STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Center for Nursing and Rehab	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)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff, resident and Resident Representative (RR) interviews, the facility failed to notify the resident and Resident Representative in writing of the reason for the transfer/discharge to the hospital and/or failed to provide a copy of the bed hold policy to the resident or Resident Representative. This affected 3 of 3 residents reviewed for transfer to the hospital (Resident #1, Resident #60 and Resident #34). The findings included:1. Resident #1 was admitted to the facility on [DATE].The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact.Review of Resident #1's face sheet revealed she was her own RR.a. The nursing progress note dated 2/15/25 revealed Resident #1 was sent to the hospital.The medical record indicated Resident #1 was transferred to the hospital on 2/15/25 and returned to the facility on 2/20/25. The medical record was reviewed, and there was no documentation that Resident #1 received written notification of the reason for her transfer/discharge to the hospital or a copy of the bed hold policy.b. The nursing progress note dated 10/27/25 revealed Resident #1 was sent to the hospital.The medical record indicated Resident #1 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. The medical record was reviewed and there was no documentation that Resident #1 received written notification of the reason for her transfer/discharge to the hospital. Resident #1 did receive the bed hold policy for the 10/27/25 hospital transfer.An interview was conducted with Resident #1 on 1/30/26 at 4:00 PM. Resident #1 confirmed that she was her own Resident Representative. Resident #1 stated she had not received a written notification of the bed hold policy or the transfer/discharge notice when she was transferred to the hospital. An interview was conducted with the Social Worker on 1/30/26 at 3:50 PM who revealed the Business Office Manager was responsible for providing residents and the RR with copies of the bed hold policy when a resident was transferred to the hospital. The Social Worker further stated that she was not aware that she was to notify the resident and resident RR in writing of transfer/discharge to the hospital. An interview was conducted with the Business Office Manager on 1/30/26 at 4:00 PM. The Business Office Manager stated that she had access to the electronic medical record remotely and followed up with the resident or Resident Representative within 24 hours of the resident being transferred to the hospital about the bed hold policy. The Business Office Manager stated a handwritten copy of the bed hold policy was sent to the resident or RR the next day after the resident was transferred to the hospital. The Business Office Manager stated she was not sure what happened with the bed hold policy for Resident #1. The Business Office Manager confirmed she could not locate evidence she had provided the bed hold policy for either of Resident #1's transfers to the hospital. The Business Office Manager stated she was not responsible for the written notification of transfer/discharge. She stated the Social Worker was responsible for written notification.During an interview with the Administrator on 1/30/26 at 4:28 PM, she stated the Social Worker was responsible for notifying the resident and Resident Representative in writing of (continued on next page)

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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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	transfer/discharge to the hospital. The Administrator further stated the Business Office Manager was responsible for making sure the bed hold policy was completed and mailed to the Resident Representative. The Administrator was unable to provide an explanation as to why the bed hold policy or the transfer/discharge notice had not been sent for Resident #1.2. Resident #60 was admitted to the facility on [DATE].The quarterly MDS assessment dated [DATE] revealed Resident #1 could not complete the Brief Interview for Mental Status (BIMS) and was determined to have moderately impaired cognitive skills for daily decision-making. The nursing progress note dated 1/3/26 revealed Resident #60 was transferred to the hospital.The medical record indicated Resident #60 was transferred to the hospital on 1/3/26 and returned to the facility on 1/13/26. The medical record was reviewed and there was no documentation that Resident # 60 or the RR received written notification of the reason for her transfer/discharge to the hospital or a copy of the bed hold policy.An interview was conducted with Resident #60's RR on 1/30/26 at 2:34 PM. The RR stated she had not received written notification of transfer/discharge or a copy of the bed hold policy when Resident #60 went to the hospital.An interview was conducted with the Social Worker on 1/30/26 at 3:50 PM who revealed the Business Office Manager was responsible for providing residents and the RR with copies of the bed hold policy when a resident was transferred to the hospital. The Social Worker further stated that she was not aware that she was to notify the resident and resident RR in writing of transfer/discharge to the hospital. An interview was conducted with the Business Office Manager on 1/30/26 at 4:00 PM. The Business Office Manager stated that she had