available for the residents or their RP's reviewed.</p> <p>An interview was conducted with the Director of Nursing (DON) on 8/29/24 at 9:25 am who revealed she was new to the position and was not able to state why the facility did not have the immunization consents and education documentation.</p> <p>An attempt to interview the previous DON was unsuccessful.</p> <p>An interview was conducted on 8/29/24 at 9:03 am with the Administrator who revealed the Director of Nursing, and the Infection Preventionist were responsible for the residents' immunizations and the maintenance of the documentation that was required. The Administrator stated she was unable to state why the information was not available because the administrative team was new to the facility.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>Based on record review and staff interviews, the facility failed to maintain vaccination consents or declination forms and failed to maintain a record of education provided for COVID-19 (Coronavirus) immunizations for 2 of 5 residents reviewed for immunizations (Resident #16 and Resident #29).</p> <p>The findings included:</p> <p>The facility policy titled, COVID-19 Vaccination last reviewed June 2023, revealed in part that COVID-19 vaccinations will be offered to residents when supplies were available, as per Centers for Disease Control and Prevention (CDC) guidelines unless contraindicated, previously immunized during the time period, or refused to receive the vaccine. The policy concluded that the facility would maintain record of education to the resident or Responsible Party (RP) regarding the risks, benefits, and potential side effects of the COVID-19 vaccine, record of each dose of the vaccine administered, and if the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.</p> <p>a. Resident #16 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed Resident # 16 was administered the COVID-19 vaccine at the facility on 12/13/23.</p> <p>The facility was unable to provide documentation that a signed immunization consent form was obtained prior to administration and that the vaccination education was provided to Resident #16 or their Responsible Party (RP) regarding the risks, benefits, and potential side effects of the COVID-19 vaccine.</p> <p>An interview was conducted on 8/28/24 at 11:37 am with the Regional Nurse Consultant who revealed she was unable to locate the consent form or education documentation for Resident #16's COVID-19 vaccine.</p> <p>b. Resident #29 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed Resident #29 was administered the COVID-19 vaccine dose #1 on 3/40/21. There was no documentation that any additional doses of the COVID-19 vaccinations were offered, administered, or declined by Resident #29.</p> <p>An interview was conducted on 8/28/24 at 11:37 am with the Regional Nurse Consultant who revealed she was unable to provide any further documentation of additional COVID-19 vaccine information for Resident #29.</p> <p>During an interview on 8/29/24 at 8:38 am with the Infection Preventionist (IP), she revealed she was new to the facility and was unable to state what occurred with Resident #16 and Resident #29 immunization information.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 8/29/24 at 9:25 am with the Director of Nursing (DON) who revealed she was new to the facility and was unable to answer questions regarding Resident #16 and Resident #29's COVID-19 immunizations.</p> <p>An attempt to interview the previous DON was unsuccessful.</p> <p>An interview was conducted on 8/29/24 at 9:03 am with the Administrator who revealed the Director of Nursing and Infection Preventionist were responsible for the facility's immunization process. The Administrator stated she was unable to state why the information was not available because the administrative team was new to the facility.</p>		