access to the electronic medical record remotely and followed up with the resident or resident's RR within 24 hours of the resident being transferred to the hospital about the bed hold policy. The Business Office Manager stated a handwritten copy of the bed hold policy was sent to the resident or RR the next day after the resident was transferred to the hospital. The Business Office Manager stated she was not sure what happened with the bed hold policy for Resident #60. The Business Office Manager confirmed she could not locate evidence she had provided the bed hold policy for Resident #60's transfer to the hospital. The Business Office Manager stated she was not responsible for the written notification of transfer/discharge. She stated the Social Worker was responsible for written notification.During an interview with the Administrator on 1/30/26 at 4:28 PM, she stated the Social Worker was responsible for notifying the resident and Resident Representative in writing of transfer/discharge to the hospital. The Administrator further stated the Business Office Manager was responsible for making sure the bed hold policy was completed and mailed to the Resident Representative. The Administrator was unable to provide an explanation as to why the bed hold policy nor the transfer/discharge notice had not been sent for Resident #60.3. Resident #34 was admitted to the facility on [DATE].The quarterly MDS dated [DATE] revealed Resident #34 was cognitively intact.The medical record indicated Resident #34 was transferred to the hospital on 1/8/26. The medical record was reviewed and there was no documentation that Resident #34 or the RR received a copy of the bed hold policy. An interview was conducted with Resident #34's Representative on 1/30/26 at 8:52 AM. The RR stated she had not received a copy of the bed hold policy when Resident #34 was transferred to the hospital on 1/8/26. The RR stated she had coordinated Resident #34's surgery date with the Director of Nursing and knew that Resident #34 would be returning to the facility to the same bed afterwards. During the interview, Resident #34's RR stated she did receive written notification of the resident's transfer to the hospital.An interview was conducted with the Director of Nursing (DON) on 1/30/26 at 10:06 AM. The DON stated that the week that Resident #34 was transferred to the hospital the Business Office Manager was out of the office and the DON tried to help. The DON stated that she had communicated with the Resident Representative about Resident #34's upcoming surgery by email (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	but she did not email the bed hold policy to Resident #34's Representative. The DON indicated she was not aware that the bed hold policy needed to be mailed to the RR. An interview was conducted with the Administrator on 01/30/2026 at 1:51 PM. The Administrator stated that the Business Office Manager was responsible for making sure the bed hold policy was completed and mailed to the Residents' Representative. The Administrator was unable to explain what happened with the bed hold policy since the Business Office Manager was out or why the bed hold form was not mailed to the RR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to date a multi-dose vial of medication when opened in 1 of 2 medication storage refrigerators reviewed for medication storage (Nurse's Station #1 medication room). The findings included: On [DATE] at 2:57 p.m., an observation was completed of the medication storage room with the Director of Nursing (DON). The observation revealed one multi-dose vial of opened Tuberculin Purified Diluted solution (used in a skin test to help diagnose tuberculosis) without an opened date written on the vial, located in the medication refrigerator. A review of the manufacturer's instruction label on the bottle indicated the medication should be discarded 30 days from the date medication was opened. An interview was completed on [DATE] at 3:18 p.m. with the DON. She indicated it was the Unit Manager's responsibility to check the medication room for expired or undated opened medications. The DON stated the undated medication should have been discarded or returned to the pharmacy. An interview was completed on [DATE] at 3:24 p.m. with the Unit Manager. The Unit Manager stated she, along with the staff nurses check the medication room for expired and undated opened medications. The Unit Manager stated she was unaware of why the vial was not dated when opened by the nursing staff member. The Unit Manager was unable to recall when she last checked the medication room and medication room refrigerator for expired or undated medications. An interview was completed on [DATE] at 2:08 p.m. with the Administrator. She stated all multi-dose medication vials should be dated when they are opened.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and staff interviews, the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) related to Registered Nurse (RN) hours for Federal Fiscal Year (FY) 2025 Quarter 2 (January through March 2025), Quarter 3 (April through June 2025), and Quarter 4 (July through September 2025). This was for 3 of 3 quarter's reviewed for sufficient nurse staffing. Findings included:a. The PBJ report for FY 2025 revealed for Quarter 2 (January 1 through March 31, 2025) there were no RN hours on the following dates: 2/16/25, 3/15/25, and 3/16/25The daily staff schedules conflicted with the PBJ information. The schedules indicated there was an RN scheduled for at least 8 hours per day on the following dates: 2/16/25, 3/15/25, and 3/16/25 b. The PBJ report for FY 2025 revealed for Quarter 3 (April 1 through June 30, 2025) there were no RN hours on the following dates: 4/5/25, 4/6/25, 4/12/25, 4/13/25, 4/19/25, 4/20/25, 4/26/25, 4/27/25, 5/3/25, 5/10/25, 5/11/25, 5/17/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 6/1/25, 6/8/25, 6/12/25, 6/15/25, 6/22/25, 6/23/25, 6/28/25, 6/29/25, and 6/30/25. The daily staff schedules conflicted with the PBJ information. The schedules indicated there was an RN scheduled for at least 8 hours per day on the following dates: 4/5/25, 4/6/25, 4/12/25, 4/13/25, 4/19/25, 4/20/25, 4/26/25, 4/27/25, 5/3/25, 5/10/25, 5/11/25, 5/17/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 6/1/25, 6/8/25, 6/12/25, 6/15/25, 6/22/25, 6/23/25, 6/28/25, 6/29/25, and 6/30/25. c. The PBJ report for FY 2025 revealed for Quarter 4 (July 1 through September 30, 2025) there were no RN hours on the following dates: 7/5/26, 7/6/25, 7/12/25, 7/13/25, 7/19/25, 7/20/25, 7/26/25, 7/27/25, 8/2/25, 8/3/25, 8/9/25, 8/10/25, 8/16/25, 8/17/25, 9/3/25, 9/6/25, 9/7/25, 9/13/25, and 9/14/25. The daily staff schedules conflicted with the PBJ information. The scheduled indicated there was an RN scheduled for at least 8 hours per day on the following dates: 7/5/25, 7/6/25, 7/12/25, 7/13/25, 7/19/25, 7/20/25, 7/26/25, 7/27/25, 8/2/25, 8/3/25, 8/9/25, 8/10/25, 8/16/25, 8/17/25, 9/3/25, 9/6/25, 9/7/25, 9/13/25, and 9/14/25. During an interview on 1/30/26 at 10:26 a.m. the Regional Nurse Consultant revealed that the dates identified with no RN hours on the PBJ reports for FY 2025 Quarter 2, Quarter 3, and Quarter 4 were inaccurate. She stated on each of the dates identified with no RN hours the facility had RN coverage for a minimum of 8 consecutive hours per day. She explained that she and the Minimum Data Set (MDS) Nurse, who was an RN, both worked shifts to ensure the requirement for RN coverage was met. She explained that since she and the MDS Nurse were both salary employees, they did not clock in or out, so their hours did not show on timecards. She stated the corporate office had to manually adjust and input any hours for salary nursing staff who worked to cover shifts. In an interview on 1/30/26 at 2:14 p.m. the Administrator explained that the corporate office was not always consistent with the process of manually adjusting and inputting nursing staff hours for payroll data to accurately reflect nursing staff hours on the PBJ reports submitted to CMS. She further explained that this was why the PBJ reports for FY 2025 Quarter 2, Quarter 3, and Quarter 4 had multiple dates with inaccurate data for RN hours. She revealed the problem had now been resolved in the first quarter of 2026. The Administrator stated that when she noticed the discrepancy in September 2025, she notified the Regional Business Office Manager and the error was fixed. Telephone calls to the Regional Business Office Manager on 2/29/26 at 2:23 p.m. and on 2/30/26 at 11:04 a.m. went unanswered and a return call was not received.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the COVID-19 vaccination for 5 of 5 residents reviewed for immunizations (Resident #8, Resident #5, Resident #2, Resident #32, and Resident #44) and failed to maintain documentation related to staff COVID-19 vaccination status.The findings included:The facility's policy titled Infection Prevention and Control Program last reviewed 1/01/26 indicated that the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy further noted that the Infection Preventionist (IP) was responsible for the oversight of the program. The facility policy titled COVID-19 Vaccination implemented on 3/01/23 indicated that it was the policy of the facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by educating and offering our residents and staff the COVID-19 vaccine. The policy further noted that the facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such. 1a. Resident #8 was admitted to the facility on [DATE] with diagnoses which included diabetes, chronic kidney disease, and chronic obstructive pulmonary disease (COPD).The Minimum Data Set (MDS) significant change assessment dated [DATE] revealed Resident #8 had moderate cognitive impairment and was coded as not up to date on the COVID-19 vaccination.Resident #8's immunization record revealed that the resident received the COVID-19 vaccination at the facility on 8/06/24. There was no documentation that the resident had been offered, given, or refused additional doses of the COVID-19 vaccination. An interview was conducted with the Unit Manager on 1/30/26 at 10:26 am who revealed she was unable to provide any documentation regarding COVID-19 vaccination status for Resident #8.b. Resident #5 was admitted to the facility on [DATE] with diagnoses which included diabetes and chronic obstructive pulmonary disease (COPD).The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #5 was cognitively intact and was coded as not up to date on the COVID-19 vaccination. Resident #5's immunization record revealed Resident #5 last refused the COVID-19 vaccination on 12/13/23. There was no documentation that Resident #5 had been offered, given, or refused any additional doses of the COVID-19 vaccination.An interview was conducted with the Unit Manager on 1/30/26 at 10:26 am who revealed she was unable to provide any documentation regarding COVID-19 vaccination status for Resident #5.c. Resident #2 was admitted to the facility on [DATE] with diagnoses which included diabetes, chronic kidney disease, and vascular dementia.The Minimum Data Set (MDS) quarterly assessment revealed Resident #2 had severe cognitive impairment and was coded as not up to date on the COVID-19 vaccination. Resident #2's immunization record revealed the resident last refused the COVID-19 vaccination in 2023. There was no documentation that the resident had been offered, given, or refused additional doses of the COVID-19 vaccination.An interview was conducted with the Unit Manager on 1/30/26 at 10:26 am who revealed she was unable to provide any documentation regarding COVID-19 vaccination status for Resident #2.d. Resident #32 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD), and hypertension.The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #32 was cognitively intact and was coded as not up to date on the COVID-19 vaccination. Resident #32's immunization record revealed no documentation that the resident had been offered, given, or refused the COVID-19 vaccination.An interview was conducted with the Unit Manager on 1/30/26 at 10:26 am who revealed she was unable to provide (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	any documentation regarding COVID-19 vaccination status for Resident #32.An interview was conducted with Resident #32 on 1/30/26 at 4:20 pm who revealed she was unable to recall if the COVID-19 vaccine had been offered to her. e. Resident #44 was admitted to the facility on [DATE] with diagnoses which included diabetes, chronic kidney disease, and obstructive sleep apnea (OSA).The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #44 was cognitively intact and was coded as not up to date on the COVID-19 vaccination. Resident #44's immunization record revealed no documentation that the resident had been offered, given, or refused the COVID-19 vaccination.Resident #44 was interviewed on 1/30/26 at 4:24 pm. Resident #44 revealed he was not sure if he had been offered the COVID-19 vaccination this past year.An interview was conducted with the Unit Manager on 1/30/26 at 10:26 am who revealed she was unable to provide any documentation regarding COVID-19 vaccination status for Resident #44.An interview was conducted with the Infection Preventionist (IP) on 1/30/26 at 10:21 am who revealed she had been the facility's IP for approximately one and a half years. The IP stated she had offered the COVID-19 vaccination to residents, but she stated no residents had wanted to have the vaccine since she had been the IP at the facility. The IP stated she was unable to locate any documentation that she had offered COVID-19 vaccinations to the residents and she was unable to recall if she had any residents sign the declination form. During an interview on 1/30/26 at 1:00 pm with the Director of Nursing (DON) she revealed she had been at the facility for approximately four months, and she had not focused on the COVID-19 vaccinations for residents since taking the position. The DON confirmed that the facility had not offered the COVID-19 vaccination to residents since she had been employed at the facility and the facility was unable to locate any documentation that the residents were offered the vaccine in 2025. An interview with the Administrator was conducted on 1/30/26 at 10:54 am who revealed the DON was ultimately responsible for the oversight of the resident COVID-19 vaccinations because the IP reported to the DON. The Administrator stated the IP was responsible for offering, administering, and documentation of resident COVID-19 vaccinations. The Administrator stated she was not sure why the COVID-19 vaccinations would not have been offered to residents because she was told by the IP that the vaccinations were offered. 2. The facility was unable to provide documentation of COVID-19 vaccination status for staff. During an interview on 1/30/26 at 11:57 am with Nurse Aide #1 she revealed she did not recall the facility offering information on the COVID-19 vaccination or giving the vaccine to staff during the last year. An interview was conducted with the Infection Preventionist (IP) on 1/30/26 at 10:21 am who revealed she had been the facility's IP for approximately one and a half years. The IP stated that she was not responsible for maintaining the staff COVID-19 vaccination status records. The IP stated she was not sure who was responsible for tracking staff COVID-19 vaccinations, but she stated she believed that department managers were responsible for their respective staff. During an interview on 1/30/26 at 1:00 pm with the Director of Nursing (DON) who revealed she had not managed the staff COVID-19 vaccination status logs at the facility, and she was not sure who was responsible to do so. The DON stated the facility offered the COVID-19 vaccine for staff, but she was not sure who received the vaccine and who kept the records. The Administrator was interviewed on 1/30/26 at 10:54 am. The Administrator revealed that she and the nursing management team, which included the IP, Unit Manager, and DON were working together to track the COVID-19 vaccinations. The Administrator stated the information was forwarded via email as the vaccinations were provided to the corporate office and she would try to obtain the information. The Administrator was unable to provide any further documentation regarding the staff COVID-19 vaccination status.